

WellShare International Final Evaluation Report

Tanzania Child Survival Project Karatu District, Tanzania

Child Survival and Health Grants Program

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Acronyms and Abbreviations

ACNM	American College of Nurse Midwives
ADDO	Accredited Drug Dispensing Outlet
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communications
CDD	Control of Diarrheal Diseases
CEDHA	Center for Educational Development in Health/Arusha
CHMT	(Karatu District) Council Health Management Team
C-IMCI	Community Integrated Management of Childhood Illnesses
CORPs	Community-Owned Resource Persons
CPAR	Canadian Physicians for Aid and Relief
CS/CSP	Child Survival/Child Survival Project
DAHA	Datoga and Hadzabe Development Association
DCCHP	District Council Comprehensive Health Plan
DD	Diarrheal Diseases
DMO	District Medical Officer
DIP	Detailed Implementation Plan
EmONC	Emergency Obstetric and Neonatal Care
FAME	Foundation for African Medicine and Education
FANC	Focused Ante-Natal Care
FE	Final Evaluation
FtF	Feed the Future
FP	Family Planning
GHI	Global Health Initiative
HBLSS	Home-based Life Saving Skills
HMHB	Health Mothers, Healthy Babies Centers
HPN	Health, Population and Nutrition
IEC	Information Education and Communication
IFA	Iron Folate Supplements
IMCI	Integrated Management of Childhood Illnesses
IPT/IPTp	Intermittent Presumptive Treatment
ISF	Ingenieria Sin Fronteras
ITN/LLIN	Insecticide Treated Net/Long Life Insecticide Treated Net
IYCF	Infant and Young Child Feeding
KPC	Knowledge, Practice and Coverage survey
LQAS	Lot Quality Assurance Sampling
MAISHA	Men Active in Sustaining Health Action
MCH	Maternal and Child Health
MIHV	Minnesota International Health Volunteers
MNC	Maternal and Newborn Care
MNCH	Maternal, Newborn and Child Health
MoHSW	Ministry of Health and Social Welfare

MTE	Mid-term Evaluation
NGO	Non-governmental Organization
ORS	Oral Rehydration Solution
PCM	Pneumonia Case Management (Acute Respiratory Infections)
PHAST	Participatory Hygiene and Sanitation Transformation
PMI	President's Malaria Initiative
POU	Point-of Use
PPC	Post-partum Care
RCHSR	Reproductive and Child Health Services Report
RMO	Regional Medical Officer
SSA	Sub-Saharan Africa
SP	Sulfadoxine Pyrimethamine
SRH	Sexual and Reproductive Health
STG	Survive and Thrive Groups
TBA	Traditional Birth Attendant
TDHS	Tanzania Demographic and Health Survey
TT	Tetanus Toxoid
USG	United States Government
VEO	Village Executive Officer
VHC	Village Health Committee
VHMC	Village Health Management Committee
VHW	Village Health Worker
VICOBA	Village Community Banking
VPR	Village Pregnancy Register
WEO	Ward Executive Officer
WRA-TZ	White Ribbon Alliance-Tanzania
W&S	Water and Sanitation Committee

A. Executive Summary

The WellShare International¹ Tanzania Child Survival Project (CSP) was implemented from 2007-2011 in 48 villages of Karatu District, one of six districts in Arusha Region, northern Tanzania. The goal of the project was to improve the health of 53,038 infants and children under the age of five and 53,038 women of reproductive age (WRA) focusing on five interventions: maternal and newborn care (35%); prevention and treatment of malaria (20%); control of diarrheal disease (15%); pneumonia case management (15%); and child spacing (15%).

The goal of the MIHV (now WellShare) Tanzania Child Survival Project was to improve the health of infants and children under the age of five and women of reproductive age in Karatu District, with special attention to children under the age of two years. The project used a phased-in approach to implementing interventions in the district.

Project-specific objectives were: 1) maternal and neonatal mortality and morbidity are decreased as a result of access to improved quality antenatal care (ANC), delivery, post-partum care (PPC) and neonatal care; 2) maternal and neonatal morbidity and mortality are decreased as a result of child spacing; and 3) the impact of malaria (M), diarrheal disease (DD), and pneumonia (ARI) on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.

Key strategies included: 1) strengthening government mandated cadres and institutions; 2) mainstreaming traditional providers (traditional birth attendants [TBAs], drug vendors); and 3) developing new community groups for high-need populations (single mothers, transport drivers, disadvantaged minority tribes). Key activities include training health worker and community cadres in Community-Integrated Management of Childhood Illnesses (C-IMCI), Home-base Life Saving Skills (HBLSS), maternal and newborn care (MNC) and reproductive health (RH); behavior change communications (BCC) and information, education and communication (IEC) campaigns; and Healthy Mothers/Healthy Babies centers at local health centers.

1. Key Findings/Results

The WellShare Final Knowledge, Practice and Coverage survey (KPC) showed statistically significant increases in 22 evidence based indicators and in several of these indicators exceeded project targets by wide margins. Illustrative results include: insecticide-treated net (ITN) use almost doubled from 46% to 91%; exclusive breastfeeding from 12% to 65%; use of modern methods of family planning 31% to 65% and appropriate care-seeking for the sick child rose from 38% to 89%.

By the end of the project, the District Council Health Management Team (CHMT) records showed that both maternal and child mortality had reduced in Karatu District. In 2010, only one community maternal death was recorded in the CHMT annual report. TBAs stated they are now empowered to advocate for mothers and get health facilities built and they are now welcomed by

¹ Formerly Minnesota International Health Volunteers or MIHV.

skilled providers to assist in deliveries in many health centers. Working with Village Executive Officers (VEOs), the project fostered community ownership of health social and behavior change communication (SBCC) activities. One VEO noted that since the project began, not a single mother or child had died in his community, in spite of the absence of any health facility nearby. Capacity building among community-level cadres in close collaboration with the CHMT has been critical to increases in coverage of multiple evidence-based preventive and care-seeking behaviors. C-IMCI training was provided along-side the CHMT and using the Tanzania Ministry of Health and Social Welfare (MoHSW) curricula. With technical assistance, from the American College of Nurse Midwives (ACNM) and project staff, the project provided HBLSS training to TBAs for emergency deliveries, while at the same time strongly encouraging all babies to be born in a health facility. At baseline, no village-based communities were engaged in health-related activities; by the end of the project every village had a functioning village health committee (VHC) or health-related management committee.

The project focused some activities on specially disadvantaged populations in the district. These activities can be models for similar groups elsewhere in Tanzania. For example, WellShare trained 15 health advocates from the vulnerable minority Hadzabe and Datoga tribes where there was higher prevalence of malaria, diarrheal disease and pneumonia. Knowledge among the health advocates on prevention of these diseases increased from 56% to 93% following the training. Twenty-two long distance drivers were trained to provide emergency transport and health education to their passengers.

The project repositioned the role of traditional birth attendants (TBAs) as partners to promote maternal prevention behaviors and skilled delivery and developed village level pregnancy and vital events registers that collected data that fed into the MoHSW information system at the district level. Project-trained TBAs led Survive and Thrive Groups (STGs) consisting of more than 320 young pregnant women or new mothers. These groups meet twice a month and provide young women with emotional support, health education and income-generating opportunities. Four of these STGs have received expanded training in micro-finance through the project's collaboration with Orgut-SEMIT, an international organization with expertise in community-based banking programs, specifically the Village Cooperative Banks (VICOBA) model in Tanzania.

WellShare responded to baseline and mid-term findings as well as their on-going monitoring and supervision activities that revealed that there was limited knowledge of specific danger signs related to pregnancy and sick child illness and very low levels of some prevention behaviors. The AFYA 1-2-3 BCC/CM campaign developed innovative health messaging that does not provide excessive amounts of information all at one time. The project used a variety of innovative other communication methodologies including an annual half-marathon, *Ngorongoro Run: the Race against Malaria* that attracted over 500 participants, and reached over 20,000 people during the life of the project. The event received national media coverage on television, radio and print media. The project also sponsored drama groups and entertainment at weekly markets and provided health education DVDs to long-distance buses. Combined with other communication strategies, messages have been found to have reached beyond Karatu district to elsewhere in Tanzania.

As early as the midterm evaluation of the project in 2009, WellShare had already made significant gains in MNC indicators, especially those related to increased demand for maternal and child health care services, ITN use and family planning. The WellShare CSP has also established an excellent model of how mobilized communities and health cadres working in partnership can lead to substantial rises in the use of modern methods of family planning by mothers of infants when the formal health sector is motivated and there is a consistent supply of multiple contraceptive methods.

Project activities reached every pregnant woman and mother of a newborn multiple times. The strategy also strengthened linkages between the health system and the mother/newborn pair. This has contributed to substantial increases in all MNC indicators pregnant women. While the baseline was somewhat higher than elsewhere in Tanzania, skilled delivery increased during the life of the project from 70% to 82%. The postpartum care (PPC) indicator, often very challenging to improve, showed a very significant increase from 20% to 83%, with similar findings for newborn checkups within 72 hours after birth.

Major constraints of the program included low availability of health human resources; global price increases (i.e. fuel, commodities) and devaluation of the US Dollar; challenging physical and infrastructure environment and changes/redefining of government policies and priorities. For example, WellShare had to abandon plans for an innovative intervention for training drug sellers for rational use of pharmaceuticals because the government was beginning its own program, but not using the same approach.

Poor water sources/supplies in some parts of the district remain a significant cause of child morbidity, but large increases in breastfeeding and Oral Rehydration Solution (ORS) use due to project SBCC activities were probably a major factor in low diarrhea mortality at the district level. Point-of-use (POU) water treatment products are only available in the largest villages and town that have drug shops. Analysis of health facility and CHMT data, plus results of the project Health Facility Assessment (HFA) conducted at the end of the project indicate that pneumonia case management still needs significant strengthening at the health facility level. Timing devices were missing in many health facilities that were surveyed at the end of the project. This is not a reflection of the WellShare project; in fact it is the project design and implementation that probably made it possible to identify the issues and draw it to the attention of the CHMT for their use in planning future programs.

2. Conclusions

The WellShare Tanzania Child Survival Project (CSP) significantly increased coverage in multiple evidence-based indicators known to decrease maternal and child morbidity and mortality by using a variety of proven strategies that reach the majority of women of reproductive age and their families using culturally acceptable and sustainable methods. Partnering with the District CHMT to strengthen and expand the roles of existing community cadres, including repositioning the role of TBAs as Reproductive Health partners is a model that could be applied to multiple situations throughout Tanzania and other Sub-Saharan African (SSA) countries. Survive and Thrive Groups (STGs) targeted toward unwed mothers, with a special emphasis on adolescents, could be models for other types of programs in Tanzania

including HIV/AIDS and adolescent reproductive health. These activities fit well with the country GHI focus on women and girls in Tanzania.

3. Recommendations

WellShare should share the most important lessons learned from implementing the CSP, such as methods to reposition the role of TBAs as partners in the health team in support of maternal and newborn survival, Survival and Thrive Groups to reach and support better outcomes in highly-vulnerable young mothers, targeted activities to empower disadvantaged minority populations in the district, and supporting and/or revitalizing existing community structures (VHCs, Community-Owned Resource Persons [CORPs], VEOs) intended to improve health practices at the household and community levels. WellShare’s bottom-up model that links communities with the formal health system is very cost-effective and helps to support the current country-ownership emphasis in U.S. Government (USG) programs and can help to inform the role out of the new Global Health Initiative and possibly Feed the Future. WellShare should share the results of the Final Evaluation with the USAID mission and continue their current efforts to expand partnerships with USAID and other programs in Tanzania. WellShare should make special efforts to disseminate their successful reproductive health results since can be particularly hard to change.

Table 1. Summary of Major Project Accomplishments

Project Objective #1: Maternal and neonatal mortality and morbidity are decreased as a result of access to improved quality ANC, delivery, PPC and neonatal care.			
Project Inputs	Activities	Outputs	Outcome
MNC and HBLSS curriculums Trainers VICOBA curriculum and supplies for STGs IEC/BCC materials	MNC training for HW, TBAs, VHCs, DAHA HBLSS training for TBAs HMHB centers STG formation AFYA 1-2-3 SBCC campaign	34 HW, 217 TBAs, 45 VHCs and 34 DAHA health advocates trained in MNC 99 TBAs, 52 health professionals and 16 master trainers trained in HBLSS 5 HMHB centers completed 21 STGs with 391 members formed % of mothers able to list two or more danger signs: in the neonate during the post- partum period increased from 27 to 92%; in the post-partum period from 17 to 81%; in pregnancy from 17 to 63%.	% of mothers who attended three or more ANC visits during their most recent pregnancy increased from 72 to 84% (four or more increased from 39 to 55%). % of children whose births were attended by a skilled health provider increased from 70 to 82%. % of children 0-23 months who received a postnatal visit from an appropriate trained health worker within three days after birth increased from 28 to 83%.

Project Objective #2: Maternal and neonatal morbidity and mortality are decreased as a result of child spacing.			
FP curriculum Trainers IEC/BCC materials	FP training for HW, TBAs, STG, CORPs AFYA 1-2-3 SBCC campaign	34 HW, 217 TBAs, 391 STG members and 577 CORPs trained in FP. DVD drama on FP	% of non-pregnant mothers of children 0-23 months, who desire no children in the next two years or are not sure and who are using a modern method of child spacing increased from 31 to 65%.
Project Objective #3: The impact of malaria (M), diarrheal disease (DD), and pneumonia (ARI) on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.			
C-IMCI, hygiene and sanitation curriculum Trainers IEC/BCC materials	C-IMCI orientation for HW C-IMCI training for CORPs, VEOs, and WEOs Hygiene and sanitation training for PHAST, teachers, students, and village water and sanitation committee members AFYA 1-2-3 SBCC campaign Ngorongoro Run: Race Against Malaria	38 HW trained in C-IMCI 577 CORPs trained in C-IMCI 30 PHAST facilitators, 34 teachers, 800 students and 120 water and sanitation committee members trained in WASH DVD drama on DD, Malaria % of mother who know at least two signs of childhood illness that require medical treatment increased from 66 to 99%.	% of children 0-23 months who slept under an ITN the previous night increased from 46 to 91%. % of children 0-5 months who were exclusively breastfed increased from 12 to 65%. % of children 0-23 months with diarrhea in the last two weeks who received ORS or recommended home fluids increased from 54 to 78%. % of children 6-23 months who received a dose of Vitamin A in the last six months increased from 54 to 89%. % of children 0-23 months experiencing danger signs in the past two weeks who were brought to a health facility increased from 38 to 89%.

B. Overview of the Project Structure and Implementation

1. Project Location and Beneficiaries

The Tanzania Child Survival Project was located in 48 villages of Karatu District, one of six districts of Arusha Region in Tanzania. Estimated beneficiaries served during the project include the following: 0-11 months, 8,746; 12-23 months, 8,746; 24-59 months, 27,332; total under 5 years, 43,731; and WRA, 43,731 in a total project area population of 218,654. Population data is based on 2006 extrapolations of the 2002 national census provided by the Karatu District Council using an annual population growth rate of 4%.

2. Project Goal, Objectives and Design

Three primary objectives supported the overall goal. (See Results Framework in Section E for additional information about project goals and objectives.) WellShare primarily used a community-based approach comprised of five technical intervention areas including: maternal and newborn care (35% of effort), prevention of and treatment of malaria (20%), control of diarrheal disease (15%), pneumonia case management (15%) and child spacing (15%). The overall project design focused on three key strategies: 1) strengthening government mandated cadres and institutions; 2) mainstreaming traditional providers (TBAs, drug vendors), and 3) developing new community groups for high-need populations. In the Detailed Implementation Plan (DIP), implementation was to follow a three-phase schedule with each phase including 15 of Karatu's villages at a time. This scheme was followed generally with the exception of C-IMCI training which was designed to be implemented at the ward level. The phased approach allowed the project to test strategies and adapt them as necessary for subsequent phases. It also provided an opportunity to monitor the sustainability of project inputs. This was especially important for addressing the problem of infant mortality. For the project to be successful all cadres of health providers needed to have the skills and resources in place to ensure quality maternal and newborn care. During the life of the project, WellShare also received additional funds from Engineers without Borders (Spain) to devote focused attention on water and sanitation in an especially needy part of the district (Mang'ola) with especially poor quality water supplies and where the NGO had not seen results from their own water and sanitation project.

3. Technical and Cross-cutting Interventions

The project's BCC strategy was called *AFYA 1-2-3* (*AFYA* means *health* in Swahili). *AFYA 1-2-3* is a multi-media campaign including print, video/DVD, live drama performance, songs and special events. A focus on three key messages for each intervention area allows for easy retention of important information. Expanded education is provided during follow-up community events. Key BCC messages focus on danger signs, proper care and treatment of the sick child as well as the importance of ANC, PPC and NNC visits. Messages were reinforced through house to house visits as well as community activities implemented by TBAs and CORPs.

Activities to address key factors for behavior change and service delivery included support of the District Council Comprehensive Health Plan, disease surveillance and introduction of a village level pregnancy register, training district and health facility staff, specific BCC campaigns including the Ngorongoro Run: The Race Against Malaria, Day of the African Child, and other high-interest public events that reach a wide percentage of the population.

In the Maternal and Newborn Care intervention, the project focused on the most important behaviors during pregnancy and in early infancy. The MNC strategy was multi-pronged and included training health providers and TBAs to support ANC, delivery with skilled provider, increasing postpartum care within 72 hours and increasing knowledge of danger signs in pregnancy, delivery and postpartum in mothers and newborns. Family planning was promoted as a means to have healthy mothers and babies. There was also a specific focus on unmarried mothers, many of whom were adolescents through "Survive and Thrive Groups" (STGs). In these groups, high-risk mothers were targeted with health-specific activities, but were also provided economic and social-support activities designed to enable them to live independently, remain healthy and integrate with society due to increased empowerment and decreased stigma.

Working closely with the CHMT first line health facilities, the project repositioned the role of TBAs as partners on the skilled delivery team, even though they were not supposed to do deliveries, and also as well-informed resource persons for reproductive and newborn health in the community. TBAs now play a significant role as advocates for WRA in their communities. TBAs interviewed during the final evaluation (FE) indicated that they did not regret giving up deliveries and like referring women to health facilities to deliver their babies. They also said that they now felt even more respected, empowered and valuable as contributors to their communities.

Child spacing activities focused on increasing the demand for modern child spacing methods. The enabling environment included the availability of a variety of modern methods of family planning, including injectables and pills that were available free of charge at government health facilities. Permanent and periodic long-term methods were available from Marie Stopes Tanzania's clinic which experienced intermittent closures during the life of the project but continued to provide outreach medical services throughout the district. Outreach activities in Karatu mobilized and informed women and the services of other partners made it possible for women to access contraceptive services once they were convinced that they wanted to use them. Project BCC messages included the importance of child spacing (36-month birth interval), the use of modern family planning methods and discussing these issues with one's partner. Project-trained TBAs and CORPs made house to house visits and counseled couples on spacing births and where services were available.

WellShare used C-IMCI as the unifying approach to child health interventions. Malaria interventions included BCC activities on indoor residual spraying (IRS) and ITN use, recognition and early care-seeking for fever, and intermittent presumptive treatment during pregnancy (IPTp) and ITN use by pregnant women. The diarrheal disease (DD) technical interventions also included raising awareness of the link between household hygiene practices and DD, recognizing the importance of immediate and exclusive breastfeeding for infants less than six months, and home-based management of diarrhea. The project did quality assurance case management capacity building at the health facilities, though clinical curative services were not a major focus of the program.

BCC child health messages included washing hands with soap, continuous feeding or breastfeeding during bouts of diarrhea, use of ORS, and use of clean water and safe storage practices. POU water treatment was promoted throughout the project area but WaterGuard and PÜR were not consistently available. The project conducted additional activities that incorporated Participatory Hygiene and Sanitation Transformation (PHAST) volunteers in seven villages in the Mang'ola area of the district where Engineers without Borders (Spain) asked WellShare for assistance when their program was not yielding desired results. Access to clean and safe water continues to remain a challenge for much of the project area.

Technical interventions for pneumonia included: caregiver education to recognize and seek timely medical care for pneumonia symptoms; exclusive breastfeeding for infants to six months of age; and provision of vitamin A every six months. WellShare supported CORPs training by bringing government health trainers and using the national C-IMCI curriculum which included 17 key areas of health intervention. CORPs are responsible to counsel and educate caregivers.

Pneumonia case management capacity building is provided by IMCI-trained health workers with regular supervision from the CHMT, but as already noted, facility-based curative health services were not a focus of the project. BCC messages focused on quick and appropriate treatment of symptoms, immunization/Vitamin A and proper nutrition for children (including exclusive breastfeeding for children less than 6 months of age).

Cross-cutting activities included training drug shopkeepers who are a major source of drugs in rational use of pharmaceuticals but these plans were modified following the mid-term evaluation at the request of the CHMT. This was due to a nation-wide program of training and accreditation drug dispensing outlets (ADDOs) that is expected to come to the district in the near future (as of 2011). WellShare was able to conduct “Secret Shopper” quality visits to drug shops and determined that prescription of antimalarials, ORS for the treatment of diarrheal disease and referrals had improved after WellShare trained them. Training was discontinued because the ADDO program was expanded to the national level. Plans are currently on hold due to lack of funding.

The project also expanded their communication strategy to include public transport drivers (MAISHA), and organized Survive and Thrive Groups for young, unwed mothers. Public transport drivers were trained in the BCC messages about topics included in the project interventions plus child spacing, sexual and reproductive health (SRH) issues, first aid and the importance of assisting with emergency transport. Local drama groups were provided with messages related to all project technical areas for performances on market days and at special events (i.e. Day of the African Child, Malaria Awareness Day, Uhuru Torch, etc).

4. Partnerships and Collaboration

The evaluation team agreed with WellShare’s statement that they have taken a lead role in the support of local CBOs and NGOs, partner agencies and public/private partnerships supporting USAID’s revised focus on local partnerships and country-driven programs. They also agreed that WellShare’s approach, working at community-level, adhering to sustainable and replicable public health principles, building strong ties with the community, and identifying community health needs and priorities has had dramatic effects on the health practices of the communities served.

The project was in regular e-mail communication with USAID Tanzania’s Health, Population and Nutrition (HPN) team during trips to Dar es Salaam and a member of the HPN team joined the FE team for two days of field visits during the final evaluation. WellShare also worked closely with the USAID Tanzania Mission to ensure project activities were in line with the objectives of the President’s Malaria Initiative (PMI) and the Global Fund. Karatu District is, or was supported by five USAID-funded NGOs: PATH, PathFinder, Jhpiego (MAISHA), EngenderHealth and EGPAF in the provision of MNCH, family planning, home-based care and HIV VCT/PMTCT programs. Through the training of TBAs and communities on the importance of PMTCT, WellShare assisted EGPAF activities in partnership with CHMT stakeholders, especially the newly formed HIV Children’s Club. WellShare also collaborated, where appropriate, with PathFinder and PATH, Jhpiego and EngenderHealth through coordination of activities during the quarterly stakeholder meetings.

A table of WellShare’s CSP project implementing partners can be found in section F. Contextual Factors.

C. Evaluation Assessment Methodology and Limitations

The Team Leader of the evaluation was an external consultant with extensive MNCH and C-IMCI experience hired by WellShare International and approved by USAID. The evaluation plan was based on the USAID CSHGP 2011 Final Evaluation Guidelines, developed collaboratively with WellShare’s health program managers from their headquarters as well as the Tanzania office and coordinated with the CHMT of Karatu district. These plans and schedule were shared with the DMO and district stakeholders. The USAID Mission was invited to participate in the final evaluation and a representative of the HPN staff participated in two days of the field visits. The evaluation methodology included a mixture of quantitative and qualitative methods designed to triangulate findings and control for bias as much as possible. A description of the evaluation methodology and tools can be found in Annex 9. Where possible, the results were compared with available national, regional and district data.

1. Quantitative Methods

WellShare conducted the KPC survey without external assistance several weeks in advance of the evaluation fieldwork which took place in early August 2011. Findings were tabulated and compared with the baseline KPC survey as well as Lot Quality Assurance Sampling (LQAS) monitoring data from program years during the lifetime of the project. Findings were also compared with the most recent available data including the 2009-2010 Tanzania Demographic and Health Survey (TDHS), CHMT annual data and the project’s own health management information system (HMIS). Although the WellShare CSP had relatively few activities targeted towards clinical MNCH services, findings from health facilities monitoring data as well as the baseline and final HFA were used to assess the status of referral facility clinical IMCI and MNC services to provide a context for analyzing quantitative and qualitative findings.

2. Qualitative Methods

Field visits were made to 12 communities that ranged from highly successful, significantly challenged and relatively “typical” where some interventions were assumed to have been more successful than others. Based on the quantitative findings as well as factors specifically requested for comment in the Final Evaluation guidelines, the team developed Focus Group Discussion (FGD) tools consisting of open-ended questions designed to solicit opinions and feedback from project beneficiaries, as well as influential members of households and communities, including VEOs, leaders of disadvantaged minority groups and members of the Survive and Thrive groups.

3. Limitations

Comparisons between Karatu District and Arusha Regional data should be interpreted with caution. Masaai comprise a much larger portion of Arusha’s regional population and have significantly different cultural and health practices than the dominant ethnic group in Karatu and results achieved in Karatu may, or may not be relevant to be applied to the rest of the region.

D. Data Quality and Use

Were there any problems with the quality of baseline and final assessments performed by the project and how do these problems affect the findings? Specifically, list any discrepancies found in the way questions were asked, indicators defined and methodologies implemented between baseline and final KPC surveys. Describe how these discrepancies affect decisions on future activities.

Some questions in the KPC tool (version 2006) appear no longer to be relevant to the situation in Tanzania, or Karatu District. Tetanus toxoid (TT) coverage questions do not take into consideration women who have already received enough TT vaccinations to be “covered” for Tetanus, so answers may be misleading. Lack of increases in two TT vaccinations in the previous pregnancy do not necessarily indicate that a mother or newborn was vulnerable to tetanus because 1) she may have had sufficient vaccinations in previous pregnancies or 2) she may have completed full tetanus immunization as part of the EPI program. The 2010 TDHS has a way to calculate “covered for tetanus” as a way to capture these mothers.

Although the handwashing indicator in the KPC rose from 0 to 19%, the project staff and the FE team felt that the actual performance of some of the handwashing behaviors could not be measured using the questions in the KPC questionnaire and achievements may have been missed because handwashing in Tanzania is not done at a stand, but with a basin that can be moved from place to place. The KPC handwashing behavioral questions are only asked if the answer to the first question about a specific place for handwashing is “yes”; coverage for handwashing behaviors may not reflect the true situation. Concerns about these questions had no relationship with the performance of the CSP, but confounded analysis of the KPC findings. The best way to address the challenges presented by these questions would be for the KPC questions to be updated by USAID to reflect changes in the epidemiologic situation for the tetanus question, and to allow for acknowledging handwashing behaviors that do not take place at a designated place for the second question.

Did the project utilize an appropriate mix of quantitative and qualitative techniques to inform decision making and measure results? Has the mix of these techniques served to strengthen or weaken the evidence presented here?

The project used both the standard KPC and HFA tools used by most PVOs in the CSHGP, plus additional assessments, especially compilations from the village Pregnancy and Vital Events Registers introduced by the project.

To what extent are project achievements based on data from the MOH/DOH HIS, and what is your assessment to the quality of that system?

Project achievements as expressed in the DIP indicators and quantitative survey instruments do not rely on the government information system, but both measure many similar indicators. On the other hand, data collected from registers (vital statistics, pregnancy) developed by the project and used by community structures (TBAs, local government structures) have *contributed* to the MOH data system and at the time of the FE District stakeholder dissemination, the DMO stated

that new data indicators collected by the project were very useful and would be added to the District HIS. In addition, data in the Karatu District Reproductive and Child Health annual report triangulated trends and presumed impacts of the project. Maternal and child deaths at the community level are now included in this report and are a direct result of the community-level HIS introduced by the project.

Was there a systematic way of collecting, reporting and using data at all project levels? How effective was the system to measure progress towards project results? Cite examples of how project data was used to make management decisions.

The project combined existing data collection through CORPs, TBAs and health facilities complemented with information from the Pregnancy Registers and information from the District HIS. At the time of the FE project quantitative survey results were compared with relevant findings from the TDHS which had been completed the year before the project ended. The TDHS results, for the most part, were for the Arusha region and should be used for comparison with caution because there are markedly different situations in other districts in the region.

Training effectiveness was measured using pre- to post-test knowledge increases and assessments during joint supportive supervision activities. In one example the project found that improvements across one of their ward-level trainings was 22% (range 71% to 93% on disease-specific questions).

The project demonstrated the ability to “dig deeper” and use alternative data analysis methods to confirm findings and check data quality. In one situation when the KPC data did not yield the findings inferred from the monitoring situation and facility records, the responses for that question were hand tabulated and a different result was found. The reasons for the discrepancies were not definite, but could possibly have been due to a software error tabulating text responses.

Results from the quantitative findings and monitoring reports were analyzed by the FE evaluation team and consensus conclusions and recommendations were shared with stakeholders at a dissemination meeting held in Karatu district. Results were also compared with national data, particularly the 2010 TDHS, where appropriate.

Trained CORPs provide their monthly reports on C-IMCI activities directly to VEOs who then provide them to the CHMT. Collection and consolidation of these data is challenging due to limited staff and resources.

The District Council Comprehensive Health Plan (DCCHP) and the Reproductive and Child Health Services Report (RCHSR) are used by the project to monitor project progress and effectiveness of interventions in appropriate areas. The MoHSW HMIS consolidates data collected from numerous levels of the health system. Quality of data varies from facility to facility. These data are used by the district to produce the DCCHP and RCHSR. A challenge for the CHMT is managing the volume of data that they receive from the community and health facilities. The district’s health programs are under staffed and funding is limited.

The HFA provided the project with insight into challenges related to proper diagnosis and treatment of common illnesses and the lack of laboratory confirmation of key diseases like malaria, ARI/pneumonia and bacterial/parasitic diarrheal disease. Health facility staff received IMCI training during the first year of the project.

In addition to Karatu District's HMIS, WellShare collaborated with the CHMT to develop and introduce Pregnancy Registers at the community level. TBAs use this to record and follow every pregnant woman. The table below provides an example of the data compiled from the registers.

Table 2. Pregnancy Register Data (12/2010-6/2011)	
Prevention in Pregnancy	(%) n=673
Pregnant woman attended at least 1 ANC visit	100%
Pregnant women attended 4 or more ANC visits	73.1
Pregnant woman received 2 or more TT doses	73.1
Pregnant woman received 1 st dose anti-malarials during pregnancy	100%
Pregnant women received 2 nd dose anti-malarials during pregnancy	73.8
Delivery	n=642
Baby born at health facility	78.5%
Baby received clean cord care	97.6%
Baby received immediate drying and wrapping	99%
Baby received immediate breastfeeding	99%
Maternal/Birth Outcomes	n=283
Premature birth	7 babies
Still birth	1 baby
Mother/infant visited within 72 hours post partum	100%
Baby died before 28 days after birth	1 baby
Mother died before 28 days after birth	0

E. Presentation of Project Results

Table 3. M & E Matrix					
Objectives	Indicators	Data Source	Baseline Value % (CI)	Final Value % (CI)	Final Target
<i>Result I: Maternal and neonatal mortality and morbidity are decreased as a result of access to improved quality ANC, delivery, PPC and neonatal care.</i>					
ANC Visits	Increase % of mothers who attended four or more ANC sessions during their most recent pregnancy.	KPC	30	55* 3 or more: 84	70%

Tetanus Toxoid	® Increase % of mothers with children 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child.	KPC	79	76	85%
Skilled Birth Attendant	® Increase % of children whose births were attended by a skilled health provider.	KPC	70	82*	85%
AMTSL	Increase % of mothers of children 0-23 months who received AMTSL during the birth of her youngest child.	KPC	28	56*	40%
Drying/ Wrapping of Newborn	Increase % of children 0-23 months who were dried and wrapped with a warm cloth or blanket immediately after birth.	KPC	37	86*	60%
Clean Cord Care	Increase % of children 0-23 months who had clean cord care at the time of birth.	KPC	54	93*	70%
Post Partum Care of Mother	Increase % of mothers who received PPC within 72 hours of their most recent delivery.	KPC	20	83*	40%
Post Partum Care of Newborn	® Increase % of children age 0-23 months who received a postnatal visit from an appropriate trained health worker within three days after birth.	KPC	28	83*	45%
Knowledge of Neonatal Danger Signs	Increase % of mothers who are able to list 2 or more neonatal danger signs during the PP period.	KPC	27	92*	50%
Knowledge of Danger Signs in Pregnancy	Increase % of mothers who are able to list 2 or more danger signs during pregnancy.	KPC	17	63*	45%

Knowledge of Danger Signs Post Partum	Increase % of mothers who are able to list 2 or more danger signs during the post-partum period.	KPC	17	81*	45%
<i>Result II: Maternal and neonatal morbidity and mortality are decreased as a result of child spacing.</i>					
Child Spacing	® Increase % of children age 0-23 months that were born at least 36 months after the previous surviving child.	KPC	57	53	75%
			24 months: 82	24 months: 82	
Use of Modern Family Planning Methods	Increase % of non-pregnant mothers of children 0-23 months who desire no children in the next two years OR are not sure AND who are using a modern method of child spacing.	KPC	31	64*	50%
FP Communication with Partner	Increase % of mothers of children 0-23 months who report talking with their partner about family planning methods.	KPC	51	65	70%
<i>RESULT III: The impact of malaria (M), diarrheal disease (DD), and pneumonia (ARI) on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.</i>					
Hand-washing	® Increase % of mothers of children 0-23 who live in a household with soap or a locally-approved cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview.	KPC	0	19*	30%
Water Treatment	® Increase % of households of children age 0-23 months that treat water effectively.	KPC	44	47	60%
ORT Use	® Increase % of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids.	KPC	54	78*	70%

ITN Use by Child	® Increase % of children 0-23 months who slept under an insecticide-treated bed net the previous night	KPC	46	91*	75%	
IPT2 during Pregnancy	Increase % of mothers who received IPTp at least twice during their most recent pregnancy.	KPC	20	52*	50%	
ITN Use by Pregnant Women	Increase % of mothers of children 0-23 months who always or usually slept under an ITN during their pregnancy with the youngest child.	KPC	19	90*	50%	
Exclusive Breast-feeding	® Increase % of children 0-5 months who were exclusively breastfed during the last 24 hours.	KPC	12	65*	40%	
Vitamin A	® Increase % of children age 6-23 months who received a dose of Vitamin A in the last 6 months.	KPC	54	89*	70%	
Appropriate Feeding of Sick Child	Increase % of mothers who report continuing to feed the same amount of food and the same amount or more fluids when their child was sick.	KPC		Avg. feeding: 29; Avg. fluids: 35	Avg. feeding: 51; Avg. fluids: 63	60%
Knowledge of Signs Requiring Medical Treatment of Child	Increase % of mothers who know at least two signs of childhood illness that require medical treatment.	KPC	66	99*	80%	
Appropriate Care Seeking for the Sick Child	Increase % of children under two experiencing danger signs within the past two weeks who were brought to a health facility.	KPC	67	88*	60%	
Other Indicators						

IRS	% of households of children 0-23 months where the interior was sprayed against mosquitoes in the past 12 months	KPC	6	10
ITN Ownership	% of households of children 0-23 months that own at least one insecticide-treated bed net	KPC	46	91*
Zinc Treatment during Diarrhea	% of children age 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements	KPC	0	5*

*Statistically significant change

® Rapid Catch indicator

F. Discussion of the Results

1. Contribution toward Objectives

At the beginning of the project, the CHMT reported that although there were not functioning Village Health Committees (VHCs) at the beginning of the project, with assistance received from the CSP, every village now has a functioning VHC or health related management committee. By the end of Year 4, 44 VHC/VHMCs and 8 Water and Sanitation Committees were trained and responsible for the oversight of health facilities and community health-related projects following capacity-building activities provided by project staff, NGO partners and the CHMT.

Objective 1: Maternal and neonatal mortality and morbidity are decreased as a result of access to improved quality ANC, delivery, PPC and neonatal care.

The project worked on MNCH at multiple levels, with the heaviest emphasis at the community/household level and strengthening linkages with health facilities. Some of the most significant project activities included:

- Repositioning the role of TBAs, who are now strongly discouraged from conducting deliveries, by training them to play a key role as community partners for maternal and newborn health and child-spacing using family planning.
- Introduction of HBLSS and Active Management of the Third Stage of Labor (AMTSL) training using the American College of Nurse Midwives (ACNM) training materials.
- Introduction and use of a pregnancy monitoring tool (Village Pregnancy Register) developed in collaboration with the CHMT to collect ANC, delivery and post-partum

care information through trained TBAs that at the time of the FE was in use in 86% (38/44) of Karatu's villages.

- Community sensitization and strengthening MNCH component of CORPs training.
- Introducing and encouraging community mechanisms to support and sustain the ability of TBAs to work in communities.
- Highly vulnerable unmarried pregnant women, many of whom were adolescents, were targeted with specific attention through Survive and Thrive Groups which linked TBAs with these specially needy and stigmatized girls and women (see description of Survive and Thrive Groups in Section G.3.).
- The project worked with first line health centers and successfully improved relations between the formal skilled providers and TBAs that resulted in significantly improved collaborative relationships. In many cases, TBAs who accompany women to health centers are invited by the skilled provider to help in the delivery inside the facility. This has improved the comfort and confidence on the part of the mothers, provided valuable assistance to the skilled provider, increased the self-esteem of the TBA and elevated her status in the community (see Results Highlights in Annex 1).

Skilled delivery increased significantly, from 70% to 82% but that does not tell the whole story. The overall project MNCH approach that included HBLSS and AMSTL training increased both the use and the quality and impacted on increasing multiple MNCH indicators. Use of Active Management of the Third Stage of Labor (AMSTL) during delivery increased from 28% to 56%, drying and wrapping the newborn 37 to 86%, and clean cord care 54 to 93%. Postpartum care for mother and newborn closely tracked the increased rate of skilled deliveries. Maternal postpartum visits increased from 20 to 83% and newborn checkups rose from 28 to 83%. Mothers told the FE team that before the TBAs were trained, mothers were mistreated at health facilities. After training, TBAs began to escort them to health facilities and say mothers are now more comfortable to go to health facilities.

Exclusive breastfeeding is recognized as the most significant evidence-based indicator for infant and child survival and the baseline indicator of 12% was extremely low. The end result was an astounding 65% and far exceeded the project end of project target of 40%. Although all MNCH indicators greatly increased, EBF alone would have been a significant achievement in evidence-based child mortality reduction impact.

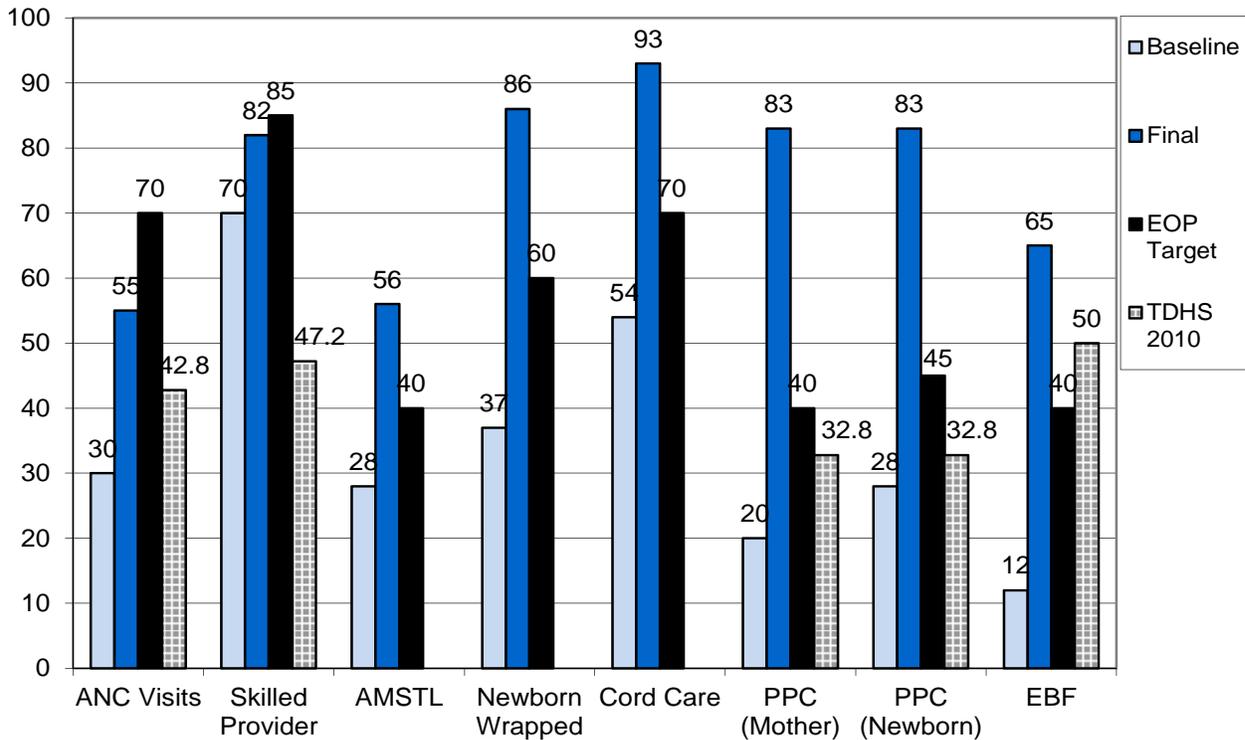


Figure 1. Project maternal and newborn care indicators compared to targets and Tanzania Demographic and Health Survey 2010.

Additional project contributions to MNCH are included in the cross-cutting approaches.

Objective 2: Maternal and neonatal morbidity and mortality are decreased as a result of child spacing.

Family planning is a national priority and information about contraception is available in mass media and other communication channels. Availability of services and commodities improved during the life of the project. Availability of multiple modern methods of contraception provided multiple options for women if they needed to change.

- Family planning content was integrated into the TBA training described in Objective 1. TBAs were trained and conducted family planning (FP) counseling during home visits and referred women and their husbands to health facilities where they could receive services.
- FP content was included in CORPs trainings and in discussions with community and influential leaders.
- The project specifically addressed male involvement in family planning and child spacing decisions. This was a formidable challenge due to significant misperceptions by men about the effect contraceptive use could have on female behaviors. Some fathers in FE focus group discussions said they talk about FP with their wives and that it creates a good relationship within the family. They say they feel that use of FP gives them time to get

ready for the next pregnancy. Several men mentioned that they want smaller family sizes due to the economy. But other men, including some CORPs have misperceptions that FP methods are dangerous.

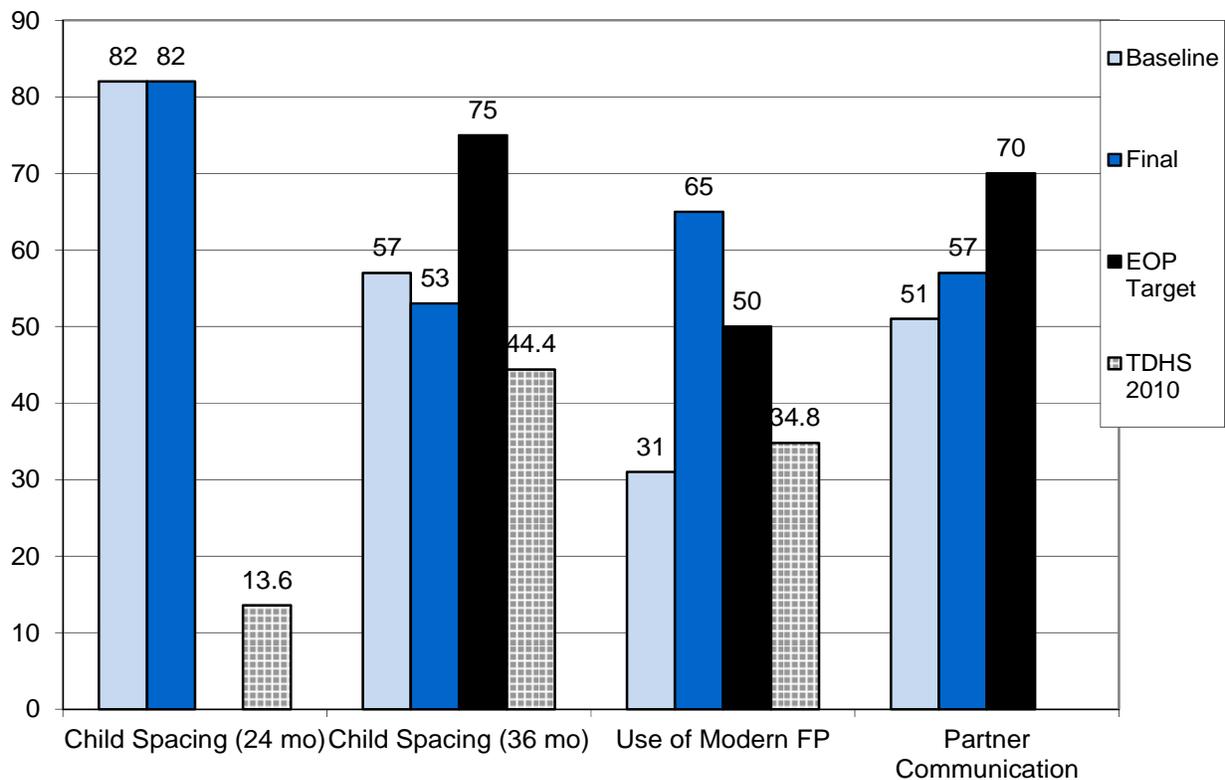


Figure 3. Project family planning indicators compared to targets and Tanzania Demographic and Health Survey 2010.

The FE team noted that in spite of the concerns of some men about family planning, use of modern family planning methods increased and is now quite high. They also concluded that while communication among partners improved, more needs to be done to give accurate information, listen to men’s concerns about FP, and link birth spacing to improved quality of life. As noted above, TBAs have shown that they can also help to reinforce accurate messages through their direct contacts with couples at the household and community level. The timeframe of the project was probably too short to see the ultimate impact of the FP contraceptive and spacing results using the objective of increasing births spaced 36 months apart because respondents to the KPC questions were mothers with children 0-23 months. In the final evaluation project KPC data, there was no statistically significant change in child spacing indicators at 24 or 36 months.

Objective 3: The impact of malaria (M), diarrheal disease (DD), and pneumonia (ARI) on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.

- **Intensive hygiene and sanitation interventions** conducted in Mang’ola and Baray Wards (October 2009-July 2010) on hygiene and sanitation practices (handwashing, purification of water, proper disposal of feces and access to latrines) **showed increases on key indicators:** handwashing (from 52% to 89.6%), purification of household water (from 49% to 93%), and access to latrines (from 37% to 83%). An additional 1,138 new latrines were constructed in the 8 project villages.
- **Trained 15 health advocates** to provide community-based services to the Hadzabe and Datoga tribes where there is a high incident of malaria, diarrheal disease and pneumonia. Knowledge among the health advocates on prevention of these diseases increased from 56% to 93% following the training.
- **Identification of an additional 12 MAISHA drivers** scheduled for training in October 2010, for a total of 22 drivers providing emergency transport and health education.

Upon completion of capacity building training, community-level cadres used their strengthened skills to improve the health of their communities.

2. Contextual Factors

The Karatu District Council created three additional villages in the project district. This posed a challenge in the training of new village leaders and the formation of new VHC/VHMCs. The project had trained members of each of the new villages (including TBAs, CORPs and PHAST Facilitators) prior to the division, and received requests for additional training for cadres in the new villages, but the project lacked additional funds to respond to these additional capacity-building requests. The number of new government health facilities, however, increased in the District since the baseline and this decreased the distance that women have to travel to reach a facility.

During the life of the project, the number of health facilities in the district rose from 38 to 46, significantly increasing access to key MNCH and other health services. Of the seven new government facilities, several were health centers constructed by remote rural communities and then staffed by the CHMT with qualified (skilled) health providers. Availability and access to contraceptives as well as assistance from FP partners over the years has institutionalized FP services in the district.

When the project began in 2006-2007, rains had been heavy and food shortages were not a significant factor in communities. In early 2011, however, the rains failed and the corn crop withered on the stalks. At the time of the FE, there were significant food shortages in many project communities. Relief food has been distributed to some of the communities, but project staff pointed out that it “is not enough.”

Karatu is also a political “opposition” area and there are strong perceptions that this contributes to lack of support from the central government. Activities were postponed for one month around the time of elections (September/October 2010).

a. Health System Factors

Health systems in Tanzania are in the process of significant change: several new initiatives are in progress—others remain “on paper”. Large numbers of nurses, midwives and doctors are in the “pipeline” and due to be placed in recently-built health facilities. But experienced national health professionals are worried because skilled health worker training programs have been “fast tracked” and will place graduates with theoretical knowledge, but little or no practical experience in health centers and dispensaries that already experience significant public health and clinical care challenges.

Additional challenges with health system weaknesses including clinical quality of care, drug supply chain management and availability of IMCI equipment (including timers) resulted in varying quality of care at referral facilities. Confusion about whether facilities could charge fees for MNCH (including sick child care), especially at private FBO facilities contributed to some reluctance on the part of beneficiary families to take their child for care, especially when they lacked the money to go there. This issue was noted by a member of the Hadzabe community, who have traditionally been discriminated against in the district, but is apparently not the feeling in the district overall. The district is working on enforcing the policy for free MNCH care in all communities.

b. Maternal and Newborn Care

Although ANC attendance increased as measured by ANC2, women start ANC late (usually during the fourth month of pregnancy). Some factors that reportedly contribute to this include: they are afraid that if they lose the pregnancy early, people in the community will talk badly of them (including that they may have gotten an abortion, which is illegal in Tanzania); when women attend earlier, the health worker cannot feel the baby so they cannot tell the mother much information; women want to wait until the baby is well formed so they can get information on how the baby’s growth is progressing and the approximate delivery date. Very young women and older women are said to go late because they are afraid people will talk negatively about them in the community because they know that childbearing is not recommended at their age. Finally, women who get pregnant too close to a previous pregnancy are embarrassed because they feel others will judge them negatively. On the positive side, increases in the numbers of health facilities and skilled providers undoubtedly has led to increases in skilled delivery, which has in turn led to better neonatal care and post-natal care. Indicators measuring those behaviors increased significantly during the project. (See comments on IPT2 below.)

Similar to other countries, the Tanzanian MoHSW stopped supporting TBA training when there was no evidence to support that it contributed to decreased maternal mortality. But more recently, NGOs and governments have agreed that TBAs have a role as partners in reproductive health and advocates for mothers. The WellShare CSP introduced a methodology for how TBAs could be engaged and included in a MNCH strategy that also supported increased institutional deliveries.

c. Child Health

C-IMCI is the integration strategy of WellShare’s project in collaboration with the CHMT who is responsible for implementation at the district level. National Government of Tanzania policy required the project to support district-level trainers using national training materials. The project

was involved in all aspects of planning district level training and implementing it in collaboration with the district trainer. WellShare, however, did not have input into the national curriculum. WellShare is also not directly operational in the health service delivery and could not control the training content. Even with some challenges in the minority/disenfranchised communities, there was an increase in care seeking behavior from the baseline to the final evaluation, exceeding the project's end of project goal.

The CSP cooperated with government's C-IMCI delivery strategy of implementation through community CORPs, supervised by the VEO with oversight at the ward level and the district's IMCI Focal Person. Their approach provides an additional model of community-based SBCC programs that are designed to achieve significant increases in coverage of key child survival and maternal/newborn care behaviors and health services.

In the final year of project implementation, C-IMCI introduction was postponed for several months awaiting revisions in the training materials from the MoHSW. Because the materials were not forthcoming, WellShare consulted with the zonal training centre and district and went ahead with the existing materials with the understanding that the district would provide update training once the new materials were available. This proved to be a wise decision on WellShare's part because as of the time of the Final Evaluation in August 2011, the national training materials and refresher training plans had not yet been introduced to Karatu District. According to the District and Regional officials involved in C-IMCI training, lack of financing is the major reason for the delay and they are looking for a source of funds when the materials become available so that they can begin the training. This will occur after the WellShare's CSP.

Diarrhea

Diarrhea and lack of clean and safe drinking water remains a significant challenge in the project area. POU water treatment options are limited largely to boiling water since WaterGuard, while available in the larger villages and town of Karatu is largely not available in rural project communities. The CSP had only 15% level of effort towards diarrhea case management as part of C-IMCI, and promoted the only POU method that could reasonably be expected to be available to target households.

As noted above, since POU water treatment products are not widely available in most of the district, POU treatment is limited largely to boiling water. Some FGD respondents noted that boiled water does not taste good. In other places, the water is salty and the concentration caused by boiling makes the taste even worse. There are also some beliefs that one POU product (Pur) leaves a toxic residue. The FE team concluded that to increase this particular indicator it would take much more project effort plus significantly increased access to water treatment products plus BCC activities to overcome some of the negative perceptions and objections to using those products.

The project promoted handwashing at key times as part of their BCC strategy. The impact of their efforts was difficult to interpret due to the skip pattern on the KPC. But the MTE found that 93% of people interviewed used soap and water for washing hands; almost everyone washes hands before and after eating; and 92% wash hands after using the toilet.

The project did intensive hygiene and sanitation SBCC activities (handwashing, purification of water, proper disposal of feces and access to latrines) in an area of 8 villages with particularly bad access to water and sanitation and poor diarrhea indicators and where another NGO had worked by had been unable to demonstrate progress, showed increases in these key indicators. For example, handwashing rose from 52% to 89.6%; water purification rose from 49% to 93% and access to latrines rose from 37% to 83%.

Malaria and Pneumonia

At baseline, pregnant women did not receive ITN voucher nets until near the birth as an incentive to return for their last ANC check-up; as a result pregnant women were not sleeping under a net. Over the lifetime of the project, campaigns have increased the coverage of households with nets and the project promoted consistent use by mothers and children. Karatu has benefited from the national distribution of ITNs to pregnant women and children under 5 through PMI and the Global Fund. At the time of the FE, Karatu was no longer a focus area for PMI due to the relatively low overall malaria prevalence in the district. By the end of the project, 91% of households with children under 2 years had at least one ITN. But utilization, by children and pregnant women, an indicator more likely related to project SBCC efforts tracked with possession at 91% and 90% respectively.

Differences in geographic characteristics in the district result in different epidemiologic patterns. For example, malaria morbidity is low at higher elevations, while at lower elevations it can be significantly higher. Increased ITN coverage has decreased actual cases of malaria, but RDT stockouts hinder ability to make malaria diagnosis. As a result ACT supplies continue to be used to treat presumptive malaria.

Through BCC campaigns and raising mothers' awareness, the project met its targets with 52% of mothers receiving IPTp2, Karatu district has not reported shortages of Sulfadoxine Pyrimethamine (S/P) as a barrier to increasing IPT2 as frequently as some of the districts in Tanzania, but as is the case in all of the malaria-endemic districts in Tanzania, assessment of the real barriers to IPT2 coverage need future investigation. In many cases, one of the factors--late initiation of ANC (after 4 months) has proven a challenge to change and affects provision of IPT in two doses before the baby is delivered.

The project was successful in training caregivers about danger signs of child illness and encouraging prompt care-seeking. Health workers were trained to use RDTs in an attempt to encourage them to distinguish between non-malarial fevers and malaria. After training they were given initial supplies of RDTs, but they have since run out and health workers still treat fevers without testing using RDTs. While the overall number of child deaths in the district has dropped, pneumonia emerged as the major cause of inpatient deaths in the District in 2010. This is probably due to the decrease of deaths from malaria. The evaluation team was concerned when the HFA found that a high percentage of health workers did not have a timing device to count respirations thereby making compliance with IMCI algorithms impossible. The question arose as to whether health workers might be using timers on their mobile phones instead of watches or formal timers, but this could not be determined from the data. It would be worthwhile for the HFA to specifically ask that question.

Tanzania national IMCI (clinical) protocols require specific assessments and actions for fever. The PMI MOP describes efforts across the country to decrease the use of expensive ACTs for cases of child fever where the cause of the fever is unlikely to be malaria and is more likely pneumonia or some other cause. Decreasing malaria prevalence has prompted the National Malaria Control Program as well as PMI to recommend malaria diagnosis with RDT or laboratory prior to treatment for malaria in areas of relatively low malaria prevalence. CHMT personnel were trained and given initial supplies of RDTs which had run out by the time of the CSP MTE. WellShare did not specifically focus on the quality of curative services in their project design and therefore did not assume responsibility for improving the quality of curative services at the health facilities. But future health projects that work with the CHMT that want to further decrease child morbidity and mortality related to fever and also address the over prescription of antimalarials for child fever cases will have to devote significant effort towards improving pneumonia case management and compliance with national IMCI protocols.

d. Roll of key partners

Partnerships at the local level were an integral part of the project strategy and synergies of effort undoubtedly either led to the results, or increased the amount that indicators increased. A list of the major project partners is included in the table below.

Table 4. Key Partners		
Partner	Interventions / Duration	Result of Collaboration
District Council Health Management Team	MoHSW programming at the district level/5 years	Initial and refresher training of community cadres, collaboration in community health events, supportive supervision of community cadres
Canadian Physicians for Aid and Relief (CPAR)	Sexual and reproductive, HIV care and treatment, micro-finance/10 years	Training of STGs in micro-finance, HIV care and treatment
Ingenieras Sans Fronteras (ISF)	Water, sanitation and hygiene programming, development of water sites, creation of community cadres for water site management/1 year	Increased hygiene and sanitation activities in 7 villages, training and support to community cadres including CORPs and PHAST facilitators
Marie Stopes Tanzania	Permanent and long-term methods of family planning, community outreach, HIV counseling and testing services, treatment of STIs, rape counseling/3years	Increase access to permanent and long-term methods of family planning, referral services for HIV counseling and testing and STI treatment, referral site for rape counseling
Jhpiego/MAISHA project	BEmONC, FANC training/2 years	Training of all district health providers in FANC, 4 district health providers trained in BEmONC
Village Wellness Project (VWP)	Home health visits, micro-finance, community distribution of ITNs in 21	Collaboration with VWP-supported CHWs, micro-finance support to

	villages/2 years	project-trained TBAs, STG members.
Elizabeth Glazer Pediatric AIDS Foundation (EGPAF)	HIV Childrens' Club, PMTCT/2 years	BCC to parents of children under 5 enrolled in clubs, PMTCT training curriculum for TBAs, CORPs
ORGUT SEDIT	Micro-finance/1 year	Support to 7 STGs in the provision of training/materials for village cooperative bank (VICOBA)
White Ribbon Alliance/Tanzania and the American College of Nurse Midwives	Training of master trainers and community volunteers in HBLSS and AMTSL training/1 year	25 master trainers and 90 community volunteers trained, 12 health providers trained in AMTSL
EngenderHealth	Training of District staff in FP services and provision of commodities	Improved FP services and consistent supply of commodities at district health facilities. Services and commodities available to clients sensitized by project SBCC.

3. Overall Design Factors that Influenced Results

Strengthening existing community cadres (TBAs, CORPs) and working through GoT structures (CHMT, VEOs, etc) enabled the project to reach all pregnant women and young mothers. Strengthening ties between these structures and formal health facilities (e.g. TBAs and skilled providers) encouraged utilization of improved health facilities. Behavior Change Communication was delivered and reinforced through using multiple communication channels delivering the same messages. These included long distance transportation drivers, community drama during market days, special events like the Malaria Marathon, Day of the African Child, World Malaria Day, World AIDS Day, etc.

G. Discussion of Potential for Sustained Outcomes, Contributing to Scale, Equity, CHW Models, Global Learning and Dissemination/Information Use

1. Progress toward Sustained Outcomes

Economic activities of the Survive and Thrive Groups (see below) were intended to sustain the empowerment and improved quality of life of group participants. The evaluation team heard multiple expressions of the strong commitment that community groups whose capacity was built by the project have towards continuing to use the skills they obtained from the project.

The DMO also stated that the project collected data on indicators that were not already included in the District HMIS, and that they would be incorporated into the CHMT data collection system.

TBAs and CORPs stated that since they are now getting support and have good relationships with the majority of skilled health providers at referral health facilities, they would continue to provide services. In communities with strong and motivated VEOs to provide support, the CORPs said they would continue to provide services.

Sustainability for the project was primarily focused on building capacity within government-supported structures at community level (VHC, TBA and CORPs) and health facility level (HW and CHMT). Training, supervision, behavior change and monitoring and evaluation are planned in collaboration with the CHMT and village-level cadres to ensure capacity-building and ownership of project goals and outcomes at multiple levels. This approach has been very successful thus far. To measure sustainability, the project continued to adapt components of the CSTS+ Child Survival Sustainability Assessment framework as noted in the Year 1 Annual Report.

TBAs and CORPs interviewed during the FE said that they felt that when the community selects the people to be trained and rewards their work, this allows the community cadres to feel that the community values their work and allows it to continue and that financial incentives were not necessarily required. This opinion was almost universal among TBAs, but some CORPS reported that if they had to do all that was expected of them as volunteers, they would have loss of income. But both groups said that if volunteers receive encouragement in other ways, then their activities could be sustained. The most frequent example of this type of encouragement cited during the FE was exemption from mandatory community service duties. In some communities, the community political leaders had already granted such exemptions, but this was not yet the case in all of the project communities.

Both the MTE and FE teams identified sitting allowances and excessive training allowances as threats to sustainability. NGOs are often expected to act as donors for routine refreshers and training for upgrades. For example, training for the ADDO program and the upcoming introduction of the updated CIMCI training for CORPs are not yet funded. This is a problem throughout the country and not unique to Karatu District. At the FE stakeholder's dissemination meeting, government trainers from Arusha said that while they were ready to initiate training with the updated C-IMCI curriculum when it became available, it was unclear how the training would be funded.

2. Contribution to Replication or Scale-up

The community-based model that WellShare used has some of the same characteristics of other successful mobilization and BCC structures (such as Care Groups) but is significantly more targeted toward maternal and newborn activities and family planning which are high priorities in Karatu, nationally and contribute to the objectives 4 and 5 of the MDGs. Even though nutrition was not specifically listed as a project intervention, the project linked breastfeeding and infant feeding activities with other interventions which also caused significant increases in those indicators. Karatu district has large numbers of TBAs who are willing to trade their role as the primary birth attendants to that of a "maternal advocate." Therefore this approach can be tried in areas with similar numbers of TBAs. Survive and Thrive Groups can be a model for many programs in Tanzania where communities identify teenage and unwed pregnancies as serious problems for development and increased risk for HIV, unplanned pregnancies and STIs.

3. Attention to Equity

Survive and Thrive Groups are comprised of unmarried pregnant women, most of whom are younger than age 25, and several are teenagers. They are organized and led by a project-trained

TBA. There is significant stigma to being unmarried and a mother, and families of the mothers consider them a financial burden. In addition to MNCH promotion, the project has provided training in income generation and life skills to reduce stigma and help the young mothers to integrate better into society. They also introduced VICOBA, a savings club. These additional activities were designed to provide STG members with independent incomes and reduce their vulnerabilities. Several STG members are now living independently and have even married. Group members say that their self-image has improved as a result of their ability to buy things in the market, especially when they can afford to buy meat and that their business enterprises (such as tea shops) have provided valuable services to their communities and also contributed to their increased status in their communities. A more detailed description of this promising approach to reach disadvantaged women can be found in the Annex 11.

The Datoga and Hadzabe are marginalized minority tribes in Karatu district. The Datoga raise cattle and the Hadzabe live as hunter-gatherers living in remote and isolated areas of the district. WellShare helped the two groups to form the Datoga and Hadzabe Development Association (DAHA), including drafting a constitution and also worked with villages to include a member of the Datoga/Hadzabe on the VHC and have worked with the CHMT to ensure their special circumstances is included in district health planning. WellShare also trained 15 health advocates to provide health education and referral to the remote family units that comprise this community.

Men were specifically targeted, especially with education about family planning. WellShare organized focus groups to hear from men about their perspectives on family planning and to provide factual information that men can use. The project found that quantitative measurement of project impact on men was too difficult (costly) and indicators were dropped at the time of the MTE.

4. Role of Community Health Workers

Tanzania is currently reviewing many different models for CHW programs and has not finalized their strategy yet including the type of CHW incentives. During the lifetime of the project however, paid Community Health Workers such as those recommended by WHO and the Earth Institute were not yet officially in place in Tanzania. (In Karatu District a partner NGO provided monthly stipends to their VHWs throughout the life of their project [2002-2010]. Upon the completion of their project activities and support, none of their VHWs remain active.)

CORPs and TBAs were the primary community-based cadres that WellShare worked with during the life of the project. The MoHSW continues to review the role of the CHW in the expanding health care system. The project worked with the DMO and VHCs to identify and support individuals with greater skills in the anticipation of changes in government policy. The consensus is that identification and retention of individuals with higher levels of education to serve in positions where they are largely volunteers is likely to be very challenging.

a. Traditional Birth Attendants

TBAs were the primary venue for maternal and newborn care and family planning. They were provided with MNC and HBLSS training. They visited every pregnant woman and encouraged her to attend ANC, get tested for HIV and use PMTCT, deliver at the health facility and to use family planning (including through partner counseling). They kept the Village Level Pregnancy

Register, (VLPR), using a tool developed by WellShare in collaboration with the CHMT. The relationship with the health facility has improved because the TBAs are referring women to seek services there. Please see Annex 11 for information of the VLPR.

With the exception of Karatu District Hospital, many health facilities allow TBAs to assist with deliveries. TBAs do not mind only doing referrals because health facility deliveries do not affect their incomes (as they were not making money on home delivery) and facility births give them less work. With home deliveries, TBAs were often providing materials for delivery to the mother; now they do not have to provide these items. With facility deliveries, TBAs have more time for their regular work. TBAs are referring mothers to the health facility when the baby is having trouble breastfeeding. TBAs want updated information. This will be a challenge after the project ends.

WellShare conducted discussions with communities that included VEOs to explore ways to encourage the work of the TBAs that would also lead to their ability to sustain their activities after the project was over. In appreciation for the work of TBAs in educating and supporting pregnant and postpartum women, communities decided to provide their own incentives to the TBAs which included exemption from community development work and/or monetary contributions to community development projects. In one FGD conducted during the FE fieldwork, TBAs told the evaluation team that at one time they are so busy working with the pregnant women, that they felt that they did not have time for their other work. They said that they took the initiative and called the VEO to discuss the problem and find ways that they could continue to fulfill their new roles as supporters of maternal and newborn health in the community and still fulfill their personal responsibilities. They were able to negotiate an exemption for the requirement to make cash contributions to the village work with the VEO. They said that the idea to try to make this negotiation came from discussions with village leaders. (The idea for this approach came out of discussions held with WellShare, VEOs and other community members.)

Health facility staff reported that a key project contribution is an increase in attendance at the health facility by pregnant women. Health facility staff reported an increase in TBAs reporting information to the health facility.

b. Community-owned Resource Persons

CORPs are community members selected to be trained in health promotion using a standardized national curriculum. They are the major Government of Tanzania cadre to implement C-IMCI activities. They are supervised by the VEO and the quality of their work depends on the motivation and capacity of the VEO. WellShare worked with the Center for Development in Health-Arusha (CEDHA), the zonal training center, to revise the curriculum to include VEOs in the C-IMCI training. CORPs reported that mothers have changed their behavior and are taking their sick children earlier to the health facility. This is reflected in the KPC care-seeking data.

5. Contribution to Global Learning

Successful strategies used in the CSP can contribute to all three areas of the USG's GHI strategy in Tanzania: 1) Access to Quality MNCH/FP services, 2) Health Systems Strengthening, 3) Improved Health Behaviors through: Improved Social Norms, Improved Cultural Norms, Emphasis on Women and Girls, and Improved Care Seeking

In addition, improved infant and child feeding practices plus the economic strengthening of single mothers in the Survive and Thrive groups can contribute to both Feed the Future programs as well as address specific challenges in HIV/AIDs, including prevention and OVC programs and also adolescent reproductive health programs.

Specific lessons learned in the project include:

- Current mandated training budget allowances make C-IMCI training prohibitive for many international NGOs. This is likely to discourage them from undertaking future activities if costs remain the same or increase.
- Effectiveness of many C-IMCI and MNC behavior change efforts will rely on availability of quality services at the health facility.
- TBAs can be very effective partners with the MoHSW to increase skilled delivery at HF and contribute to MDG 4 and 5.²
- C-IMCI works best when there is strong support from the village-level Chairman and/or the VEO.
- Family planning acceptance rates can go up when many partners contribute to making services accessible coupled with an effective community mobilization and SBCC strategy.³
- Men still need more sensitization to motivate them in good decision-making about family planning within their families.
- Experiences and lessons learned about community-based health and development activities in the project could be applied to other types of programs: family planning, HIV/AIDS (including OVC/MVCC), water and sanitation, prevention of adolescent pregnancy, etc.

6. Dissemination and Information Use

From the very beginning, sharing information for planning, managing and assessing the effectiveness of program interventions was part of the program. Initial meetings were held starting in November 2006 to orient district government stakeholders to the project and to refining the DIP. Participants included the District Executive Director, the District Commissioner, the District Council and the District Council Health Management Team (CHMT). Introductory meetings were conducted with most local CBOs and NGOs including members of the district NGO Coordinating Board who assisted with recruitment of staff for baseline assessment activities. The Ward Executive Officers (WEOs), who provide oversight to villages in their respective wards, were invited to one day of the Knowledge, Practice and Coverage (KPC) Survey training for an orientation to WellShare and the project, as well as to assist in selection of the survey clusters. Baseline assessment staff met with village leaders and hospital staff in almost every district village. Information about the project was also broadcast by

² MDG 4 indicators include increased measles immunization and reduced infant mortality. While the CSHGP projects do not measure IMR, CHMT data indicate that child deaths decreased in the district during the life of the project. MDG 5 is measured by increased skilled delivery and ANC attendance, both of these indicators increased as a direct result of project activities.

³ Marie Stopes Tanzania clinic in Karatu was closed for at least the last half of the project and had just reopened at the time of the final evaluation.

local officials over the radio⁴. Periodically, throughout the life of the project, Village Executive Officers, Ward Executive Officers and other key partners were brought into the capacity building activities of the project.

The project supported the creation of the Karatu District Stakeholders Committee focused on coordination of health activities throughout the district. This committee is headed by the DMO and meets quarterly to increase collaboration and decrease duplication of services. Mobilization and sensitization meetings were held with community leaders, capacity building on VHC roles/responsibilities, technical training to inform all of them of project activities and findings.

When the FE fieldwork was completed and all sources of project information were compiled and analyzed, the results were shared and discussed with a wide array of stakeholders, including representatives of the District Council and the CHMT, the community including TBAs and CORPs, district leaders at all levels, and the Arusha Regional Health office. In addition, WellShare's Executive Director presented an overview of the project at the CORE fall meeting in Washington DC in October 2011.

In addition, the project has produced a number of reports and papers related to the project. Copies of these can be found in Annexes 2 and 11.

H. Conclusions and Recommendations

1. Conclusions

The WellShare Child Survival Project met the objectives of their program and significantly exceeded their targets in several interventions. They developed a new community-based health model that can add to the list of possible community mobilization approaches available to PVOs/NGOs working in partnership with national Ministries of Health at the local level.

Results from the WellShare model are comparable to those achieved with other high impact approaches, including the better-known and documented Care Group approach. The multi-pronged approach of the WellShare CSP succeeded in increasing coverage of multiple evidence-based maternal, infant and child health indicators that have already been documented to be effective in reducing maternal and infant mortality and morbidity⁵.

WellShare has also successfully shown that TBAs still have a vital role to play in improving MNCH outcomes, even if they no longer conduct deliveries. Many other community-based health programs have worked with CORPs and VHCs and used BCC strategies without demonstrating the increases in specific MNCH/FP and child health indicators achieved in this project. This leads to the conclusion that the heavy emphasis that WellShare placed in making TBAs a focus for action, but supported and encouraged by community structures must have played a major role in increasing those indicators.

⁴ MIHV Child Survival DIP report, 2007.

⁵ The Lancet Child Survival Series, 2005.

While TBAs had been by-passed in many MNCH and reproductive health programs elsewhere, the WellShare approach demonstrated that TBAs are willing and capable of making vital contributions to those behaviors that are used to measure progress towards MDG 5 (skilled delivery and ANC) and newborn care (vital to reducing IMR, one indicator used to measure progress in MDG 4). Collaboration between the formal health sector (CHMT), NGOs and communities resulted in synergistic impact of their contributions. They also expanded TBAs' roles as partner's in reproductive health, including playing a direct role as couple's counselors for family planning. This took place in an area where men still have strong cultural reservations (beliefs) about the potential impact of their wives using contraceptives.

The WellShare CSP was very heavily community-health focused. Direct intervention on health facility service-delivery was limited primarily to quality assurance training. The fact that so many of the highest-impact child survival indicators increased by focusing on increased awareness, behavior change strategies and community-support provides very strong evidence for continued and increased community and household level approaches to contribute to progress in increasing coverage of key indicators. Effectiveness of some of the other C-IMCI and MNC behavior change efforts, such as care-seeking for danger signs of child illness, especially fever and respiratory infection will rely on availability of quality services at the health facility. Capacity building in the quality of care, especially related to pneumonia case management and adherence to facility-based IMCI will need additional assistance from the CHMT to continue to see improvement in child mortality and morbidity after the program is over.

Family planning acceptance rates went up because many partners contributed at multiple levels to create demand and to make services (including commodities) accessible. In an intervention where the saying is "no product, no program" this collaboration is noted here because the availability of family planning commodities was essential for the community sensitization and motivation activities of the project to be effective. WellShare has to be recognized as the major factor in the behavioral side of this (very) significant increase in contraceptive use as it was the only community-based project working on family planning in Karatu District at the time⁶.

Household and community behavior changes supported by community structures: TBA groups, CORPS, and VHMC, VHT's W&S committees (where they are active) can continue but will need support over time, whether they come from government, the private sector, or the communities themselves.

2. Recommendations

WellShare has much valuable experience that could benefit several USAID Tanzania MNCH programs, especially since they provide an alternative effective approach to mobilization and behavior change at the community level. They should share the results of the overall CSP, as well as the evaluation findings with the USAID mission in Tanzania (already planned). They have already started to seek ways to apply lessons learned and best practices to other programs in the country, including those that will be included in the Global Health Initiative and (possibly) Feed the Future. Components of the program can be beneficial to PMTCT and OVC components of PEPFAR.

6

Since increases in family planning acceptance by mothers in the WellShare program has been particularly impressive, WellShare should offer to share their experiences with organizations involved in reproductive health programs both within Tanzania and in international meetings. This has already started. In October 2011, WellShare shared program results with scores of other PVOs and NGOs working in Global Health in a featured presentation at the CORE group meeting in Washington DC.

WellShare has decades of experience in the USAID CSHGP and should share some of their concerns about the few KPC and HFA questions that caused problems in the final quantitative survey with MCHIP to provide input and suggestions about updating some of the questions. Their perspective is valuable so they should provide this feedback as soon as possible so that new USAID CSHGP grantees who will need to use the questionnaires for their baseline surveys will benefit from this experience.

Annex 1: Results Highlight – Evidence Building

Although a relatively small district, Karatu is very diverse geographically and has several micro-climates that impact on agricultural production and access to clean water. Parts of the district are mountainous, and at higher elevations malaria prevalence is significantly less than at lower elevations. The Jobaj community in the Mang'ola region of Karatu is particularly drought-prone. During the last few years of the project rainfall dropped significantly in the entire district and food shortages were common in the last year of the WellShare Child Survival project. Even though located within a short distance of major game parks and tourist destinations, the majority of the population is very poor and vulnerable, and Jobaj is one of the most challenged areas in terms of water and sanitation. Ironically, the community is not far from where some of the most sought-after export-quality onions in Africa are to be grown. But they are grown on land on the banks of a lake. There is currently no feasible way for Jobaj to use the lake as a readily available source of water.

At the beginning of the Wellshare Child Survival project, home deliveries conducted by untrained TBAs in the area threatened maternal and newborn survival but long distances to staffed health facilities limited the access that women had for skilled delivery. Like many African countries, Tanzania significantly decreased TBA training since they are now discouraged from conducting deliveries. In spite of the lack of support, TBAs have remained respected community resources for advice on reproductive health matters in communities.

Tanzania changed their national policies to promote skilled delivery in health facilities to decrease maternal and newborn deaths and make progress towards their MDG5 targets. The country is investing in training and placing additional midwives and nurses in rural health facilities. Communities have also contributed to constructing additional health facilities with staff from the CHMT.

Wellshare recognized the valuable contribution that TBAs could make to helping the country achieve MDG5 maternal survival targets and promote newborn survival by repositioning TBAs as partners with the formal health system and trained TBAs in Home Based Life Saving Skills (HBLSS), Essential Newborn Care, Promotion of Exclusive Breastfeeding and Family Planning. TBAs were instructed in clean delivery for emergency situations when women cannot make it to a facility in time. Wellshare also developed a community-based Pregnancy Register that made it possible to track every pregnancy from the time the woman revealed her pregnancy through the post-partum period. This enhanced information that the CHMT collected for their database and helped provide valuable monitoring information for joint information sharing between the project and the CHMT but also for problem solving within the community itself.

But in the Jobaj community there was no health facility for the women to realistically go to when the TBAs referred them. They recognized that they needed a health facility in their community. They discussed the problem amongst themselves and decided that they needed to take their case for a health center to the VEO (the designated political leader of the community). They convinced him, the community built the health center and the CHMT has now staffed it 24/7 with skilled nurses. The TBAs said that the training they received from the project gave them the

knowledge and then empowered them to take the action they knew was needed. They were reinforced in their convictions when they saw their collective action and the respect they have from the community yielded visible results.

From January to August of 2011, 25 babies were born--all at the health facility and there have been no maternal or newborn deaths. Although it is a common (mis)perception that TBAs will not refer women for delivery “because they don’t want to lose the income,” when they were asked about that perception, the TBAs responded, “we didn’t get paid when we did the deliveries in the past, so that isn’t a problem.” The KPC survey for the project area showed that not only had skilled delivery increased but several other evidence-based indicators associated with maternal and newborn survival (such as postpartum and newborn checkups and exclusive breastfeeding had also increased sharply. The graph below shows a comparison of the baseline and final project survey results in these indicators with comparisons to the Tanzania Demographic and Health Surveys for the Arusha Region.

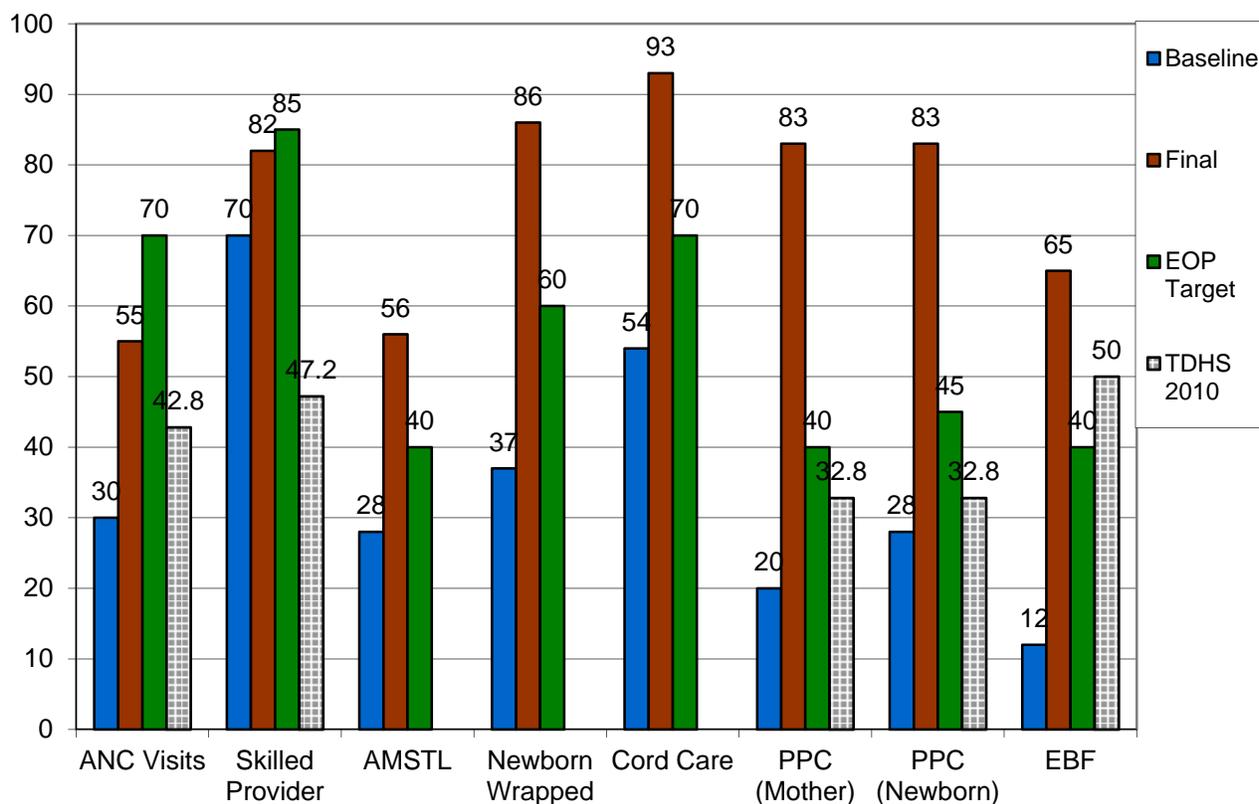


Figure 1. Project maternal and newborn care indicators compared to targets and Tanzania Demographic and Health Survey 2010.

Annex 2: List of Publications and Presentations Related to the Project

WellShare International was invited to present an oral presentation on their submitted abstract “Village-Level Pregnancy Register: Improving pregnancy and post-partum data collection in rural Tanzania” to the annual conference of the American Public Health Association (APHA). The conference was held in Philadelphia, PA from November 7- 11, 2009. Innocent Augustino, M&E Coordinator, and Laura Ehrlich, International Program Director, represented the organization at the conference.

The Tanzania Public Health Association (TPHA) also accepted a submitted abstract “Village-Level Pregnancy Register: Improving pregnancy and post-partum data collection in rural Tanzania” which was presented in poster form by Mr. Abdullah Iddi during the annual meeting held in Dodoma, Tanzania November 2-5, 2010.

In October 2011, WellShare contributed to a panel presentation of child survival projects at the Fall Core Group meeting and presented on the topic: Child Survival and Health Grants Program: Highlights from Around the World.

WellShare also presented on the Tanzania Child Survival Project to local organizations, University of Minnesota students and other groups in Minnesota.

In addition, the project was profiled in several media publications including:

- *HBLSS Training*. White Ribbon Alliance – Tanzania newsletter. March 2008 – June 2008.
- *Thirty Countries in Thirty Years*. Sarah Schewe. Barry Magazine. Fall 2008.
- *Delivering Precious Cargo: Tanzania’s Innovative Use of Donkey Ambulances*. Southwest Journal.
- *Run Well, Do Well: The Race Against Malaria*. Sarah Schewe. Canadian Running.

The Ngorongoro Run: Race Against Malaria was highlighted on several national Tanzania television stations and two stations (StarTV and TBS) aired public service announcements developed by WellShare on malaria.

Annex 3: Project Management Evaluation

Planning

The participatory process for developing the Detailed Implementation Plan (DIP) was well described in the MTE report and the participatory sharing, planning, assessing and adjusting of program activities continued throughout the project. The DIP was practical and very rooted in the reality of the project environment. Implementation over time was adjusted to fit changing circumstances. Strong relationships and processes, involving stakeholders including District and Regional health and political officials, developed in these early project activities was evident at the time of the final evaluation where all partners were engaged in analyzing the results as they were presented in the stakeholder's workshop at the end of the fieldwork. A representative of the USAID Tanzania Mission HPN team joined the evaluation team for two days of fieldwork for the evaluation, which the team took as evidence of strong USAID Mission interest in the project.

Typical challenges for developing a DIP in a child survival project include finding a balance between developing a realistic multi-year plan that is practical relative to the local situation, while at the same time presenting information about the rationale behind the technical approaches in sufficient detail for external reviewers in the United States to understand what the PVO plans to do. These reviewers may, or may not be knowledgeable about Tanzania or the specific local situation. WellShare managers stated that some of the DIP reviewers made comments, some not framed in a positive way, that did not seem relevant to the information in the DIP or responsive to the explanations provided by the WellShare team during the DIP review. The Evaluation Team felt that all implementing partners had a very clear understanding about the program approach and that the WellShare project was so integrated with the day to day operations and plans at the District level that they were consistently "on the same page" with regards to priorities and approaches. This would indicate that the planning of the project was well done.

Each Child Survival Project is unique in its approach to address the major maternal and child health challenges in the specific environment in which they work. Project designs and implementation plans must also correspond to the organizational capacity of the PVO and this can vary from one organization to another. In the case of WellShare, their strongest expertise is in developing partnership strategies for behavior change at household and community level as well as the strengthening linkages between communities and first line health facilities. While they facilitate visits of volunteer health care providers, usually physicians, clinical health care services are not a major area of focus for the organization as a whole, nor the CSP staff. Tools designed to assess and measure change in clinical services, such as the full HFA, are of limited relevance and may not be as useful for monitoring the majority their community prevention and care-seeking approach as they would be for those projects with more curative focus. On the other hand, the HFA provides valuable information about whether referral services can address needs for clinical care.

Supervision

Supervision of project staff was provided by both the Program Manager/Country Representative for WellShare, plus additional professionals on staff with specialized expertise in MNCH, BCC and Monitoring and Evaluation. WellShare conducted joint supportive supervision with the CHMT managers. They also revitalized and strengthened the functioning of VHCs and worked with VEOs to support their supervision of CORPs. They also mobilized communities to provide support to continue community-level activities introduced in the project and those that were already in place, but were not functioning well. The approach was designed to continue to contribute to improved community health services long after the project was over and external support had ended. Specific activities to promote community ownership were part of the design. Interviews with VEOs indicated that many of them had taken up the responsibility for continued support for the community structures (CORPS, VHCs, TBAs, etc.) that were strengthened during the project.

Human Resources and Staff Management

The WellShare staffing structure was not intended to remain after the end of the project, so this report will not comment on continued presence. Morale and cohesion within the staff was good and they appeared to enjoy working together as a team. Staff turnover during the life of the project was low and some of the professional health staff had already secured positions to go to before the project ended. Although the Program Manager/Country Representative was an expat, she lived and worked at the same level as a national manager would be expected to do and therefore supporting her position did not draw an undue percentage of the budget relative to her responsibilities.

Financial Management

The project had sufficient resources to complete project activities and retain the staff until the end of the project. Near the end of the project period, WellShare discovered that if they shifted some indirect costs there were sufficient funds to request a no-cost extension to complete more in-depth work on some of the sustainability recommendations that emerged from the final evaluation. USAID granted the extension for three months until December 2011. At the time of the FE, WellShare was not intending to continue an office in Karatu and program activities that were intended to be sustained were turned over to the CHMT or to the communities themselves. WellShare has been managing community-based USAID child survival projects for decades and their experience helped them to manage financial resources very effectively. They maintain a very modest presence and strive to be cost-effective and make wise use of resources to extend the impact of their use as far as possible. External technical assistance for financial management was not needed as WellShare has long experience in managing similar programs, but the headquarters financial manager did visit the project.

Logistics

Although Karatu District has many infrastructure challenges (electrical power, water, roads, etc) the program had very few logistical needs that required external procurements and there were no procurement or logistical problems that hindered progress towards the project goals and objectives. Even though Karatu District had multiple periods of “load shedding” power cuts each week, project staff adjusted their activities accordingly and used the office generator to do their

work when it was necessary. The program was designed to be as sustainable as possible and did not introduce activities that will require procurements beyond what is normally done by the CHMT after the project ends.

Information Management

WellShare already has significant technical capacity in information management at headquarter level, including ability to conduct quantitative KPC and HFA assessments. The CSP also had a designated staff member in the project to manage data and compile it for program managers to analyze and share with partners. WellShare's headquarters in the US also has a relationship with a specialist (a PhD student at the University of Minnesota School of Public Health and a former WellShare volunteer) who provides another layer of data quality checking. During the final evaluation, the team corresponded with her when they had any questions about calculations and tabulations to make sure that the calculations were correct.

WellShare's project staff has implemented **village-level data collection tools** throughout the district to improve district-level data on pregnant women and children under five years of age. The **Pregnancy Registers** introduced by the project augmented the CHMT community-based statistical collection to focus on specific details about maternal preventive and delivery behaviors. These registers have proven to be a model in community ownership of data. Periodic data collection and analysis from the registers was used by the project to monitor progress in indicators between quantitative surveys. The project provided sturdy register books to the TBAs who said that they made it so that the information written on the papers inside of the registers was more protected than the single sheets of paper they had used in the past. The **Village Vital Statistics Register** collects village-level morbidity and mortality information for children under five years of age through community 10-cell leaders (an administrative division at the village level).

All relevant project data was used to present the evidence of the project impact at a District-level stakeholder's meeting. Extensive discussion during the FE results dissemination meeting indicated that the data were clear and the results were easy to understand. The DMO stated that some project indicators that were not part of the district HIS were especially useful and that they would be added to the District CHMT information system, thus indicating that the information collected in the Child Survival project has made a significant contribution to the Ministry of Health HIS at the local level.

Technical and Administrative Support

WellShare brought consultants and used the expertise and materials from ACNM's HBLSS and AMSTL training courses and applied them to TBA and health worker training in support of their MNCH interventions. This TA occurred early in the project and proved very valuable and cost-effective in terms of the wide-spread improvements in MNCH and RH project indicators.

WellShare does not have a complex administrative structure for managing the program. The project office and the country office are the same. The Child Survival Project Manager also serves as the PVO country representative. Although she is a U.S. expatriate, she has lived and worked in rural Africa for decades and has a life and work style similar to NGO health professionals from Tanzania. The PVO headquarter's backstop staff visited the project multiple

times at key times during the project, sometimes more than once a year and stayed several weeks each time. US volunteers, many of whom are physicians, also supplemented the work of the CSP in areas not supported by the USAID grant. WellShare's Executive Director and the Finance Manager from the US headquarters also visited the project. The Project Manager said she felt that there wasn't any technical assistance needed that the project did not get.

Management Lessons Learned

Locating the only office for the PVO in the project district had several advantages including controlling costs, access to partners contributing to the community perception that the WellShare team was "part of the district." On the other hand, having the only office in Tanzania located far from Dar es Salaam where many donor and government offices are located, limited WellShare's ability to participate in many national partner meetings and also made it more challenging for them to additional funding opportunities to build on their experience and contributions from the CSP.

Other Issues Identified by the Team

Training costs to support the GoT plans in maternal and child health are quite high and child survival projects have done their part to bring resources to build capacity and show impact during the life of their projects. Tanzania still looks to donors for continued support of routine refreshers, updates and retraining for government employees and community volunteers. This was not particularly a problem during the WellShare Child Survival project and WellShare designed their program activities to be finished or turned over to the MoH before it ended. But the topic was raised during the FE dissemination meeting by Regional Trainers when the discussion about how refresher training would be done once the new C-IMCI curriculum comes available after the CSP is over.

Annex 4: Workplan Table

Objectives/Activities	Objective Met	Activity Status
Maternal and Newborn Care		
<i>Result I. Maternal and neonatal mortality and morbidity are decreased as a result of access to improved quality ANC, delivery, PPC and neonatal care.</i>		
IR I.A. Use and quality of ANC is increased.		
<p>I.A.1. Increase % of mothers who attended four or more ANC sessions during their most recent pregnancy from 39.1% to 70%.</p> <ul style="list-style-type: none"> ➤ BCC campaigns supporting ANC. ➤ Health worker training on MNC, including development of safe birthing plans. ➤ Healthy Mothers/Healthy Babies Center at district health centers. 	No	<p>All activities completed, except only 5 out of 8 HMHB centres developed. Alternative methods of reaching women were used.</p> <p>Women still delay initial ANC visit and therefore are not able to complete 4 or more visits</p>
<p>I.A.2. Increase % of health workers who counsel ANC clients on the importance of developing a safe birthing plan, the importance of delaying their next pregnancy for at least 36 months and refer for VCT</p> <ul style="list-style-type: none"> ➤ Health worker training on MNC. ➤ Coordination with Medicos del Mundo for VCT and PMTCT referrals. ➤ Coordination with Marie Stopes Tanzania, PSI, ACQUIRE and CPAR on family planning counseling and methods. ➤ Healthy Mothers/Healthy Babies Center at district health centers 	Yes	<p>All activities completed.</p> <p>Coordination with CHMT and EGPAF upon completion of Medicos del Mundo project in 2008. All women who receive ANC and/or have contact with a project-trained TBA receive counseling on birth planning, FP and referral for VCT.</p>
<p>I.A.3. Increase % of mothers with children 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child from 78.9% to 85%.</p> <ul style="list-style-type: none"> ➤ Health worker training on MNC. ➤ Coordination with Medicos del Mundo for VCT and PMTCT referrals. ➤ Coordination with Marie Stopes Tanzania, PSI, ACQUIRE and 	No	<p>All activities completed.</p> <p>Increased coordination with CPAR, EGPAF and CHMT upon completion of Medicos del Mundo project. Women having 2 or more pregnancies are not given 2 TT and young women receive TT while in school and therefore may not be given 2 TT at their first pregnancy.</p>

<p>CPAR on family planning counseling and methods.</p> <ul style="list-style-type: none"> ➤ Healthy Mothers/Healthy Babies Center at District health centers 		
<p>IR I.B. Access to safe delivery services is increased.</p>		
<p>I.B.1. Increase % of children whose births were attended by a skilled health provider from 70% to 85%.</p> <ul style="list-style-type: none"> ➤ HBLSS training of TBAs, midwives, and other health workers who attend deliveries. ➤ Mothers develop safe birth plans. ➤ VHCs develop emergency transportation funds. ➤ IEC messages educate the community on the importance of planning and supporting safe deliveries with a trained health worker. ➤ Provision of safe birthing kits to TBA/health worker trainees and donated equipment for EOC to health facilities through Rotary donations. 	<p>No</p>	<p>All activities complete. Final achieved: 82%</p> <p>Donors identified for provision of safe birthing kits. Increased access to HFs and additional ambulances allocated the district made the VHC transportation fund strategy unnecessary.</p>
<p>I.B.2. Increase % of mothers of children 0-23 months who received AMTSL during the birth of her youngest child from 28.1% to 40%.</p> <ul style="list-style-type: none"> ➤ Health worker training on MNC 	<p>Yes</p>	<p>All activities completed.</p>
<p>I.B.3. Increase % of children 0-23 months who were dried and wrapped with a warm cloth or blanket immediately after birth from 37.2% to 60%.</p> <ul style="list-style-type: none"> ➤ Health worker and TBA training on MNC. ➤ IEC messages promoting immediate drying and wrapping. 	<p>Yes</p>	<p>All activities completed</p>
<p>I.B.4. Increase % of children 0-23 months who had clean cord care at the time of birth from 54.3% to 70%.</p> <ul style="list-style-type: none"> ➤ Provision of safe birthing kits to TBA/health worker trainees. 	<p>Yes</p>	<p>Additional supplies provided by project and CHMT as needed.</p>
<p>IR. I.C. Use of postpartum care is increased.</p>		
<p>I.C.1. Increase % of mothers who received PPC within 72 hours of their most recent delivery from 19.6% to 40%.</p> <ul style="list-style-type: none"> ➤ BCC campaigns promoting PPC. ➤ Health worker training on MNC. ➤ Village Health Committee training on MNC. ➤ TBA training on MNC 	<p>Yes</p>	<p>All activities completed</p>

<p>I.C.2. Increase % of children age 0-23 months who received a postnatal visit from an appropriate trained health worker within three days after birth from 27.8% to 45%.</p> <ul style="list-style-type: none"> ➤ BCC campaigns promoting PPC. ➤ Health worker training on MNC. ➤ Village Health Committee training on MNC ➤ TBA training on MNC 	<p>Yes</p>	<p>All activities completed</p>
<p>IR. I.D. Mothers' knowledge of newborn danger signs is increased.</p>		
<p>I.D.1. Increase % of mothers who are able to list 2 or more neonatal danger signs during the PP period from 26.8% to 50%.</p> <ul style="list-style-type: none"> ➤ Health worker training on MNC and C-IMCI. ➤ C-IMCI training for VHCs, TBAs and STG participants. ➤ IEC campaign educating mothers on newborn danger signs. ➤ VHCs develop emergency transportation funds. ➤ Healthy Mothers/Healthy Babies Center at District health centers. 	<p>Yes</p>	<p>All activities completed.</p> <p>Increased access to HFs and additional ambulances allocated the district made VHC emergency funds unnecessary.</p>
<p>IR. I.E. Mothers' knowledge of danger signs during pregnancy and post partum period is increased.</p>		
<p>I.E.1. Increase % of mothers who are able to list 2 or more danger signs during pregnancy from 17.4% to 45%.</p> <ul style="list-style-type: none"> ➤ Health worker training on MNC. ➤ MNC training for VHCs, TBAs and STG participants. ➤ IEC campaign educating mothers on danger signs during pregnancy. ➤ VHCs develop emergency transportation funds. ➤ Healthy Mothers/Health Babies Center at District health centers. 	<p>Yes</p>	<p>All activities completed.</p> <p>Increased access to HFs and additional ambulances allocated the district made VHC emergency funds unnecessary.</p>

<p>I.E.2. Increase % of mothers who are able to list 2 or more danger signs during the post-partum period from 17% to 45%.</p> <ul style="list-style-type: none"> ➤ Health worker training on MNC. ➤ MNC training for VHCs, TBAs and STG participants. ➤ IEC campaign educating mothers on danger signs during pregnancy. ➤ VHCs develop emergency transportation funds. ➤ Healthy Mothers/Health Babies Center at District health centers. 	<p>Yes</p>	<p>All activities completed.</p> <p>Increased access to HFs and additional ambulances allocated the district made VHC emergency funds unnecessary.</p>
<p>Child Spacing <i>Result II. Maternal and neonatal morbidity and mortality are decreased as a result of child spacing.</i></p>		
<p>IR. II.A. More mothers are spacing their deliveries by at least 36 months.</p>		
<p>II.A.1. Increase % of children age 0-23 months that were born at least 36 months after the previous surviving child from 49.8% to 75%.</p> <ul style="list-style-type: none"> ➤ BCC campaigns promoting child spacing. ➤ IEC provided by TBAs and mothers who have had successful deliveries after stopping FP to STG members and to the general population. ➤ Promotion of effective traditional child spacing methods. ➤ Condom promotion provided by MAISHA participants. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	<p>No</p>	<p>All activities completed.</p> <p>Significant improvements were made but target was not achieved.</p>
<p>II.A.2. Increase % of non-pregnant mothers of children 0-23 months who desire no children in the next two years OR are not sure AND who are using a modern method of child spacing from 31.4% to 50%.</p> <ul style="list-style-type: none"> ➤ Community BCC campaigns on family planning methods, stressing the importance of child spacing. ➤ MAISHA and STGs receiving IEC. ➤ TBAs trained to educate current and future mothers on child spacing. ➤ Coordination with PSI, AQUIRE, Marie Stopes Tanzania, CPAR, MDM. drug shopkeepers and the CHMT to ensure continued supplies of FP methods throughout the district. ➤ Train VHCs on modern methods of child spacing. ➤ Healthy Mothers/Healthy Babies Centers at District health 	<p>Yes</p>	<p>All activities completed.</p>

centers		
II.A.3. Increase % of mothers of children 0-23 months who report talking with their partner about family planning methods from 51.2% to 70%. <ul style="list-style-type: none"> ➤ Community targeted IEC campaign to promote child spacing. ➤ IEC provided to MAISHA and STG members. ➤ Train VHCs on modern methods of child spacing. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	No	<p>All activities completed.</p> <p>Significant improvements were made but target was not achieved (in part due to the high numbers of single women interviewed for the KPC who would not be expected to talk to their partners to the same extent as married or cohabitating women).</p>
<i>Result III. The impact of malaria, diarrheal disease and pneumonia on infants and children is diminished as a result of improved prevention, home-based care and facility-based case management.</i>		
IR. III.A. Prevention: The transmission of DD in infants/children and malaria in infants/children/WRA and ARI in infants/children is decreased.		
III.A.1. % of mothers of children 0-23 who live in a household with soap or a locally-approved cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview. (DD) <ul style="list-style-type: none"> ➤ C-IMCI training and supervision of health workers, TBAs and VHCs. ➤ Community IEC campaigns promoting personal hygiene. ➤ Train VHCs, district water department, DHO and CHMT on promotion of household hand washing areas. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	No	<p>All activities completed.</p> <p>Expanded training of PHAST Facilitators in Mang'ola and Baray Wards. Significant improvements were made but target was not achieved (however, responses were hindered due to the wording of the handwashing questions on the KPC, which required a handwashing station, which is not typical in the Tanzanian context.)</p>
III.A.2. % of households of children age 0-23 months that treat water effectively. (DD) <ul style="list-style-type: none"> ➤ Community IEC campaign promoting proper treatment of water. ➤ Collaboration with ISF, CPAR, District Water Department, DHO and CHMT to promote safe water sources. ➤ Healthy Mothers/Healthy Babies Centers at District health centers 	No	<p>All activities completed.</p> <p>Expanded training of PHAST Facilitators in Mang'ola and Baray Wards. Significant improvements were made but target was not achieved (based on KPC questionnaire).</p>
III.A.3. % of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids. (DD) <ul style="list-style-type: none"> ➤ Community IEC campaign promoting proper ORS use. 	Yes	<p>All activities completed.</p>

<ul style="list-style-type: none"> ➤ Healthy Mothers/Healthy Babies Centers at District health centers. ➤ C-IMCI training and supervision 		
<p>III.A.4. % of children age 0-23 months who slept under an insecticide-treated bed net the previous night. (M)</p> <ul style="list-style-type: none"> ➤ C-IMCI training and supervision. ➤ Community IEC campaigns promoting the use of ITNs for children and pregnant women. ➤ Coordination with PSI, drug shopkeepers and the CHMT to ensure access to affordable bednets and insecticides for retreatment throughout the district. ➤ Semi-annual Malaria Awareness Days in collaboration with Malaria Control Coordinator of CHMT at ward/village level to promote use and re-treatment of bednets, increase availability of nets and increase awareness of danger signs and early and appropriate treatment. ➤ Age-appropriate malaria treatment calendars distributed widely at all levels. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	Yes	<p>All activities completed.</p> <p>Creation of annual malaria awareness event (Ngorongoro Run: The Race Against Malaria). Malaria calendar not produced due to limited resources and wide availability of calendars providing similar information.</p>
<p>III.A.5. % of mothers who received IPT at least twice during their most recent pregnancy. (M)</p> <ul style="list-style-type: none"> ➤ HW-IMCI training and supervision. ➤ Community IEC campaigns promoting ANC. ➤ Semi-annual Malaria Awareness Days at ward/village level to increase awareness of IPT during pregnancy ➤ Healthy Mothers/Healthy Babies Centers at District health centers 	Yes	<p>All activities completed.</p> <p>Creation of annual malaria awareness event (Ngorongoro Run: The Race Against Malaria). Malaria calendar not produced due to limited resources and wide availability of calendars providing similar information.</p>
<p>III.A.6. % of mothers of children 0-23 months who always or usually slept under an ITN during their pregnancy with the youngest child. (M)</p> <ul style="list-style-type: none"> ➤ C-IMCI training and supervision. ➤ Community IEC campaigns promoting the use of ITNs for pregnant women. ➤ Coordination with PSI, drug shopkeepers and the CHMT to ensure access to affordable bednets and insecticides for retreatment throughout the district. ➤ Semi-annual Malaria Awareness Days in collaboration with Malaria Control Coordinator of CHMT at ward/village level to 	Yes	<p>All activities completed.</p> <p>Creation of annual malaria awareness event (Ngorongoro Run: The Race Against Malaria). Malaria calendar not produced due to limited resources and wide availability of calendars providing similar information.</p>

<p>promote use and re-treatment of bednets, increase availability of nets and increase awareness of danger signs and early and appropriate treatment.</p> <ul style="list-style-type: none"> ➤ Age-appropriate malaria treatment calendars distributed widely at all levels. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 		
<p>III.A.7. % of children 0-5 months who were exclusively breastfed during the last 24 hours. (ARI)</p> <ul style="list-style-type: none"> ➤ Counseling women during ANC and PPC visits. ➤ Train TBAs on importance and definition of exclusive breastfeeding ➤ Support provided at STG sessions. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	Yes	All activities completed.
<p>III.A.8 % of children age 6-23 months who received a dose of Vitamin A in the last 6 months. (ARI)</p> <ul style="list-style-type: none"> ➤ Counseling women during ANC and PPC visits. ➤ Train TBAs on importance of appropriate nutrition including Vitamin A. ➤ Support provided through STG sessions ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	Yes	All activities completed.
<p>IR. III.B. Home-based Care of the sick child: Caregivers are providing appropriate homecare of the sick child.</p>		
<p>III.B.1. % of mothers who report continuing to feed the same amount of food and the same amount or more fluids when their child was sick. (All)</p> <ul style="list-style-type: none"> ➤ C-IMCI training and supervision. ➤ Community IEC campaigns on proper homecare of the sick child. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	No	<p>All activities completed.</p> <p>Significant improvements were made but target was not achieved.</p>
<p>III.B.2. % of mothers of a child with diarrhea within the past two weeks who gave their child ORS. (DD)</p> <ul style="list-style-type: none"> ➤ C-IMCI training and supervision. ➤ Community BCC campaigns promoting the use of ORS and suitable alternatives. ➤ Coordination with the CHMT to ensure availability of ORS throughout the district. 	Yes	All activities completed.

<ul style="list-style-type: none"> ➤ Train drug shopkeepers on use of ORS rather than antibiotics. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 		
IR. III.C. Referral: Caregivers are increasingly seeking appropriate healthcare services for their sick child when necessary.		
III.C.1. % of mothers who know at least two signs of childhood illness that require medical treatment. (All)		All activities completed.
<ul style="list-style-type: none"> ➤ C-IMCI training and supervision. ➤ Community BCC campaigns (including special event days) on the danger signs of the sick child that require prompt referral. ➤ IEC with STG and MAISHA participants. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	Yes	
III.C.2. % children under two experiencing danger signs within the past two weeks who were brought to a health facility. (All)		All activities completed.
<ul style="list-style-type: none"> ➤ C-IMCI training and supervision. ➤ IEC campaigns on danger signs of the sick child that require prompt referral. ➤ Healthy Mothers/Healthy Babies Centers at District health centers. 	Yes	
IR. III.D. Facility-Based Case Management: The quality of care of the sick child by health care providers is improved.		
III.D.1% of sick children under-5 years that are correctly diagnosed at health facilities. (All)		All activities completed.
<ul style="list-style-type: none"> ➤ HW/C-IMCI training and supervision. 	Yes	
III.D.2. % of drug shopkeepers who provide the correct dosage of antibiotics and/or antimalarials. (All)		Initial training completed.
<ul style="list-style-type: none"> ➤ Drug vendors trained on correct medication and proper treatment doses for malaria, ARI and DD. ➤ Advocacy for including a continuing education requirement for RX re-licensure. 	Yes	Changes in government policy led to cancelling of additional training activities, per the request of the CHMT.

Annex 5: Rapid Catch Table

Rapid Catch Table			
Indicators	Baseline (%)	Final (%)	Target (%)
Increase % of children age 0-23 months that were born at least 36 months after the previous surviving child.	57	53	75
Increase % of mothers with children 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child.	79	76	85
Increase % of children whose births were attended by a skilled health provider.	70	82*	85
Increase % of children age 0-23 months who received a postnatal visit from an appropriate trained health worker within three days after birth.	28	83*	45
Increase % of children 0-5 months who were exclusively breastfed during the last 24 hours.	12	65*	40
% of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	Breastfed children: 28	Breastfed children: 26	n/a
	Non-breastfed children: 8	Non-breastfed children: 2	
Increase % of children age 6-23 months who received a dose of Vitamin A in the last 6 months.	54	89*	70
% of children age 12-23 months who received a measles vaccination	86	94	

% of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	49	78*	
% of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	54	71	
% of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	22	15	
Increase % of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids.	54	78*	70
% of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider.	18	87*	
Increase % of households of children age 0-23 months that treat water effectively.	44	47	60
Increase % of mothers of children 0-23 who live in a household with soap or a locally-approved cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview.	0	19*	30
Increase % of children 0-23 months who slept under an insecticide-treated bed net the previous night	56	91*	75

% of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population)

27

Data not available

***Statistically significant change**

Annex 5: Rapid Catch Table

Rapid Catch Table			
Indicators	Baseline (%)	Final (%)	Target (%)
Increase % of children age 0-23 months that were born at least 24 months after the previous surviving child.	82	82	n/a
Increase % of mothers with children 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child.	79	76	85
Increase % of children whose births were attended by a skilled health provider.	70	82*	85
Increase % of children age 0-23 months who received a postnatal visit from an appropriate trained health worker within three days after birth.	28	83*	45
Increase % of children 0-5 months who were exclusively breastfed during the last 24 hours.	12	65*	40
% of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices.	Breastfed children: 28	Breastfed children: 26	n/a
	Non-breastfed children: 8	Non-breastfed children: 2	
Increase % of children age 6-23 months who received a dose of Vitamin A in the last 6 months.	54	89*	70
% of children age 12-23 months who received a measles vaccination	86	94	

% of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	49	78*	
% of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	54	71	
% of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	22	15	
Increase % of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids.	54	78*	70
% of children age 0-23 months with chest-related cough and fast and/ or difficult breathing in the last two weeks who were taken to an appropriate health provider.	57	87*	
Increase % of households of children age 0-23 months that treat water effectively.	44	47	60
Increase % of mothers of children 0-23 who live in a household with soap or a locally-approved cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview.	0	19*	30
Increase % of children 0-23 months who slept under an insecticide-treated bed net the previous night	46	91*	75

% of children 0-23 months who are underweight (-2 SD for the median weight for age, according to WHO/NCHS reference population)

27

Data not available

***Statistically significant change**

Annex 6: Final KPC Report

Tanzania Child Survival Project

Knowledge, Practice and Coverage Survey

Final Report

July 2011

Karatu District, Tanzania

WellShare International

Karatu District Council Health Management Team

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I. Executive Summary

Purpose. The final KPC Survey 2011 objectives were to identify coverage for key intervention areas (maternal and newborn care, malaria, diarrheal disease, pneumonia, and child spacing), ascertain levels of key practices and assess the health knowledge of mothers with children under the age of two in Karatu District, Tanzania.

Methods. The **131-item questionnaire**, initially developed, translated to Kiswahili and used at the project's baseline, was used to survey mothers of children under the age of two years. Survey content included: personal background, antenatal care, delivery, post-partum care, child spacing and family planning, breastfeeding, child immunizations, care of the sick child, treatment of fever of child, control of diarrhea, acute respiratory illness/pneumonia, water and sanitation, malaria control, HIV/AIDS, and health contacts. **Cluster sampling** techniques were used to select 30 clusters based on cumulative population of 45 villages in Karatu District. Thirteen households were interviewed per cluster (N=390). Initial household selection was random with additional household selection based on proximity. **Data collection** by 15 trained supervisors and interviewers took place during June 2011. Data was entered into EpiInfo version 3.5.3. **Data analysis** was completed using STATA Version 11.

Sample Characteristics. A total of 32.4% (126/389) of mothers in the sample were 25 years or younger (compared to 39.4% at baseline), while 66.8% (260/389) were over age 25 (compared to 60.6% at baseline). Age categories for the youngest child included the following: 0-5 months (32.9%, 128/389), 0-11 months (47.8%, 186/389), 6-23 months (79.7%, 310/389) and 12-23 months (42.4%, 165/389). At baseline, comparable percentages were: 0-5 months (26.2%, n=85), 0-11 months (57.4%, n=186), 6-23 months (73.8%, n=239) and 12-23 months (42.6%, n=138).

Results. For **Maternal and Newborn Care**, baseline to final analysis showed a statistically significant increase in antenatal care visits (30% at baseline to 55% at final), intermittent preventive treatment of malaria during pregnancy (20 to 52%), skilled delivery assistance (70 to 82%), drying and wrapping of the newborn (37 to 86%), clean cord care (54 to 93%), active management of the third stage of labor (28 to 56%), and post-natal visits to the mother (20 to 83%) and neonate (28 to 83%). For **Child Spacing**, baseline to final analysis showed a statistically significant increase in use of modern family planning methods (31% at baseline to 64% at final), but adequate child spacing at 24 and 36 months was unchanged or decreased slightly.

The percentage of children sick with **fever, diarrhea and acute respiratory infection** symptoms in the two weeks prior to the survey were similar from baseline to final except diarrheal disease decreased from 29% at baseline to 22% at final. There were significant increases in malaria prevention behaviors: household ownership of insecticide-treated nets (46% at baseline to 91% at final); children sleeping under an ITN the previous night (46 to 91%); and women sleeping under an ITN during pregnancy (19 to 89%). While oral rehydration therapy for diarrhea increased from 53.9% at baseline to 78% at final,

appropriate treatment of diarrhea declined from 82 to 48%, with more children taken to a health facility for treatment. Mothers reported an increase in using soap to wash their hands at two or more appropriate times (from 0% at baseline to 19% at final). Most children (86.5%) with a chest cough and difficulty breathing were taken to a health facility for care compared to 57% at baseline. This was comparable to overall care-seeking for sick children which increased from 67% at baseline to 88% at final.

Exclusive breastfeeding for children 0-5 months increased from 12% at baseline to 65% at final. Mothers also reported an increase in appropriate feeding of children during illness, more consistently giving the same amount or more fluids and solid foods when their children were sick.

Vitamin A supplementation increased from 54% at baseline to 89% at final. Immunization coverage, not a focus of the project, also improved with a statistically significant increase in access to immunization services from 49% at baseline to 78% at final.

Discussion. The final KPC indicated significant improvement over baseline for 22 evidence-based health indicators and 4 knowledge indicators. Further improvements are needed in the following areas: 1) point-of-use treatment of water and 2) appropriate treatment of malaria and ARI.

II. Background

A. Project location and background

Karatu was established in 1995 as a district of Arusha Region in northern Tanzania, located between the Ngorogoro Conservation Area in the northwest and Manyara National Park in the east (see Appendix A for map). The rural district covers 3300 sq km and is divided into four divisions and 13 wards, including 45 villages and approximately 41,300 households.ⁱ

B. Target beneficiary characteristics

The total population of Karatu District is estimated at 218,654 (210,544 at baseline) based on census projections from 2002. Total project beneficiaries, children under five years of age and women of reproductive age, are estimated at 87,462 (Table 1). Additional direct beneficiaries include men involved in health education (MAISHA groups), health workers and community health cadres such as traditional birth attendants, village health committee members, and village health workers.

Table 1. Estimated project beneficiary population.

Category	Estimated Population
0-11 months (4%)	8,746
12-23 months (4%)	8,746
24-59 months (12%)	27,332
Total under 5 years (20%)	43,731
WRA (20%)	43,731
Total Population	218,654

C. Social, economic and health conditions in Karatu District

Current Health Status: Tanzania's under-five mortality rate for the period 2005-2010 was 81 per 1000 live births (compared to 112 per 1000 from 2000-2004) and its infant mortality rate was 51 per 1000 (compared to 68 per 1000 from 2000-2004). These rates represent a sharp decline over the past 20 years, with improvements in Tanzania's urban and rural areas due to the construction and increased staffing of health facilities.

The leading causes of morbidity and mortality in Karatu for infants and children under five are pneumonia/acute respiratory infections (ARI) and diarrheal diseases, based on admissions to and deaths in Karatu health facilities. At baseline, the leading causes were malaria, pneumonia/acute respiratory infections (ARI), and diarrheal diseases (DD).

Tanzania's maternal mortality ratio for the period 1995-2004 was 578 per 100,000 live births, which is statistically similar to the 1996 estimate, which were 529 per 100,000 live births.ⁱⁱ (The *adjusted* maternal mortality ratio for Tanzania, as reported by UNICEF is estimated to be 1500 per 100,000 live births, making it one of the highest worldwide, and

results in a one-in-ten lifetime risk of maternal death for each woman.)ⁱⁱⁱ A 2000 study in Morogoro Region of Southeastern Tanzania found, “the leading causes of maternal death provided through hospital data were puerperal sepsis (35% of deaths) and postpartum hemorrhage (17%); this is compatible with the main causes reported for maternal death in settings with high levels of maternal mortality, and similar to data for other regions in Tanzania.”^{iv} The maternal mortality ratio dropped to 454 per 100,000 live births in the 2010 DHS,^v which was also consistent with the apparent reduction in maternal deaths in Karatu District.

Nationally, ANC coverage remained high with at least 96% of mothers having attended at least one ANC session. While Arusha Region^{vi} reported a relatively high rate of 84.5% at baseline, this represented the lowest regional rate for ANC coverage in all of Tanzania.^{vii} In 2010, the percentage of mothers who had received antenatal care increased to 94.1%.

In Arusha Region, an estimated 52.8% of mothers were assisted by a health professional during their most recent delivery and 50.8% delivered at a health facility at baseline. At final, 47.2% of mothers were assisted by a health professional, and only 46.2% had delivered in a health facility.

The 2004-5 DHS reported that in Arusha Region 27.2% of children are stunted and 20.0% are wasted, which are both slightly lower than the national rural averages.^{viii} At final, these percentages had increased, but are not directly comparable due to a change in WHO’s child growth standards. At baseline, the CHMT believed that while malnutrition in many rural areas is a problem, it is not a serious problem in Karatu, since neighbors share food with at-risk families and most have access to either adequate income or homegrown food.^{ix}

Karatu reported a childhood immunization rate of 82%^x in 1999 and noted that vitamin A supplementation is strong since it is being administered at national immunization days and during regular immunization clinics. Household testing found that Arusha Region has the highest percentage of homes with iodized salt (93%). These statistics were unavailable at final.

Family Planning: The total fertility rate (TFR) for rural Tanzania was 6.5 due to early marriage, early sexual debut, older men having sex with young village girls, polygamy, wife inheritance, and lack of knowledge and outreach. At final, this rate had decreased to 6.1.^{xi} Consistent with baseline, more married urban women (41.8% in 2005 compared to 46% in 2010) report using family planning methods than married rural women. However, rural women showed a higher percentage increase in contraceptive use (21.6% in 2005 to 31% in 2010).

The most popular forms of family planning methods available in Karatu District are injectables (Depo Provera), pills, and condoms in order of popularity; this remained unchanged from 2005.^{xii} The supply of pills, Depo and condoms was available consistently throughout Karatu District health facilities for free during the life of project. A wide variety of condoms were also sold through drug vendors, brothels and

commercial kiosks.

Socioeconomic Characteristics: Karatu's population is primarily Christian with some animists and Muslims. Ethnically, Karatu is homogenous; the main tribe is the Iraqw (also known as Mbulu, Mbulunge, Erok, Iraku and Kiiraqw). Approximately 90% of the population subsists on agriculture and livestock production. Crops include maize, beans, wheat, pigeon peas, coffee and barley. While recent droughts have led to increased poverty in Karatu, the overall economic forecast for the area is promising due to the growing tourism industry and the recent completion of the main paved highway to Arusha, which is greatly increasing economic traffic into the District.

At baseline, Tanzania ranked 164th in the Human Development Index and 175th in gross domestic product out of the 177 countries measured.^{xiii} In 2011, Tanzania had moved up to 152nd in the Human Development Index out of 187 countries.^{xiv} Twenty percent of Tanzanians live on less than one dollar per day, with rural women and children affected the most due to the distribution of resources within the family. In Karatu, women head 22% of households, carry a disproportionate share of the responsibilities for care of their families, and have the lowest literacy and education rates. They are much more likely than men to have been divorced, separated or widowed. Gender-based roles affect all aspects of health for the individual and the family, including use of family planning methods, decisions on when to seek medical care, and the choice of how many children to have.

Karatu District has 55 kilometers of tarmac road that is passable throughout the year and the remaining 253 km of feeder roads are only consistently passable during the dry season. This did not change during the life of project. Electricity is available in Karatu town and in the other larger towns throughout the district, however, this was periodically sporadic due to load sharing and equipment breakdowns. Cell phone usage has exploded in the past five years, which provides a potential for improving access to emergency care in the district.

Status of Health Care Services: All health care services in Karatu District fall under the jurisdiction and oversight of the CHMT, made up of the District Medical Officer (DMO) and nine coordinators with responsibility for MCH, HIV/AIDS, RH, immunizations, school health, and the health management information system (HMIS). Facility-based health care services are provided in Karatu District by government agencies, churches, and private institutions at three levels: hospital, health centers, and dispensaries. At baseline, the district had 1 hospital, 8 health centers and 29 dispensaries. During the life of project, an additional 8 health facilities were built and staffed.

The previous socialist government of Tanzania established a system of volunteer health workers (VHWs) and village health committees (VHCs) to improve PHC in rural areas and to strengthen the connections between the community and the health care facilities. Each village was to have a male and female VHW, trained to provide basic preventive and curative care. While there is general consensus that some VHWs are still providing health care, the formal connection between them and the health care system has

deteriorated to the extent that the CHMT estimates that only about one-third of villages in Karatu have a trained VHW.^{xv} A VHC was also to be established in each community to support and oversee the VHWs and their local MOH facility through data collection, prioritization of health needs, and community mobilization. At baseline, the CHMT reports that two VHCs that have been particularly active have been directly involved in recognizing and responding to disease outbreaks. By final, a health committee (VHC or VHMC) existed in every village. However, due in part to periodic shifts in village leadership, the functional strength of these committees was variable.

The national MOH is now in the second phase of a decentralization process designed to devolve authority for planning, budgeting, management, and project implementation to the districts. This puts the onus on district CHMTs to prepare and implement annual health plans and locate sources of support, largely on their own. Its success depends on the skills and commitment of district and local leaders and MOH staff. Karatu's leadership is unusually committed to health: the District Member of Parliament, the DMO, the District Executive Officer, the District Commissioner, the Chair of the District Council and community leaders at all levels (mayors, village chairmen and others) are focused on health and recognize that related needs have long been neglected. The DMO and the members of the CHMT are particularly forward thinking and committed to mobilizing resources for district health programs. There has been little turnover in the CHMT's membership over the past several years (although the project worked with three different DMOs) and it is very committed to implementing IMCI and increasing its capacity to plan, implement, monitor, and evaluate health care services together with the communities it is mandated to serve.

A variety of health practitioners function in tandem with or outside the formal health care system. At baseline, the CHMT estimated that approximately 80% of deliveries in Karatu were assisted by TBAs outside of MOH facilities. Marie Stopes/Tanzania (MS/T) identified 710 registered TBAs in Karatu in 2002. The CHMT stated that there was an informal connection between the TBAs and the health care system as many register the infants they are delivering, but it had been years since this relationship has been formalized through refresher training, consistent contact, or supportive supervision. As a result of the project, 85% of births were in health facilities with skilled providers and strong relationships had been rebuilt between TBAs and the formal health system, to the extent that in many health facilities, TBAs assisted the health workers with deliveries.

Tanzania was one of the first countries to commit to Integrated Management of Childhood Illness (IMCI), adopting it as its national strategy for reducing child mortality in 1994. The Tanzanian Evaluation of Health Improvement Project implemented an evaluation of IMCI in Tanzania beginning in 1998, under the auspices of WHO. Under-five mortality was compared between two districts that had been implementing IMCI (Morogoro and Rufiji) with two districts that had not been introduced to IMCI. The two 'IMCI districts' experienced a 13% reduction in under-five mortality while the other two districts experienced no change. WHO and UNICEF have funded production of the IMCI training materials and manuals that are now available to the districts at no charge. These materials were used by the project. At the end of the project, revised community IMCI

materials were due to be released, and the district had agreed to provide refresher training to the project-trained CORPs using the new community IMCI materials.

Some international PVOs and local NGOs are providing health-related services and programs in parts of Karatu District, focused primarily on HIV/AIDS/STIs, safe water systems, and wholesale supply of FP methods, all areas this CS project complemented and coordinated with through referrals, sharing of information, and joint participation on M&E activities. At baseline, Medicos del Mundo (MDM) was providing facility-based services throughout the District, focused primarily on HIV/AIDS/STIs, including voluntary counseling and testing (VCT), ARV for PMTCT, diagnosis/treatment of STIs/opportunistic infections, and donated test kits for health facilities. Their project closed in 2008 and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) subsequently undertook some HIV care and support activities including a HIV positive children's club which WellShare supported. Canadian Physicians for Aid and Relief (CPAR) is providing safe water systems and educating youth through the schools on safe water and hygiene in four of Karatu's 13 wards as well as operating an AIDS support group and agricultural activities. Ingeniería Sin Fronteras (ISF) provided safe water bore holes and rain water collection systems and WellShare implemented a community-based water and hygiene improvement project on their behalf in 2009-2010. The Village Wellness Program of St. Joseph Medical Center provided some education and curative care in just one of Karatu's four divisions, but has subsequently left the district. Marie Stopes/Tanzania (MS/T) offered VCT, FP, and other reproductive health through their one RH center but did not do community mobilization or demand creation. They were periodically closed during the project due to lack of funding, but were operational during the last year of the project. The Karatu Development Association (KDA), a local community based organization (CBO), targets youth and women through income generating activities. Population Services International (PSI) provided Salama condoms, Care female condoms, oral contraceptives, and bed nets/insecticides to retail outlets at baseline. JHPIEGO's MAISHA project was operational in some health facilities during the last two years of the project and trained health workers in FANC and BEMONC.

Barriers to Access and Behavioral Characteristics: People living in Karatu District face many barriers to health care: long distances to understaffed/undersupplied health facilities, poor roads, lack of transportation, the relatively high cost of services and medicines, long waiting times, and the social stigma associated with certain health care issues. While lack of knowledge is also a significant barrier, project activities successfully addressed this issue for key maternal and child health issues including danger signs requiring care-seeking.

Household Behaviors and Care Seeking Practices: At baseline, of concern for rural Tanzanian children, only half (54.9%) were being given ORS for diarrhea, only one-in-twelve (8%) slept under an ITN, and fewer than half (49.8%) with fevers were being given medicine the same day. In 2010, these statistics had changed: 44% were given ORS and 30% were given home fluids; 64% slept under an ITN; and 40.8% with fevers received anti-malarials on the same day. Household behaviors for rural pregnant women had also changed: pregnant women sleeping under ITNs increased from 9.5% in 2005 to

59.2% in 2010 and women who received intermittent presumptive treatment (IPT) during ANC increased from one-in-six in 2005 to more than three-in-six (59.4%) in 2010. While breastfeeding overall was high (96.9%), exclusive breastfeeding for the first six months is relatively low at 22.9 (however this increased from 13.5% in 2005).^{xvi}

FGDs were held with a variety of groups during the design of this project, which found an unnecessary reliance on the use of sugar-salt solution, despite the availability of ORS sachets at health facilities and various commercial vendors. Some women reported that they stop breastfeeding when they have malaria, assuming that it will transmit the disease to the child. TBAs remain a very popular source of support at deliveries since they are cheaper and familiar to the family. People said they frequently go to drug vendors first when their child is sick before going to a health facility. Many reported that they do not feel comfortable going to health facilities for family planning supplies due to the stigma. By the end of the project, data seem to suggest that some of these issues had been ameliorated.

D. Tanzania Child Survival Project/Karatu Overview

The goal of the WellShare Tanzania Child Survival Project was to improve the health of infants and children under the age of five and women of reproductive age in Karatu District, Tanzania. Key strategies included: 1) strengthening government mandated cadres (VHWs) and institutions (VHCs); 2) mainstreaming traditional providers (TBAs, drug vendors), and 3) developing new community groups for high-need populations (single mothers, transport drivers). Key activities include training health worker and community cadres in C-IMCI, HBLSS, MNC and CS; BCC and IEC campaigns; and Healthy Moms and Healthy Babies centers at local health centers. WellShare’s Child Survival project was implemented in three phases, with each phase focusing on 15 of Karatu’s 45 communities (except for the C-IMCI intervention, which did not follow this pattern).

The project focused on five interventions including:

Table 2. Level of intervention effort.

Intervention Area	Level of Effort (%)
Maternal and Newborn Care	35
Prevention and Treatment of Malaria	20
Control of Diarrheal Disease	15
Pneumonia Case Management	15
Child Spacing	15

The project had 3 key results, 10 intermediate results, and 28 quantifiable objectives. Major collaboration with key partners included partnering during training and outreach activities as well as coordination of community sensitization and mobilization programs and monitoring and evaluation.

Table 3. Key project partners.

CHMT	Primary provider of health services in the district under the auspices of the MOH,
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	Regional Health Office and Karatu District Council.
WEO	Political leaders with oversight for villages.
VEO/VHC	Political leaders responsible for health provision and data collection at the village level.
CPAR	NGO working on safe delivery, safe water harvesting, gender-based violence including FGM.
MST	NGO working on reproductive health services, HIV/AIDS and treatment of STIs.
MEDA	NGO responsible for government bed net voucher distribution.
PSI	NGO providing social marketing of condoms, bed nets and water treatment.
MAISHA	Jhpeigo program providing support to the MOH for BEmONC, FANC and quality improvement.
ACQUIRE	Engender Health program providing clinic-based family planning/spacing services.
EGPAF	NGO providing PMTCT services and support to Care and Treatment Centers (CTCs).
PathFinder	NGO providing home-based care for PLWHIV/AIDS and treatment of TB.
FAME Medical	Treatment and curative services in both in reach and outreach program.

Three partners identified in the project's DIP (Village Wellness Project, ACCESS and Medicos del Mundo [MdM]) are no longer working in the district.

D. KPC Survey objectives

The objectives of the final KPC Survey 2011 in Karatu District were to determine the effects of project interventions on knowledge, practice and coverage for key intervention areas (maternal and newborn care, malaria, diarrheal disease, ARI/pneumonia, and child spacing), ascertain levels of key practices and assess the knowledge of mothers with children under the age of two around key child health and maternal health issues. In addition, the final KPC Survey 2011 provided an opportunity to have the comparison data/information for other final evaluation activities.

III. Local Partners

The Karatu District Council Health Management Team (CHMT) has been the primary project partner. The CHMT, headed by the District Medical Officer is made up of the District's senior level personnel who oversee the preventive and curative health care services provided in Karatu District. One Health Officer was assigned as the liaison between the CHMT and WellShare. The CHMT assisted in facilitating the KPC training and logistics.

In addition, WellShare has worked closely with local government through the District Commissioner, District Executive Director, District Council, District Health Committee, Ward Executive Officers and village leaders to implement the final KPC. These partners, in addition to the Village Health Committees continued to be fully engaged in project sustainability, and are full partners in the continuing support, monitoring and supervision needed to sustain the interventions provided by the project at the community level. Throughout the project has focused on building their participation and technical and administrative capabilities so they can take the lead role in sustaining project activities.

IV. Methods

A. Questionnaire development and translation

A 131-item questionnaire (see Appendix C) was developed and utilized during the project's DIP to survey mothers of children under the age of two years in the following key areas: personal background, antenatal care, delivery, post-partum care, child spacing and family planning, breastfeeding, child immunizations, care of the sick child, treatment of fever of child, control of diarrhea, acute respiratory illness/ pneumonia, water and sanitation, malaria control with insecticide-treated bednets and indoor residual spraying, HIV/AIDS, and health contacts. Questions were compiled from required Rapid Catch Indicators and recommended questions from KPC2000+ modules.

At baseline, the content of survey questions was discussed with members of the Karatu District Council Health Management Team and modified to fit local conditions. The survey was translated into Kiswahili (see Appendix C) after determining that essentially every survey respondent would be able to converse in Kiswahili. Following translation into Kiswahili, the survey was reviewed and back-translated to English by the CHMT and supervisors hired for the project, respectively. A final draft of the survey was pre-tested with mothers of children under age two by survey supervisors and interviewers and changes made accordingly prior to implementation in the field. At final, the survey was again pre-tested and no modifications were made.

B. KPC indicators

Fifty indicators, including 17 Rapid Catch Indicators, were included as part of the KPC analysis plan. The additional indicators related to the five project intervention areas. Some of them were similar, varying by age or comparing self-reported data to information recorded on health cards (RCH cards). Section V. Results has a complete list of project indicators.

C. Sampling design

The final survey sample size calculations accounted for the small sample of children 0-5 months in a sample size of 300 at baseline. A final sample size of 390 was calculated as sufficient to calculate project indicators reliably. A cluster sampling design was used again at final to match the baseline method. Based on the estimated sample size of 390 and a cluster size of 13 households per cluster, 30 clusters were initially randomly selected using cumulative populations of all original 45 villages in Karatu District (see Appendix D). Random selection of the clusters was accomplished with assistance from all personnel involved in data collection (e.g. supervisors and interviewers) in addition to the Ward Executive Officers (WEO) from 14 of 14 wards in the district.

Protocols were developed with survey supervisors and interviewers in order to randomly select the first household in each cluster. Large villages were divided into subvillages and 10-cell units (political subdivision of ten-households) where necessary. Random selection was accomplished by assigning numbers to all units to be selected from and randomly drawing one number. Once the initial household was selected, subsequent households

were selected by proximity. Only one mother with a child under the age of two years was interviewed per household.

D. KPC training

Supervisors and interviewers were recruited primarily by WellShare International with input from the District's CHMT. Each candidate was provided with sample survey questions and asked to read and interpret the questions. Selection was based on performance and ability to communicate in English and other local languages. A total of 3 supervisors and 12 interviewers were selected. The overall field data collection process was overseen by WellShare's Monitoring and Evaluation Coordinator.

A four-day KPC Survey training was designed for survey supervisors and for survey interviewers (see Appendix E). The training covered topics such as the project background and purpose, random selection, review of the survey questions, interviewing skills, and quality data collection.

Supervisors were responsible for all aspects of data collection in the field including meeting with village leaders and health facility personnel, supervising household selection, and assuring quality data collection by interviewers. Interviewers were responsible for conducting interviews with mothers of children under the age of two years. All supervisors and interviewers reviewed the days' surveys each night to ensure completed surveys.

The final day of the training was a field test of the survey with mothers of children under the age of two. Following the field test, problems arising were discussed with all the survey collection staff. Field tested surveys were reviewed for problems in survey design and translation.

E. Data collection

Initial data collection occurred over six days (June 9-14, 2011) and was implemented by 3 supervisors and 12 interviewers in teams of 4 with 1 supervisor per team. Dates for data collection were arranged in advance with the Ward Executive Officers (WEOs), accounting for market days, community meetings, and other village activities. The WEOs informed the village leaders when the survey would take place in each village. One survey team was dispatched per vehicle per day to separate clusters in relatively close geographic proximity as appropriate and practical. The vehicle was available to transport teams during the day as some of the clusters crossed a geographic area of many kilometers.

Each survey team was provided daily with a box containing pre-numbered surveys plus four additional surveys, clipboards, rain protectors, pens/pencils, name badges, weighing scales (borrowed from neighboring health facilities) and rope to hang the scales. In addition, each supervisor was given a laminated copy of a letter introducing the project to the village leaders.

Supervisors met with village leaders after arriving in each village to ensure permission to conduct the interviews was granted and to identify geographic points for household selection. Village leaders were very helpful with logistics for data collection. Initial households were selected based on study protocols and women having children under the age of two years were interviewed in each applicable household.

Interviews generally were completed in approximately one hour, but in some situations interviews took up to two hours to complete. As an incentive for participating, each woman interviewed was given one half bar of washing soap. Interviewers and supervisors conducted an initial review of the survey data in the field and a subsequent review of each survey by the survey coordinators was done immediately upon return from the field.

F. Data management and analysis

Each survey was pre-numbered on every page to ensure reliable data collection. Once surveys were returned from the field, all responses were checked for accuracy. Missing data and/or errors were initially addressed with the interviewer and subsequently were handled using consistent criteria for all surveys.

One survey was excluded after entry for age of the baby greater than 24 months. Of the expected 390 surveys collected, 389 (99.7%) were included in the analysis.

Data was double-entered by trained individuals into Epi-Info Version 3.5.3. Double-entered data was compared for accuracy and discrepancies were checked against original surveys. The cleaned dataset was analyzed by a consultant at the University of Minnesota using STATA Version 11. Analysis included frequencies of all variables plus recoding of pre-determined indicators. All analyses used corrections for the design effect of cluster survey sampling with the analysis matching the parameters set during the baseline survey (2007).

V. Results

Respondents in the survey were mothers with children 0 to 23 months old. At final, the majority of mothers were under the age of 30 (62.25%), married (78.9%) and with a minimum of at least a primary school education (86.2%). Most worked outside the home to generate income (89.7%). Of those, 66.4% (232) reported farming, 14.7% (51) reported animal husbandry, and 18.9% (66) reported doing other duties and handicrafts as a means to extra income. Characteristics of the survey sample are summarized in Table 1. The major demographic difference between baseline and final is that respondents were more highly educated.

Table 4. Demographic characteristics of the survey sample.

Demographic Characteristics	Baseline Percent % (n) N=324	Final Percent % (n) N=389
Age of the mother		
<20 years	12.6 (41)	8.0 (31)
21-25 years	26.8 (87)	26.5 (103)
26-30 years	27.5 (89)	29.8 (116)
31-35 years	16.7 (54)	21.8 (85)
36-40 years	13.3 (43)	11.6 (45)
>40 years	3.1 (10)	2.3 (9)
Age of the youngest child		
0-5 months	26.2 (85)	27.5 (107)
0-11 months	57.4 (186)	54.2 (211)
6-23 months	73.8 (239)	72.5 (282)
12-23 months	42.6 (138)	45.8 (178)
Education level of mother		
No education n=282 (baseline); n=373 (final)	12.4 (40)	4.1 (16)
Some primary	6.4 (18)	1.9 (7)
Completed primary	88.3 (249)	46.9 (175)
Some secondary	1.4 (4)	39.9 (149)
Completed secondary or higher	3.9 (11)	11.3 (42)
Marital status of mother		
Married	79.0 (256)	78.8 (306)
Not married	21.0 (68)	21.1 (82)
Work outside the home to generate income		
Yes	79.9 (259)	77.1 (300)
No	20.1 (65)	22.8 (89)

Coverage results for MNC indicators are summarized in Table 6. Almost one-third of women (30.3%) reported having four or more ANC visits while pregnant with the youngest child at baseline, which increased to 55% at final. An examination of ANC visits reported on health cards showed that there was substantial improvement in the use of health cards between baseline and final (15.8% [50/317] compared to 61.4% [239/389]), but that not all visits may not have been recorded (55.0% self-reported versus 46.9% noted on health card). The majority of women (78.9% at baseline, 75.8% at final) reported two tetanus toxoid vaccinations prior to the birth of the youngest child, but this number may not accurately reflect tetanus coverage since younger women now receive tetanus vaccines in school and therefore may not receive/need all recommended shots during pregnancy. The use of IPT during pregnancy increased with only 19.6% reporting taking two doses of IPT during their most recent pregnancy at baseline compared to 52.4% at final. At baseline, a total of 41.8% (n=135) of women reported giving birth at their own home or someone else's home, while 57.0% (n=184) reported giving birth in a

health facility. At final, these numbers were 26.7% (n=104) at home and 73.3% (n=285) in a health facility. While the majority of births were attended by skilled health care workers (69.7%) at baseline, only 28.1% reported AMTSL and only 37.2% reported immediate drying and wrapping of the newborn. At final, 82% of births were attended by a skilled provider and 56.3% reported AMSTL and 86.4% reported immediate drying and wrapping of the newborn. There was a substantial increase in knowledge from baseline to final: two or more dangers signs in pregnancy (17.4% at baseline to 81.2% at final); two or more dangers signs in the post-partum period for mothers (17% to 63%); and, two or more dangers in the post-partum period for neonates (26.8% to 92.0%). Shaded cells denote a statistically significant increase.

Table 5. Coverage results for MNC indicators.

Maternal Newborn Care				
Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
<u>ANC Visits:</u> % of women having four or more antenatal visits when they were pregnant with the youngest child	30.3 (96/317)	24.2, 37.1	55.0* (214/389)	50.8, 59.1
<u>ANC Visits:</u> % of women having four or more antenatal visits when they were pregnant with the youngest child / per health card	48.5 (47/50)	38.1, 58.8	46.9 (112/239)	39.1, 54.8
<u>*Maternal TT Vaccination:</u> % of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child	78.9 (250/317)	72.4, 85.3	75.8 (295/389)	71.1, 80.0
<u>*Maternal TT Vaccination:</u> % of mothers with children age 0-23 months who received at least 2 tetanus toxoid vaccinations before the birth of their youngest child (on health card)	45.5 (50/110)	32.7, 58.9	71.5* (171/239)	65.0, 77.3
<u>Maternal TT Vaccination (0-11 months):</u> % of mothers with children age 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child	78.0 (145/186)	70.8, 85.1	80.6 (211/389)	74.5, 85.5
<u>Maternal TT Vaccination (0-11 months):</u> % of mothers with children age 0-11 months who received at least two tetanus toxoid injections before the birth of their youngest child (on health card)	17.2 (32/186)	11.4, 23.0	69.6* (135/239)	62.1, 76.2
<u>Prevention of Malaria During Pregnancy:</u> Percentage of mothers of children 0-23 months who took effective antimalarials during the pregnancy with their youngest child (self-report)	19.6 (62/317)	14.2, 24.9	52.4* (204/389)	47.5, 57.3

<u>Prevention of Malaria During Pregnancy</u> : Percentage of mothers of children 0-23 months who received IPT at least twice during their most recent pregnancy (on health card)	10.1 (32/317)	6.4, 13.8	57.3* (137/239)	52.7, 61.8
<u>Knowledge of Danger Signs During Pregnancy</u> : % of mothers of children 0-23 months able to list 2 or more danger signs during pregnancy	17.4 (55/317)	11.1, 23.6	63.0* (245/389)	55.4, 70.0
<u>*Skilled Delivery Assistance</u> : % of children age 0-23 months whose births were attended by skilled personnel	69.7 (221/317)	61.6, 77.9	82.0* (319/389)	78.1, 85.3
<u>Skilled Delivery Assistance (HBLSS-trained TBA)</u> : % of children age 0-23 months whose births were attended by skilled personnel or HBLSS-trained TBA	70.0 (222/317)	61.8, 78.3	82.3 (320/389)	78.2, 85.7
<u>Skilled Delivery Assistance (0-11 months)</u> : % of children age 0-11 months whose births were attended by skilled personnel or HBLSS-trained TBA	69.9 (130/186)	60.4, 79.4	83.4 (176/211)	76.9, 88.4
<u>Clean Cord Care</u> : % of children 0-23 months who had clean cord care at the time of birth	54.3 (172/317)	46.1, 62.4	93.3* (363/389)	89.9, 95.6
<u>AMTSL</u> : % of mothers of children 0-23 months who received AMTSL during the birth of her youngest child	28.1 (89/317)	21.6, 34.6	56.3* (219/389)	49.1, 63.3
<u>Delivery Care of Newborn</u> : % of children 0-23 months who were dried and wrapped with a warm cloth or blanket immediately after birth	37.2 (118/317)	30.0, 44.5	86.4* (336/389)	82.0, 89.8
<u>*Post-natal Visit to Check on Newborn</u> : % of children age 0-23 months who received a post-natal visit from an appropriate trained health worker within three days after birth	27.8 (88/317)	19.7, 35.8	82.5* (321/389)	78.6, 85.9
<u>Post-natal Visit to Check on Mother</u> : % of mothers of children age 0-23 months who received a post-partum visit from an appropriate trained health worker within 3 days after the birth of the youngest child	19.6 (62/317)	13.9, 25.2	83.3* (324/389)	78.5, 87.2
<u>Knowledge of PP danger signs for neonate</u> : % of mothers of children age 0-23 months able to list 2 or more neonatal danger signs during the PP period	26.8 (85/317)	18.5, 35.1	92.0* (358/389)	88.0, 94.8

<u>Knowledge of PP dangers signs for the mothers: % of mothers of children age 0-23 months able to list 2 or more danger signs for the mother during the PP period</u>	17.0 (54/317)	11.2, 22.9	81.2* (316/389)	76.6, 85.1
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A total of 30.6% of children (119/389) in the survey were reported to have had a fever within the past two weeks compared to 31.4% of children (101/322) at baseline. Only 15.1% (18/119) were reported to have been treated with appropriate antimalarials within 24 hours (compared to 21.7% [21/97] at baseline), however it was unclear from the data whether anti-malarials were the appropriate treatment course for the child presenting with fever. Almost every household (91.0%, 345/389) owned an insecticide-treated mosquito net (compared to 46.4% [147/317] at baseline), and of those, all children under the age of two were reported to have slept under an ITN the previous night compared to only 56.2% at baseline. While few women (18.6%) slept under ITNs consistently ('always' or 'usually') while pregnant with their youngest child at baseline, the majority of women (89.5%) slept under one at final. Indoor spraying of insecticides did not increase statistically (5.7% at baseline compared to 10% at final).

Table 6. Coverage results for malaria indicators.

Malaria				
Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
<u>*Child with Fever Receives Appropriate Antimalarial Treatment:</u> % of children 0-23 months with a febrile episode during the last two weeks who were treated with an effective antimalarial drug within 24 hours after the fever began	21.7 (21/97)	11.7, 31.6	15.1 (18/119)	8.1, 26.4
<u>ITN Ownership:</u> % of households of children 0-23 months that own at least one insecticide-treated bed net	46.4 (147/317)	36.2, 56.6	91.0* (354/389)	87.7, 93.5
<u>*Child Sleeps Under an Insecticide-treated Bed Net:</u> % of children age 0-23 months who slept under an insecticide-treated bed net the previous night	46.4 (147/317)	36.2, 56.6	91.3* (355/389)	88.0, 93.7
<u>Mother Sleeps Under Bed Net During Pregnancy:</u> % of mothers of children 0-23 months who always or usually slept under an ITN during their pregnancy with the youngest child	18.6 (59/317)	11.9, 25.3	89.5* (348/389)	84.5, 93.0
<u>Interior Spraying for Malaria:</u> % of households of children 0-23 months where the interior was sprayed against mosquitoes in the past 12 months	5.7 (18/317)	2.9, 8.5	10.0 (39/389)	6.7, 14.8

At baseline, a total of 28.8% (93/323) children in the survey were reported to have had diarrhea within the past two weeks compared to 22.4% (87/389) at final. ORT use increased from baseline (53.9%) to final (78.2), but appropriate treatment of children with diarrhea declined from 82% at baseline to 48.3% at final. The prevalence of preventive behaviors in the home remained low. Households reporting treating water prior to use showed almost no change from 43.5% at baseline to 47.3% at final. At baseline, no mother (0%) reported appropriate handwashing practices the previous day, but this was due primarily to the lack of handwashing stations. There was a statistically significant increase at final to 18.8%, but this number was still low due to the lack of a specific handwashing station (in Tanzania, movable basins are used for handwashing). While at baseline, women reported that they used soap for washing clothes and utensils and showering, by the final they also reported using soap for handwashing.

Table 7. Coverage results for control of diarrheal diseases.

Control of Diarrheal Diseases				
Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
<u>*ORT Use:</u> % of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution and/or recommended home fluids	53.9 (48/89)	41.0, 66.8	78.2* (68/87)	68.2, 85.6
<u>Appropriate Treatment of Diarrhea:</u> % of children 0-23 months with diarrhea in the last two weeks who were not treated with antidiarrheals or antibiotics	82.0 (73/89)	72.2, 91.7	48.3* (42/87)	37.8, 58.9
<u>†Zinc Treatment During Diarrhea:</u> % of children age 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements	0.0 (0/89)	0, 0	4.6 (4/87)	1.7, 11.7
<u>*Point of Use:</u> % of households of children age 0-23 months that treat water effectively	43.5 (138/317)	34.7, 52.4	47.3 184/389	42.2, 52.5
<u>*Appropriate Hand washing Practices:</u> % of mothers of children 0-23 who live in a household with soap or a locally-approved cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview	0.0 (0/317)	0, 0	18.8* (73/389)	14.7, 23.7
<u>Safe Disposal of Feces:</u> % of mothers of children 0-23 months who disposed of the youngest child's feces safely the last time she/he passed stool	56.8 (180/317)	48.2, 65.4	62.7 (244/389)	58.5, 66.8

At baseline, a total of 32.5% (105/323) of children in the survey were reported to have had an illness with a 'cough that comes from the chest' within the past two weeks at

baseline compared to 34.2% (133/389) at final. While only 57.4% of children with a chest-related cough and fast/difficult breathing in the past two weeks were taken to an appropriate health provider at baseline, 91.1% of children with similar signs were taken to a health provider at final. In addition, at baseline only 8.3% (n=27) of women identified fast/difficult breathing as a danger sign requiring care seeking and 8.6% (n=28) identified coughing as a danger sign. At final, these percentages were 50.1% (n=195) and 1.5% (n=6), respectively.

Table 8. Coverage results for pneumonia case management.

Pneumonia Case Management				
Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
<u>*Appropriate Care-Seeking for Pneumonia:</u> % of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	57.4 (58/101)	46.0, 68.9	86.5* (115/133)	79.3, 91.4

There was essentially no change in child spacing from baseline to final, both at 24 months and 36 months. However, use of modern family planning methods did increase. At baseline, 31.4% of women who did not currently want children were using a modern method of family planning; this increased to 64.1% of women at final. At baseline, only half of women (51.2%) reported discussing family planning issues with their partner, which increased significantly at final to 65.4%.

Table 9. Coverage results for child spacing indicators.

Child Spacing				
Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
<u>*Adequate Child Spacing:</u> % of children age 0-23 months who were born at least 24 months after the previous surviving child	82.6 (200/242)	77.3, 86.9	82.0 (233/284)	76.1, 86.7
<u>Adequate Child Spacing (36 mos):</u> % of children age 0-23 months who were born at least 36 months after the previous surviving child	57.0 (138/242)	48.6, 65.1	53.2 (151/284)	45.4, 60.8
<u>Access and Use of Modern Family Planning:</u> % of nonpregnant mothers of children 0-23 months who desire no children in the next two years OR are not sure AND who are using a modern method of child spacing	31.4 (91/290)	24.7, 38.0	64.1* (116/181)	56.1, 71.4

<u>Discussion of Family Planning with Partner</u> : % of mothers of children 0-23 months who report talking with their partner about family planning methods	51.2 (165/322)	41.7, 60.7	65.4 (200/306)	59.3, 71.0
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While over half of mothers (66.1%) were able to list two or more dangers signs of childhood illness that require medical treatment at baseline, almost every mother (99.0%) was able to list these danger signs at final. This translated into an increase in treatment-seeking behavior, with only 67.2% of children experiencing danger signs within the past two weeks brought to an appropriate health facility (hospital, health centre, or dispensary) at baseline compared to 88.4% at final. Appropriate fluid and solid feeding of children during illness increased from baseline, but not all increased were statistically significant. At baseline, only 4.5% of mothers of children with diarrhea in the past two weeks reported offering more fluids during the episode (although 38.2% [34]) reported offering the same amount), but at final 63.2% reported offering more fluid.

Table 10. Coverage results for care of the sick child.

Care of the Sick Child				
Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
<u>Knowledge of Danger Signs for Childhood Illness</u> : % of mothers of children age 0-23 months who can list at least two signs of childhood illness that require medical treatment	66.1 (214/324)	55.5, 76.7	99.0* (385/389)	(97.6, 100)
<u>Appropriate Care-Seeking for Childhood Illness</u> : % children 0-23 months experiencing danger signs within the past two weeks who were brought to a health facility	67.2 (123/183)	54.9, 77.5	88.4* (183/207)	83.8, 91.8
<u>Appropriate Fluid Feeding During Febrile Episode</u> : % of mothers who report continuing to give the <i>same</i> amount or <i>more</i> of fluids when their child 0-23 mo was sick was a fever	47.4 (46/97)	33.5, 61.3	63.0 (75/119)	52.6, 72.3
<u>Appropriate Solid Feeding During Febrile Episode</u> : % of mothers who report continuing to feed the <i>same</i> amount or <i>more</i> of food when their child 0-23 mo was sick with a fever	26.7 (23/86)	14.4, 39.1	46.2 (55/119)	35.4, 57.4
<u>Appropriate Fluid Feeding During Diarrhea</u> : % of children 0-23 months with diarrhea in the last two weeks who were offered <i>more</i> fluids during the illness	4.5 (4/89)	0.1, 8.8	63.2* (55/87)	52.5, 72.8

<u>Appropriate Solid Feeding During Diarrhea</u> : % of children 0-23 months with diarrhea in the last two weeks who were offered the <i>same</i> amount or <i>more</i> food during the illness	31.5 (28/89)	18.2, 44.7	54.0 (47/87)	43.1, 64.6
<u>Appropriate Fluid Feeding During Pneumonia</u> : % of mothers who report continuing to give the <i>same</i> amount or <i>more</i> of fluids when their child 0-23 mo was sick was a cough	52.5 (53/101)	40.0, 65.0	63.2 (84/133)	53.7, 71.7
<u>Appropriate Solid Feeding During Pneumonia</u> : % of mothers who report continuing to feed the <i>same</i> amount or <i>more</i> of food when their child 0-23 mo was sick with a cough	28.7 (29/101)	17.9, 39.5	53.4* (71/133)	41.0, 65.3

While breastfeeding overall remained high (92.9% ever breastfed at baseline, 100% ever breastfed at final), there was a significant increase in exclusive breastfeeding from baseline (11.6%) to final (65.1%). Other breastfeeding practices showed improvement, but results were not statistically different (e.g. 65.6% reporting no pre-lactial feeds at baseline compared to 72% at final).

Table 11. Coverage results for breastfeeding indicators.

Breastfeeding				
Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
<u>*Exclusive Breastfeeding</u> : % of children 0-5 months who were exclusively breastfed during the last 24 hours	11.6 (10/86)	4.61, 18.6	65.1 (69/106)	53.3, 75.3
<u>Immediate Breastfeeding</u> : % of newborns who were put to the breast within one hour of delivery and did not receive prelacteal feeds	46.9 (142/303)	40.0, 53.8	40.1 (156/389)	34.1, 46.4
<u>Immediate Breastfeeding (0-11 months)</u> : % of infants less than 12 months of age who were put to the breast within one hour of delivery	71.0 (132/186)	64.0, 78.0	73.0 (154/211)	64.5, 81.5
<u>Prelactial Feeds</u> : % of mothers of children 0-11 months who did not give anything other than breastmilk (prelactial feeds) in the first 3 days after birth	65.6 (122/186)	58.0, 73.2	72.0 (152/211)	66.0, 77.4
<u>Colostrum</u> : % of mothers of children 0-11 months who gave colostrum	71.5 (133/186)	64.4, 78.6	72.0 (152/211)	63.2, 79.5

Overall, vitamin A and immunization coverage increased from baseline to final with the most improvements in vitamin supplementation of children 6-23 months and improved

access to immunizations services for children 12-23 months. At baseline, a total of 146 children had BCG vaccinations (as reported on health cards) and 22 had received Hepatitis B. At final, 66.9% (119/178) children had BCG vaccinations (as reported on health cards) and 92.1% (164/178) had received Hepatitis B (as reported on health cards). Measles vaccination was reported on health cards for only 72 children at baseline, but rates of coverage for self-report and health cards combined was high at 85.5%. At final, 94.4% of children were reported to have received a measles vaccination.

Table 12. Coverage results for vitamin A and immunization indicators.

Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
Vitamin A				
Vitamin A Supplementation: % of children age 6-23 months who received a dose of Vitamin A in the last 6 months	53.9 (125/232)	44.0, 63.8	88.9 (225/253)	83.1, 92.9
Immunization				
*Measles Vaccination: % of children age 12-23 months who received a measles vaccination	85.5 (112/131)	78.4, 92.5	94.4 (168/178)	90.0, 96.9
Access to Immunization Services: % of children age 12-23 months who received a DPT1 vaccination before they reached 12 months	48.9 (64/131)	39.2, 58.6	77.5 (138/178)	70.6, 83.2
*Health System Performance Regarding Immunization Services: % of children age 12-23 months who received a DPT3 vaccination before they reached 12 months	54.2 (71/131)	44.3, 64.1	71.3 (127/178)	63.8, 77.9

At final, weights of children 0-23 months in the sample were found to be inconsistent and therefore, an analysis of percent underweight could not be determined. The 2010 Tanzania DHS found that 28.2% of children under 5 in Arusha Region were underweight by -2 S.D. and 7.6% were underweight by -3 S.D. Given the low percentage of appropriate infant and young child feeding practices in Karatu District, and the drought experienced in the area before and during survey implementation in 2011, it is likely that rates of underweight are similar or higher.

Table 13. Coverage results for nutrition indicators.

Nutrition				
Indicator (* denotes Rapid Catch Indicator)	Baseline		Final	
	% (n/N)	CI	% (n/N)	CI
*Infant and Young Child Feeding: % of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	15.5 36/232	7.6,23.4	26.6 75/282	19.3,33.9

*Underweight: % of children age 0-23 months who are underweight (-SD for the median weight for age, according to WHO/HCHS reference population)	27.4 (75,274)	21.9, 32.8	n/a	n/a
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HIV/AIDS

Data was also collected on HIV/AIDS. A slightly higher percentage (93.5% compared to 98.7% at final) had heard of AIDS. More significantly, 93.7% of women knew at least one method to prevent AIDS or the virus that causes AIDS compared to 74.4% at baseline.

Health contacts and IEC

Women reported few interactions with health professionals or community leaders in the past month, which was essentially unchanged from baseline. When asked where they obtained information on health, similar to baseline, most reported doctors (46.5%) or nurses/midwives (79.7%). However, there was an increase in health information from other groups including: CHW/village health attendant (7.4% at baseline compared to 45.5% at final); CBO/NGO (5.6% at baseline compared to 45.2% at final); VHC (4.6% at baseline compared to 15.7% at final); friend/neighbor (5.3% at baseline, 15.4% at final); mother/mother-in-law (2.2% at baseline, 8% at final).

Other groups were similar to baseline: village elder (3.4% at baseline, 2.3% at final); school teacher (3.1% at baseline, 3.6% at final); husband/partner (2.2% at baseline, 1.3% at final).

Other groups from whom health information was received at final included: TBA (15.4%), grandparent (8.5%), aunt (7.7%), sister (6.4%), traditional leader (1.8%), employer (0.5%).

Respondents also mentioned receiving health information via radio (58.4% at baseline, 67.6% at final), newspapers (16.6% at baseline, 42.7% at final), community organization (12.9% at baseline, 13.4% at final), health educator (10.6% at baseline, 30.3% at final), television (8.1% at baseline, 17.2% at final) and church (16.7%) in the past month.

VI. Discussion

Overall, the KPC results indicate significant changes in health knowledge and health-seeking behaviors among mothers of children under two years old over the life of project.

External comparisons

The final KPC data correlates with Karatu District's annual MCH reports and other district-level evidence of improvements around maternal and child health such as anecdotal reports from village leaders. MCH reports show reductions in neonatal, infant and maternal deaths. However, the timeframe of the project and lack of actual mortality data makes it difficult to show an effect specific to the project. (This is also because Tanzania's maternal and child mortality data was improving during the same time

period.) However, proxy indicators such as modern contraceptive use show similar trends as the KPC survey.

While not directly comparable, some KPC indicators show higher levels of improvement when compared to the Tanzania DHS, including the data for Arusha Region or the Northern Zone (where available). These differences may indicate an effect of the project on health behaviors. However, this cannot be proven from the existing data. The table below compares the project versus TDHS 2010 data.

Table 14. Comparison of KPC to TDHS 2010.**

Nutrition			
Indicator (* denotes Rapid Catch Indicator)	Final KPC 2011 (%)	TDHS 2010 (%)	Notes
ANC Visits	55	42.8	TDHS Rural 39.1, Urban 54.8, Total: 42.8
Skilled Provider	85	47.2	TDHS Arusha: 47.2, Total: 50.6
Post-partum Care (Mother) (w/in 72 hours)	83	32.8	TDHS Arusha: 32.8; Total 35.0
Use of Modern Family Planning	65	34.8	TDHS Arusha: 34.8; Total 23.6
ORT Use	78.2	75.7	TDHS Northern: 75.7; Total: 59.1
ITN Use by Child Under 5 (night before)	91.3	43.5	TDHS Arusha: 43.5; Total: 63.6
Intermittent Preventive Treatment (IPT2)	52.4	33.0	TDHS Arusha: 33.0; Total: 27.2

***Note: Data is not directly comparable due to differences in data collection timing, sampling and interview methodologies. However indicators are identical or very similar.*

Programmatic implications

Reinforcement of knowledge and behavior gains made during the project will be important after the project ends. Specifically, refresher training is needed to maintain skills and motivation of project-trained cadres: traditional birth attendants and community-owned resources persons. Refresher training of TBAs can likely be accomplished via close collaboration with health facility staff and involvement of TBAs in facility-based activities. CORPs require more resource-intensive updates, particularly with the new c-IMCI curriculum becoming available.

A few indicators did not show significant improvement. In particular, point-of-use water treatment still needs to be emphasized due to its effect on reducing diarrheal prevalence. Currently, chemical treatments are not widely available in the district and should be scaled up since other effective methods (boiling, filtration) are difficult to implement for various reasons. Only half of women are spacing their children the recommended three years, indicating a need for further behavior change efforts.

Additionally, while some indicators showed significant change, there is still need for further improvement. Only 55% of women attended four ANC visits, indicating that many women are not accessing all of the prenatal care they require during pregnancy. A case in point: only half of women receive two doses of anti-malarials during pregnancy; this indicator may improve if more women attended ANC earlier in pregnancy. (Additionally, there are at times stockouts of SP.) Although exclusive breastfeeding improved significantly and 65% of women at final exclusively breastfed their under six month infants, given the wide-ranging health benefits, further efforts should be employed to increase exclusive breastfeeding.

Information dissemination

Preliminary KPC data was shared with stakeholders in Karatu and the USAID mission. Final results will be disseminated to the district CHMT and USAID Washington and Tanzania.

Limitations

Self-reported data is subject to bias particularly when respondents feel a need to report socially-acceptable answers. It is possible that responses reflect this bias.

Recall bias is also a problem in self-reported data particularly when a significant amount of time has past or events are difficult to remember (e.g. food consumed in the past 24 hours). Many of the survey questions required the women to recall very specific details of events (e.g. doses of medication, activities during delivery, etc.). Recall appears to be good when different denominators were used for the same questions (e.g. 0-5 months vs. 0-23 months).

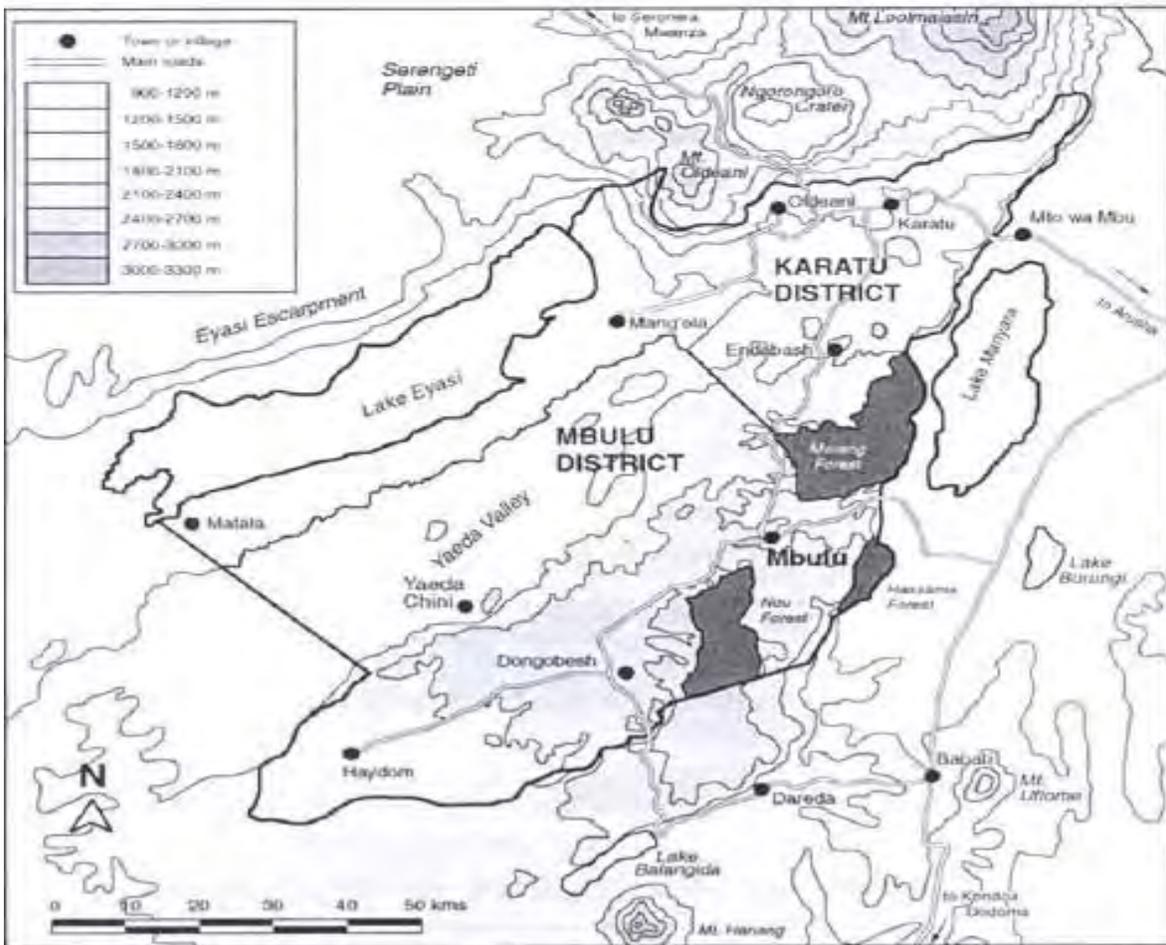
As mentioned above, weight measurements were not properly recorded at times. This could indicate that there was a quality problem with weights either as a result of interviewer error or the scales. Interviewers were trained how to appropriately measure weight and practiced. Scales were calibrated prior to use but experienced heavy wear and tear as households are geographically distant even within villages.

VII. Appendices

Appendix A: Map of Project Area



Source: Mbulu District Council (MDC) 1997
National topographic maps



Appendix B: Logistical Preparations and Schedule

Survey Schedule – KPC 2011, Karatu District Tanzania

Cluster	Date of survey	Ward	Village
1	June 14, 2011	Karatu	G. Arusha
2	June 14, 2011	Karatu	Karatu Town
3	June 14, 2011	Karatu	Karatu Town
4	June 12, 2011	Endamarariiek	Bassodawish
5	June 12, 2011	Endamarariiek	Endallah
6	June 12, 2011	Endamarariiek	Getamok
7	June 12, 2011	Endamarariiek	Khusumay
8	June 12, 2011	Buger	Ayalalio
9	June 11, 2011	Endabash	Qaru
10	June 11, 2011	Endabash	Endabash
11	June 11, 2011	Kansay	Kambi ya Faru
12	June 11, 2011	Kansay	Laja
13	June 10, 2011	Mang'ola	Endamaghan
14	June 10, 2011	Mang'ola	Malekchand
15	June 10, 2011	Baray	Qangdend
16	June 10, 2011	Baray	Mbuga Nyekundu
17	June 10, 2011	Baray	Dumbechand
18	June 11, 2011	Qurus	Gongali
19	June 11, 2011	Qurus	Bashay
20	June 11, 2011	Qurus	Bashay
21	June 13, 2011	Daa	Mang'ola Juu
22	June 13, 2011	Oldeani	Oldeani
23	June 13, 2011	Ganako	Ayalabe
24	June 13, 2011	Ganako	Tloma
25	June 13, 2011	Rhotia	ChemChem
26	June 14, 2011	Rhotia	Kainam Rhotia
27	June 14, 2011	Rhotia	Rotia Kati
28	June 9, 2011	Mbulumbulu	Lositete
29	June 9, 2011	Mbulumbulu	Slahammo
30	June 9, 2011	Mbulumbulu	Kambi ya Simba

Appendix C: Survey Questionnaire in English and Swahili

WellShare Tanzania Child Survival Project Knowledge Practice Coverage Questionnaire Mothers of Children Under Two Years of Age

INTRODUCTION

Ask the mother living in the household the age of her youngest child who lives with her. If the child is under 24 months of age, proceed with the interview. If the youngest child is 24 months or older, thank the mother and end the interview.

INFORMED CONSENT

Hello. My name is _____, and I am working with the Ministry of Health and WellShare International (formerly Minnesota International Health Volunteers), an international organization working in Karatu District. We are conducting a survey and would appreciate your participation. I would like to ask you about your health and the health of your youngest child under the age of two. This information will help us plan health services and assess whether we are meeting our goals to improve children's health. The survey usually takes 60 minutes to complete. Whatever information you provide will be kept strictly confidential. We will not pass on your name or the information you provide to any other person.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

At this time, do you want to ask me anything about the survey?

Signature of Interviewer: _____ Date: |__||__|/|__||__|/|__||__||__||__|
day / month / year

MARK ONE:

RESPONDENT AGREES TO BE INTERVIEWED (1) → BEGIN interview

RESPONDENT DOES NOT AGREE TO INTERVIEW (2) → END; Do not interview woman

IDENTIFICATION

Cluster Number: _____

Household Number: _____

Record Number: _____

Name of Mother: _____

Name of Supervisor: _____ Name of 10-Cell Leader: _____

Data Entered By: _____ Date: |__||__|/|__||__|/|__||__||__||__|
day / month / year

RESULT OF INTERVIEW (Check box and initial when completed)

	Completed interview / Interviewer review
	Supervisor review
	Data corrections completed (if necessary)

	Completed data entry
	Data entry review

Questionnaire

ALL QUESTIONS ARE TO BE ADDRESSED TO MOTHERS WITH A CHILD LESS THAN 24 MONTHS OF AGE.

RESPONDENT BACKGROUND

No.	Questions and Filters	Coding Categories	Skips
1	In which languages do you feel most comfortable communicating? RECORD <u>ALL</u> MENTIONED.	SWAHIILI.....A IRAQW.....B CHAGA.....C OTHER.....X (SPECIFY)	
2	How old are you?	AGE (in completed years) <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	
3	Do you do anything to increase your income? IF NO, CIRCLE "A" (NO OUTSIDE WORK) IF YES, ASK What kind of work do you do? RECORD <u>ALL</u> MENTIONED.	NO OUTSIDE WORK.....A HANDICRAFTS.....B FARMING.....C ANIMAL HUSBANDRY.....D SELLING FOODS.....E SHOP KEEPER/STREET VENDOR...F SERVANT/HOUSEHOLD WORKER..G SALARIED WORKER.....H OTHER.....X (SPECIFY)	
4	Have you ever attended school?	YES.....1 NO.....2	→ 6

5	What is the highest level of school you attended? CIRCLE ONE ONLY.	SOME PRIMARY.....A COMPLETED PRIMARY.....B SOME SECONDARY.....C COMPLETED SECONDARY OR HIGHER.....D	
6	What is your current marital status?	MARRIED.....A SINGLE.....B WIDOWED.....C DIVORCED.....D OTHER.....E (SPECIFY)	→ 8
7	Is the father of (NAME) currently living in the same house with you?	YES.....1 NO.....2	

CHILD SPACING

No.	Questions and Filters	Coding Categories	Skips
8	How many children living in this household are under five years of age?	ONE CHILD.....1 TWO CHILDREN.....2 THREE OR MORE CHILDREN.....3	
9	How many children do you have?	TOTAL NUMBER OF CHILDREN <input type="text"/> <input type="text"/>	
10	How many pregnancies have you had?	TOTAL NUMBER OF PREGNANCIES <input type="text"/> <input type="text"/>	
11	How many children did you give birth to?	TOTAL NUMBER OF BIRTHS <input type="text"/> <input type="text"/>	

12	What is the name, sex, date of birth of your youngest child that you gave birth to?	<p style="text-align: center;">Youngest Child</p> <p>NAME _____</p> <p style="text-align: center;">Sex</p> <p>MALE.....1</p> <p>FEMALE.....2</p> <p style="text-align: center;">Date of Birth</p> <p>DAY <input type="text"/> <input type="text"/></p> <p>MONTH <input type="text"/> <input type="text"/></p> <p>YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	
13	CHECK QUESTION 11 AND RECORD NUMBER OF CHILDREN EVER BORN.	<p>One (code 1) <input type="checkbox"/></p> <p>Two or more (code 2) <input type="checkbox"/></p>	→ 15
14	What is the name, sex, date of birth of your second youngest child that you gave birth to?	<p style="text-align: center;">Second Youngest Child</p> <p>NAME _____</p> <p style="text-align: center;">Sex</p> <p>MALE.....1</p> <p>FEMALE.....2</p> <p style="text-align: center;">Date of Birth</p> <p>DAY <input type="text"/> <input type="text"/></p> <p>MONTH <input type="text"/> <input type="text"/></p> <p>YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	

15 Who takes care of (NAME of YOUNGEST CHILD) when you are away from home?

RECORD **ALL** MENTIONED.

- MOTHER (RESPONDENT).....A
- HUSBAND/PARTNER.....B
- OLDER CHILDREN.....C
- OTHER RELATIVES _____D
(SPECIFY)
- NEIGHBORS/FRIENDS.....E
- HOUSE GIRL.....F

- OTHER _____X
(SPECIFY)

ANTENATAL CARE

No. Questions and Filters

16 Did you see anyone for antenatal care while you were pregnant with (NAME)?

IF YES: Whom did you see?

Anyone else?

PROBE FOR THE TYPE OF PERSON AND RECORD **ALL** PERSONS MENTIONED BY THE MOTHER.

17 How many times did you receive antenatal care during this pregnancy?

- Coding Categories**
- HEALTH FACILITY STAFF
- DOCTOR.....A
 - NURSE.....B
 - MIDWIFE.....C
 - MEDICAL ATTENDANT.....D
 - OTHER HEALTH STAFF WITH MIDWIFERY SKILLS.....E
- TRAINED COMMUNITY MEMBERS
- TRAINED TRADITIONAL BIRTH ATTENDANT.....F
 - HBLSS-TRAINED TRADITIONAL BIRTH ATTENDANT.....G
 - TRAINED COMMUNITY HEALTH WORKER.....H
- UNTRAINED COMMUNITY MEMBERS
- TRADITIONAL BIRTH ATTENDANT...I
 - COMMUNITY HEALTH WORKER.....J
 - RELATIVE/FRIEND.....K
 - OTHER _____X
 - NO ONE.....Z
- NUMBER OF TIMES
- DON'T KNOW.....98

Skips

18	During your pregnancy with (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is convulsions after birth?	YES.....1 NO.....2 DON'T KNOW.....8	→ 20 → 20
19	While pregnant with (NAME), how many times did you receive such an injection?	ONE.....1 TWO.....2 THREE OR MORE.....3 DON'T KNOW.....8	
20	Did you receive any tetanus toxoid injection at any time before that pregnancy, including during a previous pregnancy or between pregnancies?	YES.....1 NO.....2 DON'T KNOW.....8	→ 22 → 22
21	Before the pregnancy with (NAME), how many times did you receive a tetanus injection?	ONE.....1 TWO.....2 THREE OR MORE.....3 DON'T KNOW.....8	
22	Do you have a maternal health card for your pregnancy with (NAME)?	YES, SEEN.....A NOT AVAILABLE.....B NEVER HAD A CARD.....C	→ 26 → 26
23	LOOK AT CARD AND RECORD THE NUMBER OF ANTENATAL VISITS WHILE THE MOTHER WAS PREGNANT WITH (NAME).	NUMBER OF ANC VISITS: <input type="text"/> <input type="text"/>	

24	<p>RECORD THE DATES FOR EACH TT INJECTION LISTED ON THE CARD</p>	<p style="text-align: right;">day/month/year</p> <p>FIRST.....___/___/___</p> <p>SECOND.....___/___/___</p> <p>THIRD.....___/___/___</p> <p>FOURTH.....___/___/___</p> <p>FIFTH.....___/___/___</p> <p>SIXTH.....___/___/___</p> <p>RECORD THE NUMBER OF TT DOSES COMPLETED DURING THE MOST RECENT PREGNANCY _____</p>	
25	<p>RECORD THE DATES FOR EACH IPT DOSE LISTED ON THE CARD.</p> <p>RECORD WHICH DRUG WAS TAKEN.</p>	<p>NAME OF DRUG day /month/year</p> <p>_____ ___/___/___</p> <p>_____ ___/___/___</p> <p>_____ ___/___/___</p> <p>_____ ___/___/___</p> <p>_____ ___/___/___</p> <p>_____ ___/___/___</p> <p>WERE TWO OR MORE DOSES GIVEN DURING THE MOST RECENT PREGNANCY?</p> <p>YES.....1</p> <p>NO.....2</p>	
26	<p>When you were pregnant with (NAME) did you take any drugs to prevent you from getting malaria?</p>	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....8</p>	<p>→ 29</p> <p>→ 29</p>

27 Which drugs did you take?
 RECORD **ALL** MENTIONED.

ANTIMALARIAL	YES	NO	DK
A. SP/ORODAR.....	1	2	8
B. CHLORQUINE.....	1	2	8
C. AMODIAQUINE.....	1	2	8
D. QUININE.....	1	2	8
E. ACT.....	1	2	8
X. OTHER_____	1	2	8

(SPECIFY)

28 How many times during pregnancy did you take the drugs?
 RECORD THE NUMBER OF SEPARATE EVENTS/OCCASIONS WHEN THE DRUG WAS TAKEN, NOT THE NUMBER OF DOSES.

ANTIMALARIAL	NO. TIMES
A. SP/ORODAR.....	_____
B. CHLORQUINE.....	_____
C. AMODIAQUINE.....	_____
D. QUININE.....	_____
E. ACT.....	_____
X. OTHER_____	_____

(SPECIFY)

29 How far are you from the nearest health facility?
 WRITE THE NAME OF THE FACILITY.

KILOMETERS

--	--	--	--

(NAME OF FACILITY)

30	<p>How would you get there?</p> <p>RECORD ALL MENTIONED.</p>	<p>WALK.....A</p> <p>BICYCLE.....B</p> <p>PRIVATE CAR.....C</p> <p>DALA DALA.....D</p> <p>MOTORCYCLE.....E</p> <p>ANIMAL CART.....F</p> <p>BOAT/CANOE.....G</p> <p>AMBULANCE.....H</p> <p>SPECIAL HIRE/TAXI.....I</p> <p>STRETCHER.....J</p> <p>TRACTOR.....K</p> <p>OTHER.....X</p> <p>(SPECIFY)</p>	
31	<p>How long would it take you to get there?</p>	<p>LESS THAN 1 HOUR.....1</p> <p>1 TO 3 HOURS.....2</p> <p>GREATER THAN 3 HOURS.....3</p> <p>DON'T KNOW.....8</p>	
32	<p>Who would decide you should go there?</p> <p>RECORD ALL MENTIONED.</p>	<p>RESPONDENT.....A</p> <p>HUSBAND/PARTNER.....B</p> <p>RESPONDENT'S MOTHER.....C</p> <p>MOTHER-IN-LAW.....D</p> <p>FRIENDS/NEIGHBORS.....E</p> <p>TRADITIONAL BIRTH ATTENDANT.....F</p> <p>OTHER.....X</p> <p>(SPECIFY)</p>	

33	<p>What are the symptoms during pregnancy indicating the need to seek health care?</p> <p>RECORD <u>ALL</u> MENTIONED.</p>	<p>FEVER.....A</p> <p>SHORTNESS OF BREATH.....B</p> <p>BLEEDING.....C</p> <p>SWELLING OF THE BODY, HANDS AND/OR FACE.....D</p> <p>OTHER.....X (SPECIFY)</p> <p>DON'T KNOW.....Z</p>	
34	<p>Where is the first place you would go for care if you had these symptoms?</p>	<p><u>HEALTH FACILITY</u></p> <p>HOSPITALA</p> <p>HEALTH CENTER.....B</p> <p>DISPENSARY.....C</p> <p>FIELD/COMMUNITY HEALTH WORKER.....D</p> <p><u>OTHER SOURCE</u></p> <p>TRADITIONAL PRACTITIONER.....E</p> <p>SHOP.....F</p> <p>PHARMACY.....G</p> <p>COMMUNITY DISTRIBUTORS (UNLICENSED).....H</p> <p>FRIEND/RELATIVE.....I</p> <p>OTHER.....X (SPECIFY)</p>	
35	<p>When you were pregnant with (NAME), did you receive or buy any iron tablets or iron syrup?</p> <p>SHOW TABLETS/SYRUP TO THE MOM.</p>	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....8</p>	
DELIVERY			
No.	Questions and Filters	Coding Categories	Skips

36 Where did you give birth to (NAME)?

IF SOURCE IS HOSPITAL, HEALTH CENTER, OR DISPENSARY, WRITE THE NAME OF THE FACILITY.

(NAME OF FACILITY)

- HOME
- YOUR HOME.....A
- OTHER HOME.....B
- HEALTH FACILITY
- HOSPITAL.....C
- CLINIC.....D
- DISPENSARY.....E
- OTHER _____...X
- (SPECIFY)

37 Who assisted with the delivery of (NAME)?

Anyone else?

PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD **ALL** MENTIONED.

IF RESPONDENT SAYS NO ONE ASSISTED, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.

- HEALTH FACILITY STAFF
- DOCTOR.....A
- NURSE.....B
- MIDWIFE.....C
- MEDICAL ATTENDANT.....D
- OTHER HEALTH STAFF WITH MIDWIFERY SKILLS.....E
- TRAINED COMMUNITY MEMBERS
- TRAINED TRADITIONAL BIRTH ATTENDANT.....F
- HBLSS-TRAINED TRADITIONAL BIRTH ATTENDANT.....G
- TRAINED COMMUNITY HEALTH WORKER.....H
- UNTRAINED COMMUNITY MEMBERS
- TRADITIONAL BIRTH ATTENDANT...I
- COMMUNITY HEALTH WORKER.....J
- RELATIVE/FRIEND.....K
- OTHER _____...X
- NO ONE.....Z

38	<p>What instrument was used to cut the cord?</p> <p>RECORD ONLY ONE RESPONSE.</p>	<p>NEW RAZOR BLADE.....A</p> <p>NEW AND BOILED RAZOR BLADE...B</p> <p>USED RAZOR BLADE.....C</p> <p>USED AND BOILED RAZOR BLADE.D</p> <p>NEW SCISSORS.....E</p> <p>NEW AND BOILED SCISSORS.....F</p> <p>USED SCISSORS.....G</p> <p>USED AND BOILED SCISSORS.....H</p> <p>KNIFE.....I</p> <p>STRING.....J</p> <p>OTHER.....X</p> <p>(SPECIFY)</p> <p>DON'T KNOW.....Z</p>	
39	<p>CHECK QUESTION 37. IF MOTHER (RESPONDENT) ANSWERED A, B, D, F, OR H, RECORD "1"</p>	<p>IF A, B, D, F OR H.....1</p>	
40	<p>Was a Clean Delivery kit used during delivery?</p>	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....8</p>	
41	<p>Immediately after (NAME) was born, before the placenta was delivered, did you receive an injection to prevent you from bleeding too much?</p>	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....8</p>	<p>→ 44</p> <p>→ 44</p>
42	<p>Immediately after you got an injection to prevent you from bleeding, did the birth attendant hold your stomach and pull on cord to help the placenta come out?</p>	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....8</p>	<p>→ 44</p> <p>→ 44</p>

43	Immediately after the placenta was delivered, did someone massage your uterus to make it contract strongly and to prevent you from bleeding too much?	YES.....1 NO.....2 DON'T KNOW.....8	→ 44 → 44
44	CHECK RESPONSES TO QUESTIONS 41, 42, AND 43.	IF Q41, Q42 AND Q43 = YES (1).....1 IF Q41, Q42, Q43 = NO(2) OR DON'T KNOW(8).....2	
45	Was (NAME) dried (wiped) immediately after birth before the placenta was delivered?	YES.....1 NO.....2 DON'T KNOW.....8	
46	Was (NAME) wrapped in a warm cloth or blanket immediately after birth before the placenta was delivered?	YES.....1 NO.....2 DON'T KNOW.....8	
POST-PARTUM CARE			
No.	Questions and Filters	Coding Categories	Skips
47	Did a health care provider or traditional birth attendant check on your health after the delivery of your youngest child, either at a health facility, home or other location?	YES.....1 NO.....2	→ 52
48	How long after the delivery did the first check take place? IF LESS THAN ONE DAY, CIRCLE 0 AND RECORD HOURS; IF LESS THAN ONE WEEK, CIRCLE 1 AND RECORD DAYS; IF MORE THAN 6 DAYS, CIRCLE 2 AND RECORD WEEKS.	HOURS 0 <input type="text"/> <input type="text"/> DAYS 1 <input type="text"/> <input type="text"/> WEEKS 2 <input type="text"/> <input type="text"/> DON'T KNOW.....998	

49 Who checked your health at that time?

PROBE FOR THE MOST QUALIFIED PERSON AND CIRCLE **ONE** RESPONSE.

- HEALTH FACILITY STAFF**
- DOCTOR.....A
- NURSE.....B
- MIDWIFE.....C
- MEDICAL ATTENDANT.....D
- OTHER HEALTH STAFF WITH MIDWIFERY SKILLS.....E
- TRAINED COMMUNITY MEMBERS**
- TRAINED TRADITIONAL BIRTH ATTENDANT.....F
- HBLSS-TRAINED TRADITIONAL BIRTH ATTENDANT.....G
- TRAINED COMMUNITY HEALTH WORKER.....H
- UNTRAINED COMMUNITY MEMBERS**
- TRADITIONAL BIRTH ATTENDANT...I
- COMMUNITY HEALTH WORKER.....J
- RELATIVE/FRIEND.....K
- OTHER.....X
- NO ONE.....Z

50 Did you have any other post-partum checks?

- YES.....1
- NO.....2

51 During your postpartum check, were you counseled on the following:

	YES	NO	DK
A Child spacing?	1	2	8
B Infant nutrition?	1	2	8
C Child immunizations?	1	2	8
D Infant diarrhea?	1	2	8
E Early signs of pneumonia?	1	2	8

52 After (NAME) was born, did any health care provider or traditional birth attendant check on (NAME'S) health?

- YES.....1
- NO.....2

→ 55

53	<p>How long after the birth of (NAME) did the first check take place?</p> <p>IF LESS THAN ONE DAY, CIRCLE 0 AND RECORD HOURS; IF LESS THAN ONE WEEK, CIRCLE 1 AND RECORD DAYS; IF MORE THAN 6 DAYS, CIRCLE 2 AND RECORD WEEKS.</p>	<p>HOURS 0 <input type="text"/> <input type="text"/></p> <p>DAYS 1 <input type="text"/> <input type="text"/></p> <p>WEEKS 2 <input type="text"/> <input type="text"/></p> <p>DON'T KNOW.....998</p>	
54	<p>Who checked on (NAME'S) health at that time?</p> <p>PROBE FOR THE MOST QUALIFIED PERSON AND CIRCLE ONE RESPONSE.</p>	<p>HEALTH FACILITY STAFF</p> <p>DOCTOR.....A</p> <p>NURSE.....B</p> <p>MIDWIFE.....C</p> <p>MEDICAL ATTENDANT.....D</p> <p>OTHER HEALTH STAFF WITH MIDWIFERY SKILLS.....E</p> <p>TRAINED COMMUNITY MEMBERS</p> <p>TRAINED TRADITIONAL BIRTH ATTENDANT.....F</p> <p>HBLSS-TRAINED TRADITIONAL BIRTH ATTENDANT.....G</p> <p>TRAINED COMMUNITY HEALTH WORKER.....H</p> <p>UNTRAINED COMMUNITY MEMBERS</p> <p>TRADITIONAL BIRTH ATTENDANT...I</p> <p>COMMUNITY HEALTH WORKER.....J</p> <p>RELATIVE/FRIEND.....K</p> <p>OTHER.....X</p> <p>NO ONE.....Z</p>	
55	<p>What are the danger signs for the mother after giving birth indicating the need for health care?</p> <p>RECORD ALL MENTIONED.</p>	<p>FEVER.....A</p> <p>EXCESSIVE BLEEDING.....B</p> <p>SMELLY VAGINAL DISCHARGE.....C</p> <p>OTHER.....X</p> <p>(SPECIFY)</p> <p>DON'T KNOW.....Z</p>	

56	<p>What are the danger signs that indicate a newborn baby is ill and needs medical care?</p> <p>RECORD ALL MENTIONED.</p>	<p>POOR FEEDING.....A FAST BREATHING.....B NOT ACTIVE.....C REDNESS AROUND THE CORD.....D RED/DISCHARGING EYE.....E</p> <p>OTHER.....X (SPECIFY)</p> <p>DON'T KNOW.....Z</p>	
BREASTFEEDING			
No.	Questions and Filters	Coding Categories	Skips
57	Did you ever breastfeed (NAME)?	YES.....1 NO.....2	→ 63
58	How long after the birth did you first put (NAME) to the breast? IF LESS THAN 1 HOUR, CIRCLE CODE 0 FOR HOURS AND RECORD 00 FOR THE NUMBER OF HOURS; IF LESS THAN 24 HOURS, CIRCLE 0 AND RECORD THE HOURS; IF 24 HOURS OR MORE, CIRCLE 1 AND RECORD DAYS.	HOURS 0 <input type="text"/> <input type="text"/> DAYS 1 <input type="text"/> <input type="text"/> DON'T KNOW.....998	
59	During the first three or four days after delivery, before your regular milk began flowing, did you give (NAME) the liquid (colostrum) that came from your breasts?	YES.....1 NO.....2 DON'T KNOW.....8	
60	In the first three days after delivery, was (NAME) given anything to drink other than breast milk?	YES.....1 NO.....2 DON'T KNOW.....8	
61	Are you still breastfeeding (NAME)?	YES.....1 NO.....2	

62 For how many months did you breastfeed (NAME)?

MONTHS

--	--

IF LESS THAN 1 MONTH, RECORD "00" MONTHS.

63 Now I would like to ask you about liquids or foods (NAME) had yesterday during the day or at night.

Did (NAME) drink/eat:

READ THE LIST OF LIQUIDS (A THROUGH E, STARTING WITH BREAST MILK).

	YES	NO	DK
A Breast milk?	A.....1	2	8
B Milk (not breastmilk)?	B.....1	2	8
C Plain water?	C.....1	2	8
D Sugar or glucose water?	D.....1	2	8
E Gripe water?	E.....1	2	8
F Sugar-salt solution?	F.....1	2	8
G Fruit juice?	G.....1	2	8
H Commercially produced infant formula (e.g. Simulac, Lactogen, or Cow and Gate)?	H.....1	2	8
I Any fortified, commercially available infant and young child food [e.g. Cerelac]?	I.....1	2	8
J Any (other) porridge or gruel?	J.....1	2	8
K Tea / Infusions?	K.....1	2	8
L Honey?	L.....1	2	8
M Other _____? (SPECIFY)	M.....1	2	8

64 Now I would like to ask you about (other) liquids or foods that (NAME) may have had yesterday during the day or at night. I am interested in whether your child had the item even if it was combine with other foods.				
Did (NAME) drink/eat:		YES	NO	DK
A	Milk such as tinned, powdered or fresh animal milk?	A.....1	2	8
B	Tea or coffee?	B.....1	2	8
C	Any other liquids?	C.....1	2	8
D	Bread, rice, ugali or other foods made from grains?	D.....1	2	8
E	Pumpkin, carrots, squash or sweet potatoes that are yellow or orange inside?	E.....1	2	8
F	Irish potatoes, white yams, cassava or any other foods made from roots?	F.....1	2	8
G	Any dark green leafy vegetables?	G.....1	2	8
H	Ripe mangoes or papayas	H.....1	2	8
I	Any other fruits or vegetables?	I.....1	2	8
J	Liver, kidney, heart or other organ meats?	J.....1	2	8
K	Any meat, such as beef, pork, lamb, goat, chicken or duck?	K.....1	2	8
L	Eggs?	L.....1	2	8
M	Fresh or dried fish?	M.....1	2	8
N	Any foods made from beans, peas, lentils or nuts?	N.....1	2	8
O	Cheese, yogurt or other milk products?	O.....1	2	8
P	Any oils, fats, or butter or foods made with any of these?	P.....1	2	8
Q	Any sugary foods such as chocolates, sweets, candies, pastries, cakes or biscuits?	Q.....1	2	8
R	Any other solid or semi-solid food?	R.....1	2	8
S	Foods made with red palm oil, palm nut, palm nut pulp sauce?	S.....1	2	8

65	How many times did (NAME) eat solid, semi-solid or soft foods other than liquids yesterday during the day or at night?	NUMBER OF TIMES <input type="checkbox"/>	
	IF CAREGIVER ANSWERS 7 OR MORE TIMES, RECORD "7"	DON'T KNOW 8	
	ADAPT WITH E.G. FOR SOLID, SEMI-SOLID, OR SOFT FOODS (Ugali, viazi vya kupikwa, mayai, matunda, mboga mboga)		
	WE WANT TO FIND OUT HOW MANY TIMES THE CHILD ATE ENOUGH TO BE FULL. SMALL SNACKS AND SMALL FEEDS SUCH AS ONE OR TWO BITES OF MOTHER'S OR SISTER'S FOOD SHOULD NOT BE COUNTED.		
	LIQUIDS DO NOT COUNT FOR THIS QUESTION. DO NOT INCLUDE THIN SOUPS OR BROTH, WATERY GRUEL OR ANY OTHER LIQUID.		
	USE PROBING QUESTIONS TO HELP THE RESPONDENT REMEMBER ALL THE TIMES THE CHILD ATE YESTERDAY.		
66	Has (NAME) ever received a Vitamin A dose (like this/any of these)?	YES.....1	
	SHOW COMMON TYPES OF AMPULES/CAPSULES/SYRUPS	NO.....2	→ 68
		DON'T KNOW.....8	→ 68
67	Did (NAME) receive a Vitamin A dose within the last six months?	YES.....1	
		NO.....2	
		DON'T KNOW.....8	
CHILD IMMUNIZATIONS			
No.	Questions and Filters	Coding Categories	Skips
68	Do you have a card or child health booklet where (NAME'S) vaccinations are written down?	YES.....1	
	IF YES: May I see it?	NO.....2	→ 71
		DON'T KNOW.....8	→ 71

69	<p>RECORD THE DATES FOR EACH VITAMIN A DOSE LISTED ON THE CARD.</p>	<p style="text-align: right;">day/month/year</p> <p>FIRST.....___/___/___</p> <p>SECOND.....___/___/___</p> <p>THIRD.....___/___/___</p>	
70	<p>COPY VACCINATION DATE FOR DPT1, DPT2, DPT3, POLIO, BCG, HEPATITIS B AND MEASLES FROM THE CARD OR BOOKLET.</p> <p>IF VACCINES ARE NOT RECORDED IN THE CHILD HEALTH CARD OR BOOKLET, FILL IN 99/99/9999.</p> <p>IF MEASLES IS RECORDED ON CARD SKIP TO Q72.</p>	<p style="text-align: center;">Day Month Year</p> <p>DPT1..... _ _ / _ _ / _ _ _ _ _ </p> <p>DPT2..... _ _ / _ _ / _ _ _ _ _ </p> <p>DPT3..... _ _ / _ _ / _ _ _ _ _ </p> <p>OPV..... _ _ / _ _ / _ _ _ _ _ </p> <p>BCG..... _ _ / _ _ / _ _ _ _ _ </p> <p>HEP B.... _ _ / _ _ / _ _ _ _ _ </p> <p>Measles... _ _ / _ _ / _ _ _ _ _ </p>	<p>→ 72</p>
71	<p>Did (NAME) ever receive an injection in the arm to prevent measles?</p>	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....8</p>	
<p>CARE OF THE SICK CHILD</p>			
No.	Questions and Filters	Coding Categories	Skips

72 Sometimes children get sick and need to receive care or treatment. What are the signs of illness that would indicate your child needs treatment?

RECORD **ALL** MENTIONED.

- LOOKS UNWELL OR NOT
- PLAYING NORMALLY.....A
- NOT EATING OR DRINKING.....B
- LETHARGIC OR DIFFICULT TO WAKE.....C
- HIGH FEVER.....D
- FAST/DIFFICULT BREATH.....E
- VOMITS EVERYTHING.....F
- CONVULSIONS.....G
- OTHER _____.....W
(SPECIFY)
- OTHER _____.....X
(SPECIFY)
- OTHER _____.....Y
(SPECIFY)
- DON'T KNOW.....Z

73 Did (NAME) experience any of the following in the past two weeks?

CIRCLE **ALL** THAT APPLY.

- A** Diarrhea?
- B** Blood in stool?
- C** Cough?
- D** Difficult breathing?
- E** Fast breathing or short, quick breaths?
- F** Fever?
- G** Malaria?
- H** Convulsions?

- NO.....X
- DIARRHEA.....A
- BLOOD IN STOOL.....B
- COUGH.....C
- DIFFICULT BREATHING.....D
- FAST BREATHING / SHORT, QUICK BREATHS.....E
- FEVER.....F
- MALARIA.....G
- CONVULSIONS.....H

→ **75**

<p>74 Did you seek care for your child?</p> <p>IF YES, ASK</p> <p>Where did you seek care?</p> <p>CIRCLE <u>ALL</u> MENTIONED.</p>	<p><u>HEALTH FACILITY</u></p> <p>HOSPITALA</p> <p>HEALTH CENTER.....B</p> <p>DISPENSARY.....C</p> <p>FIELD/COMMUNITY HEALTH WORKER.....D</p> <p><u>OTHER SOURCE</u></p> <p>TRADITIONAL PRACTITIONER.....E</p> <p>SHOP.....F</p> <p>PHARMACY.....G</p> <p>COMMUNITY DISTRIBUTORS (UNLICENSED).....H</p> <p>FRIEND/RELATIVE.....I</p> <p>OTHER.....X</p> <p>(SPECIFY)</p>
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MALARIA – TREATMENT OF FEVER OF CHILD

No.	Questions and Filters	Coding Categories	Skips
75	Has (NAME) been ill with fever at any time during the last two weeks?	YES.....1 NO.....2 DON'T KNOW.....8	→ 85 → 85
76	Does (NAME) have a fever now?	YES.....1 NO.....2 DON'T KNOW.....8	
77	Did you seek treatment for the fever?	YES.....1 NO.....2	→ 80
78	How many days after the fever began did you first seek treatment for (NAME)?	SAME DAY.....0 NEXT DAY.....1 TWO OR MORE DAYS.....2	

79 Where did you first go for advice or treatment?

RECORD ONLY **ONE** RESPONSE.

IF SOURCE IS HOSPITAL, HEALTH CENTER, OR DISPENSARY, WRITE THE NAME OF THE FACILITY.

(NAME OF FACILITY)

HEALTH FACILITY

- HOSPITALA
- HEALTH CENTER.....B
- DISPENSARY.....C
- FIELD/COMMUNITY HEALTH WORKER.....D

OTHER SOURCE

- TRADITIONAL PRACTITIONER.....E
- SHOP.....F
- PHARMACY.....G
- COMMUNITY DISTRIBUTORS (UNLICENSED).....H
- FRIEND/RELATIVE.....I

OTHER_____...X
(SPECIFY)

80 At any time during the illness did (NAME) take any drugs for the fever?

YES.....1

NO.....2

DON'T KNOW.....8

→ 82

→ 82

81 What drugs did (NAME) take?
 Any other drugs?
 RECORD **ALL** MENTIONED.
 ASK TO SEE DRUG(S) IF TYPE OF DRUG IS NOT KNOWN. IF TYPE OF DRUG IS STILL NOT DETERMINED SHOW TYPICAL ANTIMALARIAL DRUGS TO RESPONDENT.
 FOR EACH ANTIMALARIAL MEDICINE ASK:
 How long after the fever started did (NAME) start taking the medicine?
 CIRCLE THE APPROPRIATE CODES:
 0 = SAME DAY
 1 = NEXT DAY AFTER THE FEVER
 2 = TWO OR MORE DAYS AFTER THE FEVER
 8 = DON'T KNOW

82 When (NAME) was sick with a fever, did you breastfeed him/her less than usual, about the same, or more than usual?

83 When (NAME) was sick with a fever, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?

84 When (NAME) was sick with a fever, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?

ANTIMALARIAL
 A. SP/ORODAR.....0 1 2 8
 B. CHLORQUINE.....0 1 2 8
 C. AMODIAQUINE.....0 1 2 8
 D. QUININE.....0 1 2 8
 E. ACT.....0 1 2 8
OTHER DRUGS
 F. ASPIRIN.....0 1 2 8
 G. PANADOL/.....0 1 2 8
 PARACETAMOL.....0 1 2 8
 H. CO-TRIMOXAZOLE 0 1 2 8
 X. OTHER.....0 1 2 8

 (SPECIFY)
 Z. UNKNOWN DRUG.....0 1 2 8

LESS.....1
 SAME.....2
 MORE3
 CHILD NOT BREASTFED.....4
 DON'T KNOW.....8

LESS.....1
 SAME.....2
 MORE3
 DON'T KNOW.....8

LESS.....1
 SAME.....2
 MORE3
 DON'T KNOW.....8

CONTROL OF DIARRHEA

No.	Questions and Filters	Coding Categories	Skips
-----	-----------------------	-------------------	-------

85	Has (NAME) had diarrhea in the last two weeks?	YES.....1	→ 95								
		NO.....2									
		DON'T KNOW.....8	→ 95								
86	Was she/he given any of the following to drink at any time since she/he started having diarrhea:	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>A.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		YES	NO	DK	A.....	1	2	8	
	YES	NO	DK								
A.....	1	2	8								
A	A fluid made from a special packet called ORS?										
B	A pre-packaged ORS liquid?	B.....1 2 8									
C	A government-recommended homemade fluid?	C.....1 2 8									
87	Was anything (else) given to treat the diarrhea?	YES.....1	→ 89								
		NO.....2									
		DON'T KNOW.....8	→ 89								
88	What (else) was given to treat the diarrhea? Anything else? RECORD ALL TREATMENTS.	<u>PILL OR SYRUP</u> ANTIBIOTIC.....A ANTIMOTILITY (e.g. Vacontil).....B ANTIPARASITIC (e.g. Flagyl).....C ZINC.....D INJECTION.....E (IV) INTRAVENOUS.....F <u>HOME REMEDY/HERBAL</u> MEDICINE.....G OTHER.....X									
89	With (NAME's) most recent illness with diarrhea, did (NAME) experience any of the following:	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>A.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		YES	NO	DK	A.....	1	2	8	
	YES	NO	DK								
A.....	1	2	8								
A	Bloody stools?										
B	Diarrhea that lasted for more than two weeks?	B.....1 2 8									

<p>90 Did you seek advice or treatment from someone outside the home for (NAME'S) diarrhea?</p>	<p>YES.....1 NO.....2</p>	<p>→ 92</p>
<p>91 Where did you first go for advice or treatment?</p> <p>RECORD ONLY ONE RESPONSE.</p> <p>IF SOURCE IS HOSPITAL, HEALTH CENTER, OR DISPENSARY, WRITE THE NAME OF THE FACILITY.</p> <hr/> <p>(NAME OF FACILITY)</p>	<p><u>HEALTH FACILITY</u></p> <p>HOSPITALA HEALTH CENTER.....B DISPENSARY.....C FIELD/COMMUNITY HEALTH WORKER.....D</p> <p><u>OTHER SOURCE</u></p> <p>TRADITIONAL PRACTITIONER....E SHOP.....F PHARMACY.....G COMMUNITY DISTRIBUTORS (UNLICENSED).....H FRIEND/RELATIVE.....I</p> <p>OTHER.....X (SPECIFY)</p>	
<p>92 When (NAME) was sick with diarrhea, did you breastfeed him/her less than usual, about the same, or more than usual?</p>	<p>LESS.....1 SAME.....2 MORE3 CHILD NOT BREASTFED.....4 DON'T KNOW.....8</p>	
<p>93 When (NAME) was sick with diarrhea, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?</p>	<p>LESS.....1 SAME.....2 MORE3 DON'T KNOW.....8</p>	
<p>94 When (NAME) was sick with diarrhea, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?</p>	<p>LESS.....1 SAME.....2 MORE3 DON'T KNOW.....8</p>	

ARI/PNEUMONIA

No.	Questions and Filters	Coding Categories	Skips
95	Has (NAME) had an illness with a cough that comes from the chest at any time in the last two weeks?	YES.....1 NO.....2 DON'T KNOW.....8	→ 104 → 104
96	When (NAME) had an illness with a cough, did he/she have trouble breathing or breath faster than usual with short, fast breaths?	YES.....1 NO.....2 DON'T KNOW.....8	
97	Did you seek advice or treatment for the cough/fast breathing?	YES.....1 NO.....2	→ 101
98	Who gave you advice or treatment? Anyone else? RECORD <u>ALL</u> MENTIONED.	DOCTOR.....A NURSE.....B MEDICAL ATTENDANT.....C TRAINED COMMUNITY HEALTH WORKER.....D OTHER.....X (SPECIFY)	

<p>99</p>	<p>Where did you first go for advice or treatment?</p> <p>RECORD ONLY ONE RESPONSE.</p> <p>IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE FACILITY.</p> <hr/> <p>(NAME OF FACILITY)</p>	<p><u>HEALTH FACILITY</u></p> <p>HOSPITALA</p> <p>HEALTH CENTER.....B</p> <p>DISPENSARY.....C</p> <p>FIELD/COMMUNITY HEALTH WORKER.....D</p> <p><u>OTHER SOURCE</u></p> <p>TRADITIONAL PRACTITIONER.....E</p> <p>SHOP.....F</p> <p>PHARMACY.....G</p> <p>COMMUNITY DISTRIBUTORS (UNLICENSED).....H</p> <p>FRIEND/RELATIVE.....I</p> <p>OTHER.....X</p> <p>(SPECIFY)</p>	
<p>100</p>	<p>Which medicines were given to (NAME)?</p> <p>RECORD ALL MENTIONED.</p>	<p>NOTHING.....A</p> <p>ASPIRIN.....B</p> <p>PANADOL/ PARACETAMOL.....C</p> <p>AMOXICILLIN.....D</p> <p>ERYTHROMYCIN.....E</p> <p>AZITHROMYCIN.....F</p> <p>OTHER.....X</p> <p>(SPECIFY)</p> <p>DON'T KNOW/NOT AVAILABLE TO VIEW.....Z</p>	
<p>101</p>	<p>When (NAME) was sick with a cough, did you breastfeed him/her less than usual, about the same, or more than usual?</p>	<p>LESS.....1</p> <p>SAME.....2</p> <p>MORE3</p> <p>CHILD NOT BREASTFED.....4</p> <p>DON'T KNOW.....8</p>	

102	When (NAME) was sick with a cough, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?	LESS.....1 SAME.....2 MORE3 DON'T KNOW.....8	
103	When (NAME) was sick with a cough, was he/she offered less than usual to eat, about the same amount, or more than usual to eat	LESS.....1 SAME.....2 MORE3 DON'T KNOW.....8	
WATER AND SANITATION			
No.	Questions and Filters	Coding Categories	Skips
104	Do you treat your water in any way to make it safe for drinking?	YES.....1 NO.....2	→ 106
105	If Yes, what do you usually do to the water to make it safer to drink? ONLY CHECK MORE THAN ONE RESPONSE IF SEVERAL METHODS ARE USUALLY USED TOGETHER, FOR EXAMPLE, CLOTH FILTRATION AND CHLORINE.	LET IT STAND AND SETTLE/SEDIMENTATION.....A STRAIN IT THROUGH CLOTH.....B BOIL.....C ADD BLEACH/CHLORINE.....D ADD WATERGUARD.....E WATER FILTER (CERAMIC, SAND, COMPOSITE).....F SOLAR DISINFECTION.....G OTHER.....X (SPECIFY) DON'T KNOW.....Z	

106	<p>Can you show me where you usually wash your hands and what you use to wash hands?</p> <p>ASK TO SEE AND OBSERVE.</p>	<p>INSIDE/NEAR TOILET FACILITY.....1</p> <p>INSIDE/NEAR KITCHEN/COOKING PLACE.....2</p> <p>ELSEWHERE IN YARD.....3</p> <p>OUTSIDE YARD.....4</p> <p>NO SPECIFIC PLACE.....5</p> <p>NO PERMISSION TO SEE.....6</p>	<p>→110</p> <p>→110</p>
107	<p>OBSERVATION ONLY: IS THERE SOAP OR DETERGENT OR LOCALLY-USED CLEANSING AGENT?</p> <p>THIS ITEM SHOULD BE EITHER IN PLACE OR BROUGHT BY THE INTERVIEWEE WITHIN ONE MINUTE. IF THE ITEM IS NOT PRESENT WITHIN ONE MINUTE, CHECK NONE EVEN IF BROUGHT OUT LATER.</p>	<p>SOAP.....1</p> <p>DETERGENT.....2</p> <p>ASH.....3</p> <p>MUD/SAND.....4</p> <p>TREE LEAVES.....5</p> <p>NONE.....6</p> <p>OTHER.....7</p>	<p>→110</p> <p>→110</p> <p>→110</p> <p>→110</p> <p>→110</p>
108	<p>Did you use soap of any kind for any reason yesterday during the day or night?</p>	<p>YES.....1</p> <p>NO.....2</p>	<p>→110</p>
109	<p>When you used soap yesterday in the day or night, what did you use it for?</p> <p>IF FOR WASHING MY OR MY CHILDREN'S HANDS IS MENTIONED, PROBE WHAT WAS THE OCCASION, BUT DO NOT READ THE ANSWERS.</p> <p>(DO NOT READ THE ANSWERS, ASK TO BE SPECIFIC, ENCOURAGE "WHAT ELSE" UNTIL NOTHING FURTHER IS MENTIONED AND CHECK <u>ALL</u> THAT APPLY.)</p>	<p>BEFORE FOOD PREPARATION.....A</p> <p>BEFORE FEEDING CHILDREN.....B</p> <p>AFTER DEFECATION.....C</p> <p>AFTER ATTENDING TO A CHILD WHO HAS DEFECATED.....D</p> <p>OTHER.....X</p>	

110	<p>The last time (NAME) passed stools, what was done to dispose of the stools?</p> <p>RECORD ONLY ONE RESPONSE.</p>	<p>CHILD USED TOILET OR LATRINE...A PUT/RINSED INTO TOILET OR LATRINE.....B PUT/RINSED INTO DRAIN OR DITCH.....C THROWN INTO GARBAGE.....D BURIED.....E LEFT IN THE OPEN.....F OTHER.....X</p>	
MALARIA – ITN USE			
No.	Questions and Filters	Coding Categories	Skips
111	<p>Does your household have any mosquito nets that can be used while sleeping?</p>	<p>YES.....1 NO.....2</p>	→ 117
112	<p>Who slept under a bed net last night?</p> <p>LISTEN TO ALL RESPONSES AND IF THE CHILD (NAME) IS MENTIONED, RECORD CHILD. IF NOT RECORD OTHER.</p>	<p>CHILD (NAME).....1 OTHER.....2</p>	→ 117
113	<p>How long ago was the bednet bought or obtained?</p>	<p>MONTHS <input type="text"/> <input type="text"/></p> <p>MORE THAN 2 YEARS AGO 95</p> <p>DON'T KNOW.....98</p>	

114	ASK THE RESPONDENT TO IDENTIFY THE BRAND OF NET THAT THE CHILD SLEPT UNDER. SHOW PICTURES OF TYPICAL NET TYPES AND BRANDS.	<p>PERMANENT NET</p> <p>PERMANENTLY-TREATED NET (e.g. OLISET).....1</p> <p>PRETREATED NET</p> <p>NET WITH NGAO.....2</p> <p>UNTREATED NET</p> <p>MMBU NET.....3</p> <p>SAFI NET.....4</p> <p>OTHER.....5</p> <p>(SPECIFY)</p> <p>DON'T KNOW BRAND.....8</p>	→ 117
115	Was the bed net that (NAME) slept under last night ever soaked or dipped in a liquid treated to repel mosquitoes or bugs?	<p>YES.....1</p> <p>NO.....2</p> <p>DON'T KNOW.....8</p>	→ 117
116	How long ago was the net last soaked or dipped? IF LESS THAN 1 MONTH AGO, RECORD 00 MONTHS. IF LESS THAN 2 YEARS AGO, RECORD MONTHS AGO. IF 12 MONTHS AGO OR 1 YEAR AGO, PROBE FOR THE EXACT NUMBER OF MONTHS.	<p>MONTHS <input type="text"/> <input type="text"/></p> <p>MORE THAN 2 YEARS AGO 95</p> <p>DON'T KNOW.....98</p>	→ 117
117	When you were pregnant with (NAME), did you sleep under a bednet? IF YES, ASK How often did you sleep under a bednet? IF NO, CIRCLE "5" FOR NEVER.	<p>ALWAYS, EVERY NIGHT.....1</p> <p>USUALLY, MOST NIGHTS.....2</p> <p>OCCASIONALLY.....3</p> <p>RARELY.....4</p> <p>NEVER.....5</p>	

118 At any time in the past 12 months, has anyone sprayed the interior walls of your dwelling against mosquitoes?

IF YES,

How many months ago was the house sprayed?

IF LESS THAN ONE MONTH, RECORD '00' MONTHS AGO.

YES.....1

NO.....2

DON'T KNOW.....8

MONTHS AGO.....

CHILD SPACING/FAMILY PLANNING

No. Questions and Filters

119 Now I would like to ask you about child spacing/family planning services in your community.

Do you know of a place where you could obtain a method of child spacing/family planning?

IF NO, CIRCLE "Z" [DON'T KNOW]

IF YES, ASK "Where is that?"

RECORD ALL MENTIONED.

IF SOURCE IS HOSPITAL, HEALTH CENTER, OR DISPENSARY, WRITE THE NAME OF THE FACILITY.

(NAME OF FACILITY.)

120 Are you currently pregnant?

Coding Categories

HEALTH FACILITY

HOSPITAL.....A

HEALTH CENTER.....B

DISPENSARY.....C

NGO CENTER.....D

FAMILY PLANNING CLINIC.....E

FIELD/COMMUNITY HEALTH WORKER.....F

PHARMACY.....G

OTHER HEALTH FACILITY.....H

(SPECIFY)

OTHER SOURCE

SHOP.....I

CHURCH.....J

FRIEND/RELATIVE.....K

OTHER.....X

(SPECIFY)

DON'T KNOW.....Z

YES.....1

NO.....2

UNSURE.....8

Skips

→124

121	Do you want to have another child?	YES.....1	→ 123
		NO.....2	
		DON'T KNOW.....8	→ 123
122	When do you want to have your next child?	WITHIN 2 YEARS.....1	
		MORE THAN 2 YEARS FROM NOW.....2	
		UNSURE WHEN.....8	
123	Are you currently doing something or using any method to delay or avoid getting pregnant?	NO METHOD.....01	
	IF NO, CIRCLE '01' [NO METHOD]	NORPLANT.....02	
	IF YES, ASK "What is the main method you or your husband/partner are using now to avoid/postpone getting pregnant?"	INJECTIONS.....03	
	CIRCLE THE APPROPRIATE RESPONSE.	PILL.....04	
		IUD.....05	
		BARRIER METHOD/DIAPHRAGM...06	
		CONDOM.....07	
		FOAM/GEL.....08	
		TUBAL LIGATION.....09	
		VASECTOMY.....10	
		LACTATIONAL AMENORRHEA (EXCLUSIVE BREASTFEEDING)...11	
		RHYTHM.....12	
		ABSTINENCE.....13	
		WITHDRAWAL.....14	
		HERBS.....15	
		OTHER.....96	
		(SPECIFY)	
124	Have you ever talked about family planning methods with your husband or partner?	YES.....1	
		NO.....2	
		DON'T KNOW.....8	

HIV/AIDS

No.	Questions and Filters	Coding Categories	Skips
125	Now I would like to talk about something else. Have you ever heard of an illness called AIDS?	YES.....1 NO.....2 DON'T KNOW.....8	→128 →128
126	Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?	YES.....1 NO.....2 DON'T KNOW.....8	→128 →128
127	What can a person do to avoid getting AIDS? Anything else? RECORD ALL MENTIONED.	ABSTAIN FROM SEX.....A USE CONDOMS.....B LIMIT SEX TO ONE PARTNER/STAY FAITHFUL TO ONE PARTNER.....C LIMIT NUMBER OF SEXUAL PARTNERS.....D AVOID SEX WITH PROSTITUTES....E AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS.....F AVOID INTERCOURSE WITH PERSONS OF THE SAME SEX.....G AVOID SEX WITH PERSONS WHO INJECT DRUGS INTRAVENOUSLY..H AVOID BLOOD TRANSFUSIONS.....I AVOID INJECTIONS.....J AVOID KISSING.....K AVOID MOSQUITO BITES.....L SEEK PROTECTION FROM TRADITIONAL HEALER.....M AVOID SHARING RAZORS, BLADES.....N OTHER:_____ X (SPECIFY) OTHER:_____..Y (SPECIFY) DON'T KNOW.....Z	

HEALTH CONTACTS AND IEC

No.	Questions and Filters	Coding Categories	Skips
128	During the past month, how frequently have you come in contact with:		
	RECORD NUMBER OF TIMES FOR <u>ALL</u> MENTIONED.		
A	Doctors	A. DOCTORS.....	<input type="text"/>
B	Nurses	B. NURSES.....	<input type="text"/>
C	Midwives	C. MIDWIVES.....	<input type="text"/>
D	Traditional birth attendants	D. TRADITIONAL BIRTH ATTENDANTS.....	<input type="text"/>
E	Community health workers	E. COMMUNITY HEALTH WORKERS.....	<input type="text"/>
F	Village health committee	F. VILLAGE HEALTH COMMITTEE.....	<input type="text"/>
G	Community leaders	G. COMMUNITY LEADERS.....	<input type="text"/>
H	Community organizations or non-governmental organizations	H. COMMUNITY ORGANIZATIONS OR NON-GOVERNMENTAL ORGANIZATIONS.....	<input type="text"/>
I	School teachers	I. SCHOOL TEACHERS.....	<input type="text"/>
J	Maisha drivers	J. MAISHA DRIVERS.....	<input type="text"/>

129 Where do you get information about health?

RECORD **ALL** MENTIONED.

FORMAL NETWORK

DOCTORS.....A

NURSES/MIDWIVES.....B

TRADITIONAL BIRTH
ATTENDANT.....C

COMMUNITY HEALTH
WORKER.....D

CBO/NGO.....E

VILLAGE HEALTH COMMITTEE.....F

VILLAGE HEALTH ATTENDANT.....G

OTHER HEALTH
WORKER.....H

(SPECIFY)

INFORMAL NETWORK

HUSBAND/PARTNER.....I

MOTHER/MOTHER-IN-LAW.....J

SISTER.....K

GRANDPARENT.....L

AUNT.....M

FRIEND/NEIGHBOR.....N

TRADITIONAL HEALER.....O

VILLAGE ELDER.....P

SCHOOL TEACHER.....Q

EMPLOYER.....R

TRADITIONAL LEADERS.....S

POLITICAL/VILLAGE LEADERS.....T

OTHER.....X

(SPECIFY)

130 In the past month, have you received any health information from the following?

READ THE LIST AND RECORD **ALL** MENTIONED.

- A** Radio
- B** Television
- C** Newspaper
- D** Health educator
- E** Community health worker
- F** Community organization
- G** Traditional leaders
- H** Political/village leaders
- X** Other

YES NO DK

- A. RADIO.....1 2 8
- B. TELEVISION.....1 2 8
- C. NEWSPAPER.....1 2 8
- D. HEALTH EDUCATOR..1 2 8
- E. COMMUNITY HEALTH WORKER.....1 2 8
- F. COMMUNITY ORGANIZATION.....1 2 8
- G. TRADITIONAL LEADERS.....1 2 8
- H. POLITICAL/VILLAGE LEADERS.....1 2 8

X. OTHER: _____
(SPECIFY)

ANTHROPOMETRICS

No. Questions and Filters

Coding Categories

Skips

131 May I weigh (NAME)?

YES.....1

NO.....2

END

|_|||_| . |_| KILOGRAMS

**WellShare International Tanzania Child Survival Project /
Mradi wa Kutunza Mama na Mtoto
Knowledge Practice Coverage Questionnaire/Dodoso kuhusu upana wa Uelewa wa Watu
Mothers of Children Under Two Years of Age / Kwa kina mama wenye watoto
wenye umri chini ya miaka miwili**

UTANGULIZI

Uliza mama anayeishi kwenye nyumba husika umri wa mtoto wake mdogo kuliko wote anayeishi nae. Kama mtoto ana umri chini ya miezi 24, endelea na dodoso. Kama mtoto aliyemdogo sana ana miezi 24 au zaidi, mshukuru mama yake na sitisha zoezi la dodoso.

UTAMBULISHO

Habari yako. Jina langu nina nafanya kazi na WellShare International (formerly Minnesota International Health Volunteers) chini ya Wizara ya Afya. Ni shirika la kimataifa linalofanya kazi Wilaya ya Karatu. Tunafanya utafiti kuhusu mama wenye watoto chini ya miaka miwili na hivyo tunaomba ushirikiano wako. Ningependa kujua afya yako na afya ya mtoto wako mdogo kabisa wa chini ya miaka miwili. Taarifa hii itatusaidia kupanga huduma ya afya na kuangalia kama tunafanikiwa katika malengo ya afya ya mtoto. Utafiti huu utachukua dakika sitini kumalizika. Habari au taarifa yoyote utakayotoa utachukuliwa kama siri Hatutasema au kutoa jina lako kwa taarifa uliyotupatia kwa yeyote.

Ushiriki katika utafiti huu ni wa hiari na unaweza kuchagua kutojibu swali lolote la binafsi au yote kwa pamoja. Hata hivyo tunatumaini kwamba utashiriki kwenye utafiti huu kwa kuwa maoni yako ni muhimu sana katika utafiti huu.

Mpaka hapa, una swali lolote unalotaka kuniuliza kuhusu utafiti huu?

Sahihi ya muulizaji: _____ Tar: |__||__|/|__||__|/|__||__||__||__|
Siku / Mwezi / Mwaka

ANGALIZO LA KWANZA:

MHOJIWA AKIKUBALI KUHOJIWA (1) _____ Anza kumhoji

MHOJIWA HAKUBALI KUHOJIWA (2) _____ Usiendeleo/Usimhoji

UTAMBULISHO

Namba ya kikundi: _____

Namba ya kaya: _____

Kumbukumbu namba: _____

Jina la mama: _____ Jina la M/kiti wa nyumba kumi _____

Jina la msimamizi: _____

Aliyeingiza taarifa: _____ Tar: |__||__|/|__||__|/|__||__||__||__|
Siku / Mwezi / Mwaka

MATOKEO YA MAHOJIANO (Angalia kama box limejazwa na kumalizika)

	Hakiki mahojiano
	Msimamizi ahakiki kazi yote
	Hakikisha masahihisho yamefanyika (kama kuna lazima)
	Taarifa imeingizwa vizuri / na kwa ukamilifu

Dodoso**MASWALI YOTE YAULIZWE/YAELEKEZWE KWA MAMA MWENYE MTOTO CHINI YA MIEZI 24.****MAELEZO YA HISTORIA YA MHOJIWA**

No.	Maswali na majibu	Namna ya kujaza (Kionyeshi)	Ruka
1	<p>Ni lugha gani ambayo ni rahisi kwako kwa mawasiliano?</p> <p>ANDIKA/TIKI LUGHA ZOTE ATAKAZOKUTAJIA.</p>	<p>KISWAHIILI.....A</p> <p>KIIRAKI.....B</p> <p>KICHAGA.....C</p> <p>LUGHA NYINGINEZO.....X</p> <p>(KAMA TOFAUTI NA HAPO JUU ATAJE)</p>	
2	<p>Una miaka mingapi?</p>	<p>ANDIKA UMRI WAKE KWA MIAKA ILIYOKAMILIKA <input type="text"/></p>	
3	<p>Unafanya shughuli gani kujiongezea kipato?</p> <p>KAMA HAPANA ZUNGUSHIA "A" (IKIMAANISHA HANA KAZI NJE).</p> <p>KAMA NDIYO,</p> <p>Uliza ni aina gani ya kazi anayofanya?</p> <p>KAMA AKITAJA ZAIDI YA MOJA YA YALIYOTAJWA ANDIKA YOTE</p>	<p>HAKUNA SHUGHULI YOYOTE NJE.....A</p> <p>KAZI ZA MIKONO.....B</p> <p>KILIMO.....C</p> <p>UFUGAJID</p> <p>UUZAJI WA VYAKULA.....E</p> <p>MUUZA DUKA/MMACHINGA.....F</p> <p>MTUMISHI WA NYUMBANI.....G</p> <p>MFANYAKAZI WA MSHAHARA.....H</p> <p>MENGINEYO TAJA.....X</p>	
4	<p>Umesoma?</p>	<p>NDIYO.....1</p> <p>HAPANA.....2</p>	→ 6
5	<p>Kiwango chako cha juu cha elimu ni?</p> <p>ZUNGUSHIA JIBU MOJA TU.</p>	<p>SIKUMALIZA ELIMU YA MSINGI.....A</p> <p>NIMEMALIZA ELIMU YA MSINGI.....B</p> <p>SIKUMALIZA ELIMU YA SEKONDARI.....C</p> <p>NIMEMALIZA ELIMU YA SEKONDARI AU ZAIDI.....D</p>	

6	Hali ya ndoa ikoje?	AMEOLEWA.....A HAJAOLEWA.....B MJANE.....C AMEACHIKA / MTALAKIWA.....D MENGINEYO.....X	→ 8
7	Je; baba wa mtoto (JINA LA MTOTO) anaishi nyumba moja naye kwa sasa?	NDIYO.....1 HAPANA.....2	

UZAZI WA MPANGO			
No.	Maswali na majibu	Namna ya kujaza (konyeshi)	Ruka
8	Kuna watoto wa ngapi chini ya umri wa miaka mitano wanaoishi kwenye nyumba hii?	MTOTO MMOJA.....1 WATOTO WAWILI.....2 WATOTO WATATU AU ZAIDI.....3	
9	Una watoto wangapi?	IDADI YA WATOTO ULIONAO <input type="text"/> <input type="text"/>	
10	Umepata ujauzito mara ngapi?	IDADI YA MIMBA/UJAUZITO <input type="text"/> <input type="text"/>	
11	Ulijifungua watoto wangapi?	NAMBA YA WATOTO WALIOZALIWA <input type="text"/> <input type="text"/>	

12	<p>Jina la mtoto wako wa mwisho kuzaliwa, jinsi yake, na tarehe ya kuzaliwa?</p>	<p>Mtoto mdogo kuliko wote</p> <p>JINA LAKE _____</p> <p>Jinsi</p> <p>KIUME.....1</p> <p>KIKE.....2</p> <p>Tarehe ya kuzaliwa</p> <p>.....TAREHE <input type="text"/> <input type="text"/></p> <p>MWEZI <input type="text"/> <input type="text"/></p> <p>MWAKA <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	
13	<p>ANGALIA SWALI NAMBA 11 NA ANDIKA/ REKODI IDADI YA WATOTO WALIOZALIWA.</p>	<p>MMOJA (andika 1)..... <input type="text"/></p> <p>WAWILI AU ZAIDI (andika 2)..... <input type="text"/></p>	→ 15
14	<p>Taja jina, jinsi na tarehe ya mtoto wako wa pili kwa udogo/uchanga kuzaliwa?</p>	<p>Mtoto wa pili kwa udogo kuzaliwa</p> <p>Jina lake _____</p> <p>Jinsi</p> <p>KIUME.....1</p> <p>KIKE.....2</p> <p>Tarehe ya kuzaliwa</p> <p>TAREHE <input type="text"/> <input type="text"/></p> <p>MWEZI <input type="text"/> <input type="text"/></p> <p>MWAKA <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	

15	<p>Nani huwa anamwalia (JINA LA MTOTO) wako mdogo kabisa wakati wewe haupo?</p> <p>ANDIKA MAJIBU YOTE YATAKAYOTAJWA.</p>	<p>MAMA (ANAJIBU).....A</p> <p>MUME.....B</p> <p>MTOTO MKUBWA.....C</p> <p>NDUGU YEYOTE TAJA.....D</p> <p>MAJIRANI/MARAFIK.....E</p> <p>MTUMISHI WA NDANI.....F</p> <p>MENGINEYO TAJA TOFAUTI NA HAPO JUU.....X</p>
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MALEZI YA MAMA MJAMZITO

No.	Maswali na Majibu	Namna ya kujaza	Ruka
16	<p>Uliweza kuonana na yeyote kuhusu afya ya mama na mtoto wakati ukiwa na ujauzito wa (JINA LA MTOTO)?</p> <p>KAMA NDIYO: Ulionana na nani?</p> <p style="padding-left: 40px;">Mwingine yeyote?</p> <p>ENDELEA KUDO DOSA KAMA ALITAFUTA/ALIONANA NA YEYOTE KWA HUDUMA/USHAURI NA AKUTAJIE NI NANI NA ANDIKA WATU WOTE WATAKAOTAJWA.</p>	<p><u>MTAALAM WA AFYA</u></p> <p>DAKTARI.....A</p> <p>MUUGUZI.....B</p> <p>MKUNGA.....C</p> <p>MHUDUMU WA AFYA.....D</p> <p>MHUDUMU YEYOTE WA AFYA MWENYE UTAALAM WA UZALISHAJI.....E</p> <p><u>WAHUDUMU WALIO NA MAFUNZO</u></p> <p>MKUNGA WA JADI MWENYE MAFUNZO.....F</p> <p>MKUNGA WA JADI MWENYE MAFUNZO YA HBLSS.....G</p> <p>MHUDUMU MWENYE MAFUNZO YA AFYA NA MAZINGIRA.....H</p> <p><u>WASIO NA MAFUNZO</u></p> <p>WAKUNGA WA JADI WASIO NA MAFUNZO NA WENYE MAFUNZO....I</p> <p>MHUDUMU WA AFYA NA MAZINGIRA ASIYE NA MAFUNZO.....J</p> <p>NDUGU/RAFIKI.....K</p> <p>MWINGINE YEYOTE.....X</p> <p>HAKUNA YEYOTE.....Z</p>	

17	Ni mara ngapi ulipata huduma ya mama na mtoto wakati ukiwa mjamzito?	NI MARA NGAPI	<input type="checkbox"/>	
		SIJUI.....98		
18	Wakati wa ujauzito wa (JINA LA MTOTO) wako ulipata chanjo kuzuia pepopunda ambayo inaweza kusababisha degedege/kifafa kwa mtoto?	NDIYO.....1		→ 20
		HAPANA.....2		
		SIJUI.....8		→ 20
19	Wakati ukiwa mjamzito (JINA LA MTOTO), ni mara ngapi ulipata chanjo ya pepopunda (TT)?	MARA MOJA.....1		
		MARA MBILI.....2		
		MARA TATU AU ZAIDI.....3		
		SIJUI.....8		
20	Ulipata chanjo ya pepopunda wakati wowote kabla ya mimba pamoja na mimba iliyotangulia au kati ya mimba ulizokwishapata?	NDIYO.....1		
		HAPANA.....2		→ 22
		SIJUI.....8		→ 22
21	Kabla ya mimba ya (JINA LA MTOTO), ni mara ngapi ulipata chanjo ya pepopunda (TT)?	MARA MOJA.....1		
		MARA MBILI.....2		
		MARA TATU AU ZAIDI.....3		
		SIJUI/SIKUMBUKI.....8		
22	Unayo kadi yako ya kliniki wakati ukiwa ujauzito wa (JINA LA MTOTO)?	NDIYO, IMEONEKANA.....A		→ 26
		HAIPO/HAIONEKANI.....B		
		SIJAWAHI KUWA NA KADI.....C		→ 26
23	ANGALIA KADI YAKE NA ANDIKA/REKODI NI MARA NGAPI AMEHUDHURIA HUDUMA YA KLINIKI WAKATI AKIWA NA UJAUZITO WA (JINA LA MTOTO).	NAMBA INAYOONYESHA NI MARA NGAPI AMEHUDHURIA HUDUMA YA KLINIKI:	<input type="checkbox"/>	

24	REKODI/ANDIKA TAREHE AMBAZO AMEPATIWA SINDANO ZA PEPOPUNDA (TT) KAMA INAVYOONYESHA KWENYE KADI YAKE.	KWANZA....._/___/___ TAR/MWEZI/MWAKA PILI....._/___/___ TAR/MWEZI/MWAKA TATU....._/___/___ TAR/MWEZI/MWAKA MARA YA NNE...._/___/___ TAR/MWEZI/MWAKA TANO....._/___/___ TAR/MWEZI/MWAKA SITA....._/___/___ TAR/MWEZI/MWAKA ANDIKA/REKODI NI MARA NGAPI AMEPATA DOZI KAMILI WAKATI WA MIMBA YA MWISHO _____	
25	REKODI/ANDIKA TAREHE ZOTE ZA KILA DOZI YA IPT (KUZUIA MALARIA). ANDIKA/REKODI DAWA ALIYOTUMIA.	JINA LA DAWA TAR/MWEZI/MWAKA _____/___/___ _____/___/___ _____/___/___ _____/___/___ _____/___/___ _____/___/___ JE; DOZI ZOTE MBILI AU ZAIDI ZILITOLEWA KWENYE UJAUZITO WA MWISHO? NDIYO.....1 HAPANA.....2	
26	Wakati ukiwa mjamzito (JINA LA MTOTO) ulitumia dawa yoyote ya kuzuia malaria?	NDIYO.....1 HAPANA.....2 SIJUI.....8	→ 29 → 29

27 Ulitumia dawa gani?

ANDIKA **DAWA ZOTE** ATAKAZOTAJA.

KINGA YA MALARIA NDIYO HAPANA SIJUJI

F. SP/ORODAR.....	1	2	8
G. CHLORQUINE.....	1	2	8
H. AMODIAQUINE.....	1	2	8
I. QUININE.....	1	2	8
J. ACT.....	1	2	8
K. DAWA NYINGINE.....	1	2	8
X. _____	1	2	8

KAMA KATI YA ZOTE HAPO JUU
HUJATUMIA TAJA DAWA ULİYOTUMIA

28 Ni mara ngapi wakati ukiwa na ujauzito ulitumia dawa?

REKODI NAMBA YA MATUKIO/WAKATI GANI
ALITUMIA DAWA LAKINI SIYO NAMBA YA DOZI
ALİYOTUMIA.

KINGA YA MALARIA MARA NGAPI UMETUMIA

F. SP/ORODAR.....	_____
G. CHLORQUINE.....	_____
H. AMODIAQUINE.....	_____
I. QUININE.....	_____
J. ACT.....	_____
X. NYINGINEZO TAJA.	_____

29 Ni umbali gani kutoka ulipo na kituo cha afya kilipo?

ANDIKA JINA LA SEHEMU YA HUDUMA/JINA LA
KITUO KILICHO KARIBU KULIKO VYOTE.

NI KILOMETA NGAPI?

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30	<p>Huwa unafikaje kwenye kituo cha afya?</p> <p>ANDIKA / REKODI MAJIBU YOTE YATAKAYOTAJWA.</p>	<p>KUTEMBEA KWA MIGUU.....A KWA BAISKELI.....B KWA GARI BINAFSI.....C KWA DALADALA.....D KWA PIKIPIKI.....E KWA GARI YA KUENDESHWA NA MNYAMA.....F KWA MTUMBWI.....G KWA GARI YA WAGONJWAH GARI YA KUKODISHA.....I TREKTA.....J MACHELA.....K NYINGINEZO/TOFAUTI NA HIZO TAJA.....X</p>	
31	<p>Inakuchukua muda gani kufika kituo cha afya?</p>	<p>CHINI YA SAA MOJA.....1 SAA MOJA HADI MASAA MATATU.....2 ZAIDI YA MASAA MATATU.....3 SIJUI.....8</p>	
32	<p>Nani anaamua kwamba utaenda pale?</p> <p>REKODI/ANDIKA MAJIBU YOTE AMBAYO ATAYATAJA.</p>	<p>ANAYEJIBU SWALI.....A MUME.....B MAMA WA MHOJIWA/ ANAYEULIZWA.....C MAMA MKWE.....D RAFIKI/JIRANI.....E MKUNGA WA JADI.....F MENGINEYO/TAJA.....X</p>	

33	Ni dalili zipi wakati wa ujauzito zinaonyesha u lazima wa kutafuta au kupatiwa huduma ya afya?	HOMA.....A KUPUMUA KWA SHIDA.....B KUTOKWA NA DAMU.....C KUVIMBA KWA MWILI, MIKONO NA AU USO.....D MENGINEYO TAJA.....X SIJUI.....Z		
	REKODI MAJIBU YOTE YATAKAYOTAJWA			
34	Ni sehemu/mahali gani pa kwanza ulienda kwa tahadhari iwapo ulikuwa/uliona dalili hizo?	<u>MAHALI</u> HOSPITALI.....A KITUO CHA AFYA.....B ZAHANATI.....C MHUDUMU WA MAZINGIRA NA AFYA.....D <u>CHANZO KINGINE</u> MGANGA WA JADI.....E DUKANI.....F DUKA LA DAWA.....G WASAMBAZAJI (WASIO NA LESENI).....H RAFIKI/NDUGU.....I MENGINEYO TAJA.....X		
35	Wakati ukiwa na ujaumzito (JINA LA MTOTO) ulipewa au kununua vidonge vya kuongeza damu? ONYESHA VIDONGE/DAWA YA MAJI KWA MAMA.	NDIYO.....1 HAPANA.....2 SIJUI.....8		
KUJIFUNGUA	No.	Maswali na majibu	Ujazaji	Ruka

36	<p>Ulimzalia wapi (JINA LA MTOTO)?</p> <p>KAMA SEHEMU ULIYOJIFUNGULIA/ULIYOZALIA NI HOSPITALI, KITUO CHA AFYA AU ZAHANATI BASI ANDIKA JINA LA AMBAPO ULIJIFUNGULIA/ULIPOZALIA</p> <hr/> <p>JINA LA KITUO ULICHOJIFUNGULIA</p>	<p><u>MAHALI</u></p> <p>NYUMBANI KWAKO.....A</p> <p>NYUMBANI KWA MTU MWINGINE.....B</p> <p><u>SEHEMU YA KUPATA HUDUMA YA AFYA</u></p> <p>HOSPITALINI.....C</p> <p>KLINIKI.....D</p> <p>ZAHANATI.....E</p> <p>KAMA NI TOFAUTI NA YALIYOTAJWA HAPO JUU BASI YATAJE.....X</p>
37	<p>Nani alikusaidia wakati unajifungua (JINA LA MTOTO)?</p> <p>Mtu mwingine yeyote?</p> <p>JITAHIDI KUDODOSA NI MTU/WATU WA NAMNA GANI WALIMSAIDIA WAKATI WA KUJIFUNGUA. REKODI/ANDIKA WOTE WATAKAOTAJWA.</p> <p>KAMA MHOJIWA ATASEMA HAKUKUWA AU HAKUSAIDIWA NA YEYOTE JITAHIDI KUMHOJI AU KUDODOSA ZAIDI ILI KUJUA KAMA KULIKUWA NA WATU WAZIMA WAKATI WA KUJIFUNGUA.</p>	<p><u>MTAALAM WA AFYA</u></p> <p>DAKTARI.....A</p> <p>MUUGUZI.....B</p> <p>MKUNGA.....C</p> <p>MHUDUMU WA AFYA.....D</p> <p>MHUDUMU YEYOTE WA AFYA MWENYE UTAALAM WA UZALISHAJI.....E</p> <p><u>WAHUDUMU WALIO NA MAFUNZO</u></p> <p>MKUNGA WA JADI MWENYE MAFUNZO.....F</p> <p>MKUNGA WA JADI MWENYE MAFUNZO YA HBLSS.....G</p> <p>MHUDUMU MWENYE MAFUNZO YA AFYA NA MAZINGIRA.....H</p> <p><u>WASIO NA MAFUNZO</u></p> <p>WAKUNGA WA JADI WASIO NA MAFUNZO NA WENYE MAFUNZO....I</p> <p>MHUDUMU WA AFYA NA MAZINGIRA ASIYE NA MAFUNZO.....J</p> <p>NDUGU/RAFIKI.....K</p> <p>MWINGINE YEYOTE.....X</p> <p>HAKUNA YEYOTE.....Z</p>

38	Ni chombo gani kilitumika kukata kitovu cha mtoto?	WEMBE MPYA.....A WEMBE MPYA NA ULIOCHEMSHWA.....B WEMBE ULIOTUMIKA.....C WEMBE ULIOTUMIKA LAKINI UKACHEMSHWA.....D MKASI MPYA.....E MKASI MPYA NA ULIOCHEMSHWA.....F MKASI ULIOTUMIKAG MKASI ULIOTUMIKA NA UKACHEMSHWA.....H KISU.....I NYUZI.....J MENGINEYO TOFAUTI NA HAPO JUU TAFADHALI TAJA.....X SIJUI.....Z.	
39	ANGALIA SWALI NAMBA 38. KAMA MAMA AMBAYE AMEJIBU HILO SWALI AMETAJA A, B, D, F, AU H, ZUNGUSHIA 1.	KAMA A, B, D, F au H ANDIKA.....1	
40	Je; wakati wa kujifungua kilitumika vifaa vyote visafi?	NDIYO.....1 HAPANA.....2 SIJUI.....8	
41	Mara tu baada ya kuzaliwa (JINA LA MTOTO), kabla kondo (plasenta) haijatoka, ulipata sindano ya kuzuia usitokwe na damu?	NDIYO.....1 HAPANA.....2 SIJUI.....8	→ 44 → 44
42	Mara tu baada ya kupata sindano ya kuzuia kutokwa na damu, je mhadumu wa kuzalisha alishika tumbo lako na kuvuta ili kusaidia kondo la nyuma (plasenta) kutoka?	NDIYO.....1 HAPANA.....2 SIJUI.....8	→ 44 → 44

43	Mara tu baada ya kondo la nyuma (plasenta) kutoka, kuna mtu aliyeuchua au kuukanda nyumba ya uzazi kuufanya usinyae kwa nguvu ili kuzuia damu kutoka kwa wingi?	NDIYO.....1 HAPANA.....2 SIJUI.....8	→ 44 → 44
44	ANGALIA MAJIBU YA NAMBA 41, 42, NA 43	KAMA SWALI NAMBA 41, 42 NA 43 NI NDIYO ZUNGUSHIA.....1 KAMA SWALI NAMBA 41, 42 NA 43 NI HAPANA ZUNGUSHIA (2) AU KAMA NI SIJUI (8) ZUNGUSHIA.....2	
45	Je; (JINA LA MTOTO) alisafishwa mara tu baada ya kuzaliwa kabla plasenta haijatoka?	NDIYO.....1 HAPANA.....2 SIJUI.....8	
46	Je; (JINA LA MTOTO) alifunikwa na nguo yenye joto au blanketi mara tu baada ya kuzaliwa kabla placenta haijatolewa?	NDIYO.....1 HAPANA.....2 SIJUI.....8	
UANGALIZI BAADA YA SIKU 40 YA UZAZI			
No.	Maswali na majibu	Namna ya kujibu	Ruka
47	Je; kuna mhudumu yeyote wa hospitali au wa kienyeji ambaye alikuchunguza afya yako mara baada ya kujifungua (JINA LA MTOTO) aidha ukiwa hospitalini, nyumbani au sehemu yoyote uliyojifungulia?	NDIYO.....1 HAPANA.....2	→ 52
48	Baada ya kujifungua (JINA LA MTOTO) ilikuchukua muda gani kuangaliwa/kufanyiwa uchunguzi wa kwanza? KAMA NI CHINI YA SIKU MOJA ZUNGUSHIA ZIRO (0) NA ANDIKA MASAA ILIYOCHUKUA; KAMA NI CHINI YA JUMA MOJA ZUNGUSHIA NAMBA 1 NA ANDIKA SIKU ALIZOTUMIA, KAMA NI ZAIDI YA SIKU SITA , ZUNGUSHIA NAMBA 2 NA ANDIKA NAMBA YA MAJUMA ILIYOTUMIA.	KAMA NI MASAA ANDIKA 0 <input type="text"/> <input type="text"/> KAMA NI SIKU ANDIKA 1 <input type="text"/> <input type="text"/> KAMA NI MAJUMA ANDIKA 2 <input type="text"/> <input type="text"/> KAMA HUIJUI ANDIKA.....998	

49 Nani alikuangalia afya yako wakati huo?

JITAHIDI KUDODOSA MTU MWENYE TAALUMA YA JUU KULIKO WOTE ALIYEKUHUDUMIA NA ZUNGUSHIA JIBU **MOJA TU** KATI YA YALIYOTAJWA UPANDE WA PILI

MTAALAM WA AFYA

- DAKTARI.....A
- MUUGUZI.....B
- MKUNGA.....C
- MHUDUMU WA AFYA.....D
- MHUDUMU YEYOTE WA AFYA MWENYE UTAALAM WA UZALISHAJI.....E
- WAHUDUMU WALIO NA MAFUNZO
- MKUNGA WA JADI MWENYE MAFUNZO.....F
- MKUNGA WA JADI MWENYE MAFUNZO YA HBLSS.....G
- MHUDUMU MWENYE MAFUNZO YA AFYA NA MAZINGIRA.....H
- WASIO NA MAFUNZO
- WAKUNGA WA JADI WASIO NA MAFUNZO NA WENYE MAFUNZO....I
- MHUDUMU WA AFYA NA MAZINGIRA ASIYE NA MAFUNZO.....J
- NDUGU/RAFIKI.....K
- MWINGINE YEYOTE.....X
- HAKUNA YEYOTE.....Z

50 Ulipata uangalizi wa karibu baada ya siku arobaini (40) za uzazi?

- NDIYO.....1
- HAPANA.....2

51 Wakati wa uchunguzi baada ya kujifungua ulishauriwa juu ya yafuatayo?

Andika 1 kama ni ndiyo kwa kila swali A-E
Andika 2 kama ni hapana kwa A-E
Andika 8 kama hujui kwa A-E

- A Uzazi wa mpango?
- B Lishe juu ya mtoto?
- C Chanjo/Kinga?
- D Kuhara/kuharisha kwa mtoto?
- E Homa ya mapafu?

	NDIYO	HAPANA	SIJUI
A.....	1	2	8
B.....	1	2	8
C.....	1	2	8
D.....	1	2	8
E.....	1	2	8

52 Baada ya kuzaliwa (JINA LA MTOTO), kuna mhudumu/mganga yeyote aliyeangalia afya ya (JINA LA MTOTO)?

- NDIYO.....1
- HAPANA.....2

<p>53</p>	<p>Ni baada ya muda gani kuzaliwa kwa (JINA LA MTOTO) aliangaliwa kwa mara ya kwanza?</p> <p>KAMA NI CHINI YA SIKU MOJA ZUNGUSHIA ZIRO (0) NA ANDIKA MASAA ILIYOCHUKUA; KAMA NI CHINI YA JUMA MOJA ZUNGUSHIA NAMBA 1 NA ANDIKA SIKU ALIZOTUMIA, KAMA NI ZAIDI YA SIKU SITA , ZUNGUSHIA NAMBA 2 NA ANDIKA NAMBA YA MAJUMA ILIYOTUMIA.</p>	<p>KAMA NI MASAA ANDIKA 0 <input type="text"/></p> <p>KAMA NI SIKU ANDIKA 1 <input type="text"/></p> <p>KAMA NI MAJUMA ANDIKA 2 <input type="text"/></p> <p>KAMA HUJUI ANDIKA.....998</p> <p><u>MTAALAM WA AFYA</u></p> <p>DAKTARI.....A</p> <p>MUUGUZI.....B</p> <p>MKUNGA.....C</p> <p>MHUDUMU WA AFYA.....D</p> <p>MHUDUMU YEYOTE WA AFYA MWENYE UTAALAM WA UZALISHAJI.....E</p> <p><u>WAHUDUMU WALIO NA MAFUNZO</u></p> <p>MKUNGA WA JADI MWENYE MAFUNZO.....F</p> <p>MKUNGA WA JADI MWENYE MAFUNZO YA HBLSS.....G</p> <p>MHUDUMU MWENYE MAFUNZO YA AFYA NA MAZINGIRA.....H</p> <p><u>WASIO NA MAFUNZO</u></p> <p>WAKUNGA WA JADI WASIO NA MAFUNZO NA WENYE MAFUNZO....I</p> <p>MHUDUMU WA AFYA NA MAZINGIRA ASIYE NA MAFUNZO.....J</p> <p>NDUGU/RAFIKI.....K</p> <p>MWINGINE YEYOTE.....X</p> <p>HAKUNA YEYOTE.....Z</p>	
<p>54</p>	<p>Ni nani aliyemhudumia (JINA LA MTOTO) wakati huo?</p> <p>JITAHIDI KUDODOSA/KUCHUNGUZA MTU MWENYE TAALUMA YA JUU KULIKO WOTE ALIYEKUHUDUMIA NA ZUNGUSHIA JIBU MOJA TU KATI YA YALIYOTAJWA UPANDE WA PILI</p>	<p>55</p> <p>Ni dalili zipi ambazo ni hatari ambazo hutokea baada ya mama kujifungua na zinahitaji huduma ya afya kwa haraka?</p> <p>ANDIKA/REKODI DALILI ZOTE ATAKAZOTAJA MHOJIWA.</p>	<p>HOMA.....A</p> <p>KUTOKWA DAMU KWA WINGI.....B</p> <p>USAHA WENYE HARUFU MBAYA KUTOKA UKENI.....C</p> <p>MENGINEYO TAJA.....X</p> <p>SIJUI.....Z</p>

56	<p>Ni dalili zipi za hatari ambazo zitaonyesha kuwa mtoto aliyezaliwa ni mgonjwa na anahitaji huduma ya afya?</p> <p>ANDIKA/REKODI DALILI/MAJIBU <u>YOTE</u> YATAKAYOTAJWA.</p>	<p>KUTOKULA VIZURI.....A KUPUMUA KWA HARAKA.....B MTOTO KUWA LEGELEGE.....C WEKUNDU KWENYE KITOVU.....D MACHO MEKUNDU AU MACHO KUTOA MAJI.....E</p> <p>MENGINEYO TAJA.....X SIJUI.....Z</p>	
UNYONYESHAJI			
No.	Maswali na majibu	Namna ya kujaza	Ruka
57	Uliwahi kunyonyesha (JINA LA MTOTO)?	<p>NDIYO.....1</p> <p>HAPANA.....2</p>	→ 63
58	<p>Baada ya kuzaliwa (JINA LA MTOTO) ilichukua muda gani kumnyonyesha?</p> <p>KAMA NI CHINI YA SAA MOJA ZUNGUSHIA NAMBA 0, KWA MASAA ZAIDI YA MOJA ANDIKA 00, CHINI YA MASAA 24 ZUNGUSHIA 0 NA ANDIKA NAMBA YA MASAA, MASAA 24 NA ZAIDI ZUNGUSHIA 1 NA NAMBA YA SIKU</p>	<p>KWA MASAA ZUNGUSHIA 0 <input type="text"/> <input type="text"/></p> <p>KWA SIKU ZUNGUSHIA 1 <input type="text"/> <input type="text"/></p> <p>KAMA HUUJUI BASI ZUNGUSHIA.....998</p>	
59	Wakati wa siku tatu au nne za mwanzo baada ya kujifungua na kabla ya maziwa kuanza kutoka, ulimpa (JINA LA MTOTO) maji maji yaliyokuwa yanatoka kwenye matiti yako?	<p>NDIYO.....1</p> <p>HAPANA.....2</p> <p>SIJUI.....8</p>	
60	Siku tatu za kwanza baada ya kujifungua, je; (JINA LA MTOTO) alipewa chochote cha kunywa tofauti na maziwa ya mama/kunyonyeshwa?	<p>NDIYO.....1</p> <p>HAPANA.....2</p> <p>SIJUI.....8</p>	
61	Bado unamnyonyesha (JINA LA MTOTO)?	<p>NDIYO.....1</p> <p>HAPANA.....2</p>	

62 Ulimnyonyesha (JINA LA MTOTO) kwa miezi mingapi?

KAMA CHINI YA MWEZI 1 ZUNGUSHIA 00.

63 Ningependa kukuuliza kuhusu vinywaji/vyakula (JINA LA MTOTO) alivyotumia jana mchana au usiku.

Je; (JINA LA MTOTO) alikunywa au kula chochote?

SOMA VINYWAJI VYOTE A-M

A Maziwa ya mama?

B Maziwa ya kawaida?

C Maji ya kawaida yasiyo na chochote?

D Sukari au maji yenye glukosi?

E Gripe water?

F Mchanganyiko wa sukari na chumvi?

G Juisi ya matunda?

H Maziwa bora (Simulac, Lactogen, Cow and Gate)?

I Chakula chochote cha kununua kama vile serelaki?

J Chochote, uji au mkate, maji maji?

K Chai?

L Asali?

M Mengineyo taja _____

MWEZI/MIEZI

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KWA MAJIBU YOTE YA NDIYO KUANZIA A-M ANDIKA 1; WAKATI YALE YOTE YA HAPANA ANDIKA 2; NA MAJIBU YOTE YA SIJUI ANDIKA 8 KAMA ILIVYOONYESHWA HAPA CHINI.

	NDIYO	HAPANA	SIJUI
A.....	1	2	8
B.....	1	2	8
C.....	1	2	8
D.....	1	2	8
E.....	1	2	8
F.....	1	2	8
G.....	1	2	8
H.....	1	2	8
I.....	1	2	8
J.....	1	2	8
K.....	1	2	8
L.....	1	2	8
M.....	1	2	8

		KWA MAJIBU YOTE YA NDIYO ANDIKA NAMBA 1, KWA MAJIBU YOTE YA HAPANA ANDIKA NAMBA 2, NA KWA MAJIBU YOTE YA SIJUI ANDIKA 8		
		NDIYO	HAPANA	SIJUI
64	Ningependa kukuuliza kuhusu vyakula/vinywaji ambavyo (JINA LA MTOTO) anaweza akawa ametumia jana wakati wa asubuhi, mchana au wakati wa usikuNapendelea kujua kama mtoto wako alitumia chochote hata kama kilichanganywa na kitu kingine (chakula kingine) Je; (JINA LA MTOTO) alikula au kunywa kati ya:			
A	Maziwa ya kopo, maziwa ya unga au maziwa freshi ya ng'ombe?	A.....1	2	8
B	Chai au coffee?	B.....1	2	8
C	Kitu kingine chochote ambacho ni kimiminika?	C.....1	2	8
D	Mkate, wali, ugali au chakula chochote cha nafaka?	D.....1	2	8
E	Boga, karoti, viazi vitamu ambavyo ni vya njano au rangi ya chungwa kwa ndani?	E.....1	2	8
F	Viazi mviringo, viazi vyeupe, mhogo au chakula chochote kilichotengenezwa kwa mizizi?	F.....1	2	8
G	Mboga mboga za kijani kibichi?	G.....1	2	8
H	Maembe yaliyoiva au mapapai?	H.....1	2	8
I	Tunda la aina yoyote au mboga mboga?	I.....1	2	8
J	Ini, figo, moyo au nyama yingine ya mnyama?	J.....1	2	8
K	Nyama yoyote kama ng'ombe, nguruwe, kondoo, mbuzi, kuku au bata?	K.....1	2	8
L	Mayai?	L.....1	2	8
M	Samaki wabichi au waliokaushwa?	M.....1	2	8
N	Chakula chochote kilichotengenezwa kwa maharagwe, njegere/mbaazi au karanga?	N.....1	2	8
O	Jibini au chochote kilichotengenezwa kwa maziwa?	O.....1	2	8
P	Mafuta aina yoyote, siagi au vyakula vyovyote vilivyotengenezwa kwa mojawapo ya hivyo?	P.....1	2	8
Q	Je; kuna vyakula vya sukari kama vile chocolate, Pp, muwa, keki, biskuti?	Q.....1	2	8
R	Chakula chochote kigumu au ambacho si kigumu sana?	R.....1	2	8
S	Vyakula vilivyotengenezwa kwa mnazi mwekundu, au mafuta ya mtende?	S.....1	2	8

65	Ni mara ngapi (JINA LA MTOTO) alikula chakula kigumu, kisicho kigumu sana au vyakula laini tofauti na vyakula vya maji maji jana mchana au wakati wa usiku?	NI MARA NGAPI? <input type="checkbox"/>	
	KAMA YAYA/MTUNZA MTOTO AKIJIBU MARA SABA AU ZAIDI ANDIKA MAJIBU 7 TU	SIJUI.....8	
	TAJA MIFANO YA VYAKULA VIGUMU, AMBAVYO SI VIGUMU SANA NA VILAINI (Ugali, viazi vya kupikwa, mayai, matunda, mboga mboga)		
	TUNATAKA KUPATA/KUTAFUTA NI MARA NGAPI MTOTO ALIKULA CHAKULA CHA KUTOSHA. VITAFUNWA KIMOJA AU VIWILI ALIVYOPEWA NA MAMA AU DADA YAKE USIVIHESABU		
	VITU/VYAKULA VYA MAJI MAJI HAVIHUSIKI KATIKA SWALI HILI. USIHUSISHE VIMIMINIKA VYOYOTE HAPA.		
	JITAHIDI KUMHOJI MHSIKA KWA MASWALI MBALIMBALI ILI KUJUA NI MARA NGAPI MTOTO ALIKULA SIKU ILIYOTANGULIA		
66	Je; (JINA LA MTOTO) aliwahi kupata dozi ya vitamini A kama hii au hata nyinginezo?	NDIYO.....1	
		HAPANA.....2	→ 68
	ONYESHA VIDONGE/DAWA ZA MAJI MAJI ZOTE ZILIZO ZOELEKA	SIJUI.....8	→ 68
67	Je; (JINA LA MTOTO) alitumia dozi ya vitamini A miezi sita iliyopita?	NDIYO.....1	
		HAPANA.....2	
		SIJUI.....8	
KINGA KWA MTOTO			
No.	Maswali na majibu	Namna ya kujaza	Ruka
68	Una kadi/kijitabu chenye chanjo alizopata (JINA LA MTOTO)?	NDIYO.....1	
		HAPANA.....2	→ 71
	KAMA NDIYO: naweza kuona?/Naomba kuona	SIJUI.....8	→ 71

69	<p>ANDIKA TAREHE ZOTE ZA KILA DOZI YA VITAMINI A ALIYOPEWA MTOTO KAMA ILIVYOONYESHWA KWENYE KADI</p>	<p>SIKU/TAREHE/MWAKA</p> <p>MARA YA KWANZA ___/___/___</p> <p>MARA YA PILI.....___/___/___</p> <p>MARA YA TATU....___/___/___</p>	
70	<p>NAKILI/ANDIKA TAREHE ZA CHANJO KWA DPT1, DPT2, DPT3, OPV, BCG, HEPATITIS B NA SURUA KUTOKA KWENYE KADI AU KIJITABU CHA MTOTO (RCH).</p> <p>KAMA TAREHE ZA CHANJO HAZIJAREKODIWA KWENYE KADI YA AFYA YA MTOTO AU KIJITABU, ANDIKA 99/99/9999.</p> <p>KAMA SURUA IMEREKODIWA KWENYE KADI RUKA NENDA SWALI NAMBA 72.</p>	<p>SIKU/TAREHE/MWAKA</p> <p>DPT1..... _ _ / _ _ / _ _ _ _ _ </p> <p>DPT2..... _ _ / _ _ / _ _ _ _ _ </p> <p>DPT3..... _ _ / _ _ / _ _ _ _ _ </p> <p>OPV..... _ _ / _ _ / _ _ _ _ _ </p> <p>BCG..... _ _ / _ _ / _ _ _ _ _ </p> <p>HEP B.... _ _ / _ _ / _ _ _ _ _ </p> <p>SURUA... _ _ / _ _ / _ _ _ _ _ </p>	<p>→72</p>
71	<p>Je: (JINA LA MTOTO) aliwahi kudungwa sindano ya kinga ya surua kwenye mkono</p>	<p>NDIYO.....1</p> <p>HAPANA.....2</p> <p>SIJUI.....8</p>	
<p>UTUNZAJI WA MTOTO MGONJWA</p>			
No.	Maswali na Majibu	Namna ya kujaza	Ruka

72 Kuna wakati watoto wadogo huwa wanakuwa wagonjwa na wanahitaji matibabu. Ni dalili zipi zitakuonyesha kuwa mtoto anahitaji matibabu?

ANDIKA **MAJIBU YOTE** YATAKAYOTAJWA

HACHEZI KAWAIDA.....A
 HALI WALA HANYWI.....B
 MCHOVU.....C
 HOMA KALI.....D
 ANAPUMUA KWA HARAKA/KWA SHIDA.....E
 ANATAPIKA KILA KITU AKILA.....F
 ANAPATA MCHAFUKO AU KIFAFU..G

 MENGINEYO TAJA.....W

 IMENGINEYO TAJA.....X

 MENGINEYO.....Y
 SIJUI.....Z

 HAPANA.....X

73 Je; (JINA LA MTOTO) amepatwa na yafuatayo kwa juma mbili zilizopita?

ZUNGUSHIA YALE **YOTE** YANAYOFAA/TAJWA

- A Kuhara/kuharisha?
- B Damu kwenye kinyesi?
- C Kukohoa?
- D Kupumua kwa shida?
- E Kupumua kwa haraka/kwa shida?
- F Homa?
- G Malaria?
- H Anapata kichefuchefu/mchafuko?

KUHARA/KUHARISHA.....A
 DAMU KWENYE KINYESI.....B
 KUKOHOA.....C
 KUPUMUA KWA SHIDA.....D
 KUPUMUA KWA HARAKA/KWA HIDA.....E
 HOMA.....F
 MALARIA.....G
 ANAPATA KICHEFUCHEFU/
 MCHAFUKOH

→75

<p>74 Ulitafuta huduma kwa mtoto?</p> <p>KAMA NDIYO, ULIZA</p> <p>Ni wapi alitafuta msaada/huduma hiyo?</p> <p>ZUNGUSHIA <u>MAJIBU YOTE</u> YATAKAYOTAJWA</p>	<p><u>KITUO CHA HUDUMA YA AFYA</u></p> <p>HOSPITALI.....A</p> <p>KITUO CHA AFYA.....B</p> <p>ZAHANATI.....C</p> <p>MHUDUMU WA MAZINGIRA NA AFYA.....D</p> <p><u>VYANZO VINGINE</u></p> <p>MGANGA WA JADI.....E</p> <p>DUKANI.....F</p> <p>DUKA LA DAWA.....G</p> <p>WASAMBAZAJI WASIO NA LESENI.....H</p> <p>RAFIKI/NDUGU.....I</p> <p>MENGINEYO TAJA.....X</p>
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MALARIA-MATIBABU YA HOMA KWA MTOTO			
No.	Maswali na majibu	Namna ya kujaza	Skips
75	Je; (JINA LA MTOTO) amekuwa na homa wakati wowote kwa juma mbili zilizopita?	<p>NDIYO.....1</p> <p>HAPANA.....2</p> <p>SIJUI.....8</p>	<p>→ 85</p> <p>→ 85</p>
76	Je; (JINA LA MTOTO) ana homa kwa sasa?	<p>NDIYO.....1</p> <p>HAPANA.....2</p> <p>SIJUI.....8</p>	
77	Ulipata matibabu kwa homa iliyompata?	<p>NDIYO.....1</p> <p>HAPANA.....2</p>	→ 80
78	Ni baada ya siku ngapi kuona kwamba (JINA LA MTOTO) ana homa ulimpeleka kwa matibabu?	<p>SIKUIHIYO HIYO.....0</p> <p>SIKU ILIYOFUATA.....1</p> <p>BAADA YA SIKU MBILI NA ZAIDI.....2</p>	

79 Ulienda wapi kwanza kwa ushauri/matibabu?

ANDIKA **JIBU MOJA** TU

KAMA CHANZO/SEHEMU ALIYOPATIWA HUDUMA NI HISPITALI, KITUO CHA AFYA AU ZAHANATI ANDIKA JINA LA HIYO SEHEMU

JINA LA SEHEMU/ENEO ALILOPATIWA HUDUMA

80 Kuna wakati wowote wa kuugua kwake (JINA LA MTOTO) alikunywa dawa?

81 Alitumia dawa zipi (JINA LA MTOTO)

Dawa nyingine zaidi?

ANDIKA **ZOTE** ZITAKAZOTAJWA

ULIZA KUJUA NI AINA GANI YA DAWA ILITUMIKA NA KAMA INAJULIKANA. KAMA AINA HIYO YA DAWA HAIJAONYESHWA, ONYESHA DAWA YA KINGA YA MALARIA KWA MHOJIWA

KWA KILA KINGA YA MALARIA ULIZA:

Ni baada ya muda gani dawa hizo zilitumika baada ya kupata homa?

ZUNGUSHIA NAMBA SAHIHI HAPA CHINI

0 = SIKU HIYO HIYO

1 = SIKU MOJA BAADA YA KUONA HOMA

2 = SIKU MBILI AU ZAIDI BAADA YA HOMA

8 = SIJUI

KITUO CHA HUDUMA YA AFYA

HOSPITALI.....A

KITUO CHA AFYA.....B

ZAHANATI.....C

MHUDUMU WA MAZINGIRA NA AFYA.....D

VYANZO VINGINE

MGANGA WA JADI.....E

DUKANI.....F

DUKA LA DAWA.....G

WASAMBAZAJI WASIO NA LESENI.....H

RAFIKI/NDUGU.....I

MENGINEYO TAJA.....X

NDIYO.....1

HAPANA.....2

SIJUI.....8

DAWA ZA KINGA YA MALARIA

A. SP/ORODAR.....0 1 2 8

B. CHLORQUINE.....0 1 2 8

C. AMODIAQUINE.....0 1 2 8

D. QUININE.....0 1 2 8

E. ACT.....0 1 2 8

DAWA YA MAJI MAJI

F. ASPIRIN.....0 1 2 8

L. PANADOL/PARACETAMOL.0 1 2 8

M. CO-TRIMOXAZOLE 0 1 2 8

X. NYINGINEZO 0 1 2 8

(TAJA KAMA KUNA ZINGINE)

Z. HAZIJULIKANI0 1 2 8

→ 82

→ 82

82	Wakati (JINA LA MTOTO) akiwa na homa, je; ulimnyonyesha chini ya kiwango cha kawaida, kawaida, au zaidi ya kiwango cha kawaida	CHINI YA MUDA WA KAWAIDA.....1 MUDA WA KAWAIDA.....2 ZAIDI YA MUDA WA KAWAIDA.....3 MTOTO HAKUNYONYESHW KABISA.....4 SIJUI.....8
83	Wakati (JINA LA MTOTO)akiwa na homa, je; alinyesha chini ya kiwango cha kawaida, kawaida au zaidi ya ilivyo kawaida	CHINI YA KAWAIDA.....1 KAWAIDA.....2 ZAIDI YA KAWAIDA.....3 SIJUI.....8
84	Wakati (JINA LA MTOTO)akiwa na homa, je; mama yake alimlisha chini ya kiwango cha kawaida, kawaida au zaidi ya ilivyo kawaida	CHINI YA KAWAIDA.....1 KAWAIDA.....2 ZAIDI YA KAWAIDA.....3 SIJUI.....8

KUTHIBITI KUJARISHA

No.	Maswali na majibu	Namna ya kujaza	Ruka								
85	Je; (JINA LA MTOTO) amewahi kuharisha kwa juma mbili zilizopita?	NDIYO.....1 HAPANA.....2 SIJUI.....8	→ 95 → 95								
86	Je; alipewa moja ya vifuatavyo vya kunywa wakati wowote baada ya kuanza kuharisha?										
A	Maji ambayo ni maalumu kwenye paketi iliyoandikwa/inayoitwa ORS?	<table border="0" style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">NDIYO</td> <td style="text-align: center;">HAPANA</td> <td style="text-align: center;">SIJUI</td> </tr> <tr> <td>A.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </table>		NDIYO	HAPANA	SIJUI	A.....	1	2	8	
	NDIYO	HAPANA	SIJUI								
A.....	1	2	8								
B	Maji kabla ya kupewa ORS?	B.....1 2 8									
C	Maji ambayo yameshauriwa na serikali?	C.....1 2 8									

87 Kuna chochote tofauti na vilivyotajwa hapo ambavyo alipewa kutibu kuharisha kwake?

NDIYO.....1

HAPANA.....2

SIJUI.....8

→ 89

→ 89

88 Ni nini tena alichopewa kutibu kuharisha kwake?

ANDIKA MATIBABU YOTE ALIYOPATIWA

VIDONGE AU DAWA YA MAJI

ANTIBIOTIC.....A

ANTIMOTILITY (e.g. Vacontil).....B

ANTIPARASITIC (e.g. Flagyl).....C

ZINC.....D

SINDANO.....E

(IV) INTRAVENOUS.....F

MITISHAMBA.....G

NYINGINEZO.....X

89 Wakati (JINA LA MTOTO) akiwa ameugua/akiharisha, je; (JINA LA MTOTO) alipatwa na yafuatayo?

A Kinyesi chenye damu?

B Kuharisha kulikozidi wiki mbili au zaidi?

	NDIYO	HAPANA	SIJUI
A.....	1	2	8
B.....	1	2	8

90 Ulitafuta ushauri/matibabu kwa yeyote nje ya nyumbani kwa ajili ya kuhara kwa (JINA LA MTOTO)

NDIYO.....1

HAPANA.....2

→ 92

91	Ulienda wapi kwa mara ya kwanza kwa ushauri au matibabu?	<u>KITUOCHA HUDUMA YA AFYA</u>	
	ANDIKA JIBU MOJA TU	HOSPITALI.....A	
	KAMA ALIENDA HOSPITALI, KITUO CHA AFYA AU ZAHANATI ANDIKA SEHEMU ALIYOPATIWA HUDUMA	KITUO CHA AFYA.....B	
		ZAHANATI.....C	
		MHUDUMU WA MAZINGIRA NA AFYA.....D	
		<u>VYANZO VINGINE</u>	
		MGANGA WA JADI.....E	
	JINA LA SEHEMU/ENEO ALILOPATIWA HUDUMA	DUKANI.....F	
		DUKA LA DAWA.....G	
		WASAMBAZAJI WASIO NA LESENI.....H	
		RAFIKI/NDUGU.....I	
		MENGINEYO TAJA.....X	
92	Wakati (JINA LA MTOTO) akiwa anaharisha, je; ulimnyonyesha chini ya ulivyo zoea, kawaida au zaidi ya ulivyo zoea kumnyonyesha?	CHINI YA KIWANGO CHA KAWAIDA.....1	
		KAWAIDA.....2	
		ZAIDI YA KIWANGO CHA KAWAIDA.....3	
		MTOTO HAKUNYONYESHWA.....4	
		SIJUI.....8	
93	Wakati (JINA LA MTOTO) akiwa mgonjwa wa kuharisha, je; alikunywa kidogo/chini ya kiwango cha kawaida, kawaida, au zaidi ya kiwango cha kawaida	CHINI YA KIWANGO CHA KAWAIDA.1	
		KAWAIDA.....2	
		ZAIDI YA KIWANGO CHA KAWAIDA.....3	
		SIJUI.....8	
94	Wakati (JINA LA MTOTO) akiwa mgonjwa wa kuharisha, je; alikula kidogo/chini ya kiwango cha kawaida, kawaida, au zaidi ya kiwango cha kawaida	CHINI YA KIWANGO CHA KAWAIDA.1	
		KAWAIDA.....2	
		ZAIDI YA KIWANGO CHA KAWAIDA.....3	
		SIJUI.....8	
HOMA YA MAPAFU (PNEUMONIA)			
No.	Maswali na majibu	Namna ya kujaza	Skips

95	Je; (JINA LA MTOTO) amekuwa na ugonjwa wa kukohoa kulikotokana na kifua wakati wowote kwa juma mbili zilizopita?	NDIYO.....1 HAPANA.....2 SIJUI.....8	→ 104 → 104
96	Wakati (JINA LA MTOTO) akiwa anakohoa, je; alikuwa na tatizo lolote katika kupumua au alikuwa anapumua kwa haraka isivyo kawaida?	NDIYO.....1 HAPANA.....2 SIJUI.....8	
97	Je; ulitafuta ushauri au matibabu yoyote kwa kukohoa au kupumua kwake kwa haraka?	NDIYO.....1 HAPANA.....2	→ 101
98	Nani alikupa ushauri/matibabu? Mwingine yeyote ANDIKA MAJIBU <u>YOTE</u> YATAKAYOTAJWA	DAKTARI.....A MUUGUZI.....B MUUGUZI MSAIDIZI.....C MHUDUMU WA MAZINGIRA NA AFYA.....D MENGINEYO TAJA.....X	
99	Ulienda wapi kwanza kwa ushauri au matibabu? ANDIKA JIBU <u>MOJA</u> TU KAMA NI HOSPITALI, KITUO CHA AFYA AU KLINIKI ANDIKA JINA LA SEHEMU ULİYOPATIWA HUDUMA _____ JINA LA SEHEMU/ENEO ULIKOPATIWA HUDUMA	<u>KITUOCHA HUDUMA YA AFYA</u> HOSPITALI.....A KITUO CHA AFYA.....B ZAHANATI.....C MHUDUMU WA MAZINGIRA NA AFYA.....D <u>VYANZO VINGINE</u> MGANGA WA JADI.....E DUKANI.....F DUKA LA DAWA.....G WASAMBAZAJI WASIO NA LESENI.....H RAFIKI/NDUGU.....I MENGINEYO TAJA.....X	

100	<p>Ni dawa gani alizopewa (taja jina la mtoto)?</p> <p>ANDIKA DAWA ZOTE ATAKAZOTAJA</p>	<p>HAKUPEWA CHOCHOTE.....A</p> <p>ASPRINI.....B</p> <p>PANADOL/ PARACETAMOL.....C</p> <p>AMOXICILLIN.....D</p> <p>ERYTHROMYCIN.....E</p> <p>AZITHROMYCIN.....F</p> <p>MENGINEYO TAJA.....X</p> <p>SIJUI/HAZIPO.....Z</p>	
101	<p>Wakati (JINA LA MTOTO) akiwa mgonjwa, je ulimnyonyesha isivyo kawaida, kawaida, zaidi ya kiwango cha kawaida?</p>	<p>CHINI YA KIWANGO CHA KAWAIDA.1</p> <p>KAWAIDA.....2</p> <p>ZAIDI YA KAWAIDA.....3</p> <p>MTOTO HAKUNYONYESHWA4</p> <p>SIJUI.....8</p>	
102	<p>Wakati (JINA LA MTOTO) akiwa mgonjwa, je; alinyweshwa chini ya kiwango cha kawaida, kawaida, au zaidi ya kiwango cha kawaida</p>	<p>CHINI YA KIWANGO CHA KAWAIDA.1</p> <p>KAWAIDA.....2</p> <p>ZAIDI YA KIWANGO CHA KAWAIDA.....3</p> <p>SIJUI.....8</p>	
103	<p>Wakati (JINA LA MTOTO) akiwa mgonjwa, je; alikula chini ya kiwango cha kawaida, kawaida, au zaidi ya kiwango cha kawaida</p>	<p>CHINI YA KIWANGO CHA KAWAIDA.1</p> <p>KAWAIDA.....2</p> <p>ZAIDI YA KIWANGO CHA KAWAIDA.....3</p> <p>SIJUI.....8</p>	
MAJI, USAFI NA MAZINGIRA			
No.	Maswali na Majibu	Namna ya kujaza	Ruka
104	<p>Je; huwa mnayatibu maji yenu kwa njia yoyote kabla ya kuyatumia?</p>	<p>NDIYO.....1</p> <p>HAPANA.....2</p>	<p>→106</p>

105	<p>Kama ndiyo, unatumia nini ili kuyafanya maji yako kuwa salama?</p> <p>KAMA ANATUMIA NJIA ZAIDI YA MOJA ANDIKA ZOTE. KAMA ANATUMIA NJIA MOJA LEO NYINGINE KESHO BASI ANDIKA MOJA TU.</p>	<p>KUYAACHA YATULIE.....A</p> <p>KUYACHUJA KWA KUTUMIA KITAMBAA.....B</p> <p>KUYACHEMSHA.....C</p> <p>KUWEKA DAWA YA KLORAIIDI.....D</p> <p>KUWEKA KINGA YA MAJIE</p> <p>KUWEKA KICHUJA MAJI KAMA MCHANGA.....F</p> <p>MWANGA WA JUA.....G</p> <p>NJIA NYINGINEYO TAJA.....X</p> <p>SIJUI.....Z</p>	→110
106	<p>Unaweza kunionyesha sehemu ambayo huwa unanawa mikono na huwa unatumia nini kuoshea mikono?</p> <p>ULIZA NA UONE KAMA KWELI KUNA HIYO SEHEMU NA ANACHOTUMIA KUNAWIA MIKONO</p>	<p>NDANI AU KARIBU NA CHOO.....1</p> <p>NDANI/KARIBU NA JIKO/AU SEHEMU YA KUPIKIA.....2</p> <p>SEHEMU YOYOTE NDANI YA ENEO LA NYUMBA.....3</p> <p>NJE YA ENEO LA NYUMBA.....4</p> <p>HAKUNA ENEO/SEHEMU MAALUM..5</p> <p>HURUHUSIWI KUONA.....6</p>	→110
107	<p>KWA KUANGALIA TU; JE; KUNA SABUNI/KIPANDE AU MAJI AU YA KIENYEJI INAYOTUMIKA?</p> <p>SABUNI HII LAZIMA IWE SEHEMU HUSIKA AU ILETWE NA MHOJIWA NDANI YA DAKIKA MOJA. KAMA HAIPO KWA MUDA WA DAKIKA MOJA USIANGALIE TENA HATA KAMA ATAILETA BAADAE.</p>	<p>SABUNI YA KIPANDE/MCHE.....1</p> <p>SABUNI YA MAJI/KIMIMINIKA.....2</p> <p>MAJIVU.....3</p> <p>MATOPE/MCHANGA.....4</p> <p>MAJANI YA MITI.....5</p> <p>HAKUNA.....6</p> <p>NYINGINE YOYOTE.....7</p>	→110
108	<p>Je; ulitumia sabuni ya aina yoyote jana aidha asubuhi, mchana au jioni kwa sababu zako binafsi?</p>	<p>NDIYO.....1</p> <p>HAPANA.....2</p>	→110

109	<p>Ulipotumia sabuni jana aidha asubuhi, mchana, au jioni ulitumia kwa ajili gani/ya nini?</p> <p>KAMA ATASEMA/ATAT AJA NI KUWAOSHA WATOTO WAKE MIKONO, ULIZA UJUE ILIKUWA NI WAKATI GANI LAKINI USISOME MAJIBU.</p> <p>USISOME MAJIBU KABISA, ULIZA ILI UPATE JIBU LA UHAKIKA, ENDELEA KUDODOSA KWA UNDANI MPAKA AFIKIE MWISHO WA KUTAJA NDIPO UANGALIE JIBU LIFAALO</p>	<p>KABLA YA KUANDAA CHAKULA.....A</p> <p>KABLA YA KUMLISHA MTOTO.....B</p> <p>BAADA YA KUJISAIDIA/KUNYA.....C</p> <p>BAADA YA KUMTAWADHA MTOTO ALIYEKUNYA.....D</p> <p>MENGINEYO.....X</p>
110	<p>Mara ya mwisho (JINA LA MTOTO) alipoenda haja, kulifanyika nini kuondoa kinyesi chake?</p> <p>REKODI/ANDIKA JIBU MOJA TU.</p>	<p>MTOTO ALITUMIA CHOO.....A</p> <p>KILIOSHWA KWA MAJI SAFI.....B</p> <p>ILITUPWA KWENYE SHIMO LA TAKA.....C</p> <p>KUTUPA KWENYE DAMPO LA TAKATAKA.....D</p> <p>KUCHIMBIA.....E</p> <p>ACHA KWENYE SEHEMU WAZI.....F</p> <p>MENGINEYO.....X</p>

MALARIA – ITN USE

No.	Maswali na majibu	Namna ya kujaza	Ruka
111	<p>Je; familia yako ina neti ya mbu inayotumika wakati wa kulala?</p>	<p>NDIYO.....1</p> <p>HAPANA.....2</p>	→ 117
112	<p>Nani alilala ndani ya neti usiku wa jana?</p> <p>SIKILIZA KWA MAKINI MAJIBU YOTE NA KAMA JINA LA MTOTO LITATAJWA ANDIKA MTOTO KAMA SIYO ANDIKA HAYO YATAKAYOTAJWA.</p>	<p>JINA LA MTOTO.....1</p> <p>MENGINEYO.....2</p>	→ 117
113	<p>Ni muda gani ambao neti ya mbu ilinunuliwa au ilipatikana?</p>	<p>MIEZI..... <input type="text"/> <input type="text"/></p> <p>ZAIDI YA MIAKA 2 ILIYOPITA 95</p> <p>SIJUI.....98</p>	

114	<p>MUULIZE MHOJIWA KUTAJA/KUONYESHA NI AINA GANI/TOLEO GANI LA NETI ALIYOMFUNIKA NAYO MTOTO. ONYESHA AINA YA NETI HALISI NA MATOLEO YAKE</p>	<p>NETI YA KUDUMU NETI ILIYOWEKWA DAWA YA KUDUMU (mf: OLISSET).....1 NETI ILIYO NA KINGA KABLA NETI NA NGAO.....2 NETI ISIYO NA KINGA NETI AINA YA MBU.....3 NETI AINA YA SAFI.....4 MENGINEYO TAJA.....5 SIJUI CHAPA.....8</p>	→ 117
115	<p>Je; kwenye neti aliyolalia (JINA LA MTOTO) usiku wa jana ilikuwa imelowekwa kwenye maji yenye dawa kwa ajili ya kuzuia mmbu au kunguni?</p>	<p>NDIYO.....1 HAPANA.....2 SIJUI.....8</p>	→ 117 → 117
116	<p>Mara ya mwisho kuloweka neti kwenye dawa ilikuwa lini? KAMA NI CHINI YA MWEZI 1 ULIOPITA, ANDIKA 00, KAMA NI CHINI YA MIAKA 2 ILIYOPITA, ANDIKA MIEZI KADHAA. KAMA NI MIEZI 12 ILIYOPITA AU MWAKA MMOJA, ULIZA AU DODOSA ZAIDI KUPATA NAMBA YA MIEZI</p>	<p>MIEZI..... <input type="text"/> <input type="text"/> ZAIDI YA MIAKA 2 ILIYOPITA.....95 SIJUI.....98</p>	
117	<p>Wakati ukiwa na ujauzito wa (JINA LA MTOTO), ulitumia neti ya mbu? KAMA NDIYO MUULIZE: Ni mara ngapi ulilala kwenye neti? KAMA HAPANA, ZUNGUSHIA NAMBA "5"</p>	<p>KILA MARA NA KILA USIKU.....1 KAWAIDA KILA USIKU.....2 KWA WAKATI FULANI FULANI3 MARA CHACHE.....4 SITUMII KABISA.....5</p>	
118	<p>Kwa muda wa miezi 12 iliyopita, kuna mmoja wenu aliyepulizia dawa kwenye kuta za nyumba unayoishi kuzuia/kufukuza mmbu? KAMA NDIYO: Ni miezi mingapi iliyopita ambapo nyumba ilipuliziwa/Nyunyiziwa dawa? KAMA NI CHINI YA MWEZI MMOJA ANDIKA 00</p>	<p>NDIYO.....1 HAPANA.....2 SIJUI.....8 MIEZI KADHAA <input type="text"/> <input type="text"/></p>	

UZAZI WA MPANGO

No.	Maswali na majibu	Namna ya kujaza	Ruka
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119	<p>Napenda kukuuliza kuhusu huduma ya uzazi wa mpango</p> <p>Unajua sehemu yoyote ambayo unaweza kupata njia kuhusu uzazi wa mpango?</p> <p>KAMA HAPANA ZUNGUSHIA “Z” (SIJUI)</p> <p>KAMA NDIYO, uliza ni wapi</p> <p>ANDIKA YOTE YATAKAYOTAJWA</p> <p>KAMA ALIENDA HOSPITALI, KITUO CHA AFYA AU ZAHANATI ANDIKA SEHEMU ALIYOPATIWA HUDUMA.</p> <hr/> <p>ANDIKA JINA LA ENEO/MAHALI ULIKOPATIWA MAFUNZO YA UZAZI WA MPANGO</p>	<p><u>KITUO CHA AFYA/SEHEMU YA HUDUMA</u></p> <p>HOSPITALI.....A</p> <p>KITUO CHA AFYA.....B</p> <p>ZAHANATI.....C</p> <p>NGO KITUO.....D</p> <p>KLINIKI YA UZAZI WA MPANGO.....E</p> <p>MHUDUMU WA AFYA NA MAZINGIRA.....F</p> <p>DUKA LA DAWA.....G</p> <p>KITUO KINGINE CHA AFYA TAJA.....H</p> <p><u>VYANZO VINGINE</u></p> <p>DUKA.....I</p> <p>KANISANI.....J</p> <p>RAFIKI/NDUGU.....K</p> <p>MENGINEYO TAJA.....X</p> <p>SIJUI.....Z</p>	
120	Je; u mjamzito kwa sasa?	<p>NDIYO.....1</p> <p>HAPANA.....2</p> <p>SINA UHAKIKA.....8</p>	→124
121	Je; ungependa kuwa na mtoto mwingine?	<p>NDIYO.....1</p> <p>HAPANA.....2</p> <p>SIJUI.....8</p>	→ 123
122	Ni lini ungependa kuwa na mtoto mwingine?	<p>KATI YA MIAKA MIWILI1</p> <p>ZAJIDI YA MIAKA 2 KUTOKA SASA....2</p> <p>SINA UHAKIKA8</p>	→ 123

123	Je; kwa sasa kuna njia yoyote unayotumia kujikinga na kupata mimba? KAMA HAPANA ZUNGUSHIA "01" (HAKUNA NJIA NYINGINE) KAMA NDIYO, ULIZA ni njia gani kuu ambayo huwa u natumia kwa sasa kuzuia kutopata mimba? ZUNGUSHIA JIBU AMBALO NI SAHIHI.	HAKUNA NJIA NINAYOTUMIA01	
		NORPLANT (KIPANDIKIZI).....02	
		SINDANO.....03	
		VIDONGE.....04	
		IUD (KITANZI).....05	
		KIWAMBO.....06	
		KONDOM.....07	
		POVU.....08	
		TUBAL LIGATION.....09	
		KUFUNGA KIZAZI KWA-ME.....10	
		KUNYONYESHA TU11	
		KALENDA.....12	
		KUACHA.....13	
		KUMWAGA NJE.....14	
		MITI SHAMBA.....15	
	NJIA NYINGINEZO KAMA ZIPO TAJA.....96		
124	Je; umewahi kuongelea swala la uzazi wa mpango wewe na mumeo au na mpenzi wako mwingine?	NDIYO.....1	
		HAPANA.....2	
		SIJUI.....8	

UKIMWI (HIV/AIDS)

No.	Maswali na majibu	Namna ya kujaza	Rukia
125	Naomba kwa sasa niongelee kitu kingine. Je; umewahi kusikia ugonjwa ujulikanao kama UKIMWI?	NDIYO.....1	
		HAPANA.....2	→128
		SIJUI.....8	→128
126	Kuna kitu ambacho mtu anaweza kufanya asipate UKIMWI au vijidudu(virus) viambukizavyo UKIMWI?	NDIYO.....1	
		HAPANA.....2	→128
		SIJUI.....8	→128

127 Je; ni kitu gani mtu anaweza kufanya asiambukizwe au kupata UKIMWI?
Kingine cha zaidi?
ANDIKA AU REKODI **VYOTE** ATAKAVYOTAJA.

- KUACHA NGONO.....A
- KUTUMIA KONDOMU.....B
- KUWA NA MPENZI MMOJA/AU
KUWA MWAMINIFU.....C
- KUWA NA IDADI NDOGO YA
WAPENZI.....D
- KUACHA NGONO NA
UMALAYA.....E
- KUACHA NGONO NA MPENZI
MWENYE WAPENZI WENGI.....F
- KUTOKUFANYA MAPENZI KWA
WATU WA JINSIA MOJA.....G
- KUACHA NGONO NA WATU
WANAOTUMIA MADAWA YA
KULEVYA.....H
- KUACHA KUWEKEWA DAMU.....I
- KUACHA KUDUNGWA SINDANO.....J
- KUACHA KUBUSIANA.....K
- KUEPUKANA NA KUNGATWA NA
MMBU.....L
- KUTAFUTA KINGA KWA WAGANGA
WA KIENYEJI.....M
- KUACHA KUSHIRIKIANA
NYEMBE.....N
- MENGINEYO TAJA.....W
- KAMA KUNA NYINGINE
TAJA.....X
- SIJUI.....Z

MAWASILIANO YA KIAFYA

No. Maswali na majibu

Namna ya kujaza

Ruka

128 Mwezi uliopita, uliweza kukutana na wafuatao mara ngapi?

ANDIKA NI MARA NGAPI KA MAJIBU **YOTE** YATAKAYOTAJWA.

A Daktari.....

B Muuguzi.....

C Mkunga/mzalishaji.....

D Mkunga wa kienyeji.....

E Mhudumu wa afya na mazingira

F Kamati ya afya ya kijiji.....

G Viongozi wa jumuiya.....

H Jumuiya zisizo za kiserikali /uongozi wa serikali

I Walimu wa shule.....

J Maisha drivers

A. DAKTARI.....

B. MUUGUZI.....

C. MKUNGA/MZALISHAJI.....

D. MKUNGA WA KIENYEJI.....

E. MHUDUMU WA AFYA NA MAZINGIRA.....

F. KAMATI YA AFYA YA KIJJI.....

G. VIONGOZI WA JUMUIYA.....

H. JUMUIYA ZISIZO ZA KISERIKALI /UONGOZI WA SERIKALI.....

I. WALIMU WA SHULE.....

J. MAISHA DEREVA.....

129 Unapata wapi taarifa kuhusu mambo ya afya?

ANDIKA MAJIBU **YOTE** UTAKAYOAMBIWA.

MTANDAO RASMI

DAKTARI.....A

WAUGUZI/WAKUNGA.....B

MZALISHAJI WA KIJADI.....C

MHUDUMU WA MAZINGIRA NA
AFYA.....D

JUMUIYA ZISIZO ZA KISERIKALI.....E

KAMATI YA AFYA YA KIJJI.....F

MHUDUMU WA AFYA WA KIJJI.....G

MHUDUMU YEYOTE TAJA.....H

MTANDAO USIO RASMI

MUME/MUME MWENZA/HAWARA.....I

MAMA/MAMA MKWE.....J

DADA.....K

BIBI/BABU.....L

SHANGAZI.....M

RAFIKI/JIRANI.....N

MPONYAJI WA KIENYEJI.....O

MKUU WA KIJJI.....P

MWALIMU WA SHULE.....Q

MWAJIRI.....R

VIONGOZI WAJADI.....S

KIONGOZI WA KISIASA/KIJJI.....T

MWINGINE YEYOTE
TAJA.....X

130 Je; mwezi uliopita umepata au kupokea taarifa yoyote kuhusu yafuatayo?

SOMA ORODHA YOTE NA ANDIKA AU REKODI MAJIBU **YOTE** YATAKAYOTAJWA.

- A Radio
- B Kituo cha televisheni
- C Magazeti
- D Mtoa elimu ya afya
- E Mhudumu wa kijijini wa mazingira na afya
- F Jumuiya mbalimbali
- G Viongozi wa jadi
- H Viongozi wa kisiasa/kijiji
- X Mengineyo taja

NDIYO HAPANA SIJUI

A. RADIO.....	1	2	8
B. KITUO CHA TELEVISHENI.....	1	2	8
C. MAGAZETI.....	1	2	8
D. MTOA ELIMU YA AFYA...1		2	8
E. MHUDUMU WA KIJIJINI WA MAZINGIRA NA AFYA...1		2	8
F. JUMUIYA MBALIMBALI....1		2	8
G. VIONGOZI WA JADI.....1		2	8
H. VIONGOZI WA KISIASA/ KIJJI.....1		2	8
X. MENGINEYO TAJA.....1		2	8

UZITO

No.	Maswali na majibu	Namna ya kujaza	Ruka
131	Naweza kupima uzito wa (JINA LA MTOTO)?	NDIYO.....1 HAPANA.....2 _ _ . _ KILOGRAMS	MWISHO

Appendix D: Sampling Frame

Population of Karatu District					
Population Projection from National Census 2002					
KATA	KIJIJI		CUMULATIVE POPULATION	SAMPLING INTERVAL	CLUSTER NUMBER
KARATU	G/ARUSHA	4,013	4,013	2964	1
	G/LAMBO	5,936	9,949		
	KARATU MJINI	13,083	23,032	10420	2 & 3
	TOTAL	23,032			
ENDAMARARIEK	BASODAWISH	5,847	28,879	25332	4
	ENDALLAH	5,540	34,419	32788	5
	GETAMOCK	5,969	40,388	40244	6
	ENDAMARARIEK	7,261	47,649		
	KHUSUMAY	2,711	50,360	47700	7
	TOTAL	27,328			
BUGER	ENDANYAWET	3,592	53,952		
	AYALALIO	2,867	56,819	55156	8
	BUGER	4,203	61,022		
	TOTAL	10,662			
ENDABASH	QARU	7,635	68,657	62612	9
	ENDABASH	6,506	75,163	70068	10
	TOTAL	14,141			
KANSAY	KAMBI YA FARU	3,587	78,750	77524	11
	KANSAY	4,102	82,852		
	LAJA	4,378	87,230	84980	12
	NGAIBARA	2,637	89,867		
	TOTAL	14,704			
MANG'OLA	ENDAMAGHAN	4,490	94,357	92436	13
	MANGOLA	4,749	99,106		
	MALEKCHAND	3,799	102,905	99892	14
	LAGANGERER	2,603	105,508		
	TOTAL	15,641			
BARAY	QANGDED	5,411	110,919	107348	15
	MBUGA NYEKUNDU	4,206	115,125	114804	16
	JOBAJ	3,639	118,764		
	DUMBECHANDE	3,947	122,711	122260	17
	MATALA	4,169	126,880		
	TOTAL	21,372			
QURUS	GONGALI	5,758	132,638	129716	18
	QURUS	3,123	135,761		
	BASHAY	9,850	145,611	137172	19+20
	TOTAL	18,731			
DAA	CHANGARAWAWE	2,120	147,731		
	ENDASHANGWET	2,850	150,581		

	MANGOLA JUU	3,999	154,580	152084	21
	MAKHOROMBA	1,760	156,340		
	TOTAL	10,729			
OLDEANI	OLDEANI	8,320	164,660	159540	22
	TOTAL	8,320			
GANA KO	AYALABE	4,252	168,912	166996	23
	TLOMA	7,115	176,027	174452	24
	TOTAL	11,367			
RHOTIA	K/MOJA	5,455	181,482		
	CHEM CHEM	5,563	187,045	181908	25
	RHOTIA KAINUM	3,814	190,859	189364	26
	RHOTIA KATI	6,675	197,534	196820	27
	K/TEMBO	4,233	201,767		
	TOTAL	25,740			
MBULUMBULU	LOSITETE	2,896	204,663	204276	28
	U/KITETE	4,852	209,515		
	SLAHHAMO	8,161	217,676	211732	29
	K/SIMBA	6,029	223,705	219188	30
	TOTAL	21,938			
	GRAND TOTAL	223,705			
		7456.833			

Appendix E: Training Guide and Schedule for KPC Survey Training

WellShare International Tanzania Child Survival Project, Karatu

KPC TRAINING AGENDA

June 2: Day One: Planning Meeting with Supervisors

Topic	Details	Facilitator(s)	Time
Welcome and overview Brief introduction of MIHV		Jolene Mullins Innocent Augustino CHMT member	9:00 am
Review/Back Translate Questionnaire and develop lexicon			10:00 am
Design and review Events calendar			12:30 pm
Random Selection of Respondents			2:00 pm
Review KPC Logistics Plan (including selection of households) and Survey Teams.			3:00 pm
Close Day 1			5:00 pm
Day 1 Evening	Update questionnaire, translate and copy for training. Update training materials. Update schedules/plans. Translate.		

June 3: Day Two: Training of Supervisors and Interviewers and CHMT

Topic	Details	Facilitator(s)	Time
Welcome and Introductions		Jolene, Innocent	10:00 am
Project Overview			10:30 am
Purpose for the final assessment.			11:00 am
What information do we need to collect?			
Explain final assessment tools			
Review Schedules-dates			
Random sampling and the selection process			
Select villages		Jolene, CHMT member	12:00 pm Lunch to follow
Supervisor and Interviewer Roles and Responsibilities			
Giving and receiving feedback using the QA Checklist.			

Protocol for interviews including household selection			
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June 6: Day three: Training of Supervisors and Interviewers

Topic	Details	Facilitator(s)	Time
Review, Questions/Answers		Innocent	9:00 am
Large Group Questionnaire Review			9:30 am
Manual Tabulation			11:00 am
Review selection of respondents.			12:00 pm
Finalize events calendar			1:30 pm
Interviewing techniques.			2:30 pm
Practice Interviews.			3:00 pm
Weight measurement techniques			4:00 pm
Review Directions for Field Practice Close Day 3			

June 7: Day four: Field Test with Supervisors and Interviewers

Topic	Details	Facilitator(s)	Time
Review, Questions/Answers		Innocent, Jolene	9:00am
Field Practice			10:00 am
Questions/Answers, review "results" from Field Practice			9:00 am
Review KPC Interview Schedule.			10:30 am
Review final changes to the questionnaire, if needed.			11:00 am
Make final copies and number the questionnaires.			12:00 pm
Starting of data collection			

KPC TRAINING NOTES

1-Welcome Remarks

- Introductions: Name/title/affiliation
- Brief introduction to WellShare International as an organization and the Tanzania Child Survival Project (TCSP)
- “How many of you have done a KPC or KAP survey in the past?”
- “You are the supervisors for this survey – important role. Tomorrow we will be discussing more about what that will entail.”
- “Today = planning meeting rather than the first day of training. Normally, we would start with an overview of the project and the purpose of the baseline assessment, but today we need to get your input as we finalize the questionnaire and our plans. Tomorrow the entire team will get together to cover these issues.”
- Provide an overview of today and tomorrow’s agenda.

2-Review/Back translate Questionnaire

- Overview:
 - Respondents
 - Purpose: What it will tell us/what it won’t tell us.
 - Background
 - different modules covering the leading causes of maternal/child morbidity and mortality.
 - Staffing
 - Implementation
- Read each question/responses (ROUND ROBIN) and review each for:
 - Accuracy of the translation (Back Translate).
 - Appropriateness to the local situation.
 - Any changes to the questionnaire. (RECORD ON FLIP CHART.)
 - Establish a lexicon of key terms/definitions in each of the languages. (FLIP CHARTS FOR EACH LANGUAGE.)

3- Random Selection of Respondents

- “What problems result from the use of incorrect data?” (BRAINSTORM ON FLIP CHARTS. MAKE SURE EACH OF THE FOLLOWING IS INCLUDED.)
 - Focus on the wrong health problems. We do not detect an important health problem.
 - Choose the wrong strategies.
 - Get in trouble in the evaluation.
 - Lose credibility.
- “What are some sources of bias and how do we correct for it?” (BRAINSTORM ON FLIP CHARTS – ONE COLUMN FOR PROBLEM AND ONE COLUMN FOR SOLUTIONS. MAKE SURE EACH OF THE FOLLOWING IS INCLUDED.)
 - Respondent does not tell the truth. (Lack of trust)
 - Wrong respondent (Improper selection)
 - Bad penmanship.
 - Respondent does not understand the question.
 - Interviewer does not understand the respondent.
- “Too expensive and time consuming to interview every mother in the district. What

can we do?” (QUESTIONS LEADING TO SAMPLING.)

- “We need to define two terms. Can anyone define ‘sample’? Can anyone define ‘random sample’?”
- Sample: A group of units (such as individuals or households) selected from a general population.
- Random Sample: A method of selecting a sample that ensures that each unit in the population has an equal chance of being selected.
- Options for determining a random sample for a KPC:
 - Simple Random Sampling (SRS)
 - 30-cluster sampling
 - Lot quality assurance sampling (LQAS)
- Rationale for using 30-cluster for this baseline:
 - Easier to train on.
 - Does not require an accurate census.
 - Can be done in a large area at lower cost.
- Select: “Identifying who we will interview is very important process. It will be done at two levels:
 - Selecting the clusters/communities
 - Selecting the household/first respondent.
- “We have used a standardized process for identifying which communities to do the interviews. Identifying which households to interview presents some interesting challenges, especially for this project. This is how we usually do it.” LEAD THEM THROUGH AN EXERCISE USING THE PAPER HOUSES.
- “How can we replicate this in the communities in a way that does not create bias?”
- EXERCISE TO GROUP THE SELECTED CLUSTERS INTO TYPES AND LANGUAGE. BRAINSTROM WAYS TO DO RANDOM SELECTION SPECIFIC TO EACH.

4- Review KPC Logistics Plan and Survey Teams.

- Develop Teams and identify clusters for each team.

5-Closing

- Any questions from today’s work?
 - What could have been done differently/better?
 - Have you learned anything new today? What was it? What did you already know?
- Review evening’s agenda.
- Review next day’s agenda.
- Remind about starting time for the next day.

6-Welcome, Introductions and Overview

- Introductions
- Name/title/affiliation/languages spoken/experience working with the community.
- “You are the Supervisors and Interviewers who will actually be implementing the survey in the field. The Supervisors met yesterday to review the questionnaire and plans for the survey. Today is the first formal day for the KPC training.”
- TRAINING OBJECTIVES: “Upon completing your training, each of you will have participated in a Field Practice experience that mimics an actual KPC survey and will

have an understanding of:

- The purpose for doing the KPC and how the results will be used.
- The roles of the team members in implementing the KPC.
- How to select respondents using random selection methods.
- Giving and receiving feedback.
- Completing and checking KPC survey questionnaires.
- “This process will be informal and participatory. Feel free to ask questions and tell us if something is not clear or confusing.”
- Training done in English and Kiswahili.
- Overview of the KPC schedule. (**OVERHEAD AND HANDOUT**)
- “How many of you have done surveys in the past? What happened?”
- “Can anyone describe, What a KPC or KAP survey is?”
- “What do you want to learn from this experience?” (**LIST ON FLIP CHART**)

7-Project Overview

Child Survival Overview-targeted populations and interventions

WellShare’s project goals and objectives was based on discussions with Karatu leaders

Information on Phased project

- “Most projects have a life cycle that is pretty consistent.” (PROJECT LIFE CYCLE: RFA – PROPOSAL – IMPLEMENTATION/MONITORING – EVALUATION.) TR 1-7
- Describe each box
 - RFA “Can anyone tell me what an RFA is and what it does?” Asks questions: (1) What are the needs? (2) How will you address those needs? (3) Who should be involved – partners? (4) Are you qualified? (5) What is it going to cost?
 - Proposal “These questions are what we answer in the proposal.”
 - Provide information on USAID and responsibilities to US Government at all levels.
 - Implementation and Monitoring: This where you do the real work and track your progress.
 - Evaluation: What is working and what needs to be changed? Reporting back to the donors.
 - Reapply to start the process over again.
- **Provide information on how final KPC illustrates the successes and challenges of the project and the evaluation process.**

8-Purpose of the Final Assessment

Final Assessment Purpose

- To better understand the results of the project area.
- To determine whether any changes were made and provide comments on the content of the project design or implementation plan.
- To inform the results of the project plan covering the five-year life of the TCSP, including the Performance Monitoring Plan.
- To strategically review a limited number of key indicators to use for

monitoring and evaluating the project; compare baseline rates and determine success in reaching end-of-project targets.

- To determine the impact of the relationships among the partners, reaffirm a commonly held purpose for the project, and build sustainability through partner roles and responsibilities beyond the TCSP
- Ensure that the project is in full compliance with donor, organizational and TCSP project guidelines and requirements.
- “Is there anything you would like to add to this list?” (LIST ON FLIP CHART.)
(Possible answers: Help us plan Phase II strategies, identify capacity building needs for the staff, etc.)

9-What information do we need to collect?

“Together we came up with a document that covered the following:

- What will be in place in 2011 that demonstrates that the TCSP has been a success?
- How will we know these things are happening?
- How will we use this information?
- Who has this information?
- How will we collect this information?
- Who is responsible for collecting this information?

Include project indicators-

“The KPC you will be doing is one of several methods we will be using to collect this information.”

10-Final Assessment Tools

“During the final we will be collecting two kinds of information that requires different types of tools.”

- **Quantitative** Information – What is happening?
 - Knowledge Practice Coverage (KPC) Survey of mothers of children under 2.
 - Health Facility Assessment (“Have any of you participated in the HFA?”)
 - Other sources
 - Operations Research
- **Qualitative** Information – Why is it happening and what can we do about it?
 - Interviews
 - Focus Group Discussions: Women, men and youth
 - Sustainability plan
 - Operations Research
- KPC Overview:
 - Respondents
 - Purpose: What it will tell us/what it won’t tell us.
 - Background
 - 15 modules covering the leading causes of maternal/child morbidity and

- mortality.
- Staffing
- Implementation

11-Review Dates

Final Evaluation Schedule

KPC Schedule

HFA

12-Random sampling and the selection process

Review of sampling and random sampling

Explain how villages will be selected

Select villages

13-Interviewer and Supervisor Roles

“You are the supervisors and the interviewers. You have the most important responsibilities because you are the point of contact between the project and the people we are serving.”

“The group will be broken up into teams: Each team with a supervisor and 2 interviewers. Each team will be responsible for doing ten interviews in one community per day.”

Supervisor Responsibilities: (TR 1-85, TR 1-86,)

- Helps find the cluster.
- Meets with community leaders.
- Determines first house.
- Makes sure the interviewers following the sampling guidelines.
- Reviews all the questionnaires for completeness and accuracy before leaving the cluster.
- Observes at least one interview by each interviewer each day.
- Provides positive feedback to the interviewers.
- Communicates any difficulties to the project staff.
- OTHERS?

Interviewer Responsibilities:

- Correctly identifies the respondents.
- Interviews mothers.
- Completes questionnaire and submits to the supervisor
- Responds to feedback from the Supervisor.
- OTHERS?

“What do you think are important characteristics of effective Interviewers and Supervisors?” (BRAINSTROM ON FLIP CHART. MAKE SURE THE FOLLOWING ARE INCLUDED:

- Literate in Kiswahili and any other local languages.
- Knows the communities

- Can build trust.
- Physically fit.

14-Giving and receiving feedback using the QI checklist.

“One of the responsibilities for both Supervisors and Interviewers that we listed above deals with feedback. Can anyone give me a good definition for feedback?” (BREAK INTO SMALL GROUPS TO BRAINSTROM ANSWERS TO THE FOLLOWING TWO QUESTIONS.)

- How should a Supervisor provide feedback?
 - Provide specific examples and suggestions.
 - Include appreciative comments for what was done well.
 - Include self-evaluation first.
 - Immediately discuss the results – **Don’t delay.**
 - Create an exchange of ideas and information.
 - Verify understanding by asking questions back.
 - Consider the needs of the person receiving the feedback – don’t give them more information than they can use – not the quantity the giver wants to give.
- What should an Interviewer do in response to feedback?
 - Listen to the entire comment without interrupting.
 - Ask questions before responding to make sure there is clear understanding of the feedback.
 - Don’t get defensive. (CAN YOU GIVE AN EXAMPLE?)
 - Help the giver of feedback to be specific with the feedback.
 - Be thankful for the input.

“Did you get anything different?” (WRITE ON FLIP CHART.)

- QI Checklist **TR 2-17**
- Checklist of errors **TR 2-18**
- Daily Interview form **TR 2-19** (tracking of refusals)

15-Protocol for interviews including household selection

16-Questions and Answers from the Previous Day

- Any questions?
- Overview for today.

Hand out any updated documents.

17-Large Group Questionnaire Review

- “Now we want to review the questionnaire as a group.”
- “The changes suggested by the Supervisors from the other day have been made in this version.”
- “Each of you is going to be asked to read a question and the responses.”
- For each question discuss:
 - Skips
 - Directions that should be/should not be read.
 - Words from the “Lexicon”

- Ways to reword the question if need be.
- Any changes
- Concerns or questions

18-Manual Tabulation

19-Selection of Respondents

(NOTE: TRAINERS WILL DEVELOP THIS TRAINING PLAN AND THE RELATED MATERIALS THE NIGHT BEFORE, BASED ON THE RESULTS FROM #3 ABOVE.)

20-Interviewing Techniques

“Collecting information from mothers can be challenging and difficult, especially in rural communities. Why is this?” (BRAINSTORM AND LIST ON FLIP CHARTS.)

“What can we do as interviewers and supervisors to address some of these issues and concerns? (BRAINSTORM AND LIST ON FLIP CHARTS. MAKE SURE THE FOLLOWING ARE INCLUDED.)

- A. Be courteous, polite, respectful, and non-judgmental.
- B. Maintain confidentiality.
- C. If there are people around the respondent, ask them politely to leave. (ASK THE TRAINEES: “What is the best way to do this?”)
- D. Ask each question exactly as it is written. When questions have to be repeated, use the phrases and minor wording changes that were agreed upon during the training.
- E. When an answer is unclear, ask the question again or ask it in a slightly different way, but be careful not to change the meaning or lead the respondent into a particular response. If an answer seems inconsistent with previous information given by the respondent, or if there is some reason to disbelieve an answer, try to discover the truth by asking him/her another question or asking a question in a slightly different way. However, do not be overly persistent. A person may change his/her answer just because persistent questioning suggests that the interviewer is dissatisfied with the initial answer.
- F. Do not imply that some answers are better than others.

For example, suppose a caregiver mentions that the child was given “a special drink” while he or she had diarrhea. Do not ask a leading follow-up question such as “Do you mean that you used ORS?” Instead ask an open question like “What kind of special drink?” or “What was in the drink?”

21-Practice Interviews:

- Review of **TR 2-12 - TR 2-14**.
- Break up into small groups with 1 Supervisor and 2 Interviewers, where one of the Interviewers will be a mother and the other one will be the Interviewers.
 - “Moms: Don’t make it too easy for the Interviewer:
 - Tell them you don’t understand a few of the questions.
 - Give inappropriate answers a few times.
 - Get angry about sensitive questions. “
- “The Supervisor will use the Quality Improvement Checklist (**TR 2-17**) and provide feedback after the interview.”

- “Then repeat with the Interviewers switching roles.”

DEBRIEF IN LARGE GROUP – HAVE SUPERVISORS READ THE COMMENTS FROM THEIR QUALITY ASSESSMENT REPORTS AND HAVE THE INTERVIEWERS EXPLAIN FROM THEIR PERSPECTIVE.

22-Weight measurement techniques

Hanging scale **TR 2-22**

Protocols **TR 2-23**

Standardization test form **TR 2-24**

Scale and baby

23-Review Directions for Field Practice

- Organize vehicles
- Explain the community and review random selection process/selection logarithm.
 - The Supervisor should talk with community leaders and identify the first household and subsequent ones.
 - Each Interviewer should do two interviews.
 - The Supervisor should observe and provide feedback for at least one interview per Interviewer.
 - Before leaving the cluster, the Supervisor should review the questionnaires to make sure they are complete and accurate.
- Make sure:
 - Everyone has been assigned to a team.
 - Pens.
 - Food and beverages.
 - Every Supervisor has:
 - Been assigned to a community and vehicle for his/her team.
 - Blank quality checklist forms (One per Interviewer)
 - Blank questionnaires for his/her team. (One for the Supervisor and two for each Interviewer.)
 - Pens.
 - Clip boards/clear bags.
 - Food and beverages.
 - Every Interviewer has:
 - Pens.
 - Clear bag for carrying questionnaires.

24-Q &A and Field Practice

Supervisors and Interviewers go to one community where they will identify the first household, complete at least two interviews per Interviewer, do quality review/feedback, and then review the questionnaires for completeness. The Supervisor will be responsible for turning in his/her team’s completed questionnaires and Quality Improvement (QI) Checklists.

NOTE: Jolene and Innocent will work with the Data Entry programme while the Supervisors and Interviewers are doing the Field Practice exercise.

<p><u>25-Debriefing</u> <u>(LIST ANSWERS ON FLIP CHARTS.)</u></p> <ul style="list-style-type: none"> • “Any surprises?” • “Did any mothers refuse to answer questions or participate? If so, why?” • “Were there any problems with the questionnaires? <ul style="list-style-type: none"> ○ Understand the questions? ○ Were there a lot of ‘other’ responses? ○ Did you encounter many refusals? • “Which languages did you use? Was this a problem?” • “We will now take the questionnaires and enter the results on the computer for discussion tomorrow.” • Collect the questionnaires.
<p><u>26-Close of Day 4</u> Preparations for KPC implementation, changes in questionnaire.</p>
<p><u>27- Q &A and Review ‘results’ from Field Practice.</u> HAVE THE DATA ENTRY STAFF EXPLAIN ANY PROBLEMS THEY FOUND IN THE FIELD PRACTICE QUESTIONNAIRES.</p>
<p><u>28-Review KPC Interview Schedule</u></p>
<p><u>29-Review final changes to the questionnaire (if necessary)</u></p>
<p><u>30-Make final copies and number questionnaires</u> Setup teams to:</p> <ul style="list-style-type: none"> • Photocopy the questionnaires. • Staple. • Number the first page of each questionnaire in sequence (1-300). • Number pages 2+ of each questionnaire. • Organize the numbered questionnaires by teams. • Provide the numbered questionnaires to each Supervisor.
<p><u>31-Close Day 5</u></p> <ul style="list-style-type: none"> • Make sure each person knows: <ul style="list-style-type: none"> ○ Other team members and their driver ○ Start time/meeting place. ○ Communities ○ Contact Information

KPC Survey Equipment/Supply/Food List

ITEMS	Quantity	Available?
EQUIPMENT		
LCD projector (With an extra bulb)	1	
Computers for data entry (Each with at least one USB port)	2	
Computer printer	1	
Identify best Photocopy machines	2	
<u>SUPPLIES</u>		
Reams of photocopy paper (One ream=500 sheets)	5	
Staplers (Good ones!)	2	
Boxes of staples	1	
Name tags	20	
Letters of introduction for the Supervisors/Interviewers.	20	
Flip chart paper pads	2	
Markers in different colors	6	
Roll of Tape	2	
Pens for the Interviewers and Supervisors	30	
Notebooks for the Interviewers and Supervisors to put their notes/handouts received during the training.	25	
“My Clear Bags” for the Interviewers to hold the questionnaires, in case of rain/dirt.	20	
Clip boards	20	
Boxes for carrying surveys, medicines	5	
<u>FOOD/BEVERAGES</u>		
Coffee, tea and snacks for breaks during the training.		
Meals for during the training. (NOTE: If possible, it is always better to eat together as a group so we don't lose people in the afternoons.)		
Drinking water and boxed lunches for the fieldwork.		
Extra beverages and snacks (biscuits) for the field.		

Appendix F: Data Tables for Each Question

1. In which languages do you feel most comfortable communicating?

language:	percentages	se	lb	ub	obs
swahili					
FALSE	5.1	1.3	3.0	8.7	20.0
TRUE	94.9	1.3	91.3	97.0	369.0
Total	100.0				389.0

language:	percentages	se	lb	ub	obs
iraqw					
FALSE	89.5	1.7	85.4	92.5	348.0
TRUE	10.5	1.7	7.5	14.6	41.0
Total	100.0				389.0

language:	percentages	se	lb	ub	obs
chaga					
FALSE	100.0	0.0			389.0

language:	percentages	se	lb	ub	obs
other					
FALSE	99.5	0.5	96.1	99.9	387.0
TRUE	0.5	0.5	0.1	3.9	2.0
Total	100.0				389.0

2. How old are you?

Age	percentages	lb	ub	obs
16	0.3	0.0	2.0	1.0
17	0.8	0.2	2.4	3.0
18	1.0	0.4	2.7	4.0
19	1.0	0.4	2.7	4.0

20	4.9	3.3	7.2	19.0
21	4.1	2.5	6.6	16.0
22	3.9	2.2	6.8	15.0
23	4.4	2.6	7.2	17.0
24	5.9	3.7	9.4	23.0
25	8.2	5.9	11.3	32.0
26	5.4	3.3	8.7	21.0
27	4.6	3.0	7.0	18.0
28	4.9	3.3	7.2	19.0
29	6.7	4.6	9.6	26.0
30	8.2	5.7	11.8	32.0
31	3.1	1.8	5.2	12.0
32	5.7	3.5	8.9	22.0
33	5.1	3.0	8.7	20.0
34	2.8	1.4	5.6	11.0
35	5.1	3.3	8.0	20.0
36	2.3	1.2	4.5	9.0
37	2.3	1.3	4.1	9.0
38	2.1	0.9	4.6	8.0
39	2.8	1.5	5.3	11.0
40	2.1	1.0	4.3	8.0
41	0.3	0.0	2.0	1.0
42	0.8	0.2	2.4	3.0
43	0.3	0.0	2.0	1.0
44	0.5	0.1	2.1	2.0
45	0.3	0.0	2.0	1.0
52	0.3	0.0	2.0	1.0
Total	100.0			389.0

3. Do you do anything to increase your income?

Extra				
work: no				
outside				
work	percentages	lb	ub	obs
-----+				
FALSE	77.1	70.8	82.4	300.0
TRUE	22.9	17.6	29.2	89.0
Total	100.0			389.0

Extra |
work: |

handicrafts	percentages	lb	ub	obs
FALSE	79.7	73.7	84.6	310.0
TRUE	20.3	15.4	26.3	79.0
Total	100.0			389.0

Extra work: farming	percentages	lb	ub	obs
FALSE	47.6	41.2	54.0	185.0
TRUE	52.4	46.0	58.8	204.0
Total	100.0			389.0

Extra work: animal husbandry	percentages	lb	ub	obs
FALSE	92.3	88.8	94.8	359.0
TRUE	7.7	5.2	11.2	30.0
Total	100.0			389.0

Extra work: selling foods	percentages	lb	ub	obs
FALSE	97.7	95.9	98.7	380.0
TRUE	2.3	1.3	4.1	9.0
Total	100.0			389.0

Extra work: shop keeper	percentages	lb	ub	obs

FALSE	97.2	94.2	98.6	378.0
TRUE	2.8	1.4	5.8	11.0
Total	100.0		389.0	

Extra				
work:				
servant	percentages	lb	ub	obs
FALSE	98.7	97.0	99.5	384.0
TRUE	1.3	0.5	3.0	5.0
Total	100.0		389.0	

Extra				
work:				
salaried				
worker	percentages	lb	ub	obs
FALSE	96.7	93.8	98.2	376.0
TRUE	3.3	1.8	6.2	13.0
Total	100.0		389.0	

Extra				
work:				
other	percentages	lb	ub	obs
FALSE	98.5	96.2	99.4	383.0
TRUE	1.5	0.6	3.8	6.0
Total	100.0		389.0	

Q3text	percentages	lb	ub	obs
business	16.7	0.6	87.0	1.0
nurse	16.7	1.2	76.3	1.0
seamstre	33.3	5.3	81.8	2.0
selling	16.7	0.6	87.0	1.0
selling	16.7	0.6	87.0	1.0
Total	100.0		6.0	

Q3calc	percentages	lb	ub	obs
1	21.9	11.7	37.3	25.0
2	78.1	62.7	88.3	89.0
Total	100.0			114.0

4. Have you ever attended school?

Attended school	percentages	lb	ub	obs
yes	95.9	92.6	97.8	372.0
no	4.1	2.2	7.4	16.0
Total	100.0			388.0

5. What is the highest level of school you attended?

Q5prim	percentages	lb	ub	obs
1	46.8	42.3	51.3	174.0
2	53.2	48.7	57.7	198.0
Total	100.0			372.0

Q5sec	percentages	lb	ub	obs
2	100.0			372.0

6. What is your current marital status

currently married	percentages	lb	ub	obs
yes	78.9	74.3	82.8	306.0
no	21.1	17.2	25.7	82.0
Total	100.0			388.0

7. Is the father of [CHILD] currently living in the same house with you?

Q7	percentages	lb	ub	obs
yes	79.2	74.1	83.5	305.0
no	20.8	16.5	25.9	80.0
Total	100.0			385.0

8. How many children living in this household are under five years of age?

number of under-fiv e children in HH	percentages	lb	ub	obs
1, One c	49.9	44.0	55.7	194.0
2, Two c	36.2	31.3	41.6	141.0
3, Three	13.9	10.1	18.7	54.0
Total	100.0			389.0

9. How many children do you have?

Q9	percentages	lb	ub	obs
1	27.8	23.2	32.8	108.0
2	19.5	15.4	24.5	76.0
3	18.8	14.8	23.5	73.0
4	11.3	8.3	15.2	44.0
5	12.9	9.4	17.3	50.0
6	5.1	2.9	8.9	20.0
7	2.3	1.2	4.5	9.0
8	0.8	0.2	2.4	3.0
9	1.0	0.4	2.7	4.0
10	0.5	0.1	3.9	2.0
Total	100.0			389.0

10. How many pregnancies have you had?

Q10	percentages	lb	ub	obs
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	percentages	lb	ub	obs
1	26.2	21.5	31.5	102.0
2	18.5	14.7	23.0	72.0
3	18.3	14.5	22.7	71.0
4	10.8	8.1	14.3	42.0
5	13.4	9.9	17.8	52.0
6	6.9	4.3	11.1	27.0
7	2.1	1.1	3.8	8.0
8	1.5	0.6	3.8	6.0
9	1.0	0.3	3.4	4.0
10	1.3	0.5	3.6	5.0
Total	100.0			389.0

11. How many children did you give birth to?

Q11	percentages	lb	ub	obs
1	27.0	22.3	32.3	105.0
2	18.5	14.3	23.6	72.0
3	18.5	14.3	23.7	72.0
4	12.1	8.9	16.1	47.0
5	12.6	9.3	16.9	49.0
6	5.4	3.1	9.2	21.0
7	2.8	1.6	5.0	11.0
8	0.8	0.2	2.4	3.0
9	1.0	0.4	2.7	4.0
10	1.0	0.3	3.4	4.0
31	0.3	0.0	2.0	1.0
Total	100.0			389.0

12. What is the name, sex, date of birth of your youngest child that you gave birth to?

Sex of youngest child	percentages	lb	ub	obs
1, Male	52.4	46.5	58.4	204.0
2, Femal	47.6	41.6	53.5	185.0
Total	100.0			389.0

14. What is the name, sex, and date of birth of the second youngest child that you gave birth to?

sex of second youngest child	percentages	lb	ub	obs
1, Male	49.8	43.0	56.6	130.0
2, Femal	50.2	43.4	57.0	131.0
Total	100.0			261.0

15. Who takes care of [YOUNGEST CHILD] when you are away from home?

Care of youngest child: mother	percentages	lb	ub	obs
FALSE	53.2	48.2	58.1	207.0
TRUE	46.8	41.9	51.8	182.0
Total	100.0			389.0

Care of youngest child: husband	percentages	lb	ub	obs
FALSE	81.2	75.0	86.2	316.0
TRUE	18.8	13.8	25.0	73.0
Total	100.0			389.0

Care of youngest child: older children	percentages	lb	ub	obs
FALSE	67.1	62.1	71.7	261.0
TRUE	32.9	28.3	37.9	128.0

Total	100.0			389.0

Care of youngest child: other relative	percentages	lb	ub	obs
FALSE	79.4	73.7	84.2	309.0
TRUE	20.6	15.8	26.3	80.0
Total	100.0			389.0

Care of youngest child: neighbor/ friend	percentages	lb	ub	obs
FALSE	77.1	71.9	81.6	300.0
TRUE	22.9	18.4	28.1	89.0
Total	100.0			389.0

Care of youngest child: house girl	percentages	lb	ub	obs
FALSE	93.8	90.6	96.0	365.0
TRUE	6.2	4.0	9.4	24.0
Total	100.0			389.0

Care of youngest child: other person	percentages	lb	ub	obs

FALSE	95.9	92.6	97.8	373.0
TRUE	4.1	2.2	7.4	16.0
Total	100.0			389.0

Q15tx1	percentages	lb	ub	obs
aunt	13.0	4.9	30.3	6.0
brother	2.2	0.3	15.4	1.0
cousin	2.2	0.3	15.4	1.0
grandmot	52.2	35.1	68.8	24.0
mother i	13.0	6.2	25.4	6.0
sister	13.0	6.4	24.9	6.0
younger	2.2	0.3	15.4	1.0
younger	2.2	0.3	14.1	1.0
Total	100.0			46.0

Q15tx2	percentages	lb	ub	obs
aunt	6.3	0.6	41.6	1.0
brother	6.3	0.6	41.6	1.0
grandmot	43.8	18.3	73.0	7.0
mother i	31.3	8.9	68.0	5.0
mother-i	6.3	0.7	37.4	1.0
no one	6.3	0.7	37.4	1.0
Total	100.0			16.0

**16. Did you see anyone for antenatal care while you were pregnant with [CHILD]?
If yes, whom did you see? Anyone else?**

Antenatal	care:	percentages	lb	ub	obs
doctor					
FALSE		56.8	49.2	64.1	221.0
TRUE		43.2	35.9	50.8	168.0
Total		100.0			389.0

Antenatal |

care: nurse	percentages	lb	ub	obs
FALSE	16.2	11.1	23.0	63.0
TRUE	83.8	77.0	88.9	326.0
Total	100.0		389.0	

Antenatal care: midwife	percentages	lb	ub	obs
FALSE	83.0	73.8	89.5	323.0
TRUE	17.0	10.5	26.2	66.0
Total	100.0		389.0	

Antenatal care: medical attendant	percentages	lb	ub	obs
FALSE	89.7	86.4	92.3	349.0
TRUE	10.3	7.7	13.6	40.0
Total	100.0		389.0	

Antenatal care: other health staff	percentages	lb	ub	obs
FALSE	94.3	90.8	96.6	367.0
TRUE	5.7	3.4	9.2	22.0
Total	100.0		389.0	

Antenatal care: trained TBA	percentages	lb	ub	obs
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	percentages	lb	ub	obs
FALSE	95.9	92.7	97.7	373.0
TRUE	4.1	2.3	7.3	16.0
Total	100.0			389.0

Antenatal care: trained HBLSS

	percentages	lb	ub	obs
FALSE	99.2	97.6	99.8	386.0
TRUE	0.8	0.2	2.4	3.0
Total	100.0			389.0

Antenatal care: trained CHW

	percentages	lb	ub	obs
FALSE	99.5	97.9	99.9	387.0
TRUE	0.5	0.1	2.1	2.0
Total	100.0			389.0

Antenatal care: relative/friend

	percentages	lb	ub	obs
FALSE	99.7	98.0	100.0	388.0
TRUE	0.3	0.0	2.0	1.0
Total	100.0			389.0

Antenatal care: no one

	percentages	lb	ub	obs
FALSE	98.2	96.4	99.1	382.0
TRUE	1.8	0.9	3.6	7.0

Total	percentages	lb	ub	obs
1	97.9	96.1	98.9	373.0
2	2.1	1.1	3.9	8.0
Total	100.0			389.0

17. How many times did you receive antenatal care during this pregnancy?

number of antenatal care visits	percentages	lb	ub	obs
0	0.3	0.0	2.0	1.0
1	4.4	2.6	7.2	17.0
2	11.3	8.8	14.4	44.0
3	29.0	24.3	34.3	113.0
4	29.6	24.9	34.7	115.0
5	12.1	9.4	15.4	47.0
6	3.1	1.7	5.5	12.0
7	1.5	0.7	3.3	6.0
9	0.3	0.0	2.0	1.0
10	0.3	0.0	2.0	1.0
20	0.3	0.0	2.0	1.0
don't kn	8.0	5.3	11.8	31.0
Total	100.0			389.0

18. During your pregnancy with [CHILD] did you receive an injection in the arm to prevent the baby from getting tetanus, that is convulsions after birth?

received tetanus shot while pregnant	percentages	lb	ub	obs
yes	90.0	85.7	93.1	350.0
no	9.5	6.7	13.4	37.0

don't kn	0.5	0.1	2.1	2.0
Total	100.0			389.0

19. While pregnant with [CHILD] how many times did you receive such an injection?

how many				
tetanus				
shots				
while				
pregnant	percentages	lb	ub	obs
+				
1	26.8	22.1	32.0	94.0
2	38.2	32.9	43.8	134.0
3	31.3	25.8	37.5	110.0
8	3.7	2.0	6.9	13.0
Total	100.0			351.0

20. Did you receive any tetanus injection at any time before that pregnancy, including during a previous pregnancy or between pregnancies?

received				
tetanus				
shot				
before				
current				
pregnancy	percentages	lb	ub	obs
+				
yes	73.2	68.7	77.3	284.0
no	24.2	20.3	28.6	94.0
don't kn	2.6	1.3	5.0	10.0
Total	100.0			388.0

21. Before the pregnancy with [CHILD] how many times did you receive a tetanus injection?

how many |
tetanus |
shots |
before |

pregnancy	percentages	lb	ub	obs
1	32.2	25.2	40.1	93.0
2	32.2	26.1	38.9	93.0
3	28.4	22.4	35.2	82.0
8	7.3	4.6	11.4	21.0
Total	100.0		289.0	

22. Do you have a maternal health care for your pregnancy with [CHILD]?

Has maternal health card	percentages	lb	ub	obs
A, Yes,	61.4	55.8	66.8	239.0
B, Not a	38.0	32.8	43.6	148.0
C, Never	0.5	0.1	2.1	2.0
Total	100.0		389.0	

23. LOOK AT THE CARD AND RECORD THE NUMBER OF ANTENATAL VISITS WHILE THE MOTHER WAS PREGNANT WITH [CHILD]

number of antenatal visits recorded on card	percentages	lb	ub	obs
1	5.9	3.8	9.0	14.0
2	15.1	11.3	19.7	36.0
3	32.2	25.7	39.5	77.0
4	28.0	22.6	34.1	67.0
5	13.8	10.2	18.5	33.0
6	4.6	2.5	8.4	11.0
12	0.4	0.1	3.2	1.0
Total	100.0		239.0	

24. RECORD THE DATES FOR EACH TT INJECTION LISTED ON THE CARD

TT doses during most recent pregnancy	percentages	lb	ub	obs
0	5.9	3.5	9.8	14.0
1	22.8	17.2	29.5	54.0
2	35.0	28.5	42.1	83.0
3	20.3	15.2	26.5	48.0
4	8.9	5.7	13.6	21.0
5	6.3	3.5	11.2	15.0
6	0.8	0.2	3.4	2.0
Total	100.0			237.0

25. RECORD THE DATES FOR EACH IPT DOSE LISTED ON THE CARD. WERE TWO OR MORE DOSES GIVEN DURING THE MOST RECENT PREGNANCY?

2+ IPT doses given during last pregnancy	percentages	lb	ub	obs
yes	31.4	26.8	36.4	122.0
no	29.0	25.7	32.7	113.0
don't kn	39.6	34.0	45.5	154.0
Total	100.0			389.0

26. When you were pregnancywith [CHILD] did you take any drugs to prevent you from getting malaria?

took antimalar ial drugs during last pregnancy	percentages	lb	ub	obs
yes	87.1	83.0	90.4	339.0

no	11.8	8.6	16.0	46.0
don't kn	1.0	0.4	2.7	4.0
Total	100.0			389.0

27. Which drugs did you take?

Antimalar				
ial				
treatment				
:				
sp/orodar	percentages	lb	ub	obs
+				
yes	100.0			328.0

Antimalar				
ial				
treatment				
:				
chlorquin				
e	percentages	lb	ub	obs
+				
yes	50.0	0.0	100.0	1.0
no	50.0	0.0	100.0	1.0
Total	100.0			2.0

Antimalar				
ial				
treatment				
:				
amodiaqui				
ne	percentages	lb	ub	obs
+				
yes	88.9	37.4	99.1	8.0
no	11.1	0.9	62.6	1.0
Total	100.0			9.0

Antimalar |
ial |
treatment |

```

: quinine | percentages      obs
-----+-----
no |      100.0      1.0
-----

```

```

Antimalar |
ial |
treatment |
: act | percentages      lb      ub      obs
-----+-----
yes |      96.8      76.0      99.6      30.0
no |       3.2      0.4      24.0      1.0
|
Total |      100.0                      31.0
-----

```

```

Antimalar |
ial |
treatment |
: other | percentages      obs
-----+-----
yes |      100.0      1.0
-----

```

28. How many times during pregnancy did you take the drugs?

```

number of |
times |
sp/orodar |
was taken | percentages      lb      ub      obs
-----+-----
1 |      37.8      32.5      43.4      124.0
2 |      55.5      50.8      60.1      182.0
3 |       6.4      4.0      10.2      21.0
4 |       0.3      0.0      2.3      1.0
|
Total |      100.0                      328.0
-----

```

```

number of |
times |
chlorquin |
e was |
taken | percentages      obs
-----+-----
1 |      100.0      1.0
-----

```

number of times amodiaqui ne was taken	percentages	lb	ub	obs
1	66.7	14.9	95.8	4.0
2	16.7	0.9	81.4	1.0
3	16.7	0.9	81.4	1.0
Total	100.0			6.0

number of times quinine was taken	Freq.	Percent	Cum.
.	389	100.00	100.00
Total	389	100.00	

number of times act was taken	percentages	lb	ub	obs
1	62.1	37.8	81.5	18.0
2	27.6	13.8	47.5	8.0
3	6.9	1.6	25.8	2.0
4	3.4	0.4	22.7	1.0
Total	100.0			29.0

number of times other drugs were taken	Freq.	Percent	Cum.
1	1	0.26	0.26
.	388	99.74	100.00
Total	389	100.00	

Q28text	Freq.	Percent	Cum.
.	389	100.00	100.00
Total	389	100.00	

29. How far are you from the nearest health facility?

Distance from health facility, in km	percentages	lb	ub	obs
1	57.3	48.0	66.1	223.0
2	14.7	10.6	19.9	57.0
3	7.2	4.2	12.0	28.0
4	4.1	2.3	7.2	16.0
5	5.7	3.0	10.5	22.0
6	3.6	1.5	8.1	14.0
7	4.1	2.0	8.2	16.0
8	2.3	0.7	7.7	9.0
9	0.5	0.1	2.1	2.0
13	0.3	0.0	2.0	1.0
30	0.3	0.0	2.0	1.0
Total	100.0		389.0	

30. How would you get there?

Mode of transport ation: walk	percentages	lb	ub	obs
FALSE	6.7	4.4	10.0	26.0
TRUE	93.3	90.0	95.6	363.0
Total	100.0		389.0	

Mode of |
transport |
ation: |

bicycle	percentages	lb	ub	obs
FALSE	86.1	79.3	90.9	335.0
TRUE	13.9	9.1	20.7	54.0
Total	100.0		389.0	

Mode of transport: private car

car	percentages	lb	ub	obs
FALSE	98.7	96.4	99.5	384.0
TRUE	1.3	0.5	3.6	5.0
Total	100.0		389.0	

Mode of transport: dala dala

dala dala	percentages	lb	ub	obs
FALSE	96.1	91.7	98.3	374.0
TRUE	3.9	1.7	8.3	15.0
Total	100.0		389.0	

Mode of transport: motorcycle

motorcycle	percentages	lb	ub	obs
FALSE	95.6	92.0	97.7	372.0
TRUE	4.4	2.3	8.0	17.0
Total	100.0		389.0	

Mode of transport: ation:

animal cart	percentages	lb	ub	obs
FALSE	100.0			389.0

Mode of transport ation: boat/cano e	percentages	lb	ub	obs
FALSE	100.0			389.0

Mode of transport ation: ambulance	percentages	lb	ub	obs
FALSE	99.0	97.3	99.6	385.0
TRUE	1.0	0.4	2.7	4.0
Total	100.0			389.0

Mode of transport ation: taxi	percentages	lb	ub	obs
FALSE	99.7	98.0	100.0	388.0
TRUE	0.3	0.0	2.0	1.0
Total	100.0			389.0

Mode of transport ation: stretcher	percentages	lb	ub	obs
FALSE	100.0			389.0

Mode of |

transportation: tractor	percentages	lb	ub	obs
FALSE	100.0			389.0

Q30x	percentages	lb	ub	obs
FALSE	99.7	98.0	100.0	388.0
TRUE	0.3	0.0	2.0	1.0
Total	100.0			389.0

31. How long would it take you to get there?

Time taken to reach health center	percentages	lb	ub	obs
less than 1-3 hour	74.8	66.2	81.8	288.0
more than 3 hours	22.1	15.5	30.4	85.0
more than 3 hours	3.1	1.1	8.7	12.0
Total	100.0			385.0

32. Who would decide you should go there?

Decision maker for health respondent	percentages	lb	ub	obs
FALSE	24.4	20.5	28.8	95.0
TRUE	75.6	71.2	79.5	294.0
Total	100.0			389.0

Decision maker for

health: husband	percentages	lb	ub	obs
FALSE	65.6	59.7	71.0	255.0
TRUE	34.4	29.0	40.3	134.0
Total	100.0		389.0	

Decision maker for health: mother	percentages	lb	ub	obs
FALSE	83.3	78.1	87.5	324.0
TRUE	16.7	12.5	21.9	65.0
Total	100.0		389.0	

Decision maker for health: mother-in -law	percentages	lb	ub	obs
FALSE	95.9	91.7	98.0	373.0
TRUE	4.1	2.0	8.3	16.0
Total	100.0		389.0	

Decision maker for health: friend	percentages	lb	ub	obs
FALSE	95.6	92.7	97.4	372.0
TRUE	4.4	2.6	7.3	17.0
Total	100.0		389.0	

Decision |
maker for |
health: |

TBA	percentages	lb	ub	obs
FALSE	97.9	95.4	99.1	381.0
TRUE	2.1	0.9	4.6	8.0
Total	100.0		389.0	

Decision maker for health: other relative	percentages	lb	ub	obs
FALSE	99.0	97.3	99.6	385.0
TRUE	1.0	0.4	2.7	4.0
Total	100.0		389.0	

33. What are the symptoms during pregnancy indicating the need to seek health care?

Symptom: fever	percentages	lb	ub	obs
FALSE	21.9	17.4	27.1	85.0
TRUE	78.1	72.9	82.6	304.0
Total	100.0		389.0	

Symptom: shortness of breath	percentages	lb	ub	obs
FALSE	42.7	34.6	51.2	166.0
TRUE	57.3	48.8	65.4	223.0
Total	100.0		389.0	

Symptom: bleeding	percentages	lb	ub	obs
FALSE	46.0	39.3	52.9	179.0
TRUE	54.0	47.1	60.7	210.0

Total	percentages	lb	ub	obs
100.0				389.0
Symptom: swelling				
FALSE	percentages	lb	ub	obs
68.1		61.8	73.9	265.0
TRUE	percentages	lb	ub	obs
31.9		26.1	38.2	124.0
Total	100.0			389.0
Symptom: other				
FALSE	percentages	lb	ub	obs
87.1		82.5	90.7	339.0
TRUE	percentages	lb	ub	obs
12.9		9.3	17.5	50.0
Total	100.0			389.0

34. Where is the first place you would go for care if you had these symptoms?

First place respondent goes when symptoms occur	percentages	lb	ub	obs
A, HOSPI	27.0	18.5	37.6	105.0
B, HEALT	27.5	21.0	35.1	107.0
C, DISPE	45.0	35.7	54.6	175.0
D, FIELD	0.3	0.0	2.0	1.0
G, PHARM	0.3	0.0	2.0	1.0
Total	100.0			389.0

35. When you were pregnant with [CHILD] did you receive or buy any iron tablets or iron syrup?

Iron tablets/s

yrup during pregnancy	percentages	lb	ub	obs
yes	75.8	70.7	80.3	295.0
no	23.7	19.4	28.5	92.0
don't kn	0.5	0.1	2.1	2.0
Total	100.0		389.0	

36. Where did you give birth to [CHILD]?

Location of delivery	percentages	lb	ub	obs
A, YOUR	26.2	20.5	32.9	102.0
B, OTHER	0.3	0.0	2.0	1.0
C, HOSPI	49.9	41.8	58.0	194.0
D, CLINI	2.3	1.2	4.5	9.0
E, DISPE	21.1	16.4	26.7	82.0
F, ON TH	0.3	0.0	2.0	1.0
Total	100.0		389.0	

Q36txt	Freq.	Percent	Cum.
on the road	388	99.74	99.74
	1	0.26	100.00
Total	389	100.00	

Q36calc	percentages	lb	ub	obs
1	73.3	66.8	78.9	285.0
2	26.7	21.1	33.2	104.0
Total	100.0		389.0	

37. Who assisted with the delivery of [CHILD]? Anyone else?

Assistanc
e during
delivery:

doctor	percentages	lb	ub	obs
FALSE	67.1	60.6	73.0	261.0
TRUE	32.9	27.0	39.4	128.0
Total	100.0		389.0	

Assistance during delivery: nurse	percentages	lb	ub	obs
FALSE	38.0	31.1	45.5	148.0
TRUE	62.0	54.5	68.9	241.0
Total	100.0		389.0	

Assistance during delivery: midwife	percentages	lb	ub	obs
FALSE	83.0	77.2	87.6	323.0
TRUE	17.0	12.4	22.8	66.0
Total	100.0		389.0	

Assistance during delivery: medical attendant	percentages	lb	ub	obs
FALSE	95.6	92.3	97.5	372.0
TRUE	4.4	2.5	7.7	17.0
Total	100.0		389.0	

Assistance during delivery:
other

health staff	percentages	lb	ub	obs
FALSE	92.3	89.1	94.6	359.0
TRUE	7.7	5.4	10.9	30.0
Total	100.0		389.0	

Assistance during delivery: trained TBA	percentages	lb	ub	obs
FALSE	88.7	84.3	92.0	345.0
TRUE	11.3	8.0	15.7	44.0
Total	100.0		389.0	

Assistance during delivery: trained HBLSS	percentages	lb	ub	obs
FALSE	99.0	97.3	99.6	385.0
TRUE	1.0	0.4	2.7	4.0
Total	100.0		389.0	

Assistance during delivery: trained CHW	percentages	lb	ub	obs
FALSE	100.0			389.0

Assistance during delivery: trained TBA	percentages	lb	ub	obs

FALSE	100.0			389.0
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Assistance during delivery: CHW	percentages	lb	ub	obs
FALSE	97.4	95.3	98.6	379.0
TRUE	2.6	1.4	4.7	10.0
Total	100.0			389.0

Assistance during delivery: relative/friend	percentages	lb	ub	obs
FALSE	90.0	85.6	93.1	350.0
TRUE	10.0	6.9	14.4	39.0
Total	100.0			389.0

Assistance during delivery: other	percentages	lb	ub	obs
FALSE	97.9	94.7	99.2	381.0
TRUE	2.1	0.8	5.3	8.0
Total	100.0			389.0

Assistance during delivery: no one	percentages	lb	ub	obs
FALSE	99.5	97.9	99.9	387.0
TRUE	0.5	0.1	2.1	2.0

Total		100.0		389.0	

Q37text		percentages	lb	ub	obs

husband		25.0	4.0	72.5	2.0
mother		37.5	12.5	71.6	3.0
mother i		12.5	0.7	75.5	1.0
mother-i		12.5	1.1	63.7	1.0
neighbor		12.5	0.4	83.2	1.0
Total		100.0		8.0	

Q37calc		percentages	lb	ub	obs

1		82.1	78.4	85.3	312.0
2		17.9	14.7	21.6	68.0
Total		100.0		380.0	

38. What instrument was used to cut the cord?

Instrumen						
t used to						
cur the						
cord			percentage	lb	ub	obs

A, NEW RAZOR BLADE		48.6	42.0	55.2	189.0	
B, NEW/BOILED RAZOR BLADE		5.7	3.4	9.4	22.0	
D, USED/BOILED RAZOR BLADE		0.3	0.0	2.0	1.0	
E, NEW SCISSORS		20.3	15.5	26.2	79.0	
F, NEW/BOILED SCISSORS		5.7	3.5	8.9	22.0	
H, USED/BOILED SCISSORS		13.1	9.7	17.5	51.0	
I, KNIFE		0.5	0.1	2.1	2.0	
J, STRING		1.3	0.5	3.6	5.0	
Z, DON'T KNOW		4.6	2.9	7.2	18.0	
Total		100.0			389.0	

40. Was a Clean Delivery kit used during delivery?

Clean
delivery |

kit used	percentages	lb	ub	obs
yes	73.6	67.2	79.2	285.0
no	22.7	18.1	28.2	88.0
don't kn	3.6	2.1	6.2	14.0
Total	100.0			387.0

41. Immediately after [CHILD] was born, before the placenta was delivered, did you receive an injection to prevent you from bleeding too much?

Injection to stop bleeding	percentages	lb	ub	obs
yes	62.2	54.8	69.0	240.0
no	35.0	28.3	42.3	135.0
don't kn	2.8	1.6	5.0	11.0
Total	100.0			386.0

42. Immediately after you got an injection to prevent you from bleeding did the birth attendant hold your stomach and pull on cord to help the placenta come out?

Assistance to remove placenta	percentages	lb	ub	obs
yes	93.5	89.5	96.0	229.0
no	5.7	3.4	9.5	14.0
don't kn	0.8	0.2	3.3	2.0
Total	100.0			245.0

43. Immediately after the placenta was delivered, did someone massage your uterus to make it contract strongly and to prevent you from bleeding too much?

Uterus massage to limit bleeding	percentages	lb	ub	obs
----------------------------------	-------------	----	----	-----

yes	90.2	85.1	93.6	220.0
no	9.4	6.2	14.1	23.0
don't kn	0.4	0.1	3.1	1.0
Total	100.0			244.0

AMSTL Yes or No

Q44	percentages	lb	ub	obs
yes	56.3	49.1	63.3	219.0
no	43.7	36.7	50.9	170.0
Total	100.0			389.0

45. Was [CHILD] wiped/dried immediately after birth before the placenta was delivered?

Infant				
wiped				
before				
placenta				
removal	percentages	lb	ub	obs
yes	87.4	83.0	90.7	339.0
no	7.7	5.1	11.6	30.0
don't kn	4.9	2.9	8.1	19.0
Total	100.0			388.0

46. Was [CHILD] wrapped in a warm cloth or blanket immediately after birth before the placenta was delivered?

Infant				
wrapped				
before				
placenta				
removal	percentages	lb	ub	obs
yes	96.1	93.2	97.9	374.0
no	2.3	1.2	4.5	9.0
don't kn	1.5	0.7	3.3	6.0

Total	100.0			389.0
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47. Did a health care provider or traditional birth attendant check on your health after the delivery of your youngest child, either at a health facility, home or other location?

Healthcar e provider or TBA checked in after delivery	percentages	lb	ub	obs
yes	86.6	82.0	90.2	337.0
no	13.4	9.8	18.0	52.0
Total	100.0			389.0

48. How long after the delivery did the first check take place?

Time of first check-up	percentages	lb	ub	obs
HOURS				
0	47.5	39.4	55.7	160.0
1	13.6	8.9	20.3	46.0
2	3.0	1.5	5.8	10.0
3	0.3	0.0	2.3	1.0
4	1.5	0.6	3.4	5.0
5	1.8	0.8	3.8	6.0
6	1.5	0.5	4.2	5.0
7	0.3	0.0	2.3	1.0
8	1.2	0.5	3.1	4.0
9	0.6	0.1	2.4	2.0
10	1.2	0.4	3.9	4.0
12	1.8	0.7	4.5	6.0
15	2.7	1.1	6.3	9.0
16	0.3	0.0	2.2	1.0
20	0.9	0.2	3.9	3.0
24	0.6	0.1	2.4	2.0
25	0.3	0.0	2.3	1.0
30	4.2	1.9	8.8	14.0

45	1.5	0.4	4.8	5.0
60	0.3	0.0	2.3	1.0
DAYS				
100	3.0	1.5	5.8	10.0
101	6.8	4.3	10.8	23.0
102	1.2	0.4	3.1	4.0
103	1.2	0.4	3.1	4.0
104	0.6	0.1	4.4	2.0
110	0.6	0.1	2.4	2.0
111	0.3	0.0	2.3	1.0
WEEKS				
200	0.3	0.0	2.2	1.0
202	0.9	0.3	2.7	3.0
206	0.3	0.0	2.3	1.0
Total	100.0		337.0	

49. Who checked your health at that time?

Who checked in after delivery	percentages	lb	ub	obs
A, DOCTO	28.2	22.2	35.1	95.0
B, NURSE	52.5	45.0	60.0	177.0
C, MIDWI	7.4	4.0	13.2	25.0
E, OTHER	0.3	0.0	2.2	1.0
F, TRAIN	10.7	7.4	15.2	36.0
K, RELAT	0.6	0.1	2.4	2.0
X, OTHER	0.3	0.0	2.3	1.0
Total	100.0		337.0	

50. Did you have any other post-partum checks?

Other post-part um checks	percentages	lb	ub	obs
yes	87.2	81.3	91.4	292.0
no	12.8	8.6	18.7	43.0
Total	100.0		335.0	

51. During your postpartum check, were you counseled on the following:

Counselin g topic: child spacing	percentages	lb	ub	obs
yes	75.4	69.7	80.4	255.0
no	24.6	19.6	30.3	83.0
Total	100.0			338.0

Counselin g topic: infant nutrition	percentages	lb	ub	obs
yes	70.7	64.6	76.2	239.0
no	29.3	23.8	35.4	99.0
Total	100.0			338.0

Counselin g topic: child immunizat ions	percentages	lb	ub	obs
yes	69.2	61.3	76.2	234.0
no	30.8	23.8	38.7	104.0
Total	100.0			338.0

Counselin g topic: infant diarrhea	percentages	lb	ub	obs
yes	40.2	34.4	46.3	136.0
no	59.5	53.3	65.3	201.0
don't kn	0.3	0.0	2.2	1.0

Total	percentages	lb	ub	obs
Total	100.0			338.0

Counselin				
g topic:				
pneumonia				
signs	percentages	lb	ub	obs

yes	32.2	26.0	39.2	109.0
no	66.9	60.1	73.0	226.0
don't kn	0.9	0.3	2.8	3.0

Total	100.0			338.0

52. After [CHILD] as born did any health care provider or traditional birth attendant check on [CHILD's] health?

After birth, anyone checked in on baby	percentages	lb	ub	obs
yes	86.1	82.3	89.1	334.0
no	13.9	10.9	17.7	54.0

Total	100.0			388.0

53. How long after the birth of [CHILD] did the first check take place?

Time of check-up after birth	percentages	lb	ub	obs
0	47.8	39.2	56.4	161.0
1	15.1	10.6	21.1	51.0
2	2.7	1.5	4.8	9.0
3	0.3	0.0	2.3	1.0
4	0.6	0.1	2.4	2.0
5	1.2	0.4	3.1	4.0
6	1.2	0.3	4.0	4.0
7	0.3	0.0	2.3	1.0

8	0.6	0.1	2.4	2.0
9	0.3	0.0	2.2	1.0
10	3.3	1.3	8.1	11.0
12	1.2	0.3	4.0	4.0
14	0.3	0.0	2.3	1.0
15	2.7	1.1	6.6	9.0
20	1.5	0.4	4.8	5.0
30	3.3	1.5	7.0	11.0
45	1.2	0.3	4.9	4.0
98	0.3	0.0	2.3	1.0
100	3.6	2.1	6.0	12.0
101	7.4	4.7	11.6	25.0
102	1.8	0.8	3.8	6.0
103	0.9	0.3	2.8	3.0
104	0.6	0.1	2.4	2.0
106	0.3	0.0	2.2	1.0
108	0.3	0.0	2.2	1.0
110	0.3	0.0	2.2	1.0
111	0.3	0.0	2.3	1.0
114	0.3	0.0	2.3	1.0
201	0.3	0.0	2.3	1.0
204	0.3	0.0	2.2	1.0
Total	100.0			337.0

54. Who checked on [CHILD's] health at that time?

Who checked in after birth	percentages	lb	ub	obs
A, DOCTO	21.4	16.4	27.3	72.0
B, NURSE	59.3	53.3	65.1	200.0
C, MIDWI	6.5	4.0	10.4	22.0
D, MEDIC	0.3	0.0	2.2	1.0
E, OTHER	0.6	0.1	2.4	2.0
F, TRAIN	9.5	6.7	13.2	32.0
G, HBLSS	0.3	0.0	2.3	1.0
J, CHW	0.9	0.1	6.5	3.0
K, RELAT	0.9	0.3	2.8	3.0
X, OTHER	0.3	0.0	2.3	1.0
Total	100.0			337.0

55. What are the danger signs for the mother after giving birth indicating the need for health care?

Danger signs for mother: fever	percentages	lb	ub	obs
FALSE	15.2	10.8	20.9	59.0
TRUE	84.8	79.1	89.2	330.0
Total	100.0		389.0	

Danger signs for mother: excessive bleeding	percentages	lb	ub	obs
FALSE	9.5	6.5	13.6	37.0
TRUE	90.5	86.4	93.5	352.0
Total	100.0		389.0	

Danger signs for mother: vaginal discharge	percentages	lb	ub	obs
FALSE	55.5	46.9	63.8	216.0
TRUE	44.5	36.2	53.1	173.0
Total	100.0		389.0	

Danger signs for mother: other	percentages	lb	ub	obs
FALSE	87.1	82.8	90.5	339.0
TRUE	12.9	9.5	17.2	50.0

Total	100.0		389.0	

Danger signs for mother: don't know	percentages	lb	ub	obs

FALSE	96.7	93.8	98.2	376.0
TRUE	3.3	1.8	6.2	13.0
Total	100.0		389.0	

Q55txt	percentages	lb	ub	obs

BP	2.1	0.3	14.8	1.0
back pain	2.1	0.3	14.8	1.0
complications	2.1	0.3	14.8	1.0
complications	2.1	0.3	14.8	1.0
deep pain	4.3	1.0	16.7	2.0
dizziness	27.7	16.5	42.5	13.0
dry skin	2.1	0.3	15.4	1.0
epilepsy	2.1	0.3	15.4	1.0
fainting	4.3	1.1	15.3	2.0
fatigue	8.5	3.3	20.1	4.0
high BP	2.1	0.3	15.4	1.0
high blood pressure	2.1	0.2	16.0	1.0
malaria	6.4	1.8	19.9	3.0
pain	10.6	2.7	33.5	5.0
retention	4.3	1.0	16.7	2.0
stomach	10.6	4.7	22.5	5.0
vomiting	6.4	1.4	25.0	3.0
Total	100.0		47.0	

56. What are the danger signs that indicate a newborn baby is ill and needs medical care?

57. Did you ever breastfeed [CHILD]?

58. How long after the birth did you first put [CHILD] to the breast?

Time between birth and first feed	percentages	lb	ub	obs
0	56.3	47.4	64.8	219.0
1	19.8	14.6	26.2	77.0
2	2.6	1.5	4.4	10.0
3	2.3	1.2	4.5	9.0
4	0.3	0.0	2.0	1.0
5	0.8	0.2	2.4	3.0
8	0.5	0.1	2.1	2.0
10	0.3	0.0	2.0	1.0
13	0.3	0.0	2.0	1.0
15	2.1	0.8	5.3	8.0
20	2.1	0.6	6.4	8.0
25	0.3	0.0	2.0	1.0
30	7.5	3.4	15.4	29.0
45	0.5	0.1	3.9	2.0
98	0.5	0.1	2.1	2.0
100	0.5	0.1	2.1	2.0
101	1.8	0.8	4.0	7.0
102	0.8	0.2	2.4	3.0
103	0.3	0.0	2.0	1.0
109	0.3	0.0	2.0	1.0
114	0.5	0.1	2.1	2.0
Total	100.0		389.0	

59. During the first three or four days after delivery, before your regular milk began flowing, did you give [CHILD] the liquid (colostrum) that came from your breasts?

Gave colostrum in first 3-4 days	percentages	lb	ub	obs
yes	72.2	63.6	79.5	281.0
no	27.2	20.2	35.6	106.0
don't kn	0.5	0.1	2.1	2.0
Total	100.0		389.0	

60. In the first three days after delivery, was [CHILD] given anything to drink other than breastmilk?

Gave anything other than milk in first 3 days	percentages	lb	ub	obs
yes	28.5	24.1	33.5	111.0
no	71.5	66.5	75.9	278.0
Total	100.0			389.0

61. Are you still breastfeeding [CHILD]?

Still breastfeeding	percentages	lb	ub	obs
yes	84.3	80.2	87.6	327.0
no	15.7	12.4	19.8	61.0
Total	100.0			388.0

62. For how many months did you breastfeed [NAME]?

Months spent breastfeeding	percentages	lb	ub	obs
0	1.0	0.3	3.4	4.0
1	8.5	6.6	11.0	33.0
2	5.9	4.1	8.6	23.0
3	2.6	1.5	4.4	10.0
4	6.5	4.4	9.4	25.0
5	3.9	2.4	6.2	15.0
6	3.1	1.6	6.0	12.0
7	3.9	2.3	6.4	15.0
8	4.7	3.0	7.1	18.0
9	5.2	3.3	8.1	20.0

10	5.9	4.1	8.6	23.0
11	4.4	2.9	6.6	17.0
12	9.3	7.0	12.2	36.0
13	4.1	2.7	6.4	16.0
14	3.9	2.4	6.2	15.0
15	4.4	2.7	7.0	17.0
16	4.7	3.0	7.0	18.0
17	2.3	1.2	4.5	9.0
18	5.2	3.5	7.7	20.0
19	1.0	0.3	3.4	4.0
20	2.8	1.6	5.0	11.0
21	2.6	1.4	4.7	10.0
22	1.8	0.9	3.6	7.0
23	2.1	0.9	4.6	8.0
24	0.3	0.0	2.0	1.0
Total	100.0			387.0

63. Now I would like to ask you about liquids or foods [CHILD] had yesterday during the day or at night.

Foods				
yesterday				
: breast				
milk	percentages	lb	ub	obs
0	13.9	10.5	18.2	54.0
yes	86.1	81.8	89.5	335.0
Total	100.0			389.0

Foods				
yesterday				
: milk	percentages	lb	ub	obs
0	30.8	26.5	35.6	120.0
yes	69.2	64.4	73.5	269.0
Total	100.0			389.0

Foods |
yesterday |
: plain |

water	percentages	lb	ub	obs
0	31.1	26.7	35.8	121.0
yes	68.9	64.2	73.3	268.0
Total	100.0			389.0

Foods yesterday : sugar

water	percentages	lb	ub	obs
0	83.0	78.6	86.7	323.0
yes	16.7	13.3	20.9	65.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			389.0

Foods yesterday : gripe

water	percentages	lb	ub	obs
0	95.9	93.0	97.6	373.0
yes	3.6	2.2	5.9	14.0
don't kn	0.5	0.1	2.1	2.0
Total	100.0			389.0

Foods yesterday : sugar-salt solution

water	percentages	lb	ub	obs
0	89.2	85.5	92.1	347.0
yes	10.8	7.9	14.5	42.0
Total	100.0			389.0

Foods

yesterday				
: fruit				
juice	percentages	lb	ub	obs
0	82.5	77.9	86.4	321.0
yes	17.5	13.6	22.1	68.0
Total	100.0		389.0	

Foods				
yesterday				
: infant				
formula	percentages	lb	ub	obs
0	96.4	93.3	98.1	375.0
yes	1.3	0.5	3.0	5.0
don't kn	2.3	1.0	5.2	9.0
Total	100.0		389.0	

Foods				
yesterday				
:				
fortified				
child				
food	percentages	lb	ub	obs
0	95.6	93.0	97.3	372.0
yes	4.4	2.7	7.0	17.0
Total	100.0		389.0	

Foods				
yesterday				
:				
porridge	percentages	lb	ub	obs
0	50.1	45.0	55.3	195.0
yes	49.9	44.7	55.0	194.0
Total	100.0		389.0	

Foods yesterday				
: tea	percentages	lb	ub	obs
0	60.4	53.9	66.5	235.0
yes	39.3	33.4	45.6	153.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			389.0

Foods yesterday				
: honey	percentages	lb	ub	obs
0	94.1	91.6	95.9	366.0
yes	5.9	4.1	8.4	23.0
Total	100.0			389.0

Foods yesterday				
: other	percentages	lb	ub	obs
0	33.3	8.1	74.0	4.0
yes	66.7	26.0	91.9	8.0
Total	100.0			12.0

64. Now I would like to ask you about (other) liquids or foods that [CHILD] may have had yesterday during the day or at night. I am interested in whether your child had the item even if it was combined with other foods. Did [CHILD] drink/eat:

Other foods yesterday				
: milk	percentages	lb	ub	obs
0	27.8	24.3	31.7	108.0
yes	72.2	68.3	75.7	280.0
Total	100.0			388.0

Other foods yesterday : tea/coffee	percentages	lb	ub	obs
0	70.7	64.9	75.9	275.0
yes	29.3	24.1	35.1	114.0
Total	100.0			389.0

Other foods yesterday : other liquids	percentages	lb	ub	obs
0	47.8	41.1	54.6	186.0
yes	51.9	45.1	58.7	202.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			389.0

Other foods yesterday : grains	percentages	lb	ub	obs
0	57.6	52.4	62.6	224.0
yes	42.2	37.0	47.4	164.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			389.0

Other foods yesterday : orange foods	percentages	lb	ub	obs
0	80.5	76.5	83.9	313.0
yes	19.5	16.1	23.5	76.0

Total		100.0			389.0
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Other foods yesterday					
: roots		percentages	lb	ub	obs

0		88.4	83.3	92.1	344.0
yes		11.6	7.9	16.7	45.0
Total		100.0			389.0

Other foods yesterday					
: leafy vegetable		percentages	lb	ub	obs

0		58.5	52.8	64.0	227.0
yes		41.5	36.0	47.2	161.0
Total		100.0			388.0

Other foods yesterday					
: mango/papaya		percentages	lb	ub	obs

0		93.6	89.5	96.1	364.0
yes		6.4	3.9	10.5	25.0
Total		100.0			389.0

Other foods yesterday					
: other fruit/veg		percentages	lb	ub	obs

	percentages	lb	ub	obs
0	75.8	71.1	80.0	295.0
yes	24.2	20.0	28.9	94.0
Total	100.0			389.0

Other foods yesterday : organ meats

	percentages	lb	ub	obs
0	91.5	88.0	94.1	356.0
yes	8.5	5.9	12.0	33.0
Total	100.0			389.0

Other foods yesterday : meat

	percentages	lb	ub	obs
0	83.3	77.7	87.7	324.0
yes	16.5	12.2	21.8	64.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			389.0

Other foods yesterday : eggs

	percentages	lb	ub	obs
0	68.9	63.9	73.5	268.0
yes	30.8	26.3	35.8	120.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			389.0

Other foods yesterday |

: fish	percentages	lb	ub	obs
0	93.6	90.4	95.7	364.0
yes	5.9	3.9	8.9	23.0
don't kn	0.5	0.1	2.1	2.0
Total	100.0			389.0

Other foods yesterday

: legume	percentages	lb	ub	obs
0	87.1	82.9	90.5	339.0
yes	12.3	9.3	16.3	48.0
don't kn	0.5	0.1	2.1	2.0
Total	100.0			389.0

Other foods yesterday

: milk products	percentages	lb	ub	obs
0	92.3	89.5	94.4	359.0
yes	6.9	4.9	9.7	27.0
don't kn	0.8	0.2	2.4	3.0
Total	100.0			389.0

Other foods yesterday

: fats	percentages	lb	ub	obs
0	89.2	83.8	92.9	347.0
yes	10.0	6.5	15.2	39.0
don't kn	0.8	0.2	2.4	3.0
Total	100.0			389.0

Other foods yesterday				
	percentages	lb	ub	obs
0	86.4	80.8	90.5	336.0
yes	12.1	8.4	17.0	47.0
don't kn	1.5	0.7	3.3	6.0
Total	100.0			389.0

Other foods yesterday				
	percentages	lb	ub	obs
0	71.5	66.9	75.6	278.0
yes	28.3	24.2	32.7	110.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			389.0

Other foods yesterday				
	percentages	lb	ub	obs
0	96.6	94.0	98.1	375.0
yes	0.5	0.1	2.1	2.0
don't kn	2.8	1.4	5.5	11.0
Total	100.0			388.0

65. How many times did [CHILD] eat soli, semi-solid or soft foods other than liquids yesterday during the day or at night?

Number of times child ate solid foods

yesterday	percentages	lb	ub	obs
0	35.2	30.5	40.3	137.0
1	8.5	6.3	11.4	33.0
2	28.0	23.5	33.1	109.0
3	15.4	11.0	21.3	60.0
4	0.5	0.1	2.1	2.0
5	1.0	0.4	2.7	4.0
7	11.3	7.9	15.9	44.0
Total	100.0			389.0

66. Has [CHILD] ever received a Vitamin A dose (like this/any of these)?

Vitamin A dose	percentages	lb	ub	obs
yes	78.1	74.6	81.4	304.0
no	20.3	17.3	23.7	79.0
don't kn	1.5	0.6	3.8	6.0
Total	100.0			389.0

67. Did [CHILD] receive a Vitamin A dose within the last six months?

Vitamin A dose in past 6 month	percentages	lb	ub	obs
yes	87.1	82.5	90.7	271.0
no	12.9	9.3	17.5	40.0
Total	100.0			311.0

68. Do you have a card or child health booklet where [CHILD's] vaccinations are written down?

Child has health booklet	percentages	lb	ub	obs
yes	75.6	68.9	81.2	291.0

no	24.2	18.5	30.9	93.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			385.0

69. RECORD THE DATES FOR EACH VITAMIN A DOSE LISTED ON THE CARD.

70. COPY VACCINATION DATE FOR DPT1, DPT2, DPT3, POLIO, BCG, HEPATITIS B AND MEASLES FROM THE CARD OR BOOKLET.

71. Did [CHILD] ever receive an injection in the arm to prevent measles?

Received				
measles				
vaccine	percentages	lb	ub	obs
1	59.2	54.3	64.0	228.0
2	40.8	36.0	45.7	157.0
Total	100.0			385.0

72. Sometimes children get sick and need to receive care or treatment. What are the signs of illness that would indicate your child needs treatment?

Sign of				
child				
illness:				
looks				
unwell	percentages	lb	ub	obs
FALSE	84.3	80.6	87.5	328.0
TRUE	15.7	12.5	19.4	61.0
Total	100.0			389.0

Sign of				
child				
illness:				
not				
eating	percentages	lb	ub	obs
FALSE	20.8	16.6	25.8	81.0

TRUE	79.2	74.2	83.4	308.0
Total	100.0		389.0	

Sign of				
child				
illness:				
lethargic	percentages	lb	ub	obs
FALSE	73.8	66.8	79.8	287.0
TRUE	26.2	20.2	33.2	102.0
Total	100.0		389.0	

Sign of				
child				
illness:				
high				
fever	percentages	lb	ub	obs
FALSE	21.3	16.2	27.6	83.0
TRUE	78.7	72.4	83.8	306.0
Total	100.0		389.0	

Sign of				
child				
illness:				
difficult				
y				
breathing	percentages	lb	ub	obs
FALSE	49.9	41.7	58.0	194.0
TRUE	50.1	42.0	58.3	195.0
Total	100.0		389.0	

Sign of				
child				
illness:				
vomit	percentages	lb	ub	obs

FALSE	41.4	35.0	48.1	161.0
TRUE	58.6	51.9	65.0	228.0
Total	100.0		389.0	

Sign of				
child				
illness:				
convulsio				
ns	percentages	lb	ub	obs
FALSE	89.2	84.7	92.5	347.0
TRUE	10.8	7.5	15.3	42.0
Total	100.0		389.0	

Sign of				
child				
illness:				
other 1	percentages	lb	ub	obs
FALSE	83.3	78.3	87.3	324.0
TRUE	16.7	12.7	21.7	65.0
Total	100.0		389.0	

Q72txt1	percentages	lb	ub	obs
burns	1.6	0.2	12.3	1.0
coughing	9.8	4.5	20.2	6.0
crying	50.8	35.9	65.6	31.0
crying a	6.6	2.3	17.1	4.0
diarrhea	8.2	3.3	19.1	5.0
difficul	1.6	0.2	10.8	1.0
fatigue	1.6	0.2	12.3	1.0
fever	1.6	0.2	11.9	1.0
flu	8.2	3.5	18.0	5.0
loss of	1.6	0.2	12.3	1.0
malaria	1.6	0.2	11.6	1.0
not cryi	1.6	0.2	11.9	1.0
not nurs	1.6	0.2	12.3	1.0
redness	1.6	0.2	11.9	1.0
vomiting	1.6	0.2	11.9	1.0

Total	100.0		61.0
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Sign of child illness: other 2	percentages	lb	ub	obs
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FALSE	94.1	89.7	96.7	366.0
TRUE	5.9	3.3	10.3	23.0

Total	100.0		389.0
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Q72txt2	percentages	lb	ub	obs
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crying a	4.3	0.5	31.0	1.0
diarrhea	13.0	3.1	41.5	3.0
not nurs	73.9	44.2	91.0	17.0
vomiting	8.7	1.6	36.4	2.0

Total	100.0		23.0
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Q72txt3	Freq.	Percent	Cum.
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.	389	100.00	100.00
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Total	389	100.00	
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Sign of child illness: don't know	Freq.	Percent	Cum.
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FALSE	388	99.74	99.74
TRUE	1	0.26	100.00

Total	389	100.00	
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73. Did [CHILD] experience any of the following in the past two weeks?

In past 2 weeks, child had:

diarrhea	percentages	lb	ub	obs
FALSE	77.6	72.2	82.3	302.0
TRUE	22.4	17.7	27.8	87.0
Total	100.0		389.0	

In past 2 weeks, child had: blood in stools

	percentages	lb	ub	obs
FALSE	97.9	95.8	99.0	381.0
TRUE	2.1	1.0	4.2	8.0
Total	100.0		389.0	

In past 2 weeks, child had: cough

	percentages	lb	ub	obs
FALSE	66.1	59.2	72.3	257.0
TRUE	33.9	27.7	40.8	132.0
Total	100.0		389.0	

In past 2 weeks, child had: difficult breathing

	percentages	lb	ub	obs
FALSE	85.9	81.6	89.3	334.0
TRUE	14.1	10.7	18.4	55.0
Total	100.0		389.0	

In past 2 weeks, child had: fast breathing				
	percentages	lb	ub	obs
FALSE	86.1	81.8	89.6	335.0
TRUE	13.9	10.4	18.2	54.0
Total	100.0		389.0	

In past 2 weeks, child had: fever				
	percentages	lb	ub	obs
FALSE	69.7	63.8	74.9	271.0
TRUE	30.3	25.1	36.2	118.0
Total	100.0		389.0	

In past 2 weeks, child had: malaria				
	percentages	lb	ub	obs
FALSE	88.7	84.0	92.1	345.0
TRUE	11.3	7.9	16.0	44.0
Total	100.0		389.0	

In past 2 weeks, child had: convulsions				
	percentages	lb	ub	obs
FALSE	98.7	96.4	99.5	384.0
TRUE	1.3	0.5	3.6	5.0

Total		100.0		389.0
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74. Did you seek care for your child? If yes, where did you seek care?

Health care: hospital		percentages		lb		ub		obs
FALSE		90.7		85.1		94.4		353.0
TRUE		9.3		5.6		14.9		36.0
Total		100.0						389.0

Health care: health center		percentages		lb		ub		obs
FALSE		89.7		85.1		93.0		349.0
TRUE		10.3		7.0		14.9		40.0
Total		100.0						389.0

Health care: dispensary		percentages		lb		ub		obs
FALSE		65.3		57.2		72.6		254.0
TRUE		34.7		27.4		42.8		135.0
Total		100.0						389.0

Health care: CHW		percentages		lb		ub		obs
FALSE		99.7		98.0		100.0		388.0
TRUE		0.3		0.0		2.0		1.0
Total		100.0						389.0

Health care: traditional practitioner	percentages	lb	ub	obs
FALSE	99.7	98.0	100.0	388.0
TRUE	0.3	0.0	2.0	1.0
Total	100.0			389.0

Health care: shop	percentages	lb	ub	obs
FALSE	99.2	97.6	99.8	386.0
TRUE	0.8	0.2	2.4	3.0
Total	100.0			389.0

Health care: pharmacy	percentages	lb	ub	obs
FALSE	92.5	88.5	95.3	360.0
TRUE	7.5	4.7	11.5	29.0
Total	100.0			389.0

Health care: community distributor	percentages	lb	ub	obs
FALSE	99.5	97.9	99.9	387.0
TRUE	0.5	0.1	2.1	2.0
Total	100.0			389.0

Health care: friend/relative	percentages	lb	ub	obs
FALSE	99.0	96.6	99.7	385.0
TRUE	1.0	0.3	3.4	4.0
Total	100.0		389.0	

Health care: other	percentages	lb	ub	obs
FALSE	98.5	96.7	99.3	383.0
TRUE	1.5	0.7	3.3	6.0
Total	100.0		389.0	

Q74text	Freq.	Percent	Cum.
	383	98.46	98.46
none	6	1.54	100.00
Total	389	100.00	

75. Has [CHILD] been ill with fever at any time during the last two weeks?

Child had fever in past 2 weeks	percentages	lb	ub	obs
yes	30.6	25.2	36.6	119.0
no	69.4	63.4	74.8	270.0
Total	100.0		389.0	

76. Does [CHILD] have a fever now?

Child has fever now	percentages	lb	ub	obs
yes	36.1	29.0	43.9	43.0

no	63.9	56.1	71.0	76.0
Total	100.0			119.0

77. Did you seek treatment for the fever?

Sought treatment	percentages	lb	ub	obs
yes	94.1	87.5	97.3	112.0
no	5.9	2.7	12.5	7.0
Total	100.0			119.0

78. How many days after the fever began did you first seek treatment for [CHILD]?

Seeking care since fever onset	percentages	lb	ub	obs
same day	0.9	0.1	6.6	1.0
next day	39.6	26.6	54.3	44.0
2+ days	52.3	38.8	65.4	58.0
don't kn	7.2	3.4	14.5	8.0
Total	100.0			111.0

79. Where did you first go for advice or treatment?

Where care was sought	percentages	lb	ub	obs
A, HOSPI	15.2	7.7	27.6	17.0
B, HEALT	17.9	11.0	27.7	20.0
C, DISPE	60.7	47.0	72.9	68.0
G, PHARM	6.3	3.3	11.5	7.0
Total	100.0			112.0

80. At any time during the illness did [CHILD] take any drugs for the fever?

Child took drugs for fever	percentages	lb	ub	obs
yes	90.8	81.4	95.7	108.0
no	8.4	3.6	18.3	10.0
don't kn	0.8	0.1	6.0	1.0
Total	100.0			119.0

81. What drugs did [CHILD] take?

Antimalarial treatment: sp/orodar	percentages	lb	ub	obs
same day	50.0	15.6	84.4	10.0
next day	50.0	15.6	84.4	10.0
Total	100.0			20.0

Antimalarial treatment: chlorquine	percentages	obs
next day	100.0	1.0

Antimalarial treatment: amodiaquine	percentages	lb	ub	obs
same day	33.3	4.2	85.1	2.0

next day	66.7	14.9	95.8	4.0
Total	100.0		6.0	

Antimalar				
ial				
treatment				
: quinine	percentages	lb	ub	obs
+				
same day	50.0	0.0	100.0	1.0
next day	50.0	0.0	100.0	1.0
Total	100.0		2.0	

Antimalar				
ial				
treatment				
: act	percentages	lb	ub	obs
+				
same day	6.3	0.6	41.7	1.0
next day	81.3	51.6	94.6	13.0
2+ days	12.5	2.7	42.3	2.0
Total	100.0		16.0	

Antimalar				
ial				
treatment				
: aspirin	percentages	lb	ub	obs
+				
same day	14.3	1.0	74.3	1.0
next day	71.4	21.5	95.8	5.0
2+ days	14.3	1.0	74.3	1.0
Total	100.0		7.0	

Antimalar				
ial				
treatment				
:				
aracetamo				
l	percentages	lb	ub	obs

	percentages	lb	ub	obs
same day	14.8	7.8	26.2	9.0
next day	75.4	63.2	84.6	46.0
2+ days	9.8	4.7	19.6	6.0
Total	100.0			61.0

Antimalarial treatment : co-trimoxazole				
	percentages	lb	ub	obs
same day	4.3	0.5	31.2	1.0
next day	78.3	55.1	91.3	18.0
2+ days	17.4	6.3	39.7	4.0
Total	100.0			23.0

Antimalarial treatment : other				
	percentages	lb	ub	obs
same day	11.1	0.7	69.8	1.0
next day	77.8	25.7	97.2	7.0
2+ days	11.1	0.7	69.8	1.0
Total	100.0			9.0

Q81text	percentages	lb	ub	obs
ORS	12.5	1.6	56.4	1.0
amoxicil	37.5	4.8	87.7	3.0
amoxycil	12.5	1.6	56.4	1.0
chioroci	12.5	0.6	77.2	1.0
septrim	12.5	0.6	77.2	1.0
vitamins	12.5	1.6	56.4	1.0
Total	100.0			8.0

Antimalar ial treatment : unknown drug	percentages	lb	ub	obs
next day	66.7	0.3	99.9	2.0
2+ days	33.3	0.1	99.7	1.0
Total	100.0		3.0	

82. When [CHILD] was sick with a fever, did you breastfeed him/her less than usual, about the same or more than usual?

Breastfeed ing during fever	percentages	lb	ub	obs
less	21.7	13.8	32.3	26.0
same	62.5	52.7	71.4	75.0
more	5.8	3.2	10.5	7.0
child no	9.2	5.3	15.4	11.0
don't kn	0.8	0.1	5.9	1.0
Total	100.0		120.0	

83. When [CHILD] was sick with a fever, was he/she offered less than usual to drink, about the same amount or more than usual to drink?

Drinks during fever	percentages	lb	ub	obs
less	31.3	22.7	41.4	35.0
same	58.9	46.5	70.3	66.0
more	8.0	4.5	14.0	9.0
don't kn	1.8	0.4	7.0	2.0
Total	100.0		112.0	

84. When [CHILD] was sick with a fever, was he/she offered less than usual to eat, about the same amount or more than usual to eat?

Food during fever	percentages	lb	ub	obs
less	49.5	38.3	60.8	55.0
same	48.6	36.9	60.5	54.0
more	0.9	0.1	6.7	1.0
don't kn	0.9	0.1	6.7	1.0
Total	100.0		111.0	

85. Has [CHILD] had diarrhea in the last two weeks?

Child had diarrhea in past 2 weeks	percentages	lb	ub	obs
yes	22.4	17.7	27.8	87.0
no	77.6	72.2	82.3	302.0
Total	100.0		389.0	

86. Was she/he given any of the following to drink at any time since she/he started having diarrhea?

Child given ORS packet fluid since diarrhea	percentages	lb	ub	obs
yes	66.7	56.1	75.8	58.0
no	32.2	22.8	43.2	28.0
don't kn	1.1	0.1	8.4	1.0
Total	100.0		87.0	

Child given pre-packa |

ged ORS	percentages	lb	ub	obs
since				
diarrhea				
yes	24.4	16.2	35.0	21.0
no	74.4	63.5	83.0	64.0
don't kn	1.2	0.2	8.4	1.0
Total	100.0		86.0	

Child	percentages	lb	ub	obs
given				
homemade				
fluid				
since				
diarrhea				
yes	22.4	15.8	30.6	19.0
no	76.5	68.7	82.8	65.0
don't kn	1.2	0.2	8.5	1.0
Total	100.0		85.0	

87. Was anything (else) given to treat the diarrhea?

Other	percentages	lb	ub	obs
treatment				
yes	51.7	40.3	62.9	45.0
no	47.1	36.9	57.6	41.0
don't kn	1.1	0.2	8.2	1.0
Total	100.0		87.0	

88. What (else) was given to treat the diarrhea?

Other	percentages	lb	ub	obs
treatment				
:				
antibioti				
c				
FALSE	95.4	93.2	96.9	371.0

TRUE	4.6	3.1	6.8	18.0
Total	100.0		389.0	

Other				
treatment				
:				
antimotil				
ity	percentages	lb	ub	obs
+				
FALSE	98.7	97.0	99.5	384.0
TRUE	1.3	0.5	3.0	5.0
Total	100.0		389.0	

Other				
treatment				
:				
antiparas				
itic	percentages	lb	ub	obs
+				
FALSE	94.3	91.8	96.1	367.0
TRUE	5.7	3.9	8.2	22.0
Total	100.0		389.0	

Other				
treatment				
: zinc	percentages	lb	ub	obs
+				
FALSE	99.0	97.3	99.6	385.0
TRUE	1.0	0.4	2.7	4.0
Total	100.0		389.0	

Other				
treatment				
:				
injection	percentages	lb	ub	obs
+				
FALSE	99.5	97.9	99.9	387.0
TRUE	0.5	0.1	2.1	2.0

Total	100.0			389.0

Other treatment : intravenous	percentages	lb	ub	obs
FALSE	99.7	98.0	100.0	388.0
TRUE	0.3	0.0	2.0	1.0
Total	100.0			389.0

Other treatment : home remedy	percentages	lb	ub	obs
FALSE	99.5	97.9	99.9	387.0
TRUE	0.5	0.1	2.1	2.0
Total	100.0			389.0

Other treatment : other	percentages	lb	ub	obs
FALSE	100.0			389.0

Q88text	Freq.	Percent	Cum.	
.	389	100.00	100.00	

89. With [CHILD's] most recent illness with diarrhea, did [CHILD] experience any of the following?

Diarrhea + bloody stools	percentages	lb	ub	obs
yes	11.5	6.1	20.5	10.0

	percentages	lb	ub	obs
no	88.5	79.5	93.9	77.0
Total	100.0			87.0

Diarrhea				
for 2+				
weeks	percentages	lb	ub	obs
yes	8.0	3.9	15.8	7.0
no	92.0	84.2	96.1	80.0
Total	100.0			87.0

90. Did you seek advice or treatment from someone outside the home for [CHILD's] diarrhea?

91. Where did you first go for advice or treatment?

	percentages	lb	ub	obs
A, HOSPI	13.0	4.7	31.4	9.0
B, HEALT	15.9	8.5	27.9	11.0
C, DISPE	65.2	47.8	79.4	45.0
G, PHARM	5.8	2.2	14.2	4.0
Total	100.0			69.0

92. When [CHILD] was sick with diarrhea, did you breastfeed him/her less than usual, about the same or more than usual?

	percentages	lb	ub	obs
less	27.6	17.8	40.1	24.0
same	59.8	47.3	71.1	52.0
more	5.7	2.7	11.9	5.0
child no	6.9	2.8	16.1	6.0

Total	100.0			87.0
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93. When [CHILD] was sick with diarrhea, was he/she offered less than usual to drink, about the same amount or more than usual to drink?

Drinks				
during				
diarrhea	percentages	lb	ub	obs
less	32.9	23.1	44.5	27.0
same	62.2	51.1	72.1	51.0
more	4.9	1.5	15.1	4.0
Total	100.0			82.0

94. When [CHILD] was sick with diarrhea, was he/she offered less than usual to eat, about the same amount or more than usual to eat?

Food				
during				
diarrhea	percentages	lb	ub	obs
less	40.5	28.4	53.9	32.0
same	58.2	45.3	70.1	46.0
more	1.3	0.2	9.3	1.0
Total	100.0			79.0

95. Has [CHILD] had an illness with a cough that comes from the chest at any time in the last two weeks?

Child had				
cough in				
past 2				
weeks	percentages	lb	ub	obs
yes	34.2	27.9	41.1	133.0
no	65.8	58.9	72.1	256.0
Total	100.0			389.0

96. When [Child] had an illness with a cough, did he/she have trouble breathing or breath faster than usual with short, fast breaths?

Child had trouble breathing	percentages	lb	ub	obs
yes	42.1	33.9	50.7	56.0
no	57.1	49.0	64.9	76.0
don't kn	0.8	0.1	5.5	1.0
Total	100.0		133.0	

97. Did you seek advice or treatment for the cough/fast breathing?

Sough advice for breathing	percentages	lb	ub	obs
yes	93.9	88.2	97.0	124.0
no	6.1	3.0	11.8	8.0
Total	100.0		132.0	

98. Who gave you advice or treatment?

Sought advice: doctor	percentages	lb	ub	obs
FALSE	82.8	78.6	86.3	322.0
TRUE	17.2	13.7	21.4	67.0
Total	100.0		389.0	

Sought advice: nurse	percentages	lb	ub	obs
FALSE	81.0	75.6	85.4	315.0
TRUE	19.0	14.6	24.4	74.0

Total	percentages	lb	ub	obs
100.0				389.0

Sought advice: medical attendant				
	percentages	lb	ub	obs

FALSE	97.9	95.8	99.0	381.0
TRUE	2.1	1.0	4.2	8.0
Total	100.0			389.0

Total	percentages	lb	ub	obs
100.0				389.0

Sought advice: trained CHW				
	percentages	lb	ub	obs

FALSE	97.7	95.2	98.9	380.0
TRUE	2.3	1.1	4.8	9.0
Total	100.0			389.0

Total	percentages	lb	ub	obs
100.0				389.0

Sought advice: shop				
	percentages	lb	ub	obs

FALSE	98.5	96.2	99.4	383.0
TRUE	1.5	0.6	3.8	6.0
Total	100.0			389.0

99. Where did you first go for advice or treatment?

Health care source	percentages	lb	ub	obs
A, HOSPI	16.0	8.4	28.5	20.0
B, HEALT	20.0	12.4	30.6	25.0
C, DISPE	54.4	41.7	66.6	68.0
F, SHOP	0.8	0.1	5.8	1.0
G, PHARM	8.8	4.9	15.3	11.0

Total	100.0		125.0	
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100. Which medicines were given to [CHILD]?

medicine				
given:				
nothing	percentages	lb	ub	obs
FALSE	98.7	95.2	99.7	384.0
TRUE	1.3	0.3	4.8	5.0
Total	100.0		389.0	

medicine				
given:				
aspirin	percentages	lb	ub	obs
FALSE	97.9	95.0	99.2	381.0
TRUE	2.1	0.8	5.0	8.0
Total	100.0		389.0	

medicine				
given:				
paracetamol	percentages	lb	ub	obs
FALSE	87.1	82.2	90.9	339.0
TRUE	12.9	9.1	17.8	50.0
Total	100.0		389.0	

medicine				
given:				
amoxicillin	percentages	lb	ub	obs

medicine				
given:				
erythromycin				

cin	percentages	lb	ub	obs
FALSE	93.3	90.1	95.6	363.0
TRUE	6.7	4.4	9.9	26.0
Total	100.0			389.0

medicine given: azithromy				
cin	percentages	lb	ub	obs
FALSE	100.0			389.0

medicine given: other				
cin	percentages	lb	ub	obs
FALSE	95.9	92.6	97.8	373.0
TRUE	4.1	2.2	7.4	16.0
Total	100.0			389.0

Q100txt	percentages	lb	ub	obs
IV	5.9	0.5	42.7	1.0
Piriton	5.9	0.5	42.7	1.0
Pozacof	5.9	0.7	35.3	1.0
amodiaqu	5.9	0.7	35.3	1.0
ampicill	5.9	0.5	42.7	1.0
bactrim	5.9	0.7	35.3	1.0
chestcof	5.9	0.7	35.3	1.0
co-trimo	11.8	2.5	40.5	2.0
cotrimox	5.9	0.5	42.7	1.0
delased	5.9	0.6	39.1	1.0
flagyl	5.9	0.6	39.1	1.0
koflin	5.9	0.6	39.1	1.0
metrodia	5.9	0.5	42.7	1.0
penicill	11.8	2.3	43.5	2.0
piriton	5.9	0.7	35.3	1.0
Total	100.0			17.0

medicine given: don't know	percentages	lb	ub	obs
FALSE	99.0	97.3	99.6	385.0
TRUE	1.0	0.4	2.7	4.0
Total	100.0		389.0	

101. When [CHILD] was sick with a cough, did you breastfeed him/her less than usual, about the same or more than usual?

Breastfee ding during cough	percentages	lb	ub	obs
less	15.0	9.2	23.5	20.0
same	66.9	58.3	74.6	89.0
more	8.3	4.5	14.7	11.0
child no	9.0	4.7	16.7	12.0
don't kn	0.8	0.1	5.6	1.0
Total	100.0		133.0	

102. When [CHILD] was sick with diarrhea, was he/she offered less than usual to drink, about the same amount or more than usual to drink?

Drinks during cough	percentages	lb	ub	obs
less	31.2	23.0	40.8	39.0
same	63.2	51.5	73.5	79.0
more	4.0	1.4	10.6	5.0
don't kn	1.6	0.4	6.4	2.0
Total	100.0		125.0	

103. When [CHILD] was sick with diarrhea, was he/she offered less than usual to eat, about the same amount or more than usual to eat?

Food during cough	percentages	lb	ub	obs
less	41.1	29.6	53.8	51.0
same	55.6	43.2	67.4	69.0
more	1.6	0.4	6.3	2.0
don't kn	1.6	0.4	6.5	2.0
Total	100.0		124.0	

104. Do you treat your water in any way to make it safe for drinking?

Treat water	percentages	lb	ub	obs
yes	52.1	46.6	57.5	202.0
no	47.9	42.5	53.4	186.0
Total	100.0		388.0	

105. If yes, what do you usually do to the water to make it safer to drink?

Water treatment : let sit	percentages	lb	ub	obs
FALSE	95.6	93.9	96.9	372.0
TRUE	4.4	3.1	6.1	17.0
Total	100.0		389.0	

Water treatment : strain through cloth	percentages	lb	ub	obs
FALSE	97.2	94.7	98.5	378.0
TRUE	2.8	1.5	5.3	11.0
Total	100.0		389.0	

Water treatment				
: boil	percentages	lb	ub	obs
FALSE	55.3	49.9	60.5	215.0
TRUE	44.7	39.5	50.1	174.0
Total	100.0		389.0	

Water treatment				
: add bleach/chlorine	percentages	lb	ub	obs
FALSE	97.2	95.4	98.3	378.0
TRUE	2.8	1.7	4.6	11.0
Total	100.0		389.0	

Water treatment				
: add waterguard	percentages	lb	ub	obs
FALSE	97.7	95.5	98.8	380.0
TRUE	2.3	1.2	4.5	9.0
Total	100.0		389.0	

Water treatment				
: water filter	percentages	lb	ub	obs
FALSE	100.0			389.0

Water treatment

: solar disinfect ion	percentages	lb	ub	obs
FALSE	99.7	98.0	100.0	388.0
TRUE	0.3	0.0	2.0	1.0
Total	100.0		389.0	

Water treatment : bottle	percentages	lb	ub	obs
FALSE	99.5	97.9	99.9	387.0
TRUE	0.5	0.1	2.1	2.0
Total	100.0		389.0	

Q105txt	percentages	lb	ub	obs
bottled	100.0		2.0	

Water treatment : don't know	percentages	lb	ub	obs
FALSE	100.0		389.0	

106. Can you show me where you usually wash your hands and what you use to wash your hands?

Hand washing station	percentages	lb	ub	obs
1, INSID	2.8	1.5	5.3	11.0
2, INSID	5.9	3.4	10.0	23.0
3, ELSEW	16.5	12.4	21.5	64.0
4, OUTSI	4.6	2.8	7.7	18.0
5, NO SP	69.3	62.6	75.3	269.0
6, NO PE	0.8	0.2	2.4	3.0

Total	100.0			388.0
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Key: percentages = cell percentages

107. OBSERVATION ONLY: IS THERE SOAP OR DETERGENT OR LOCALLY-USED CLEANSING AGENT?

Soap/dete rgent present	percentages	lb	ub	obs
1, SOAP	78.9	71.9	84.5	97.0
2, DETER	7.3	3.5	14.7	9.0
3, ASH	3.3	1.3	7.9	4.0
6, NONE	10.6	6.3	17.1	13.0
Total	100.0			123.0

108. Did you use soap of any kind for any reason yesterday during the day or night?

Used soap yesterday	percentages	lb	ub	obs
yes	98.1	92.2	99.6	103.0
no	1.9	0.4	7.8	2.0
Total	100.0			105.0

109. When you used soap yesterday in the day or night, what did you use it for?

Used soap yesterday : before food prep	percentages	lb	ub	obs
FALSE	89.5	85.1	92.7	348.0
TRUE	10.5	7.3	14.9	41.0
Total	100.0			389.0

Used soap |
yesterday |

: before feeding children	percentages	lb	ub	obs
FALSE	86.9	82.8	90.2	338.0
TRUE	13.1	9.8	17.2	51.0
Total	100.0		389.0	

Used soap yesterday : after defecatio n	percentages	lb	ub	obs
FALSE	83.0	77.0	87.8	323.0
TRUE	17.0	12.2	23.0	66.0
Total	100.0		389.0	

Used soap yesterday : after helping defecatin g child	percentages	lb	ub	obs
FALSE	93.1	89.4	95.5	362.0
TRUE	6.9	4.5	10.6	27.0
Total	100.0		389.0	

Used soap yesterday : other	percentages	lb	ub	obs
FALSE	94.1	90.3	96.5	366.0
TRUE	5.9	3.5	9.7	23.0
Total	100.0		389.0	

110. The last time [CHILD] passed stools, what was done to dispose of the stools?

How disposed of stools	percentages	lb	ub	obs
A, CHILD	8.7	6.1	12.4	34.0
B, PUT/R	54.0	50.3	57.6	210.0
C, PUT/R	15.9	13.3	18.9	62.0
D, THROW	3.9	2.2	6.8	15.0
E, BURIE	15.4	11.8	19.9	60.0
F, LEFT	0.8	0.2	2.4	3.0
X, OTHER	1.3	0.5	3.0	5.0
Total	100.0		389.0	

111. Does your household have any mosquito nets that can be used while sleeping?

Household has bed nets	percentages	lb	ub	obs
yes	93.3	90.0	95.6	363.0
no	6.7	4.4	10.0	26.0
Total	100.0		389.0	

112. Who slept under a bed net last night?

Who slept under net last night	percentages	lb	ub	obs
child	99.7	97.9	100.0	362.0
other	0.3	0.0	2.1	1.0
Total	100.0		363.0	

113 How long ago was the bednet bough or obtained?

how long ago was net

bought, in months	percentages	lb	ub	obs
1	1.4	0.6	3.3	5.0
2	2.5	1.2	5.2	9.0
3	3.0	1.6	5.9	11.0
4	1.7	0.8	3.5	6.0
5	1.7	0.8	3.5	6.0
6	3.0	1.7	5.4	11.0
7	2.2	1.2	4.2	8.0
8	3.0	1.7	5.4	11.0
9	6.1	3.8	9.6	22.0
10	6.1	4.2	8.8	22.0
11	1.4	0.4	5.1	5.0
12	17.7	13.5	23.0	64.0
13	1.7	0.7	4.0	6.0
14	2.5	1.3	4.8	9.0
15	2.2	1.2	4.1	8.0
16	1.7	0.7	4.1	6.0
18	1.4	0.6	3.2	5.0
21	0.6	0.1	2.3	2.0
22	0.6	0.1	2.3	2.0
24	2.2	1.1	4.6	8.0
2+ years	31.3	26.7	36.3	113.0
don't kn	6.1	2.7	13.2	22.0
Total	100.0		361.0	

114 ASK THE RESPONDENT TO IDENTIFY THE BRAND OF NET THAT THE CHILD SLEPT UNDER, SHOW PICTURES OF THE TYPICAL NET TYPES AND BRANDS.

Bed net brand	percentages	lb	ub	obs
1, PERMANENTLY TREATED NET	93.3	89.3	95.9	334.0
2, NET WITH NGAO	5.6	3.2	9.7	20.0
3, MMBU NET	0.3	0.0	2.1	1.0
4, SAFI NET	0.8	0.2	3.7	3.0
Total	100.0		358.0	

115. Was the bed net that [CHILD] slept under last night ever soaked or dipped in a liquid treated to repel mosquitoes or bugs?

Net re-treated	percentages	lb	ub	obs
yes	50.0	27.5	72.5	17.0
no	50.0	27.5	72.5	17.0
Total	100.0			34.0

Last time net was dipped	percentages	lb	ub	obs
0	4.8	0.5	35.2	1.0
1	33.3	16.3	56.3	7.0
2	4.8	0.6	29.9	1.0
3	4.8	0.6	29.9	1.0
10	9.5	1.8	38.3	2.0
12	4.8	0.6	29.9	1.0
2+ years	19.0	4.2	55.8	4.0
don't kn	19.0	4.5	54.0	4.0
Total	100.0			21.0

117. When you were pregnant with [CHILD] did you sleep under a bednet?

When pregnant, slept under net	percentages	lb	ub	obs
1, ALWAYS	42.2	36.2	48.4	164.0
2, USUAL	47.3	40.7	54.0	184.0
3, OCCAS	1.3	0.5	3.0	5.0
4, RAREL	2.6	1.1	5.9	10.0
5, NEVER	6.7	4.4	9.9	26.0
Total	100.0			389.0

118. At any time in the past 12 months, has anyone sprayed the interior walls of your dwelling against mosquitoes?

walls sprayed	percentages	lb	ub	obs
0	90.0	85.2	93.3	350.0
yes	10.0	6.7	14.8	39.0
Total	100.0			389.0

119. Do you know of a place where you could obtain a method of child spacing/family planning? If yes, where is that?

FP source: hospital	percentages	lb	ub	obs
FALSE	73.8	64.6	81.2	287.0
TRUE	26.2	18.8	35.4	102.0
Total	100.0			389.0

FP source: health center	percentages	lb	ub	obs
FALSE	68.1	61.7	73.9	265.0
TRUE	31.9	26.1	38.3	124.0
Total	100.0			389.0

FP source: dispensar y	percentages	lb	ub	obs
FALSE	44.0	34.4	54.0	171.0
TRUE	56.0	46.0	65.6	218.0
Total	100.0			389.0

FP
source:

NGO center	percentages	lb	ub	obs
FALSE	91.8	86.2	95.2	357.0
TRUE	8.2	4.8	13.8	32.0
Total	100.0		389.0	

FP source: FP clinic	percentages	lb	ub	obs
FALSE	89.5	86.1	92.1	348.0
TRUE	10.5	7.9	13.9	41.0
Total	100.0		389.0	

FP source: CHW	percentages	lb	ub	obs
FALSE	97.2	93.4	98.8	378.0
TRUE	2.8	1.2	6.6	11.0
Total	100.0		389.0	

FP source: pharmacy	percentages	lb	ub	obs
FALSE	99.2	96.6	99.8	386.0
TRUE	0.8	0.2	3.4	3.0
Total	100.0		389.0	

FP source: other health facility	percentages	lb	ub	obs
FALSE	99.7	98.0	100.0	388.0

TRUE		0.3	0.0	2.0	1.0
Total		100.0			389.0

FP					
source:					
church		percentages	lb	ub	obs

FALSE		99.7	98.0	100.0	388.0
TRUE		0.3	0.0	2.0	1.0
Total		100.0			389.0

FP					
source:					
friend/re					
lative		percentages	lb	ub	obs

FALSE		99.2	97.6	99.8	386.0
TRUE		0.8	0.2	2.4	3.0
Total		100.0			389.0

FP					
source:					
school		percentages	lb	ub	obs

FALSE		99.5	97.9	99.9	387.0
TRUE		0.5	0.1	2.1	2.0
Total		100.0			389.0

Q119txt2		percentages			obs

school		100.0	1.0		

FP					
source:					
don't					
know		percentages	lb	ub	obs

FALSE	93.6	90.4	95.7	364.0
TRUE	6.4	4.3	9.6	25.0
Total	100.0			389.0

FP source:				
shop	Freq.	Percent	Cum.	
+				
FALSE	389	100.00	100.00	
+				
Total	389	100.00		

Q119txt1	Freq.	Percent	Cum.	
+				
.	389	100.00	100.00	
+				
Total	389	100.00		

Q119txt2	Freq.	Percent	Cum.	
+				
	388	99.74	99.74	
school	1	0.26	100.00	
+				
Total	389	100.00		

120. Are you currently pregnant?

Currently				
pregnant	percentages	lb	ub	obs
+				
yes	3.9	2.2	6.6	15.0
no	95.9	93.2	97.5	372.0
don't kn	0.3	0.0	2.0	1.0
Total	100.0			388.0

121. Do you want to have another child?

Want				
another				
child	percentages	lb	ub	obs
+				
yes	42.2	36.5	48.3	158.0
no	52.4	46.5	58.2	196.0
don't kn	5.3	3.3	8.5	20.0

Total	100.0			374.0
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122. When do you want to have your next child?

When want				
next				
child	percentages	lb	ub	obs
within 2	9.9	5.9	16.3	16.0
more tha	71.4	64.6	77.4	115.0
unsure	18.6	13.1	25.8	30.0
Total	100.0			161.0

123. Are you currently doing something or using any method to delay or avoid getting pregnant? If yes, what is the main method you or your husband/partner are using now to avoid/postpone getting pregnant?

current				
FP method	percentages	lb	ub	obs
no metho	32.4	26.7	38.7	122.0
norplant	10.6	8.0	14.1	40.0
injectio	37.2	32.4	42.3	140.0
pill	3.5	1.8	6.7	13.0
IUD	1.1	0.4	2.8	4.0
condom	2.9	1.6	5.1	11.0
foam/gel	0.3	0.0	2.0	1.0
tubal li	1.6	0.7	3.4	6.0
LAM	3.2	1.8	5.6	12.0
rhythm	4.0	2.3	6.8	15.0
abstinen	0.8	0.3	2.5	3.0
withdraw	1.9	0.7	5.0	7.0
herbs	0.3	0.0	2.0	1.0
other	0.3	0.0	2.0	1.0
Total	100.0			376.0

124. Have you ever talked about family planning methods with your husband or partner?

Discussed |

FP with partner	percentages	lb	ub	obs
yes	57.1	51.7	62.3	222.0
no	42.4	37.2	47.8	165.0
don't kn	0.5	0.1	2.1	2.0
Total	100.0			389.0

125. Have you ever head of an illness called AIDS?

Ever heard of HIV	percentages	lb	ub	obs
yes	98.7	96.4	99.5	384.0
no	1.3	0.5	3.6	5.0
Total	100.0			389.0

126. Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?

Anything to avoid HIV	percentages	lb	ub	obs
yes	93.7	90.5	95.9	357.0
no	3.7	1.9	7.0	14.0
don't kn	2.6	1.3	5.1	10.0
Total	100.0			381.0

127. What can a person do to avoid getting AIDS? Anything else?

Avoid HIV: abstain	percentages	lb	ub	obs
FALSE	45.5	39.6	51.5	177.0
TRUE	54.5	48.5	60.4	212.0
Total	100.0			389.0

Avoid HIV: condoms	percentages	lb	ub	obs
FALSE	24.9	18.8	32.3	97.0
TRUE	75.1	67.7	81.2	292.0
Total	100.0		389.0	

Avoid HIV: only 1 partner	percentages	lb	ub	obs
FALSE	52.7	45.4	59.9	205.0
TRUE	47.3	40.1	54.6	184.0
Total	100.0		389.0	

Avoid HIV: limit sex partners	percentages	lb	ub	obs
FALSE	86.1	80.2	90.5	335.0
TRUE	13.9	9.5	19.8	54.0
Total	100.0		389.0	

Avoid HIV: no prostitutes	percentages	lb	ub	obs
FALSE	70.4	64.5	75.8	274.0
TRUE	29.6	24.2	35.5	115.0
Total	100.0		389.0	

Avoid HIV: no

sex with multi-par tner person	percentages	lb	ub	obs
FALSE	75.3	69.6	80.2	293.0
TRUE	24.7	19.8	30.4	96.0
Total	100.0		389.0	

Avoid HIV: no same-sex	percentages	lb	ub	obs
FALSE	92.5	89.1	94.9	360.0
TRUE	7.5	5.1	10.9	29.0
Total	100.0		389.0	

Avoid HIV: no sex with injectors	percentages	lb	ub	obs
FALSE	88.9	85.4	91.7	346.0
TRUE	11.1	8.3	14.6	43.0
Total	100.0		389.0	

Avoid HIV: no blood transfusi ons	percentages	lb	ub	obs
FALSE	91.5	87.6	94.3	356.0
TRUE	8.5	5.7	12.4	33.0
Total	100.0		389.0	

Avoid
HIV: no

injection s	percentages	lb	ub	obs
FALSE	93.3	90.0	95.6	363.0
TRUE	6.7	4.4	10.0	26.0
Total	100.0			389.0

Avoid HIV: tradition al healer	percentages	lb	ub	obs
FALSE	99.7	98.1	100.0	388.0
TRUE	0.3	0.0	1.9	1.0
Total	100.0			389.0

Avoid HIV: no sharing razors	percentages	lb	ub	obs
FALSE	62.7	56.4	68.7	244.0
TRUE	37.3	31.3	43.6	145.0
Total	100.0			389.0

Avoid HIV: other	percentages	lb	ub	obs
FALSE	97.9	95.8	99.0	381.0
TRUE	2.1	1.0	4.2	8.0
Total	100.0			389.0

Avoid HIV: no kissing	Freq.	Percent	Cum.
FALSE	389	100.00	100.00
Total	389	100.00	

Avoid HIV: no mosquito bites	Freq.	Percent	Cum.
FALSE	389	100.00	100.00
Total	389	100.00	

Q127y	Freq.	Percent	Cum.
FALSE	389	100.00	100.00
Total	389	100.00	

Avoid HIV: don't know	Freq.	Percent	Cum.
FALSE	389	100.00	100.00
Total	389	100.00	

Q127txt1	percentages	lb	ub	obs
avoid in	12.5	1.2	62.3	1.0
avoid te	12.5	0.8	71.7	1.0
get test	12.5	1.2	62.3	1.0
loving G	12.5	0.8	71.7	1.0
stop dri	37.5	7.0	82.6	3.0
test blo	12.5	0.8	71.7	1.0
Total	100.0		8.0	

128. During the past month, how frequently have you come in contact with:

In past month, number contacts with: doctor	percentages	lb	ub	obs
0	58.8	51.9	65.3	228.0
1	20.6	15.6	26.7	80.0

2	10.8	7.8	14.8	42.0
3	6.4	4.3	9.6	25.0
4	3.1	1.6	5.8	12.0
10	0.3	0.0	2.0	1.0
Total	100.0			388.0

In past					
month,					
number					
contacts					
with:					
nurse		percentages	lb	ub	obs
0	34.2	27.3	41.8	133.0	
1	33.4	27.4	40.0	130.0	
2	18.3	14.2	23.2	71.0	
3	6.9	4.4	10.7	27.0	
4	3.9	2.1	6.8	15.0	
5	1.5	0.6	3.8	6.0	
6	1.0	0.4	2.7	4.0	
7	0.3	0.0	2.0	1.0	
8	0.3	0.0	2.0	1.0	
10	0.3	0.0	2.0	1.0	
Total	100.0			389.0	

In past					
month,					
number					
contacts					
with:					
midwife		percentages	lb	ub	obs
0	86.3	80.5	90.6	333.0	
1	6.7	3.6	12.2	26.0	
2	2.6	1.5	4.4	10.0	
3	2.8	1.5	5.3	11.0	
4	0.8	0.2	2.4	3.0	
5	0.5	0.1	2.1	2.0	
10	0.3	0.0	2.0	1.0	
Total	100.0			386.0	

In past month, number contacts with: TBA	percentages	lb	ub	obs
0	90.4	85.2	94.0	350.0
1	3.9	2.1	7.1	15.0
2	2.1	1.0	4.3	8.0
3	1.0	0.3	3.4	4.0
4	1.0	0.3	3.5	4.0
5	0.5	0.1	2.1	2.0
6	0.3	0.0	2.0	1.0
7	0.3	0.0	2.0	1.0
10	0.5	0.1	2.1	2.0
Total	100.0			387.0

In past month, number contacts with: CHW	percentages	lb	ub	obs
0	79.3	71.4	85.4	306.0
1	9.3	5.9	14.4	36.0
2	6.0	3.5	10.1	23.0
3	3.1	1.5	6.3	12.0
4	1.8	0.6	5.3	7.0
9	0.3	0.0	2.0	1.0
13	0.3	0.0	2.0	1.0
Total	100.0			386.0

In past month, number contacts with: village health committee	percentages	lb	ub	obs
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0	86.5	79.3	91.4	333.0
1	6.0	3.5	10.0	23.0
2	4.9	2.6	9.1	19.0
3	1.0	0.2	5.0	4.0
4	0.3	0.0	2.0	1.0
5	1.0	0.4	2.7	4.0
9	0.3	0.0	2.0	1.0
Total	100.0			385.0

In past					
month,					
number					
contacts					
with:					
community					
leader		percentages	lb	ub	obs
0	91.2	87.1	94.1	353.0	
1	4.4	2.4	7.9	17.0	
2	2.1	1.1	3.9	8.0	
3	1.3	0.5	3.0	5.0	
4	0.8	0.2	2.4	3.0	
6	0.3	0.0	2.0	1.0	
Total	100.0			387.0	

In past					
month,					
number					
contacts					
with:					
NGOs		percentages	lb	ub	obs
0	82.7	76.5	87.5	320.0	
1	9.0	5.7	14.1	35.0	
2	3.6	1.9	6.7	14.0	
3	2.3	0.9	5.8	9.0	
4	0.8	0.2	2.4	3.0	
5	0.8	0.2	2.4	3.0	
7	0.3	0.0	2.0	1.0	
9	0.3	0.0	2.0	1.0	
10	0.3	0.0	2.0	1.0	

Total	percentages	lb	ub	obs
	100.0			387.0

In past month, number contacts with: school teacher	percentages	lb	ub	obs
0	92.0	86.4	95.4	356.0
1	4.1	2.0	8.5	16.0
2	2.1	0.8	5.0	8.0
3	0.5	0.1	2.1	2.0
5	0.8	0.2	2.4	3.0
6	0.3	0.0	2.0	1.0
10	0.3	0.0	2.0	1.0
Total	100.0			387.0

In past month, number contacts with: maisha driver	percentages	lb	ub	obs
0	98.7	97.0	99.4	376.0
1	1.0	0.4	2.7	4.0
2	0.3	0.0	2.0	1.0
Total	100.0			381.0

129. Where do you get information about health?

health information from: doctor	percentages	lb	ub	obs
FALSE	53.5	45.6	61.2	208.0
TRUE	46.5	38.8	54.4	181.0

	percentages	lb	ub	obs
Total	100.0			389.0

health informati				
on from:				
nurse	percentages	lb	ub	obs
FALSE	20.3	15.9	25.6	79.0
TRUE	79.7	74.4	84.1	310.0
Total	100.0			389.0

	percentages	lb	ub	obs
TBA	percentages	lb	ub	obs
FALSE	84.6	78.0	89.5	329.0
TRUE	15.4	10.5	22.0	60.0
Total	100.0			389.0

	percentages	lb	ub	obs
CHW	percentages	lb	ub	obs
FALSE	72.5	64.4	79.4	282.0
TRUE	27.5	20.6	35.6	107.0
Total	100.0			389.0

	percentages	lb	ub	obs
CBO/NGO	percentages	lb	ub	obs
FALSE	54.8	45.1	64.1	213.0
TRUE	45.2	35.9	54.9	176.0
Total	100.0			389.0

health informati on from: village health committee	percentages	lb	ub	obs
FALSE	84.3	78.0	89.1	328.0
TRUE	15.7	10.9	22.0	61.0
Total	100.0		389.0	

health informati on from: village health attendant	percentages	lb	ub	obs
FALSE	82.0	76.2	86.6	319.0
TRUE	18.0	13.4	23.8	70.0
Total	100.0		389.0	

health informati on from: other health worker	percentages	lb	ub	obs
FALSE	95.9	92.5	97.8	373.0
TRUE	4.1	2.2	7.5	16.0
Total	100.0		389.0	

health informati on from: husband	percentages	lb	ub	obs
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FALSE	98.7	95.8	99.6	384.0
TRUE	1.3	0.4	4.2	5.0
Total	100.0		389.0	

health				
informati				
on from:				
mother/in				
-law	percentages	lb	ub	obs
FALSE	92.0	88.2	94.7	358.0
TRUE	8.0	5.3	11.8	31.0
Total	100.0		389.0	

health				
informati				
on from:				
sister	percentages	lb	ub	obs
FALSE	93.6	89.7	96.1	364.0
TRUE	6.4	3.9	10.3	25.0
Total	100.0		389.0	

health				
informati				
on from:				
grandpare				
nt	percentages	lb	ub	obs
FALSE	91.5	87.5	94.3	356.0
TRUE	8.5	5.7	12.5	33.0
Total	100.0		389.0	

health				
informati				
on from:				
aunt	percentages	lb	ub	obs

FALSE	92.3	88.1	95.1	359.0
TRUE	7.7	4.9	11.9	30.0
Total	100.0		389.0	

health				
informati				
on from:				
friend/ne				
ighbor	percentages	lb	ub	obs
FALSE	84.6	80.5	87.9	329.0
TRUE	15.4	12.1	19.5	60.0
Total	100.0		389.0	

health			
information			
from:			
traditional			
healer	Freq.	Percent	Cum.
FALSE	389	100.00	100.00
Total	389	100.00	

health				
informati				
on from:				
village				
elder	percentages	lb	ub	obs
FALSE	97.7	95.5	98.8	380.0
TRUE	2.3	1.2	4.5	9.0
Total	100.0		389.0	

health				
informati				
on from:				
school				
teacher	percentages	lb	ub	obs
FALSE	96.4	92.9	98.2	375.0

TRUE	3.6	1.8	7.1	14.0
Total	100.0			389.0

health				
informati				
on from:				
employer	percentages	lb	ub	obs
+				
FALSE	99.5	97.9	99.9	387.0
TRUE	0.5	0.1	2.1	2.0
Total	100.0			389.0

health				
informati				
on from:				
tradition				
al leader	percentages	lb	ub	obs
+				
FALSE	98.2	96.0	99.2	382.0
TRUE	1.8	0.8	4.0	7.0
Total	100.0			389.0

health			
information			
from:			
village			
leader	Freq.	Percent	Cum.
+			
FALSE	389	100.00	100.00
+			
Total	389	100.00	

health				
informati				
on from:				
other	percentages	lb	ub	obs
+				
FALSE	96.1	92.7	98.0	374.0
TRUE	3.9	2.0	7.3	15.0
Total	100.0			389.0

 . tabulate q129txt2, m

Q129txt2	Freq.	Percent	Cum.
	374	96.14	96.14
clinic	9	2.31	98.46
clinic workers	1	0.26	98.71
hospital	5	1.29	100.00

Total	389	100.00	

130. In the past month have you received any health information from the following?

In past month, received health info from: radio	percentages	lb	ub	obs
yes	67.6	58.4	75.5	254.0
no	32.4	24.5	41.6	122.0
Total	100.0			376.0

In past month, received health info from: televisio n	percentages	lb	ub	obs
yes	17.2	10.9	26.2	67.0
no	82.8	73.8	89.1	322.0
Total	100.0			389.0

In past month, |

received health info from: newspaper	percentages		lb	ub	obs
yes	42.7	35.1	50.6	166.0	
no	57.3	49.4	64.9	223.0	
Total	100.0			389.0	

In past month, received health info from: health educator	percentages		lb	ub	obs
yes	30.3	22.4	39.6	118.0	
no	69.7	60.4	77.6	271.0	
Total	100.0			389.0	

In past month, received health info from: CHW	percentages		lb	ub	obs
yes	44.7	36.1	53.6	174.0	
no	55.3	46.4	63.9	215.0	
Total	100.0			389.0	

In past |
month, |
received |
health |
info |
from: |

community organizat ion	percentages	lb	ub	obs
yes	13.4	8.8	19.7	52.0
no	86.6	80.3	91.2	337.0
Total	100.0			389.0

In past month, received health info from: tradition al leader	percentages	lb	ub	obs
yes	8.5	5.2	13.5	33.0
no	91.5	86.5	94.8	356.0
Total	100.0			389.0

In past month, received health info from: village leader	percentages	lb	ub	obs
yes	1.3	0.5	3.0	5.0
no	98.7	97.0	99.5	383.0
Total	100.0			388.0

In past |
month, |
received |
health |
info |
from: |

other	percentages	lb	ub	obs
yes	40.0	15.4	70.9	6.0
no	60.0	29.1	84.6	9.0
Total	100.0			15.0

Q130txt	percentages	lb	ub	obs
1	33.3	4.2	85.1	2.0
TBA	16.7	0.9	81.4	1.0
church	16.7	0.9	81.4	1.0
dispensa	16.7	0.9	81.4	1.0
neighbor	16.7	0.9	81.4	1.0
Total	100.0			6.0

INDICATORS

ANTENATAL CARE

Antenatal care (ANC) visits

number of antenatal care visits	percentages	lb	ub	obs
0	0.3	0.0	2.0	1.0
1	4.4	2.6	7.2	17.0
2	11.3	8.8	14.4	44.0
3	29.0	24.3	34.3	113.0
4	29.6	24.9	34.7	115.0
5	12.1	9.4	15.4	47.0
6	3.1	1.7	5.5	12.0
7	1.5	0.7	3.3	6.0
9	0.3	0.0	2.0	1.0
10	0.3	0.0	2.0	1.0
20	0.3	0.0	2.0	1.0
don't kn	8.0	5.3	11.8	31.0
Total	100.0			389.0

Antenatal care (ANC) visits: 4+

4+ anc visits	percentages	lb	ub	obs
0	45.0	40.9	49.2	175.0
1	55.0	50.8	59.1	214.0
Total	100.0			389.0

Key: percentages = cell percentages
 lb = lower 95% confidence bounds for cell percentages
 ub = upper 95% confidence bounds for cell percentages
 obs = number of observations

Antenatal care (ANC) visits: 3+

3+ anc visits	percentages	lb	ub	obs
0	15.9	13.0	19.4	62.0
1	84.1	80.6	87.0	327.0
Total	100.0			389.0

Key: percentages = cell percentages
 lb = lower 95% confidence bounds for cell percentages
 ub = upper 95% confidence bounds for cell percentages
 obs = number of observations

Antenatal care (ANC) visits: according to health card

anc_card	percentages	lb	ub	obs
0	53.1	45.2	60.9	127.0
1	46.9	39.1	54.8	112.0
Total	100.0			239.0

TETANUS SHOTS

2+ tetanus toxoid shots while pregnant

tt_2	percentages	lb	ub	obs
0	24.2	20.0	28.9	94.0
1	75.8	71.1	80.0	295.0

Total		100.0		389.0
-------	--	-------	--	-------

2+ tetanus toxoid shots while pregnant: according to health card

tt_card		percentages	lb	ub	obs
0		28.5	22.7	35.0	68.0
1		71.5	65.0	77.3	171.0
Total		100.0			239.0

Key: percentages = cell percentages

lb = lower 95% confidence bounds for cell percentages

ub = upper 95% confidence bounds for cell percentages

obs = number of observations

DELIVERY

Skilled delivery assistance (doctor, nurse, midwife, or health staff with midwife training)

skill		percentages	lb	ub	obs
0		18.0	14.7	21.9	70.0
1		82.0	78.1	85.3	319.0
Total		100.0			389.0

Skilled delivery assistance (doctor, nurse, midwife, health staff with midwife training, or HBLSS-trained health worker)

skill_2		percentages	lb	ub	obs
0		17.7	14.3	21.8	69.0
1		82.3	78.2	85.7	320.0
Total		100.0			389.0

Active Management of the Third Stage of Labor (AMTSL)

amstl		percentages	lb	ub	obs
0		43.7	36.7	50.9	170.0
1		56.3	49.1	63.3	219.0

Total		100.0		389.0
-------	--	-------	--	-------

 Key: percentages = cell percentages

lb = lower 95% confidence bounds for cell percentages

ub = upper 95% confidence bounds for cell percentages

obs = number of observations

NEWBORN CARE

Newborn care / drying and wrapping

newborn_c	are	percentages	lb	ub	obs
0		13.6	10.2	18.0	53.0
1		86.4	82.0	89.8	336.0
Total		100.0			389.0

 Clean cord at time of birth

Clean cord care	are	percentages	lb	ub	obs
0		6.7	4.4	10.1	26.0
1		93.3	89.9	95.6	363.0
Total		100.0			389.0

POST-PARTUM CARE

Post-partum care (PPC) for mom within 72 hours

PPC within 72 hours	are	percentages	lb	ub	obs
0		16.7	12.8	21.5	65.0
1		83.3	78.5	87.2	324.0
Total		100.0			389.0

POST-NATAL VISIT

Postnatal visit for infant within 72 hours

Postnatal visit within 72 hours	percentages	lb	ub	obs
0	17.5	14.1	21.4	68.0
1	82.5	78.6	85.9	321.0
Total	100.0			389.0

BREASTFEEDING

Exclusive breastfeeding, children age 0-5 months

Child age 0-5 months, exclusive breastfeeding	percentages	lb	ub	obs
0	34.9	24.7	46.7	37.0
1	65.1	53.3	75.3	69.0
Total	100.0			106.0

Immediate breastfeeding

Immediate breastfeeding	percentages	lb	ub	obs
0	59.9	53.6	65.9	233.0
1	40.1	34.1	46.4	156.0
Total	100.0			389.0

Immediate breastfeeding, less than 12 months

12 months old, breastfed in one

hour	percentages	lb	ub	obs
0	60.4	54.4	66.1	235.0
1	39.6	33.9	45.6	154.0
Total	100.0			389.0

Prelactial breastfeeding

Nothing other than breastmilk 3 days	percentages	lb	ub	obs
0	28.0	22.6	34.0	59.0
1	72.0	66.0	77.4	152.0
Total	100.0			211.0

Colostrum

Infants under 12 months receiving colostrum	percentages	lb	ub	obs
0	28.0	20.5	36.8	59.0
1	72.0	63.2	79.5	152.0
Total	100.0			211.0

DANGER SIGNS

Knowledge of neonatal danger signs in post-partum period

Know 2+ neonatal danger signs	percentages	lb	ub	obs
0	8.0	5.2	12.0	31.0
1	92.0	88.0	94.8	358.0

Total	100.0		389.0
-------	-------	--	-------

Knowledge of maternal danger signs during pregnancy

Know 2+				
danger				
signs in				
pregnancy	percentages	lb	ub	obs
0	37.0	30.0	44.6	144.0
1	63.0	55.4	70.0	245.0
Total	100.0		389.0	

Knowledge of maternal danger signs during post-partum period

Know 2+				
danger				
signs in				
post-part				
um period	percentages	lb	ub	obs
0	18.8	14.9	23.4	73.0
1	81.2	76.6	85.1	316.0
Total	100.0		389.0	

CHILD SPACING

Child spacing: 36+ months

space	Freq.	Percent	Cum.
0	3	1.15	1.15
8	1	0.38	1.54
12	2	0.77	2.31
13	1	0.38	2.69
15	5	1.92	4.62
16	3	1.15	5.77
17	3	1.15	6.92
18	5	1.92	8.85
19	10	3.85	12.69
20	7	2.69	15.38
21	2	0.77	16.15

22	4	1.54	17.69
23	5	1.92	19.62
24	8	3.08	22.69
25	7	2.69	25.38
26	7	2.69	28.08
27	7	2.69	30.77
28	5	1.92	32.69
29	9	3.46	36.15
30	10	3.85	40.00
31	4	1.54	41.54
32	7	2.69	44.23
33	7	2.69	46.92
34	6	2.31	49.23
35	5	1.92	51.15
36	5	1.92	53.08
37	4	1.54	54.62
38	5	1.92	56.54
39	6	2.31	58.85
40	5	1.92	60.77
41	4	1.54	62.31
42	4	1.54	63.85
43	8	3.08	66.92
44	3	1.15	68.08
45	2	0.77	68.85
46	4	1.54	70.38
47	5	1.92	72.31
48	1	0.38	72.69
49	4	1.54	74.23
50	3	1.15	75.38
51	3	1.15	76.54
52	5	1.92	78.46
53	1	0.38	78.85
54	2	0.77	79.62
55	1	0.38	80.00
56	1	0.38	80.38
57	4	1.54	81.92
58	3	1.15	83.08
60	1	0.38	83.46
62	1	0.38	83.85
63	1	0.38	84.23
64	1	0.38	84.62
65	3	1.15	85.77
66	3	1.15	86.92
68	1	0.38	87.31
70	3	1.15	88.46
71	3	1.15	89.62

73	1	0.38	90.00
74	3	1.15	91.15
75	1	0.38	91.54
76	1	0.38	91.92
79	2	0.77	92.69
83	1	0.38	93.08
84	2	0.77	93.85
85	1	0.38	94.23
86	1	0.38	94.62
88	1	0.38	95.00
89	1	0.38	95.38
92	1	0.38	95.77
93	1	0.38	96.15
101	1	0.38	96.54
106	1	0.38	96.92
108	1	0.38	97.31
118	1	0.38	97.69
123	1	0.38	98.08
128	2	0.77	98.85
131	1	0.38	99.23
151	1	0.38	99.62
189	1	0.38	100.00

Total	260	100.00
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36 months |

apart	percentages	lb	ub	obs
-------	-------------	----	----	-----

0	46.8	39.2	54.6	133.0
---	------	------	------	-------

1	53.2	45.4	60.8	151.0
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Total	100.0			284.0
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Child spacing: 24+ months

24 months |

apart	percentages	lb	ub	obs
-------	-------------	----	----	-----

0	18.0	13.3	23.9	51.0
---	------	------	------	------

1	82.0	76.1	86.7	233.0
---	------	------	------	-------

Total	100.0			284.0
-------	-------	--	--	-------

Desire for child spacing

desire for child spacing	percentages	lb	ub	obs
0	35.9	28.6	43.9	65.0
1	64.1	56.1	71.4	116.0
Total	100.0		181.0	

FAMILY PLANNING

Talk with partner about family planning

talked with partner about FP	percentages	lb	ub	obs
0	34.6	29.0	40.7	106.0
1	65.4	59.3	71.0	200.0
Total	100.0		306.0	

MALARIA PREVENTION

ITN bed net ownership

Own a ITN bed net	percentages	lb	ub	obs
0	9.0	6.5	12.3	35.0
1	91.0	87.7	93.5	354.0
Total	100.0		389.0	

Child slept under insecticide-treated bednet last night

Child
slept
under
insectici
de-treate

d bednet last night	percentages	lb	ub	obs
0	8.7	6.3	12.0	34.0
1	91.3	88.0	93.7	355.0
Total	100.0			389.0

Interior walls sprayed in past 12 months

walls sprayed	percentages	lb	ub	obs
0	90.0	85.2	93.3	350.0
yes	10.0	6.7	14.8	39.0
Total	100.0			389.0

Mothers who usually slept under insecticide-treated bednet while pregnant

Mom usually slept under bednet while pregnant	percentages	lb	ub	obs
0	10.5	7.0	15.5	41.0
1	89.5	84.5	93.0	348.0
Total	100.0			389.0

WATER - SANITATION

Soap/cleanser use inside household

Soap used appropria tely yesterday	percentages	lb	ub	obs
0	81.2	76.3	85.3	316.0

1	18.8	14.7	23.7	73.0
Total	100.0			389.0

Effective water treatment

water_rx	Freq.	Percent	Cum.
0	18	8.91	8.91
1	172	85.15	94.06
2	9	4.46	98.51
3	3	1.49	100.00
Total	202	100.00	

Water treatment	percentages	lb	ub	obs
0	8.9	6.1	12.8	18.0
1	91.1	87.2	93.9	184.0
Total	100.0			202.0

Vitamin A

Vitamin A	percentages	lb	ub	obs
in past 6				
months,				
children				
age 6-23				
months				
0	11.1	7.1	16.9	28.0
yes	88.9	83.1	92.9	225.0
Total	100.0			253.0

Measles vaccination

Measles
vaccine,
children
age 12-23

months	percentages	lb	ub	obs
0	5.6	3.1	10.0	10.0
1	94.4	90.0	96.9	168.0
Total	100.0			178.0

DPT1 vaccine

DPT1 vaccine, children age 12-23

months	percentages	lb	ub	obs
0	22.5	16.8	29.4	40.0
1	77.5	70.6	83.2	138.0
Total	100.0			178.0

DPT3 vaccine

DPT3 vaccine, children age 12-23

months	percentages	lb	ub	obs
0	28.7	22.1	36.2	51.0
1	71.3	63.8	77.9	127.0
Total	100.0			178.0

FEEDING PRACTICES

Feeding + fluids while child is sick - fever

feeding same or more while fever

months	percentages	lb	ub	obs
0	53.8	42.6	64.6	64.0
1	46.2	35.4	57.4	55.0

	percentages	lb	ub	obs
Total	100.0			119.0

fluids				
same or more				
while				
fever	percentages	lb	ub	obs

0	37.0	27.7	47.4	44.0
1	63.0	52.6	72.3	75.0

Total	100.0			119.0

Feeding + fluids while child is sick - pneumonia

	percentages	lb	ub	obs
feeding				
same or more				
while				
pneumonia	percentages	lb	ub	obs

0	46.6	34.7	59.0	62.0
1	53.4	41.0	65.3	71.0

Total	100.0			133.0

	percentages	lb	ub	obs
fluids				
same				
while				
pneumonia	percentages	lb	ub	obs

0	36.8	28.3	46.3	49.0
1	63.2	53.7	71.7	84.0

Total	100.0			133.0

Feeding + fluids while child is sick - diarrhea

	percentages	lb	ub	obs
feeding				
same				
while				
diarrhea	percentages	lb	ub	obs

0	46.0	35.4	56.9	40.0
1	54.0	43.1	64.6	47.0
Total	100.0			87.0

fluids				
same				
while				
diarrhea	percentages	lb	ub	obs
0	36.8	27.2	47.5	32.0
1	63.2	52.5	72.8	55.0
Total	100.0			87.0

Appropriate minimum feeding practices
Breastfed children

min_foods	Freq.	Percent	Cum.
0	3	1.06	1.06
1	39	13.83	14.89
2	42	14.89	29.79
3	55	19.50	49.29
4	57	20.21	69.50
5	44	15.60	85.11
6	29	10.28	95.39
7	11	3.90	99.29
8	2	0.71	100.00
Total	282	100.00	

Minimum				
feeding				
practices				
-				
breastfee				
ding	percentages	lb	ub	obs
0	73.8	67.5	79.2	208.0
1	26.2	20.8	32.5	74.0
Total	100.0			282.0

Non-breastfed children

min_foods	Freq.	Percent	Cum.
1	1	2.33	2.33
2	4	9.30	11.63
3	6	13.95	25.58
4	7	16.28	41.86
5	13	30.23	72.09
6	10	23.26	95.35
7	1	2.33	97.67
8	1	2.33	100.00
Total	43	100.00	

Minimum	percentages	lb	ub	obs
feeding				
practices				
- not				
breastfee				
ding				
0	97.7	82.7	99.7	42.0
1	2.3	0.3	17.3	1.0
Total	100.0			43.0

DANGER SIGNS

Signs a child needs medical treatment

signs	Freq.	Percent	Cum.
0	29	7.46	7.46
1	116	29.82	37.28
2	102	26.22	63.50
3	93	23.91	87.40
4	36	9.25	96.66
5	8	2.06	98.71
6	4	1.03	99.74
7	1	0.26	100.00
Total	389	100.00	

Signs a
child |

needs	percentages	lb	ub	obs
0	37.3	32.2	42.6	145.0
1	62.7	57.4	67.8	244.0
Total	100.0			389.0

In the past 2 weeks, child showed danger signs and was treated

danger	Freq.	Percent	Cum.
0	182	46.79	46.79
1	70	17.99	64.78
2	39	10.03	74.81
3	47	12.08	86.89
4	22	5.66	92.54
5	28	7.20	99.74
6	1	0.26	100.00
Total	389	100.00	

Child with signs treated in health facility	percentages	lb	ub	obs
0	11.6	8.2	16.2	24.0
1	88.4	83.8	91.8	183.0
Total	100.0			207.0

DISEASE TREATMENT

Malaria treatment

Child with malaria treated	percentages	lb	ub	obs
0	84.9	73.6	91.9	101.0
1	15.1	8.1	26.4	18.0

Total | 100.0 119.0

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- ⁱ Comprehensive Council Health Plan 2006/2007, Karatu District Council, April 2006.
- ⁱⁱ Tanzania DHS 2004-5.
- ⁱⁱⁱ State of the World's Children – 2005. UNICEF. NOTE: To compute an adjusted maternal mortality ratio, UNICEF, WHO and UNFPA periodically evaluate government reports on maternal mortality and “make adjustments to account for the well-documented problems of underreporting and misclassification of maternal deaths.”
- ^{iv} “Maternal mortality in rural district of southwestern Tanzania: an application of the sisterhood method.” International Journal of Epidemiology 2000;29:107-112. 2000
- ^v Tanzania DHS 2006-10.
- ^{vi} The Tanzania DHS 2004-5 report breaks down the results for several indicators to the regional level. Karatu District is part of Arusha Region and while Karatu District is primarily rural, Arusha region also includes the City of Arusha, which had an estimated population of over 270,000 in 2002. It should be noted that there are several significant differences found when comparing the rural and urban populations in Tanzania.
- ^{vii} Tanzania DHS 2004-5.
- ^{viii} Tanzania DHS 2004-5.
- ^{ix} Weight-for-age measurements will be done of children under two as part of the project's baseline and final evaluation KPCs and the results will be discussed with the CHMT. (Reference the Rapid Catch indicators.)
- ^x MS/T 2000.
- ^{xi} Tanzania DHS 2006-10.
- ^{xii} “Report on Baseline Survey and Community Needs Assessment for Reproductive Health in Karatu District – Arusha Region” Marie Stopes/Tanzania. July 2000.
- ^{xiii} Human Development Report – 2005 – Country Fact Sheet for Tanzania. UNDP. 2005.
- ^{xiv} <http://hdrstats.undp.org/en/countries/profiles/TZA.html>
- ^{xv} Comprehensive Council Health Plan 2005/2006, Karatu District Council, March 2005.
- ^{xvi} Tanzania DHS 2004-5 and Tanzania DHS 2010.

Annex 7: CHW Training Matrix

Project Area	Type of CHW	Official government CHW or Grantee developed cadre	Paid or Volunteer	Number Trained over life of project	Focus of Training
Karatu District	Traditional Birth Attendants	Government	Volunteer	217	<ul style="list-style-type: none"> • Signs of pregnancy/danger signs during pregnancy, labor and delivery • Importance of attending ANC & PNC • Breast feeding • FP • Infection control/hygiene before and after birth • Referrals • Birth plans and preparation • Delivery and placenta management • Baby care after birth/clean cord care • Care of pregnant women • Immunization • PMTCT • Data management including village pregnancy register
Karatu District	Community Owned Resource Persons (CORPs)	Government	Volunteer	577	<ul style="list-style-type: none"> ▪ Child growth promotion and development ▪ Disease prevention ▪ Care seeking and compliance to treatment ▪ Advice/criteria for selecting practices at the community level
Mang'ola and Baray Wards	PHAST Facilitators	Government	Volunteer	30 at village level 4 at district level	<ul style="list-style-type: none"> • Making water safe to drink • Hand washing • Importance of building and uses of latrine • Handling of feces • Promotion of hygiene and sanitation behavior in the community • Protection of water sources • Community by laws to improve hygiene and sanitation
Mang'ola and Baray Wards	Child-to-Child Facilitators	Government	Volunteer	43	<ul style="list-style-type: none"> • Hand washing • Protection of water sources from pollution • Water treatment techniques • Dangers caused by the polluted water source

					<ul style="list-style-type: none"> • Toilets and their proper use
Karatu District	Survive and Thrive Group Facilitators	Grantee developed cadre	Volunteer	391	<ul style="list-style-type: none"> • Family planning • Breast feeding • Postnatal care • Antenatal care • Self employment/resource mobilization for establishing economic activities for sustainability
Karatu District and National	HBLSS Master Trainers	Grantee developed cadre/Government and NGO partners	Paid	16	<ul style="list-style-type: none"> • HBLSS dissemination skills • Safe delivery • First aid care • Referral
Karatu District	HBLSS TOT (Health Professionals)	Government	Paid	52	<ul style="list-style-type: none"> • HBLSS dissemination skills • Safe delivery • First aid care • Referral
Karatu District	HBLSS TOT (TBAs)	Grantee Developed cadre	Volunteer	99	<ul style="list-style-type: none"> • Safe delivery • First aid care • Referral
Karatu District	Village Level Surveillance Data Collectors	Grantee Developed cadre	Volunteer	172	<ul style="list-style-type: none"> • Management of morbidity and mortality surveillance records • Data collection, utilization of data in planning of health related programs/projects
Mang'ola Division	Hadzabe and Datoga Health Advocates	Grant developed cadre	Volunteer	34	<ul style="list-style-type: none"> • Leadership capacity building • Entrepreneurship capacity building • Promotion of hygiene/sanitation practices among DAHA • Disease prevention

Annex 8: Evaluation Team Members and Their Titles

Name	Title
<i>Consultant</i>	
Jean Meyer Capps	Team Lead
<i>USAID (2 days)</i>	
Dr. Raz Stevenson	Quality of Care and Services Delivery Specialist
<i>WellShare International</i>	
Nuru Abruhamma	National volunteer
Innocent Augustino	M & E Coordinator
Laura Ehrlich	International Program Director
Agustina Kinabo	Administrative Assistant
Veronica Mariray	MNC Assistant Manager
Harry Gaspar Massey	Training Coordinator
Jolene Mullins	Tanzania Country Director
Iscah Monday Ngukay	MNC Manager
Febronia Nicodemis	National volunteer
Joyce Panga	STG Coordinator
Honest Siril	Driver
Bertilla Tesha	Office Assistant
Silvery Tesha	BCC Manager
Flora Thomas	Office Assistant
<i>Other NGOs</i>	
Japhet Emmanuel	Country Director, CPAR
Evans Handi	Hifadhi Mazingira (HIMAKA)
Jeremia Joseph	Imani Focus Foundation
Gabriel Tango	
<i>Translator</i>	
Miriam Idi	

Annex 9: Evaluation Assessment Methodology

The Team Leader of the evaluation was an external consultant with extensive MNCH and c-IMCI experience hired by WellShare International and approved by USAID. The evaluation plan was based on the USAID CSHGP 2011 Final Evaluation Guidelines, developed collaboratively with WellShare's health program managers from their headquarters as well as the Tanzania office. The evaluation team was divided into four field teams with at least one member stakeholder representative of the team who was not employed by the WellShare CSP. These plans and schedule were shared with the DMO and other stakeholders. An HPN officer from the USAID Tanzania Mission joined the team for FGD field visits on two days.

The evaluation methodology included a mixture of quantitative and qualitative methods designed to triangulate findings and control for bias as much as possible.

Quantitative Methods

Wellshare conducted the KPC survey without external assistance several weeks in advance of the evaluation fieldwork which took place in early August 2011. Findings were tabulated and compared with the baseline KPC survey as well as LQAS monitoring data from program years during the lifetime of the project. Findings were also compared with the most recent available data including the 2009-2010 TDHS, CHMT annual data and the project's own HMIS. Although the Wellshare CSP had relatively few activities targeted towards clinical MNCH services, findings from Health Facilities monitoring data as well as the baseline and final HFA were used to assess the status of referral facility clinical IMCI and MNC services to provide a context for analyzing quantitative and qualitative findings.

Qualitative Methods

Field visits were made to 12 communities that ranged from highly successful, significantly challenged and relatively "typical" where some interventions were assumed to have been more successful than others. Based on the quantitative findings as well as factors specifically requested for comment in the Final Evaluation guidelines, the team developed Focus Group Discussion (FGD) tools consisting of open-ended questions designed to solicit opinions and feedback from project beneficiaries, as well as influential members of households and communities. These included:

- Pregnant women
- Mothers of children under 1 year of age
- TBAs
- CORPs
- VEOs
- Community Leaders (including Community Chairpersons)
- Health Workers
- Survive and Thrive Groups (unmarried mothers)
- Senior Women

To assess equity and gender impacts of project activities FGDs were conducted specific groups targeted for special attention by the project. They included:

- Survive and Thrive Groups (unmarried mothers under 25 years of age)
- Men
- Datoga and Hadzabe Development Association Members

Key informant interviews

- DMO
- District Head of Reproductive Health Services
- District Head of IMCI Services

Document Review

- Detailed Implementation Plan
- KPC and HFA Reports
- Midterm Evaluation Report
- Project Briefing Documents
- Media (Newspaper articles)
- Annual Reports
- Tanzania Demographic and Health Survey (2010)
- CHMT Annual Statistics Report
- CHMT Reproductive and Child Health Annual Report 2010
- Tanzania National Roadmap Strategic Plan to Accelerate reduction of Maternal, Newborn and Child Deaths, 2008-2015
- USAID Child Survival and Health Grants Program, Technical Reference Materials 2003-2008
- USAID Global Health Initiative Tanzania
- Tanzania Malaria Operational Report FY2011 (PMI)
- Tanzania National Malaria Control Program Plan
- Feed the Future Implementation Plan Tanzania 2010
- The Lancet, Child Survival Series, 2005

Results

Results of the quantitative and qualitative assessments were shared and discussed at a stakeholder's meeting that included representatives of local government, CHMT, Arusha Regional Health office, NGO partners and community representatives who all contributed to the consensus conclusions and recommendations. Data were compared to available regional and national surveys. The project manager visited the USAID office in Dar es Salaam to share the results and discuss ways that lessons learned and experience in the project can be used to contribute to other health and nutrition programs in Tanzania. Selected findings from the evaluation were shared at the CORE meeting in Washington, DC in October 2011

Focus Group Discussion Questionnaires

Focus Group Questionnaire for Mothers of Children under One Year

Village Name: _____ Date: _____

Interviewer(s): _____

Notetaker(s): _____

1. Has anything changed with regard to the health of mothers and small children since WellShare/Minnesota started working in your community?
2. (*Interviewer Prompt: Go around in a circle and ask the mothers how old their babies are.*)
3. What are you currently feeding your baby? (*Record responses along with the age of the mother's baby determined from Question 2.*)
4. In your opinion, is breastmilk alone enough for a child under six months?
 Yes
 No
 - a. If no, what other foods/liquids should a baby under 6 months of age receive?
5. At what age is the right time to introduce additional (complementary) foods/liquids to the baby?
6. Why do you think some mothers who have children under six months of age introduce additional foods?
7. When a baby is born, sometimes he/she is not given the breast right away. Do you have any ideas why that might be?
8. Sometimes babies are given something other than the breast when they are born. What are they given? Why are they given something other than the breast?
9. What food would you give your child if he/she was sick?
10. Should you give the same amount, less or more?
11. What fluids would you give your child if he/she was sick?
12. Should you give the same amount, less or more?
13. For the child who is eating solid food, how many times per day should you give the child food?
14. We have heard that more mothers that want to space their children are using contraceptives. Why do you think more mothers are using family planning?

15. What makes it easier for a mother to use contraceptives than before?
16. Which contraceptives do you think women prefer to use?
17. After you bring the water into the house, do you do anything to the water before you use it for drinking?
 - a) If yes, what do you do to the water?
 - b) If no, why not?
18. Did the TBA help you when you were pregnant or after you delivered?
 - a) If yes, how did the TBA assist you?

Focus Group Questionnaire for Pregnant Women

Village Name: _____ Date: _____

Interviewer(s): _____

Notetaker(s): _____

1. Has anything changed with regard to the health of mothers and small children since WellShare/Minnesota started working in your community?
2. What are the reasons to go for antenatal care during pregnancy?
3. Have you (all) been to antenatal care? ____ Yes ____ No
4. When you go for antenatal care, what services do you receive? (*Prompt: "Is there anything more?"*)
5. How many antenatal visits do you think a pregnant woman should make? (Record range of responses from the group.)
6. When should a pregnant woman first go for antenatal care?
7. When did you (all) first go for antenatal care?
8. Why do you think many women do not go for antenatal when they first notice they are pregnant?
9. Do you know when you will deliver your baby? (Record the range of responses from the group.)
10. What should a woman do to prepare for her baby's birth?
11. Have you done anything yet? (*Record the range of responses from the group.*)
12. If yes, what kinds of things have you done?
13. Where do you plan to deliver? (*Record the range of responses from the group.*)
 - a. If at home, why have you decided to deliver at home?
 - b. If at a health facility, why have you decided to delivery at a health facility?
14. In this community, if a woman like you has a danger sign and she needs to urgently go to the hospital, what could she do?
15. Did you get any advice about what you should do during pregnancy to have a healthy baby?

16. Where did you get this information?
17. What do you plan to feed your new baby after it is born? (Probe: “Anything else?”)
18. When do you plan to do that for the first time?
19. When do you plan to introduce porridge to your baby?
20. After the baby is born, when is the first time you should go back to the clinic?
21. After you bring the water into the house, do you do anything to the water before you use it for drinking?
 - a. If yes, what do you do to the water?
 - b. If no, why not?
22. Did the TBA help you when you were pregnant or after you delivered?
 - a. If yes, how did the TBA assist you?

Focus Group Questionnaire for Survive and Thrive Groups

Village Name: _____ **Date:** _____

Interviewer(s): _____

Notetaker(s): _____

1. Has anything changed with regard to the health of mothers and small children since WellShare/Minnesota started working in your community?
2. When was your STG group formed?
3. How many members do you have?
4. How often do you meet?
5. What activities does your STG do?
 - a) If health topics, what are the health topics you discuss/learn?
 - b) Do you do activities other than health education?
 - c) What are they?
6. Has any of these health or other topics or activities been helpful for you personally?
 - a) If yes, in what ways have they been helpful?
7. Is there anything else you would like to tell us about the work WellShare/ Minnesota has done with you?
8. When the WellShare/Minnesota project ends, will you continue your STG?
 - a) What will help your STG continue?
 - b) Is there any place else (other than WellShare/Minnesota) from which you are getting support?

Focus Group Questionnaire for Fathers of Children under Five Years of Age

Village Name: _____ **Date:** _____

Interviewer(s): _____

Notetaker(s): _____

1. Has anything changed with regard to the health of mothers and small children since WellShare/Minnesota started working in your community?
 - a) If positive change has occurred, why do you think this change has occurred?
2. Please tell us the danger signs during pregnancy when a woman needs to go to the health facility.
3. Please tell us the danger signs in children when a child needs to go to the health facility.
4. Please tell us the critical times when a person should wash their hands?
5. Do you treat the water in your house?
 - a) If yes, how do you treat your water?
 - b) If no, why do you not treat your water?
6. Do you know what newborns should be fed?
 - a) When should newborn feeding start?
7. What should a man do to support the care of his pregnant wife?
8. What should a man do to support the care of his child/children?
9. How many children are ideal to have in a family?
10. We know that more women are using contraception to space their children. Do you have any ideas why this has changed?
11. What is your perception of women in your community who use family planning?

Focus Group Questionnaire for TBAs

Village Name: _____ Date: _____

Interviewer(s): _____

Notetaker(s): _____

1. Has anything changed with regard to the health of mothers and small children since WellShare/Minnesota started working in your community?
2. Were you trained by WellShare/Minnesota in safe delivery?
3. What were the major things you were taught?

Interviewer: Ask to review the village pregnancy register. Check to see if the register is fully completed. Please note the status of the register below.

If the register has sections that are not completed, ask:

- a. Are there parts of this register that are difficult to fill in? If yes, please explain why it is difficult to fill out.
4. Were you trained in HBLSS?
 - a. Please tell me how you use HBLSS.
 - b. What parts of the HBLSS training are most helpful?
 - c. What parts of the HBLSS training are less helpful?
5. Has the way you are assisting women in your community changed since the beginning of WellShare's project?
 - a. If yes, how has it changed?
6. Did you change the way you are assisting women because of the training you received from WellShare?
 - a. If yes, what parts of the training helped you do things differently?
7. When do you advise mothers to go for their first antenatal care visit?
8. Where do you recommend mothers to give birth?
 - ___ Home
 - ___ Health Center/Dispensary
 - ___ Hospital

9. When do you advise women to return to the clinic after you have given birth?
10. What advice do you give mothers about when to start breastfeeding?
11. What advice do you give to mothers about family planning?
12. Do you talk with men about pregnancy, delivery and child health?
 - a. What activities do you do?
 - b. What topics do you cover?
 - c. Describe how the information has been received by the men in your community.
13. Do you receive support from any of the following (*Interviewers: probe for answers*):
 - a) Dispensary
 - b) Health centre
 - c) Hospital
 - d) VEO
 - e) VHC
 - f) Community members
 - g) Other village leaders _____ (specify)
 - h) Other TBAs
 - i) Church leaders _____ (specify)
 - j) None
 - a. How would you describe the support?
 - Very good
 - Good
 - Poor
 - b. What kind of support do you receive?
14. How is your relationship with health facility staff?
15. What kind of support does the health facility provide to you?
16. What kind of support do you receive from local government or the community?
17. Are you a member of the village health committee or village health management committee?

Focus Group Questionnaire for CORPs

Village Name: _____ Date: _____

Interviewer(s): _____

Notetaker(s): _____

1. Has anything changed with regard to the health of mothers and small children since WellShare/Minnesota started working in your community?
2. What is your profession?

<i>Interviewer: List the profession for each CORP.</i>	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

3. When did you complete your c-IMCI training?
4. What are your responsibilities with regards to the health of mothers and children in your community? (*Interviewer: Probe for additional responses.*)
5. What topics were you trained in?
 - a) Were you trained in household treatment of water?
 - b) What were you trained to do in household treatment of water?
6. Did you receive any job aides?
 - a) What were the job aides you received?
 - b) What do you think has been helpful or not helpful?
7. How many home visits did you make in July?

<i>Interviewer: Fill in the number of home visits made by each CORP in July</i>									
1	2	3	4	5	6	7	8	9	10

8. At how many community meetings have you provided health information since you finished your c-IMCI training?

<i>Interviewer: Fill in the number of community meetings facilitated since CORPs finished c-IMCI training</i>									
1	2	3	4	5	6	7	8	9	10

9. Who supervises your work in c-IMCI?

a) How often do they provide supervision to you?

10. Do you think c-IMCI training has benefited your community?

a) If yes, how has it benefitted your community?

11. Do you receive any support for your work as a CORPs from the community?

a) What support do you receive?

12. How do you feel about your work as a CORPs?

13. What challenges do you have in carrying out your work in c-IMCI as a CORPs?

14. Can you give a specific example (e.g. success story) how your work as CORPs has benefitted the community?

Questionnaire for VHC / VHMC

Village Name: _____ **Date:** _____

Interviewer(s): _____

Notetaker(s): _____

1. Has anything changed with regard to the health of mothers and small children since WellShare/Minnesota started working in your community?
2. How many members are on the committee?
3. How many men? How many women?
4. Who is represented on the committee (e.g. profession, position)?
5. Did WellShare assist you in helping form or improve the VHC?
6. If yes, what did WellShare assist with?
7. How often does the VHC meet?
8. Does the VHC keep minutes?
9. What health events has the VHC supported in the past three months? (Interviewer probe: What was the topic or focus?)
10. Does your VHC have an emergency transportation plan?
 - a) How does it function?
11. What are some of the major health accomplishments of the VHC?
12. What are some of your major challenges?

Questionnaire for VEO

Village Name: _____ **Date:** _____

Interviewer(s): _____

Notetaker(s): _____

1. Has anything changed with regard to the health of mothers and small children since WellShare/Minnesota started working in your community?
2. What are your major responsibilities with regard to the health of mothers and children in your village?
3. What do you do to supervise CORPs?
4. What do you do to supervise TBAs?
5. Do you receive monthly reports consistently from the CORPs you supervise?
6. What are the main issues in your community brought up by the CORPs?
7. In your opinion has the training provided to CORPs been effective in helping them do their work?
8. In your opinion has the training provided to TBAs been effective in helping them do their work?
9. Have your responsibilities in supervising the CORPs and the TBAs had an effect on your workload?
10. Have you completed your village action plan?
 - a) Why or why not?
 - b) If completed: Does the village action plan include mother and child health-related activities?
 - c) If completed: Describe what mother and child health-related activities you have included in your action plan?
 - d) If completed: Describe what mother and child health-related activities you have achieved as part of your action plan.
 - e) If completed: Describe what challenges have you encountered in implementing mother and child health-related activities.

Annex 10: List of Persons Interviewed and Contacted During the Final Evaluation

Name	Title	Location
Dr. Lucas Kazingo	District Medical Officer	Karatu Town
Sr. Hasina Sandewa	District Reproductive and Child Health Coordinator	Karatu Town
Dr. Robert Tello	Acting District Medical Officer, District Home Based Care Coordinator	Karatu Town
Mr. Mather Sedoyeka	District Commissioner	Karatu Town
Mr. Momoya	Chairperson, Datoga and Hadzabe Development Association	Mang'ola
Village Chairman		Bassodawish
Village Chairman		Kambi ya Simba
Village Chairman		Jobaj
Village Chairman		Changarawe
STG Members		Bassodawish
STG Members		Kambi ya Simba
STG Members		Jobaj
STG Members		Changarawe
Village members		Bassodawish
Village members		Tloma
Village members		Kambi ya Simba
Village members		Kainam Rhotia
Village members		Ngaibara
Village members		Buger
Village members		Laja
Village members		Changarawe
Village members		Makhromba
Village members		Maleckchand
Village members		Qangded
Village members		Laghangarere

Annex 11: Special Reports

(See attached.)

WellShare International | Tanzania Child Survival Project (2006-2011)

Survive and Thrive Groups: Providing Young Women with Alternatives

Background/Objectives

In rural Tanzania the average age of first pregnancy is 16. Young single mothers may be shunned by their families and communities. Because they become pregnant at such a young age, they are at increased risk for STIs and HIV, complications in pregnancy, and higher maternal and infant morbidity and mortality.

Being forced to leave school during their pregnancy, they often lack higher (secondary) education and skills to provide for themselves and their infants. As a consequence, the health and nutritional status of the mother and the child suffers. In desperation, mothers may abandon their babies and seek work in the towns and plantations, placing them at an even risk of additional unplanned pregnancies, physical and emotional abuse, HIV/AIDS and other sexually transmitted infections.

“I was very young when my baby was born. I did not know how to take good care of him. The STG helped me very much. The group helped me take better care of my baby and myself.

Young mother.
Endamaghan

These young women are in need of appropriate health education and peer support to have the most positive pregnancy outcome. They must be supported by their families and communities at this most challenging time, and be encouraged and supported in their quest to either return to school or find an alternative route to provide care and support to their child.

WellShare designed the Survive and Thrive Group intervention to meet the needs of these young women within their communities. The selection of project-trained Traditional Birth Attendants (TBAs) to facilitate these groups was made to provide the members with a respected community mentor and advocate.

In addition, the project partnered with micro-finance programs to provide the necessary financial literacy, skills and resources, to enable the members to support themselves, their families and become respected and contributing members of their community. It is well known that financial stability allows women heads of household to expand their opportunities and increases their access to improved healthcare, education and standard of living. Families with dependable income have better health and nutritional status, the ability to support their children and send them to school, and ultimately an increased capacity and confidence to take control of their lives.

Implementation

Under the supervision of WellShare’s Maternal and Newborn Care Manager and Assistant Manager, the Survive and Thrive Group Coordinator worked with project trained TBAs to assist women to take charge of their own health care by empowering them with knowledge and improving their access to care. The intervention’s primary focus was improved maternal and newborn health with bi-weekly meetings covering a variety of health topics including the prevention of infectious diseases (malaria, diarrheal disease and pneumonia) as well as the

prevention of mother-to-child transmission of HIV, family planning/child spacing, antenatal care, safe delivery, immediate and exclusive breastfeeding, post-partum care including newborn care, and nutrition.

In addition, group members were introduced to income generating activities of their choosing (including sewing, baking, animal husbandry, etc.) and microfinance utilizing the VICOBA model. WellShare received technical assistance from ORGUT-SEDT in the introduction of the VICOBA model of village-based savings and loan scheme. The model assists in the provision of materials and resources, but all funds available for the implementation of the various loan programs (small business, school and healthcare) come from weekly contributions of group members.

A key implementation factor was strong support of each village's leadership including the Village Executive Officer. Villages provided meeting space along with other types of support.

Results/Conclusions

The Survive and Thrive Group model successfully enable its members to improve their knowledge and health-seeking behaviors as well as their income and community status. The table below shows the various groups formed, their membership and key activities.

Village	Membership	Activities
Malekchand	16	Sewing; baking; VICOBA
Lagangareri	13	Sewing; baking; VICOBA
Kambi ya Simba	25	Baking; sewing; plant nursery; restaurant
Changarawe	23	Animal husbandry
Jobaj	16	VICOBA; individual businesses
Makhoromba	13	VICOBA
Oldeani (2 groups)	39	STG training
Ayalabe	22	Agriculture
Kainum Rhotia	25	Sewing. Agriculture
Mikocheni	14	Animal husbandry; agriculture
Endamaghang	21	Animal husbandry; agriculture
Qaru	33	Animal husbandry; agriculture
Khusumay	12	STG training
Endonyawet	13	Sewing; agriculture
Laja	19	Dawa donkey; weaving
Endamarariiek	20	Restaurant
Bassodawish	17	Restaurant, animal husbandry
N'gaibara	16	Weaving
Endashangwet	22	Animal husbandry
Dumbechand	13	STG training, VICOBA (with Jobaj)
Karatu (UMATU)	75	Sewing, baking, knitting
TOTAL	467	

Membership in Survive and Thrive Groups differed from village-to-village and group-to-group depending on the activities taking place in the group and group dynamics. It was found that women's groups were not common in the project area, especially among young women. The creation of stable, sustainable groups based on pregnancy status was a new idea, which was supported by village leaders, but at varying degrees. For example, the women of Kambi ya Simba were so successful with their income generation activities (i.e. baking and plant nursery) that village leaders provided them with free land in the village center for their horticultural activities and a village building for their baking/tea shop. The women of Kainam Rhotia, Laghangarere and Malekchand are currently operating successful tailoring business as well as the baking of breads at the community level. The items sewn by many of the Survive and Thrive Group members (including bags, tablecloths/napkins and aprons) have been sold at the tourist hotels of Karatu and Moshi.

WellShare International | Tanzania Child Survival Project (2006-2011)

Alternative Transport: The Dawa Donkey

Rationale

WellShare International's Tanzania Child Survival project worked hard to ensure that women were aware of the danger signs associated with pregnancy. Unfortunately, knowledge is not enough. When the unexpected happens and there is a need for emergency care, access to transportation to the nearest staffed and equipped health facility is essential.

In 2007, Karatu district had one ambulance to provide services to a population of approximately 250,000 scattered over an area of covering 2,500 square km. This single vehicle was responsible for providing 24 hour on-call services for 45 villages and was used as a transport vehicle for distribution of medical supplies, ferrying the District Council Health Management Team for monitoring and supervision and utilization by the District leadership when necessary. One ambulance was simply not enough. In the early days of WellShare's project, the district was permitted to charge a fee for the use of the ambulance to cover fuel costs and maintenance. This policy changed in 2010.

"I was told it would cost me TSh 140,000 for the ambulance to take me to the hospital. I did not have the money and so I went home to die

Young mother,
Mbuga Nyekundu village

Recognizing the great need for affordable, appropriate and low-tech transportation for the most remote villages, which was reliable and culturally acceptable, WellShare International designed the "Dawa Donkey" cart ("*dawa*" is the Kiswahili word for medicine). The use of draft animals for transportation is not new; however, the use of donkeys for carrying patients needing medical services was new to the people of Karatu District.

Implementation

Villages were selected for the "Dawa Donkey" project based on the needs of the community, access to health care services, presence of project-trained Traditional Birth Attendants (TBAs), knowledge of animal husbandry/availability of donkeys and the commitment of village leadership to support the care and maintenance of the cart.

The "Dawa Donkey" cart was designed in association with a mechanic and a veterinarian. Manufactured using metal to replace the traditional wooden cart structure for the hauling of goods and supplies, the cart was designed with a suspension system to provide maximum comfort and flexibility and utilized motorcycle wheels and axle to provide good navigation on rough roads. The cart is designed to safely carry the patient (in a prone or sitting position), an attendant and the "driver". The cart is outfitted with a mattress, canvas cover (removable) and a first aid kit. The harnessing was designed to be "animal friendly" and can be rearranged for one or two donkeys.



The community selected for the piloting of the “Dawa Donkey” cart, Laja, was the most isolated village with the nearest health facility approximately 10 km away. Community meetings including community members, TBAs and village leaders were held to discuss the utilization of the cart and care and maintenance. It was decided that the TBAs would have direct oversight to the



“Dawa Donkey” cart with patient, 2011

cart and that the village would provide support in the maintenance and servicing of the cart. No fee for the utilization of the cart would be charged. Laja residents identified three teams of donkeys to be trained on the pulling of the cart. The care and maintenance of the cart, as well as the care and feeding of the donkeys were the primary contributions of the community.

Following three months of utilizing the cart, the wheel and axle system was redesigned and the hinges on the rear of the cart were reinforced. The village also requested additional carts for the hauling of water and general goods. These carts were donated with the understanding that the fees for renting these carts would be used for the care and maintenance of all carts including the “Dawa Donkey.”

Results/Conclusions

Laja TBAs utilize the cart approximately three times per week to transport patients to the nearest health center. They have found that some women fear the use of the cart and are hesitant to utilize it at night on rough roads. The TBAs now use the cart during the daylight hours for transporting patients including pregnant women and anyone who is ill.

In 2009, the village completed construction on a new health facility and staff quarters. They are currently awaiting staff and equipment. The community plans to continue using the “Dawa Donkey” cart to transport patients from neighboring sub-villages, some as distant as 5 km, when their dispensary opens.

Following successful piloting of the first “Dawa Donkey” cart, two additional villages received carts in 2011. Kainum Rhotia (8 km from the nearest health facility) and Endamaghan (12 km from the nearest health facility) received their carts in November 2011.

WellShare International | Tanzania Child Survival Project (2006-2011)

Support to the Disenfranchised: The Hadzabe Tribe

Rationale

The Hadzabe people of Karatu District live around the Lake Eyasi Basin in the southwestern part of the district. They are reported to be the last remaining ancestors of the original hunter-gatherer tribes who first inhabited Tanzania approximately 10,000 years ago. The Hadzabe are persevering and very skilled hunters and gatherers. Their traditional living conditions, including the use of traditional healers and untrained birth attendants, not habitating in structured houses and limited access to health services have resulted in an undocumented high infant and maternal mortality rate and low life expectancy. In addition, because of their unique culture they also have garnered the interest of tourist and have begun to adopt habits that are having a negative impact on their health including smoking, alcohol and drug use, and unprotected sex with multiple partners. It is currently estimated that the Hadzabe population of Karatu District is between 3,000 and 5,000.

During WellShare International's Tanzania Child Survival Project baseline knowledge, practice and coverage survey, leaders of the Hadzabe Tribe were interviewed. They discussed their tribal priorities which did not include health. Addressing the health needs of the Hadzabe people was not a priority in the district.

The last few years of the project were characterized by drought conditions, further reducing the wild animal population along with the plants, berries and honey on which the Hadzabe depend. Men wander farther for hunting. Small animals sustain them for the hunt, and they only return when a larger animal is killed. Left behind are women, children and older men who experience chronic hunger or starvation conditions.



Discussion of community health issues with Hadzabe/Datoga leaders, DAHA members, WellShare International and FAME-Medical, 2010

Implementation

WellShare International Tanzania continued to meet with tribal leaders following the baseline survey, as appropriate, and began to work closely to mentor a new civil society organization, the Datoga Hadzabe Development Association (DAHA). Through WellShare's work and support of



WellShare International’s Country Director, Jolene Mullins, listens to Hadzabe and Datoga women discuss their most important health issues, 2010

DAHA, strong ties and trusted relationships were fostered with the Hadzabe people. In 2010, WellShare was asked to train community health advocates in key maternal, newborn and child health areas (including malaria, diarrheal disease and pneumonia) as well as nutrition, HIV and sexually transmitted infections and tuberculosis. These key areas were identified by the Hadzabe as their greatest health needs.

WellShare International has worked closely with the leaders of DAHA to begin to address the most key health issues, sexually transmitted infections and HIV/AIDS, prevention of malaria, diarrheal disease, pneumonia and maternal and

newborn care through the training of 15 “Health Advocates” and tribal elders. The project created culturally appropriate job aids for the health advocates and provided training in three languages: Kiswahili, Hadzabe, and Datoga.

In addition, WellShare was instrumental in bringing outreach health services to the Hadzabe and Datogo people through collaboration with a U.S.-based non-governmental organization, FAME-Medical. FAME-Medical provides monthly medical outreach services to remote areas of the district in collaboration with WellShare trained community members and the District Council Health Management Team.

Results/Conclusions

The 15 project-trained Health Advocates remain active and provide information during family/household visits and monthly community gatherings including DAHA meetings. The Health Advocates are recognized by the tribal leaders and are given time during community gatherings to provide information on health and referral services and answer questions. They are closely linked to FAME-Medical and are used to provide information during mobile outreaches as well as mobilize community members to access services. They have provided hundreds of hours of service to their communities and have provided information to the over 50% of Hadzabe and Datoga families/households.

During community focus group discussions and key informant interviews held during the final evaluation, it was found that knowledge of key health dangers signs was high among community members and the community health advocates continue to provide education at the individual, family and household level. Access to health services is increasing with the expansion of mobile outreach services and the recruitment of health staff for area health facilities. Unfortunately,

community members have identified some discrimination in their access to services and reported that mothers were asked to pay for health services which should be free based on government policy. This was discussed with the Ward and Village level leaders, the District Health Management Team and DAHA leaders.

The use of the leadership of DAHA to facilitate the project's entrance into the community has enhanced WellShare's ability to access this community and to provide life saving information. The collaboration of the government and non-governmental sector in the expansion of services to this underserved and disenfranchised group has been essential to the provision of services to this community.

WellShare International | Tanzania Child Survival Project (2006-2011)

Community level data collection: Village Level Pregnancy Register

Background and Objectives

The collection of valid, reliable data is essential to determining the health needs of a community, district, region and nation. Tanzania's health data is primarily facility-based information collected quarterly during monitoring and supervision visits. This data is reported using complex tools including the government's MTUHA books, donor checklists and reporting forms, and community surveillance data. The analysis of this data is made at the district, region and national level with few opportunities for communities to access the data for planning purposes.

"Not a single mother or baby has died in this village during the pre and post natal period since the project began in 2007. We know this because we now have the data book."

Village Executive Officer,
Lagangarare Village

Community-level data of key maternal and newborn care (MNC) indicators including access to pre- and post-natal services, maternal and child mortality and post-partum care is difficult to collect since many women utilize the services of Traditional Birth Attendants (TBAs) with approximately half (50%) of women delivering their babies at home with an unskilled birth attendant.

To determine the impact of WellShare International's Tanzania Child Survival Project's activities on key MNC indicators, a Village Level Pregnancy Register (VLPR) was designed, piloted and implemented in 45 villages of Karatu District.

Forty-two key indicators were tracked at the community level by project-trained TBAs from the first encounter with the pregnant women to 42 days post-partum. The VLPR also serves as a birth register at the village level.

Implementation

The VLPR was designed to include key MNC indicators as required by the Ministry of Health and Social Welfare (MoHSW) as well as key project related indicators.

A draft version of the VLPR was designed in collaboration with the Karatu District Health Management Team's Reproductive and Child Health Coordinator and was introduced to seven pilot villages in 2008. Pilot villages were selected to represent areas with and without health facilities, and health facility staff and TBAs from the pilot villages received training in the use of the tool as well as the summary of data for collection monthly (initially) and quarterly (thereafter). Following the initial six months of implementation, revisions were made in the tool and an additional 10 villages were added to the pilot area. At this time, training in the VLPR was incorporated into on-going project TBA training and on-site supportive supervision activities. During data collection, TBAs reviewed the tool with challenges identified and addressed.



TBA learns to use the VLPR during training, 2009

To ensure the quality of data collected, a random sample of 10% of women in the register were visited and interviewed by project staff and their responses were checked against those recorded in the VLPR. The quality assurance activities also included a review of Reproductive and Child Health Cards (RCH Cards) when available.

By November 2010 all villages in the project area had at least two trained TBAs and all TBAs had been introduced to the VLPR. In villages with a health facility, the VLPR has been kept at the health facility. The District Health Management Team collects this data during supportive supervision and includes much of the data in the annual RCH Report. In villages without health facilities, TBAs have selected a lead TBA to maintain the VLPR and provide information to the village leadership.

In November 2009, WellShare International was invited to give an oral presentation on the VLPR at the annual conference for the American Public Health Association in Philadelphia, PA and at the annual conference of the Tanzania Public Health Association in Dodoma, Tanzania.

In November 2010, WellShare International was invited by the Zonal Health Management Team for the Northern and Central Zones to present on the VLPR and to provide technical support in the expanded use of this tool to other regions and districts.

Results/Conclusions

From the initial piloting of the village level pregnancy register to the end of the project, approximately 2,000 women have been followed, with more than 80% tracked through 42 days post partum. The data below provides village level maternal and newborn data which would not have been available utilizing facility level data collection tools.

Of note, quality assurance interviews and RCH Card reviews showed 98% accuracy of the data reported in the VLPR.

Key Pregnancy Register Data Indicators (5/08-6/11)

Prevention in Pregnancy	(%) n=1850
Pregnant woman attended at least 1 ANC visit	100%
Pregnant women attended 4 or more ANC visits	68.1
Pregnant woman received 2 or more TT doses	72.1
Pregnant woman received 1 st dose anti-malarials during pregnancy	100%
Pregnant women received 2 nd dose anti-malarials during pregnancy	70.8
Delivery	n=1537
Baby born at health facility	78.5%
Baby received clean cord care	99%
Baby received immediate drying and wrapping	99%
Baby received immediate breastfeeding	99%
Maternal/Birth Outcomes	n=1537
Premature birth	26 babies
Still birth	12
Mother/infant visited within 72 hours post partum	100%
Baby died before 28 days after birth	7
Mother died before 28 days after birth	3

WellShare International | Tanzania Child Survival Project (2006-2011)

Water, Sanitation and Hygiene Project: Man'gola and Baray Wards, Karatu District

Background and Objectives

Ingenieria sans Fronteras (ISF; *Engineers Without Borders*) implemented a water and sanitation project in Mang'ola and Baray Wards of Karatu District for approximately seven years. At the completion of their project in 2008, the final evaluation findings noted: 1) communities had not been fully sensitized to the project 2) water user associations and project-trained PHAST facilitators required refresher training, and 3) the District had not taken ownership of the project to ensure sustainability. In 2009, WellShare International contracted with ISF for a one-year extension of project activities. Based on ISF's strategies, key activities included:

1. Refresher training for active Participatory Hygiene and Sanitation Transformation (PHAST) facilitators and identification of new facilitators as needed
2. Training of PHAST master trainers for the Karatu District Council
3. Incorporation of project activities into the District Council's Comprehensive Health Plan and Water and Sanitation Plan
4. Training of master teachers at 8 primary schools in the Child-to-Child curriculum and creation of 8 Child-to-Child clubs
5. Review of existing community hygiene and sanitation by-laws with community meetings held to discuss enforcement of these laws

These key project activities enhanced the existing Tanzania Child Survival Project activities focusing on the prevention of diarrheal disease.

Implementation

WellShare employed a Project Manager for the duration of the ISF project and hired a lawyer to consult on the review of village-level hygiene and sanitation by-laws and to provide village council and community education on the enforcement of the by-laws.

To ensure sustainability of the Child-to-Child program, WellShare introduced the curricula to the teachers associated with school-based health and hygiene clubs. These clubs are standard in all schools and are in need of support and additional activities to encourage student participation. During the year of project implementation, WellShare sponsored a Hygiene and Sanitation Day in coordination with the Day of the African Child, which provided prizes to participating schools with students presenting songs, dramas, poems, etc. Each school was presented with hand washing stations and the winning school receiving a 5,000-liter water storage tank.

WellShare identified active PHAST facilitators and worked with the community and water user associations to develop a system of support for these community volunteers. In areas with no active PHAST facilitators, WellShare-trained Community Owned Resource Persons (CORPs) were identified by the community to fill these positions. Additional training was provided to these individuals.



Breaking the chain of diarrheal disease messages were painted on the walls of each participating primary school, 2010.

The District Water and Sanitation Management Committee was selected to provide training and support to the PHAST Facilitators. Five members of this committee received training as master trainers in PHAST.

Through close collaboration with the District Council Health Management Team, the District Education Office and the District Water and Sanitation Management Team, WellShare was able to lobby for inclusion of project-related activities into the district’s annual comprehensive plans.

Through close collaboration with the District Council Health Management Team, the District Education Office and the District Water and Sanitation Management Team, WellShare was able to lobby for inclusion of project-related activities into the district’s annual comprehensive plans.

Results/Conclusions

Baseline (N=50) and final (N=310) surveys were conducted using LQAS sampling methods to assess project outcomes. Key findings are presented below.

Latrine coverage and use

Overall, 72% of respondents interviewed at final had latrines for their households.

Village	Percent of households reporting latrines (%)
Qangdend	61
Malekichand	72
Mangola Barazani	64
Mbuga Nyekundu	90
Jobaj	73

In addition, 16% of respondents reported that they share latrines. A total of 42% of respondents reported that their latrines were built during the life of the project.

Community education/mobilization

- At final, respondents noted that they had received education and information on the promotion of hygiene and sanitation with 88% (274/310) stating that they benefitted from the education activities compared with only 31% at WellShare's baseline in September 2009.
- At final, 83% of respondents agreed that they had benefitted from the project's information, education and trainings. Respondents noted that they had perceived a change in behavior at the community level with increased participation in the promotion of hygiene and sanitation.
- At final, 77% of respondents reported that they had received information and education at community meetings held at sub village and village level. In addition, 12% of respondents reported that they had been visited in their household by a PHAST facilitator.
- At final, 87% of the respondent (269/310) had heard health messages from January 2010 to May 2010 compared to only 1.7% reporting that they had heard health messages in 2009.

Water source and treatment

- At final, 85% of respondent (262/310) reported that they were collecting water from distribution points compared to 8% at baseline. At final, 10% reported collecting water from the water channel (*Mfereji*) and 6% reported collecting water from springs compared to 7% and 5% at baseline.
- More than half of respondents (52%) reported treating water before drinking at final compared to 22% of respondents at baseline. At final, methods of treatment included boiling (39%) and using WaterGuard (56%).

Behavior change hand washing practices

The final survey showed that 95% (295/310) of respondents wash their hands before eating and 54% (167/310) wash their hands following farm work (including fumigation, weeding, and harvesting root crops). In addition, 45.88% (142/310) respondents reported washing their hands after using the toilet, 43.35% after cleaning a baby, 11.5% before cooking and 6.4% wash their hands after cooking.

Hand washing Indicator	Baseline	Final	% Change
Before eating	84	95	+11
Following work	16	54	+38
After toileting	16	46	+30
After changing baby	12	43	+31
Before cooking	22	12	-10
After cooking	2	6	+4

Community understanding of hygiene and sanitation by-laws

The review and enforcement of existing hygiene and sanitation by-laws was deemed an essential component in the sustainability of project activities following the end of interventions.

Awareness and community understanding of existing hygiene and sanitation by-laws and individual perceptions of the enforcement of these by-laws were assessed during the final survey. The following chart shows the reported understanding of existing by-laws from baseline and final survey:

Understanding of by-laws	Baseline	Final	% change
Good	14	75	+61
Fair	60	21	-39
Poor/low	20	0	-20
Do not know	6	4	-2

Child Survival and Health Grants Program Project Summary

May-07-2012

Minnesota International Health Volunteers (Tanzania)

General Project Information

Cooperative Agreement Number: GHS-A-00-06-00021
MIHV Headquarters Technical Backstop: Laura Ehrlich
MIHV Headquarters Technical Backstop Backup:
Field Program Manager: Jolene Mullins
Midterm Evaluator: Richard Crespo
Final Evaluator: Jean Capps
Headquarter Financial Contact: Laura Ehrlich
Project Dates: 10/1/2006 - 12/31/2011 (FY2006)
Project Type: Standard
USAID Mission Contact: Andrew Rebold
Project Web Site:

Field Program Manager

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Alternate Field Contact

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Grant Funding Information

USAID Funding: \$1,500,000 **PVO Match:** \$519,321

General Project Description

Wellshare International (previously MIHV), a 2006 Standard category grantee, is implementing the *Tanzania Child Survival Project* in Karatu District, Arusha Region, Tanzania. The project goal is to improve the health of children under five years and women of reproductive age by focusing on maternal and newborn care, child spacing, and common childhood illnesses.

The project will use a multi-pronged approach at the community level to: (1) establish and strengthen government-mandated village-level health cadres and institutions; (2) engage and train traditional health care providers (e.g., traditional birth attendants and drug vendors); and (3) create new community groups for especially vulnerable segments within the project's beneficiary population (e.g., single mothers and transport drivers).

Key activities include training health worker and community cadres in community integrated management of childhood illnesses (C-IMCI), home-based life-saving skills (HBLSS), maternal and newborn care (MNC) and reproductive health (RH); behavior change communication (BCC) and information, education, and communication (IEC) campaigns; and Healthy Mothers/Healthy Babies centers at local health centers.

Project Location

Latitude: -3.33	Longitude: 35.67
Project Location Types:	Rural
Levels of Intervention:	District Hospital Health Center Health Post Level Home Community
Province(s):	Arusha Region
District(s):	Karatu District
Sub-District(s):	--

Operations Research Information

There is no Operations Research (OR) component for this Project.

Partners

American College of Nurse Midwives (Subgrantee)	\$30,000
Karatu District Council Health Management Team (Collaborating Partner)	\$0
Village Health Committees (45 villages) (Collaborating Partner)	\$0
JHPIEGO/ACCESS (Collaborating Partner)	\$0
JSI/DELIVER (Collaborating Partner)	\$0
Engender Health/ACQUIRE (Collaborating Partner)	\$0
Medicos del Mundo (Collaborating Partner)	\$0
Canadian Physicians for Aid and Relief (Collaborating Partner)	\$0
Marie Stopes Tanzania (Collaborating Partner)	\$0
Population Services International (Collaborating Partner)	\$0
MEDA (Collaborating Partner)	\$0
EGPAF (Collaborating Partner)	\$0
White Ribbon Alliance in Tanzania (Collaborating Partner)	\$0
Foundation for African Medicine and Education (Collaborating Partner)	\$0
Sangoma (Collaborating Partner)	\$0
Foundation for African Medicine and Education (Collaborating Partner)	\$0
Village Wellness Project (Collaborating Partner)	\$0
Ingenierias Sans Fronteras (Collaborating Partner)	\$0
Rift Valley Children's Fund (Collaborating Partner)	\$0
Datoga and Hadzabe Development Association (Collaborating Partner)	\$0
Orgut-SEDI VICOBA (Collaborating Partner)	\$0
Pathfinder (Collaborating Partner)	\$0

Strategies

Social and Behavioral Change Strategies:	Community Mobilization Group interventions Interpersonal Communication Social Marketing Mass media and small media
Health Services Access Strategies:	Emergency Transport Planning/Financing Implementation with a sub-population that the government has identified as poor and underserved
Health Systems Strengthening:	Quality Assurance Supportive Supervision Developing/Helping to develop job aids Monitoring health facility worker adherence with evidence-based guidelines Monitoring CHW adherence with evidence-based guidelines Referral-counterreferral system development for CHWs Community role in supervision of CHWs Community role in recruitment of CHWs Coordinating existing HMIS with community level data Community input on quality improvement
Strategies for Enabling Environment: Tools/Methodologies:	Building capacity of communities/CBOs to advocate to leaders for health BEHAVE Framework Sustainability Framework (CSSA) Rapid Health Facility Assessment LQAS MAMAN Framework

Capacity Building

Local Partners:	Local Non-Government Organization (NGO) Pharmacists or Drug Vendors Dist. Health System Health Facility Staff Health CBOs Other CBOs Government sanctioned CHWs Non-government sanctioned CHWs TBAs Private Providers (Other Non-TBA)
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Interventions & Components

Immunizations	IMCI Integration	CHW Training HF Training
Nutrition	IMCI Integration	CHW Training HF Training
Vitamin A	IMCI Integration	CHW Training HF Training
Micronutrients		CHW Training HF Training
Pneumonia Case Management (15%) - Case Management Counseling - Recognition of Pneumonia Danger Signs - Zinc	IMCI Integration	CHW Training HF Training
Control of Diarrheal Diseases (15%) - Hand Washing - ORS/Home Fluids - Feeding/Breastfeeding - Care Seeking - Case Management/Counseling - POU Treatment of water - Zinc	IMCI Integration	CHW Training HF Training
Malaria (20%) - Training in Malaria CM - Access to providers and drugs - Antenatal Prevention Treatment - ITN (Bednets) - Care Seeking, Recog., Compliance - IPT - Environmental Control	IMCI Integration	CHW Training HF Training
Maternal & Newborn Care (35%) - Emergency Obstetric Care - Neonatal Tetanus - Recognition of Danger signs - Newborn Care - Post partum Care - Child Spacing - Normal Delivery Care - Birth Plans	IMCI Integration	CHW Training HF Training

- Home Based LSS
- Control of post-partum bleeding
- Emergency Transport

Healthy Timing/Spacing of Pregnancy (15%)

- Healthy Timing and Pregnancy Spacing Promotion
- Pre/Post-Natal Service Integration

IMCI Integration

CHW Training
HF Training

Breastfeeding

- Promote Exclusive BF to 6 Months

IMCI Integration

CHW Training
HF Training

HIV/AIDS

- PMTCT

CHW Training
HF Training

Family Planning

- Knowledge/Interest
- Maternal/Neonatal Integration

IMCI Integration

CHW Training
HF Training

Tuberculosis

IMCI Integration

CHW Training
HF Training

Infant & Young Child Feeding

- Promote Excl. BF to 6 Months

Operational Plan Indicators

Number of People Trained in Maternal/Newborn Health			
Gender	Year	Target	Actual
Female	2010	264	
Female	2010		370
Male	2010		50
Male	2010	10	
Female	2011	150	
Female	2011		180
Male	2011		52
Male	2011	5	
Female	2012	0	
Male	2012	0	
Female	2013	0	
Male	2013	0	
Number of People Trained in Child Health & Nutrition			
Gender	Year	Target	Actual
Female	2010	35	
Female	2010		42
Male	2010		42
Male	2010	35	
Female	2011	30	
Female	2011		180
Male	2011		52
Male	2011	30	
Female	2012	0	
Male	2012	0	
Female	2013	0	
Male	2013	0	
Number of People Trained in Malaria Treatment or Prevention			
Gender	Year	Target	Actual
Female	2010		101
Female	2010	75	
Male	2010		101
Male	2010	75	
Female	2011		58
Female	2011	30	
Male	2011		52
Male	2011	30	
Female	2012	0	
Male	2012	0	
Female	2013	0	
Male	2013	0	

Locations & Sub-Areas

Total Population:

218,654

Target Beneficiaries

Tanzania - MIHV - FY2006

Children 0-59 months	43,731
Women 15-49 years	43,731
Beneficiaries Total	87,462

Rapid Catch Indicators: DIP Submission

Sample Type: 30 Cluster				
Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	200	242	82.6%	6.7
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	250	317	78.9%	6.4
Percentage of children age 0-23 months whose births were attended by skilled personnel	221	317	69.7%	7.2
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth	88	317	27.8%	7.0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	10	86	11.6%	9.6
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	125	232	53.9%	9.1
Percentage of children age 12-23 months who received a measles vaccination	112	131	85.5%	8.5
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	64	131	48.9%	12.1
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	71	131	54.2%	12.1
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	21	97	21.6%	11.6
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	48	89	53.9%	14.6
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	58	101	57.4%	13.6
Percentage of households of children age 0-23 months that treat water effectively	138	317	43.5%	7.7
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	0	317	0.0%	0.0
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	147	317	46.4%	7.8
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	75	274	27.4%	7.5
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	62	239	25.9%	7.9

Rapid Catch Indicators: Mid-term

Sample Type: LQAS				
Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	0	0	0.0%	0.0
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	58	93	62.4%	9.8
Percentage of children age 0-23 months whose births were attended by skilled personnel	79	93	84.9%	7.3
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth	0	0	0.0%	0.0
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	25	93	26.9%	9.0
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	0	0	0.0%	0.0
Percentage of children age 12-23 months who received a measles vaccination	0	0	0.0%	0.0
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	0	0	0.0%	0.0
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	0	0	0.0%	0.0
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	0	0	0.0%	0.0
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	51	91	56.0%	10.2
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	0	0	0.0%	0.0
Percentage of households of children age 0-23 months that treat water effectively	31	93	33.3%	9.6
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	10	93	10.8%	6.3
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	61	93	65.6%	9.7
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	0	0	0.0%	0.0
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	0	0	0.0%	0.0

Rapid Catch Indicators: Final Evaluation

Sample Type: 30 Cluster				
Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child.	233	284	82.0%	6.3
Percentage of mothers with children age 0-23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	295	389	75.8%	6.0
Percentage of children age 0-23 months whose births were attended by skilled personnel	319	389	82.0%	5.4
Percentage of children age 0-23 months who received a post-natal visit from an appropriately trained health worker within three days after birth	321	389	82.5%	5.3
Percentage of children age 0-5 months who were exclusively breastfed during the last 24 hours	69	106	65.1%	12.8
Percentage of children age 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	225	253	88.9%	5.5
Percentage of children age 12-23 months who received a measles vaccination	168	178	94.4%	4.8
Percentage of children age 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	138	178	77.5%	8.7
Percentage of children age 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	127	178	71.3%	9.4
Percentage of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	18	119	15.1%	9.1
Percentage of children age 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids	68	87	78.2%	12.3
Percentage of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider	115	133	86.5%	8.2
Percentage of households of children age 0-23 months that treat water effectively	184	389	47.3%	7.0
Percentage of mothers of children age 0-23 months who live in households with soap at the place for hand washing	73	389	18.8%	5.5
Percentage of children age 0-23 months who slept under an insecticide-treated bednet (in malaria risk areas, where bednet use is effective) the previous night	355	389	91.3%	4.0
Percentage of children 0-23 months who are underweight (-2 SD for the median weight for age, according to the WHO/NCHS reference population)	0	0	0.0%	0.0
Percentage of infants and young children age 6-23 months fed according to a minimum of appropriate feeding practices	75	282	26.6%	7.3

Rapid Catch Indicator Comments

Results for the following indicators were affected by the standard wording of the question: 1) handwashing - the place for handwashing in Tanzania is a basin, not a fixed place leading to undercounting of individuals practicing appropriate handwashing procedures; 2) malaria treatment - with the increase in use of LLINs (91%) and introduction of RDTs (although use was sporadic), fever was not always treated as malaria, a change from baseline; 3) maternal TT - since young girls/women are now getting the TT vaccine in school, they do not always get two vaccinations during pregnancy and women who have had multiple pregnancies do not always get the vaccine during pregnancy leading. Therefore the data indicates a lower coverage than what is likely actual. The IYCF indicator was also problematic due to its complexity. The underweight indicator is not reliable per a thorough review of data by weight and age of child which revealed outliers. Malfunctioning scales are suspected; interviewers reported the scales were calibrated for each measure.

Upon completion of the survey report, it was noticed that a couple baseline indicators did not match final (due to use of different denominators). As a result baseline indicators for ANC visits and child spacing were corrected.

Annex 12: Project Data Form

(See attached.)

Annex 13: Grantee Plans to Address Final Evaluation Findings

WellShare has shared preliminary evaluation findings with the USAID Tanzania mission and will provide the mission with a copy of this report. In addition, WellShare has sought out opportunities for sharing lessons learned and partnership with other organizations. WellShare submitted an application to replicate some of the family planning activities in Bariadi District, Simiyu Region, Tanzania and will provide cross-training to WellShare Uganda programs. WellShare will also provide feedback to the M & E working group of the CORE group and MCHIP on KPC and HFA survey issues.