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CRITERIA FOR SELECTION OF FIELD TRAINING AREAS TO SUPPORT TRAINING INSTITUTIONS

by

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INTRODUCTION

It is of vital importance for students of biology, chemistry and physics to be exposed to laboratory work to grasp the theoretical phase of their orientation. It is also essential for proper orientation in clinical medicine to give the students ample opportunity to examine cases in relation to various special branches of medicine, be it in the hospital laying-in wards or in the outpatient. Equally important is the exposure of students of public health to field training and experience in dealing with people as well as working in a team.

As the need for FTAs with particular emphasis on family health care (covering MCH and family planning) becomes felt and more or less conceptualized, it is also carried further now from being necessary only for **pre-service** orientation to become a continuous **in-service** activity. Also, while it is better to start by each category on intensive basis first, yet somewhere along the line pre-service training within and as a part of the team must be accounted for to build up the team spirit needed both in leadership and membership of a team.

In setting criteria for selecting FTAs to support training institutions, some variation around a main theme must be expected to accommodate certain local conditions

The continuous evaluation of the output as performance and effectiveness of trainees and due consideration to the feedback from those trainees at all levels should be the main guide and monitor for continuous betterment and development of FTAs.

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I BASIC REQUIREMENT FOR FTA PROGRAMMES

1.1 Good Rapport with·

1.1.1 Local public health department - through:

(a) actions research programmes to serve the purpose of upgrading the service in the area as a model for the rest of the Region;

(b) providing pre-service and in-service opportunities for local health personnel of all categories (administrative, physicians, nursing, auxiliary, etc.);

(c) entertaining actual positive sharing from senior public health personnel in field training activities, supervision and discussions,

(d) incentives for lower level public health personnel and auxiliary sharing positively in the activity.

1.1.2 Local medical or public health institutions - through:

(a) applied field research touching on all areas of interest of these institutions, data collection and research activities could be implemented through well-supervised activity of trainees;

(b) providing training opportunities for undergraduate and post-graduate students and all levels of practitioners (training interns, residents, demonstrators as well as young faculty),

(c) incentives for anybody who shares in this activity from the institutions

1.1.3 Concerned national or international (United Nations) agencies - through:

(a) proper proposals and information to entertain support especially in the line of transportation, equipment and probably experts or fellowships to prepare trainers,

(b) regular reporting of achievements as well as difficulties to maintain support and exchange of experience

1.2 Original Local or Regional Interest in the Need for FTAs:

1.2.1 On the national level - to render support to this activity through·

(a) proper statutes and legislations for concerned public health and medical institutions endorsing field training,

(b) medical education committee to plan for and evaluate different aspects of education including field training,

(c) medical education workshops and seminars to propagate the idea and importance of field training,

(d) allocation of necessary funds needed to support this activity of field training,

(e) the state should designate certain areas in the country, not necessarily central where field training activity could be implemented;

(f) observation of certain criteria in the choice of FTAs; promising talents for this activity should not be monopolized centrally;

(g) team approach, especially during practical part and field training for the public health team need to be adopted in developing countries,

(h) old strictly hospital-oriented teaching for medical students and nurses should be gradually denounced as an incomplete unrealistic orientation pattern for the preparation of personnel in our developing countries.

1.2.2 On the international level - support to this activity could be rendered along several lines of approach which are not mutually exclusive:

(a) national, regional, and inter-regional seminars and workshops on recent trends in education and training of the public health team; such seminars should involve young teachers in the medical and public health line, and the workshops should be designed to enlist and incorporate the understanding of senior leaders in the lines of education and training in different countries;

(b) follow-up on the returns from these seminars and workshops is fundamental to realize several objectives:

(i) To find out early enough who, of the seminar young groups of educators, is promising enough to be encouraged and capitalized upon in his local capacity.

Also it should be possible, with due respect to national rights of nomination for workshops, to discover and avoid the senior people who would repeatedly appear in workshops but are not seriously giving the expected push in spite of their influence.

(ii) To find out local or national hindrances that stand in the way of effective change in medical and public health education, and try to overcome such hindrances through diplomatic efforts of senior international personnel (like Regional Advisers or Temporary Advisers).

(c) The most important next step is that the international bodies should anticipate the need rather than wait for demand or requests for help and support for the development of FTAs, provided of course that the interested national personnel are found. This is especially important where the given country is known to attend to primary and vital priorities, or where, in a given country, the tendency is known to be towards centralized and rigid decision making patterns

The help of international organizations should be placed with due regard to socio-economic and administrative machinery pattern in the different countries, and enough orientation of the leading persons in different countries (e.g. through printed booklets) in the proper channels to get the international support should be implemented. Otherwise, it might happen that most of the international support would be distributed, irrespective of real need and already available funds, so that it might at times gravitate to countries and institutions or persons who are familiar with the channels of request for grants, fellowships and support for country programmes, to the exclusion of more deserving and needy institutions and countries.

Selection of certain promising institutions (with available interested and dedicated personnel) for regional training short courses, for certain scientific workshops or seminars and making some visiting experts available as well as incorporating such centres in collaborative studies in operational research in family health or comprehensive health care, are some of the ways for assistance where national support is known to be lacking or unduly delayed.

Without such support on the national level where the policy makers and the socio-economic conditions of the country allow, or on the international level to maintain and promote a promising institution, it might be difficult to keep the morale of some dedicated public health workers in developing countries. If national support is insufficient and below the standard, things could fall apart after a lively start or could possibly be aborted before they get started, because they would then be lacking group support and recognition, not to mention that they might also suffer from specific resistance and criticism.

II SPECIFIC CRITERIA FOR SELECTING FTAs TO SUPPORT TRAINING INSTITUTIONS

1. Distance from the institution should be within fifteen to twenty kilometres reach from the institution, or in terms of time at a less than one hour's reach. Roads for access should be reasonably prepared for regular vehicles.

This would allow better utilization of FTA for visits needed for orientation as well as makes supervision possible.

2. Size of such FTA should be large enough to accommodate a phased plan of a health service action research which would extend over five to ten years. It is not necessary that the terrain covered by FTA is extensive but the localities or aggregation of dwelling units (like villages or hellas etc.) should be of a number

between forty to fifty units. This will allow shifting training activities at times from one place to the other with the benefit of new experience to either the trainees or the population served during this function.

3. Socio-economic characteristics of the population should better be representing the majority of the people in the region where the institution lies. Agrarian rather than industrial and upper lower S/E or lower middle S/E classes will support better and welcome an FTA initiated for their service.

4. Demographic characteristics - rural rather than urban population in developing countries will be in more need for FTA activity especially so where birth rate is still high as well as the infant mortality which will require a lot of effort to upgrade the health services available if any.

The more stable the population in this area is the better for the progress of the work where follow-up longitudinal studies in an FTA could be carried on for five to ten years. Instability of the population will be the source of trouble in the evaluation of final outputs and results.

5. To ensure programme-oriented field training, an FTA should preferably be the site of an on-going action research in development of maternal and child health/family planning services or the site of a programme for evaluation of available basic health service together with other aspects of development in the rural set-up.

6. Physical facilities for rendering good service as well as for housing the trainees in case of resident programmes should be reasonably good.

If the hostel facilities for residence of trainees are in sharp contrast to their regular life experience, this could be reflected on the whole group and not only is productivity affected but the association of the experience with such inconvenience might lead to reversal of attitude change leading to antagonism to service in rural areas.

A brief description of an existing and functional FTA (Abnub area) in relation to Assiut University Medical Faculty, Assiut, Egypt, is attached as Annex I.

ABNUB CENTRE FOR MEDICAL RESEARCH AND TRAINING

(Description of an Existing and Functional FTA in Relation to Assiut University Medical Faculty, Assiut, Egypt - by Dr. H.M. Hammam, WHO Temporary Adviser)

Introduction

The work for preparing Abnub FTA started in 1965 and several pilot activities were undergone starting 1966 on voluntary basis for interested students during summer vacation and mid-year recess. Starting 1970 the first formal field training season started on daily-visiting basis, followed in 1971 and up till present by resident field training activity for seven to ten days as a regular activity sponsored by the University.

Besides field training activity, this area has been the site of research and model service action as well as integrated community development approaches by the University of Assiut, in collaboration with the concerned agencies in Assiut Governorate.

This has contributed greatly to the intimate good rapport with the local inhabitants as well as local authorities.

1. General Description

(a) Location (distance from a known point, e.g. a medical school, etc.).

The central point in this FTA is around twelve kilometres to the north-east of Assiut University Faculty of Medicine, across the Nile.

(b) Size of area, in sq. miles/kilometres, localities (villages/towns, etc.).

This area is approximately 100 sq. kilometres and encompasses one district town (Abnub) and forty-five villages.

(c) General socio-economic characteristics of population.

The population is mainly agrarian with a moderate rural standard of living; crops are usually the traditional cash crops but at times citrus, bananas and grapes are grown on a limited scale.

The families are mostly the extended family type which brings about some fatal confrontations when some traditional considerations are violated. Tribal

pride and belonging prevails especially in areas at periphery as we get farther from the city of Assiut or close to the Eastern plateau and mountain range.

(d) Demographic information on population e.g. urban/rural, sex and age composition (population pyramid), vital rates, in/out migrations.

Total population is 270 000. The district town of Abnub is acout 10 per cent of the population and is in fact semi-urban. The rest (90 per cent) are living under rural conditions. 70 per cent of males and 90 per cent of females are illiterate.

The age and sex distribution is typical of the distribution in Egypt as a whole with 42 per cent of the population under fifteen years and with some difference in the working age (twenty to forty years) in favour of females due to outward migration of males to work in norther areas like Cairo and other coastal cities like Alexandria and Port Said. During the 1967-1973 period, some influx of migrants from Suez, Ismailia and Port Said (Canal zone) have moved temporarily into this area living in temporary resorts under government social and medical supervision, but they have been returned back to their original places during 1974. (The number of these migrants was around 5 000 distributed in several villages beside the district town of Abnub.)

Birth rate varies between 40 and 50/1000 population in some of the rural localities, and infant mortality rate varies between 110 and 140 in the different rural localities in this area.

(e) Other relevant information, e.g. specific features of access, logistics, coordination with local administration/health services, etc.

This FTA is well circumscribed with a triangular boundary limited on the north-east and south-east by the eastern mountain range and on the western side by the Nile.

It is accessible from Assiut by crossing the Nile to the eastern bank across Assiut Barrage and a macadamized road covers fifteen kilometres out of thirty kilometres, the length of the oblong triangle. The rest of the long road to the north and the tributaries reaching to peripheral areas east and west are dusty embankments of dug canals and drains.

The area is accessible by land travel and riverine communication but no railways reach the eastern side of the Nile in this part of the country. The bus service is relatively regular but infrequert and does not cover all villages. However, taxi-cab service is always available, and covers all the villages.

The activities in the Abnub FTA are completely coordinated with the local health authorities as well as the local governmental bodies, and whenever possible

other disciplines in the University as rural extension and veterinary health training are invited for joint research and training activities.

2. Existing Health Services

(a) Physical facilities, types, locations, utilization by population, etc.:

i. The most peripheral are the rural health units serving 5 000 people comprising about five rooms in the lower level for general medical examination, MCH, registration of vital events, endemic disease laboratory and small dispensary (pharmacy); on the higher level, a small furnished efficiency apartment for the physician-in-charge of the unit.

ii. The rural health centre was an older project which provided health care for 15 000 including out-patient general and endemic diseases as well as MCH and in-patient care. Beds varied from twenty to thirty-two for both sexes and there exists a well equipped theatre for surgery and obstetrics within the boundaries of such centres. There was always a safe water supply mostly from deep underground source together with public baths, latrines and common washing facilities.

A fully equipped more sophisticated residence for the medical officer-in-charge of the centre is formed either on the higher level of the dispensary and out-patient clinics or as a separate villa, if all the building is on one level.

Dormitories for the nurse/midwives working in the centre are also available, dormitories for female aids are available on a separate side of the centre.

iii. A third category more recently introduced is the combined unit which besides health component for 15 000 population, covers also educational, social and agricultural demonstration components.

The health component is occupying a part of a big complex and includes the same services in the rural health centre with in-patient beds, fourteen to eighteen in number.

The medical officer-in-charge is usually housed in a small villa, within a residential complex for all senior staff working in other disciplines of the combined unit.

In Abnub FTA, about thirteen rural health units (RHUs), four rural health centres (RHCs) and two combined units (CUs) exist.

The demand for MCH care and general family health is growing in this area as the personnel apply themselves more to raise health consciousness and

standard of service When the work in this area started, the utilization of MCH centres and personnel for obstetric care was less than 25 per cent in a good number of the villages.

The district health officer runs the administrative sides of all personnel provisions, as well as attends to registration, supervision, epidemiologic investigation, food control and environmental sanitation activities.

(b) Staff, categories, numbers, in case of special categories some description of previous education and health training, etc.

Table I

Category of Staff	RHU	RHC	CL
Physicians	1	2	2
Nurse/Midwives	-	2	2
Assistant Nurse/Midwives	2	4	4
Sanitarians	-	1	1
Sanitary Inspectors	1	-	-
Laboratory Technicians	-	1	1
Laboratory Assistants	1	-	-
Clerks	1	2	2
Pharmacists *	-	1	1
Female Attendants	2	4	4
Male Attendants	3	6	6

* Pharmacist recently availed on rural level.

(c) Functional and operational aspects.

The work or the development of health services in this FTA has started from both ends as well as on the referral system between the two.

The hospital has been developed to the extent of being now among the best equipped and staffed hospitals in the Governorate. Bed occupancy and utilization has been studied and continuous progress is observed in all aspects of specialization, e.g. ophthalmology, surgery, obstetrics/gynaecology, paediatrics, urology, internal medicine and endemic diseases. The staff has been reinforced by consultants from the Faculty of Medicine, working hand in hand with local staff Together with this in-patient activity, a general practice service

was developed to screen the out-patient work to spare the specialists for referred cases whether from Abnub town or from any of the forty-five villages draining in this hospital.

Also MCH, school health and vaccination activities were incorporated in the well baby/ante-natal and periodic school examinations. Home visiting and school visiting has been activated accordingly due to the time saved for the home visiting personnel previously spent in vaccination and sick child care.

Prior to that, and as part of the programme-oriented training for nurses and interns, complete coverage of Abnub town for demographic, social environmental and health status and family folders have been arranged with family health card for record retrieval and linkage.

All registration of births, deaths, admissions, discharge for hospital or out-patient care are to be linked to folder of family through the household number on the family card.

Such system ensures a sense of belonging between the persons and the health institutions.

The same thing was done on the other end in rural villages where medical students prepared family folders, and proper record linkage is also maintained. Up till now, about twenty-five villages out of forty-five have been covered. 25 000 people are covered every year by the medical students.

The referral system between village RHU, RHC or CU on one side and the district hospital on the other side has been improved in the following ways:

i. periodical meetings for rural health officers with specialists in hospitals and discussion of problems;

ii a specially designed form where both the referring and reporting physicians write down necessary data to help each other for benefit of the case,

iii. special arrangement for reception and immediate care for referred cases from villages covering considerable land travel to reach the hospital, to facilitate direct access to specialists.

iv. relief of specialists from general practice work previously done for Abnub town in absence of general practice clinic.

The next step, after confidence of public is ascertained in the services rendered for this health care and restoration, will be the stress on more effective domiciliary duties especially for family health, maternal and child health care.

(d) Existing health conditions, e g infant mortality rate, leading causes of morbidity and mortality, notable health problems, etc

Infant mortality rate is still above 120/1000 live birth.

Main cases of morbidity are.

i. schistosomiasis and its urinary complications,

ii. paediatric diseases especially summer diarrhoea, malnutrition, skin infections and ophthalmias;

iii. ophthalmias, trachoma and its complications in all ages;

iv. chronic obstructive lung diseases with bronchial asthma in adult population,

v. scorpion bites and casualties from aggression,

vi. other endemic parasitic diseases (ankylostomiasis, amoebiasis and ascariasis).

Mortality causes

i. prematurity, and malnutrition coupled with frequent attacks of diarrhoea,

ii. broncho pneumonia especially complicating measles below the age of three years;

iii. post-partum haemorrhage puerperal sepsis where obstetric care is done by unqualified attendants;

iv. scorpion bites in children and sometimes adults;

v. aggression through fire arm injuries,

vi. remote complications of schistosomiasis like cancer bladder or hepato-splenomegaly.

(e) Special health plans, e.g. periodic health plans for expansion of health services, physical facilities, training of health personnel, etc.

Reinforcement of physical facilities as well as personnel especially in the six larger RHCs and CUs to accommodate trainees has been done two years back.

(f) Blank record cards/forms, e.g. family and clinical records:

A blank record card in the local Arabic language together with an English translation is attached.

3. Services in Relation to Family Planning/Family Health

(a) Kind of services - broad details·

The whole theme of work is developed along total family health care approach whether through the home visiting by trainees during the preparation of family folders or through the interviewing and health status assessment during a collaborative research activity on the relation between family size and family health in the same FTA.

Better maternal health care is being ensured through ante-natal clinics, home visiting and good obstetric management in the hospital.

Family planning methods are explained for attendants and are rendered available including access to the specialized laparoscopic sterilization centre in Assiut University hospital.

(b) Acceptance - data - broad details

The main complaint comes from pills users who claim that they cannot put up enough effort in their home obligations when they are taking the pills. This initiated a study on the effect of the pill on the liver function.

Intra-uterine contraceptive device is still being applied by the obstetrician and in fact, on close gynaecologic examination for a fair number of females in some rural areas, gynaecologic findings contra-indicating use of the loop have been encountered in the majority of the group which rendered simple acceptance not enough and stressed the importance of proper gynaecologic examination before applying such a contraceptive measure.

(c) KAP study reports, etc.:

KAP studies over the last eight years do not show very promising change and while favourable answers on attitudes towards contraceptions are expressed in almost 50 per cent of couples only 10 per cent were practical users of any measure for contraception.

It is hoped that slow but a more staying effect will come about after bridging the confidence gap which existed previously between the rural people and the medical profession.

4. Teaching Activities

(a) Main institutions/departments responsible, staff involved in teaching in the field, categories, designations, numbers, etc.:

The main department responsible for field training activity is the Department of Preventive Medicine and Epidemiology, Faculty of Medicine, Assiut University.

All members of the Department are on duty in the resident field training study, from the Chairman of the Department to three assistants and six demonstrators. They are divided to supervise alternately different batches with one senior and two junior staff. Most of the other departments of the Faculty of Medicine share by sending a member who is an assistant professor, assistant lecturer. This is reasonably regular from the departments of paediatrics, obstetrics/gynaecology, ophthalmology, chest diseases, general medicine and general surgery.

(b) Arrangements for students, e.g. years/categories, numbers, manner of involvement (data collection, participation in health care, etc.), daily visits or hostel arrangements, etc.:

The main activity is still for the fourth-year medical students, but voluntary participation is entertained from first-year medical students at advantages.

However, the resident group are only from fourth-year medical students who are all required to attend this activity as a part of their course work formally approved by the Faculty Council as well as the University Council.

Number of students per class on fourth year medical school was ranging between 200 and 250 during the last five years and the batches usually five per class ranged from forty to fifty students per batch. Probation for nursing groups field training as well as for interns, veterinary public health training has also been included at times to see how far integration of these varied activities could be achieved.

Manner of involvement:

i. data collection on environmental conditions, demographic information, utilization of maternal and child health service and other health institutions;

ii. KAP studies,

iii. assessment of nutritional status;

iv. general health examination survey with special stress on endemic diseases (including minor laboratory work),

v. provision of health care within the limits of available resources;

vi. health education on MCH/family planning, nutrition and prevention of endemic diseases.

The field training is done on continuous residence basis in the rural health institution where the work is done. Hostel arrangements are made within reasonable limits of encouraging adaptation to rural service life.

(c) Teaching schedules, time tables, weekly/monthly, hours of each activity, and teaching methods used, e.g. lectures, group discussions, practical work supervision, etc. - description of how these and other methods are utilized with comments on their effectiveness and shortcomings.

Weekly field visits to orient the students in the proper delivery of varied public health activities in the field are conducted a good part of the fourth academic year, in coordination with the lecture and discussion groups programme.

The number of field visits programme is around fifteen visits, each one preceded by half an hour briefing by a lecture and one of the public health officials conducting the service. The field visit continues for about two hours during

the morning hours (at the same time as the clinical rounds in the hospital), one hour of group discussion for the same batch is held to evaluate the field visit and to compare with other experiences in different countries as shown on film strips, slides or 16 mm sound films from the audio-visual library of the department.

The resident field training part of the orientation, when it starts, finds the students with enough background knowledge and some favourable attitudes. They spend a whole week working very hard acquiring first hand skills in different aspects described above and getting charged continuously in favour of community sense and better understanding of the effect of environment on health as well as better appreciation for the doctor-patient relationship and ways and means of taking history and health educating the rural population. They also become more considerate for the traditions of the people and a start of feeling responsible for the leadership role of a physician as a change agent in such rural community is appreciated.

The programme starts by an exposure to a public meeting with community leaders and the youth club in the village, usually after Friday's prayers. In this meeting the objectives of the work are explained and discussion takes place on different aspects of local facilities required including guides for easy access to households (which have been numbered and mapped by a geographical reconnaissance team before field work is started).

On the same afternoon, visits to households are started by students covering aspects of inquiry in the attached form with health education. This time of the day is the best for meeting heads of households and all working members of the family who are usually not available during the day. The whole family is invited to undergo physical examination and laboratory investigation for endemic diseases next morning.

So the next morning's work is mainly for assessment of nutritional status, general physical and laboratory investigation including Hb estimation. If any member of the family is found in need for medical care he is provided such care if locally available. If hospitalization or sophisticated specialist care is needed, then referral is done to the district hospital or the university hospital and whenever possible follow-up of the case by the student is made possible to ensure continuity of experience.

The evenings are utilized in two main activities: one is group discussions attended by senior professors as well as authorized public health administrators and the second is to check the day's work and write journals.

Supervision during household interview is conducted by the junior members of the department of epidemiology and public health, under guidance from senior staff of the same department.

The morning health examination survey followed by health care is attended by junior staff deployed from different clinical departments, especially obstetrics/gynaecology, paediatrics, ophthalmology, internal medicine, urology and surgery. The organization and coordination of this morning activity is undertaken by the members of the public health department in collaboration with the local public health authority.

Rounds from some clinical professors have been successfully conducted in paediatrics, obstetrics/gynaecology, ophthalmology and surgery in the rural set up capitalizing on the early phases of disease lacking in the hospitals.

Such rounds are ultimately geared towards stress of the importance of primary prevention and early diagnosis and treatment.

For effectiveness of different methods of teaching, please consult the following table:

Table II

Attitude of final-year medical students at graduation in November 1972 towards different phases of orientation in preventive medicine in Assiut

Points of attitude study		Positive benefit and its relative extent as a proportion of the total positive						Negative attitude	Grand total
		25%	40%	60%	80%	N.S.*	Total		
Field visits	No.	2	6	43	41	-	92	2	94
	%	2.8	6.5	46.7	45.5			2	
Lectures	No.	6	12	24	40	1	83	9	92
	%	7.2	14.5	29	48.2			10	
Discussion periods	No.	2	13	25	49	3	72	21	93
	%	2.8	18	34.7	40.3			22.5	
Summer field training	No.	1	5	16	53	-	75	13	88
	%	1.3	6.7	21.3	70.5			15	

* N.S. = non specified extent

(d) Assessment of student participation, e.g. examination, maintenance of field-work journals/diaries, written reports, etc.

Mainly through:

i. field work journals which are later accumulated into a complete written report about his total experience with comments and recommendations, which were at times very useful for replanning of some details of work;

ii. statistical analysis of data,

iii. degree of cooperation with colleagues and rest of the team;

iv. degree of success with the local population as observed by supervisors;

v. attitudes reflected by discussion;

vi. one question in the final written examination (out of four).

5. Conclusions

(a) So far the present status and the arrangements at the FTA are satisfactory, but there is still a lot to be done to make it more useful. Change in the proper direction is taking place but at a slow rate.

(b) Brief comment on preserving the usefulness of an FTA-main problems in this connection and their solutions:

To preserve the usefulness of an FTA:

i. It is necessary to avoid repeated calling on the same group of people in a limited area (like one or two villages). People will become offended and the impression on the trainees will be un-wholesome. This can be avoided if the FTA is large enough with a good number of villages included to allow changing places for trainees as well as build up a reasonably complete job at the end of a certain period (five to ten years).

ii. Another difficulty will be the absence of continuity in the effect and service felt by the people which is particularly intensified during the training of larger numbers. Local bodies and community leaders could have strong argument against such exploitation which could jeopardize the future success in the programmes of an FTA.

This difficulty could be avoided only through programme-oriented field training. The training function should fit properly within a well integrated plan for development of the area chosen. Part of that plan should be upgrading the service which is rendered possible through community diagnosis. Continued interest and community organization efforts will be the key to the solution.

(c) Planned changes or modifications.

Exploration phase for certain changes is almost completed prior to implementation and this covers the following items:

i. extending the training to the early years in the faculty of medicine on formal planned programme basis to include first and third years,

ii. extending the activity to the nursing school and the sanitarians of the health institute,

iii. other disciplines like sociology, veterinary, public health, agricultural extension and education.

For items (i) and (ii), integrated training as one team is attempted and will be the basis of the plan. For item (iii), coordination is underway to ensure wholesome approach to community development which reflects on maternal and child health as well as affect family planning attitudes.

مشروع تطوير القريه بمحافظه أسيوط

مشروع بحث وعمل

اسم الباحث _____
اسم القرية _____
رقم المنزل _____
عدد العائلات بالمنزل _____

اسم رب الأسرة : _____ العنوان للمراسلة _____ هل يوجد راديو نعم ( ) لا ( )

عدد الزوجات فى العصمة : _____ قراءة الزوجة (أو الزوجات) للروح _____

هل سمحت الأسرة عن مشروع تحديد النسل ؟ رأى الزوجة : نعم ( ) لا ( ) رأى الزوج نعم ( ) لا ( )

هل توافق الأسرة على استعمال وسائل تحديد النسل ؟ أو رأى الزوجه نعم ( ) لا ( ) رأى الزوج نعم ( ) لا ( )

هل تستعمل الأسرة وسائل منع الحمل ؟ نعم ( ) لا ( ) — ما هى الوسيلة :
- حبوب ( )
- لولبيات ( )
- أخرى (تذكر) ( )

من الذى يرعى الأم عند الولادة ؟ الدايه ( ) مركز رعاية الطفل ( ) مستشفى ( )

عدد مرات الحمل ( ) عدد الولادات الحية ( )

رقم	الاسم	القرابه لرب الاسره	السن	النوع	الديانه	العمل	الحاله زواجيه	الحاله العلمية
١								
٢								
٣								
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٦								
٧								
٨								
٩								
١٠								

بيان

الحالة الزوجية :
(١) لم يتزوج أبداً (٢) متزوج
(٣) مطلق (٤) أرمل

الحالة العلمية :
(١) أمى (٢) يعرف القراءة والكتابة
(٣) يدرس بالمدرسة الابتدائية
(٤) يدرس بالاعدادية
(٥) يدرس بالثانوية
(٦) يدرس بالجامعة أو أعلى

المسكن : دائم أو طوب أحمر ( ) طوب أو طوب نى ( ) — عدد الأدوار ( ) — عدد الحجرات ( ) —

الأرضية : بلاط ( ) أسمنت ( ) طوب ( ) طبيعية ( ) — الفرش : موجود ( ) غير موجود ( )

الاضاءة الطبيعية : كافية ( ) متوسطة ( ) رديئة ( )

التهوية كافية ( ) متوسط ( ) رديئة ( )

مورد المياه مواسير وحنفيات بالمسكن ( ) حنفيات عامة ( ) طلمبات خاصة ( ) مصدر آخر (يذكر) :

المراحيض توجد ويستعمل ( ) موجود وغير مستعمل ( ) غير موجود ( ) — هل توافق على تركيب مراحيض نعم ( ) لا ( )

الحظيرة توجد ومنفصلة ( ) توجد ومتصلة ( ) لاتوجد ( ) — نعم ( ) لا ( )

الحيوانات المستأنسة (يذكر العدد) جمال ( ) جاموس ( ) بقر ( ) خيل وبغال ( ) حمير ( ) غنم وماعز ( )

تربية الدواجن : توجد (تذكر) ——— لا توجد ( ) الصناعات المنزلية (يذكر) ———

حيوانات ضارة بالمنزل : فئران ( ) ثعابين ( ) أخرى (تذكر) ———

حشرات ضاره بالمنزل : عقرب ( ) رعوث ( ) بق ( ) اخرى (تذكر) ———

رقم	الرأس	العينان	الأسنان	العنق	القلب	الرئتين	اعضاء الهضمى	اعضاء الحركى	الجلد	الفحص العملى والتحريات								
										H	W	Hb	S	A	B	P	T	X
١																		
٢																		
٣																		
٤																		
٥																		
٦																		
٧																		
٨																		
٩																		
١٠																		

طبعه طبعة أ ـ و ط ٣٠٦/١٩٧١/١٠٠٠٠

Translation

Original: Arabic

Name of research worker:

Name of village:

House No.:

No. of families living in the house:

Assiout University

Research Cum Action Project

Project for Village Development in Assiout Governorate

- Name of head of family _____ Address _____ Does he have a radio set: Yes( ) No( )
- Number of his spouses: _____ Relationship of spouse (s) to him _____
- Has the family heard of the birth control project ? Yes ( ) No ( ) Opinion of the Spouse: Yes ( ) No ( )
  Opinion of the husband: Yes ( ) No ( )
- Does the family agree to the use of birth control methods? Yes( ) No ( ) Nature of contraceptive methods used: pills/loops/ Others (Please indicate)
- Who attends to the mother in delivery? Daya( ) (Local midwife) Child care centre ( ) Hospital ( )
- Number of pregnancies( ) Number of live births ( )

No.	Name	Relationship to head of family	Age	Sex	Religion	Nature of work	Marital status	Educational status	Explanatory Remarks
1									**Marital Status** 1) Never married 2) Married 3) Divorced 4) Widower **Educational Status** 1) Illiterate 2) Reads and writes 3) In primary school 4) In preparatory school 5) In secondary school 6) At the University/graduated
2									
3									
4									
5									
6									
7									
8									
9									
10									

House·of stones/red bricks( )of bricks/raw bricks ( ) - No of storeys ( ) No. of rooms ( )
Floor: Tiles ( ) - cement ( ) bricks ( ) - Mud floor ( ) Oven · Available ( ) Not available ( )
Natural lighting: Adequate ( ) Average ( ) Poor ( )
Water source Piped water in the house ( ) Public taps ( ) special pump ( ) Other ( )
Latrine· Available and used ( ) Available but not used ( ) Not available ( ) Do you agree to installing a latrine ?·
Yes ( ) No ( )
Animal house Available but separate ( ) Available as part of the house ( ) Not available ( )
Domestic animals (Number) Camels ( ) Buffaloes ( ) Cows ( ) Horses/Mules ( ) Donkeys ( ) Sheep/goats ( )
Poultry· Available /Not available House industry, if any ( )
(Please indicate)
Harmful animals Mice ( ) Snakes ( ) Other ( )
Harmful insects Scorpions ( ) Fleas ( ) Bugs ( ) other ( )

No	Head	Eyes	Teeth	Neck	Heart	Lungs	Digestive System	Locomotor System	Skin	Laboratory exam. and Investigation								
										X	T	D	R	A	S	Hb	W	H
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		