**Template for Requests for Revisions to the DHS Model Questionnaires, Optional Modules, and Biomarkers for DHS-8 (2018-2023)**

# **Section I. Information about the requesting party**

1. Is this request being submitted on behalf of a group? If so, please provide the name of the group and the participating parties.

This request is being submitted by the USAID Urban Health Working Group.

# **Section II. Indicator definition and rationale**

2. Please define the indicator or indicators you are requesting The DHS Program to incorporate. *Multiple indicators derived from a single set of questions should be included in the same submission.* (Response required)

N/A

3. What is the rationale for measuring this indicator (each of these indicators) in DHS surveys? (Response required)

N/A

# **Section III. Proposed additions/revisions to the questionnaires or biomarkers**

4. Please describe the requested addition or revision.

*If the requested change is the addition of new questions to the DHS questionnaires or modules, complete questions 4.1 and 4.1.1. If the requested change is a revision to existing questions, complete question 4.2. If the change relates to anthropometry or a biomarker, please complete question 4.3.*

4.1. **For additions**: If you have developed a question or set of questions to measure the indicator(s), please provide them in the space below or in a separate file attached with your submission.

4.1.1 If requesting multiple questions, please specify the relative priority of each new question.

4.2. **For revisions to existing questions**: Please specify the DHS-7 question number, the proposed revision to the question, and the rationale.

|  |  |  |  |
| --- | --- | --- | --- |
| **DHS-7 question number** | **DHS-7 question text** | **Proposed new question** | **Rationale** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
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4.3. **For anthropometry and biomarkers**: Please describe the measurement procedures or specimen collection procedures, point-of-care or laboratory testing procedures (as relevant), and any recommendations for return of results.

5. Can any related questions be deleted from the questionnaire to make room for the proposed new content? If so please specify which questions using the DHS-7 question numbers.

N/A

6. What are the implications of these requested changes on measurement of trends using DHS data?

N/A

# **Section IV. Indicator calculation**

7. Indicate how to calculate the indicator(s). Include detailed definitions of the numerator and denominator of each individual indicator. If you have developed a tabulation plan for the indicator(s), please attach a file including the suggested table(s) with your submission.

We are requesting that for countries with informal settlements or “slums,” the data be constructed in such a way to tabulate health status by informal settlement or “other urban” or “peri-urban”. Additionally we are requesting that wealth quintile be included for within urban settings. Please see Section VI for details.

8. Is the indicator useful when measured at the national level, or is it useful only when disaggregated to specific subnational areas, such as endemicity zones or project intervention regions?

*For each indicator, select one of the three options by clicking in the appropriate box.*

|  |  |  |  |
| --- | --- | --- | --- |
| Indicator | Useful only for subnational endemicity zones or project intervention regions. A single estimate at the national level is not meaningful. | Useful at both national and subnational regions, as sample size allows. | Useful only at the national level. Subnational estimates are not needed. |
| “slum” | ☐ | X | ☐ |
|  | ☐ | ☐ | ☐ |
|  | ☐ | ☐ | ☐ |
|  | ☐ | ☐ | ☐ |
|  | ☐ | ☐ | ☐ |
|  | ☐ | ☐ | ☐ |

# **Section V. Prior testing of the proposed question(s)**

9. Have the proposed questions undergone any formal validation; i.e., have the questions been tested against a “gold standard” to assess their accuracy? If yes, please describe how well or poorly the questions performed and/or provide a publication or report of the validation exercise (or a link).

N/A

10. Have the questions undergone any other kind of testing; e.g., cognitive testing, pilot testing. If so, please describe the results of the testing and/or provide a publication or report of the findings (or a link).

N/A

# **Section VI. Other considerations**

11. Please provide information relevant to the kinds of questions below, and/or anything else you wish to share with us about this indicator (these indicators).

* Describe how the data for this indicator are being used (or will be used).
	+ Are the data produced by this indicator actionable?
	+ Who will use the data?
	+ What kinds of decisions will be made using these data?
* For what kinds of countries would the indicator(s) be most useful?
* Does the DHS survey offer any particular advantage over other available data sources for measuring this indicator? If so, what?

The world is becoming increasingly urbanized and this is happening at a particularly rapid rate in low and middle income countries (LMICs) (Harpham, T., 2009; Vlahov, D. et al, 2007; APHRC, 2012). A bi-product of rapid urbanization in LMICs has been the increase in informal settlements or slums, (Friel et al., 2011; United Nations Human Settlements Programme, 2003). Approximately 14% of the world’s population lives in slums (Fink et al., 2012). As a result, there is a pressing need to understand the intra-urban health disparities that affect these growing and heterogeneous urban populations in order to better plan health resources and provide for their needs.

Currently the DHS sampling methodology does not conduct sampling in and around urban centers to a level of being able to easily disaggregate to populations living in informal settlements (“slums”) and other administrative levels (such as peri-urban spaces), thus compromising health and service coverage measurements for these populations. The USAID Urban Health working group recently conducted an internal analysis of selected maternal and child health indicators using the most recent DHS data from 6 sub-Saharan African countries as background for a Broad Agency Announcement released in December 2018. The working group found it quite challenging to be able to disaggregate the data in a way that would allow for an understanding of the health patterns for the urban poor, peri-urban, and informal settlement residents. To this end, we are requesting that the DHS program consider oversampling at lower administrative levels in peri-urban and urban settings in order to facilitate these types of subgroup analyses (and include a marker to indicate that a settlement meets a working definition of “slum,” perhaps from UN Habitat [definition](http://mirror.unhabitat.org/documents/media_centre/sowcr2006/SOWCR%205.pdf)).

Furthermore, descriptive analyses that included consideration of peri-urban and informal settlements would go a long way in better understanding demographic and health shifts over time in these settings in order to better influence policy and programming. This can come in the form of the bivariate tables that are presented and/or a specific module that is dedicated to urban health. For example, many of the tables that show household characteristics and household population (often chapter 2 in final reports) could further breakdown place of residence into peri-urban and informal settlement and then show the distribution for any of the household and population characteristics of interest. Specifically, tables that show the distribution of:

1- household drinking water,

2- availability of water,

3- household sanitation facilities,

4- household characteristics,

5- household refuse disposal,

6- household possessions,

7- wealth quintiles,

8- handwashing,

9- household population by age and sex, and

10- household composition

 would be helpful to understand by place of residence.

Similarly, as another example, for maternal and child health variables tables that show the distribution of:

1- five-year early childhood mortality rates according to background characteristics,

2- perinatal mortality,

3- antenatal care,

4- number of antenatal care visits and timing of first visit,

5- components of antenatal care,

6- tetanus toxoid injections,

7- place of delivery,

8- assistance during delivery,

9- caesarean section,

10- timing of first postnatal check for the mother,

11- type of provider of first postnatal check for the mother,

12- timing of first postnatal check for the newborn,

13- type of provider of first postnatal check for the newborn,

14- content of postnatal care for newborns,

15- discharge timing,

16- child’s size and weight at birth,

17- possession and observation of vaccination cards,

18- according to background characteristics,

19- vaccinations by background characteristics,

20- reasons vaccinations were missed, late, or not given,

21- prevalence and treatment of symptoms of ARI,

22- prevalence and treatment of fever,

23- feeding practices during diarrhoea,

24- oral rehydration therapy, zinc, and other treatments for diarrhoea, and

25- knowledge of ORS packets and clinic-recommended homemade fluids

would also be helpful to understand by place of residence.

Due to the nature and volume of variables in this request, it may be more comprehensive to present these data in an urban health focused module as part of the final report. If presented in an urban health focused module a sample table on tetanus toxoid injection (taken from the 2016 South Africa DHS Survey Final Report) could look like:

Sample Proposed DHS8 Table on Tetanus Toxoid Injection

|  |  |  |  |
| --- | --- | --- | --- |
| Background Characteristic | Percentage receiving two or more injections during the pregnancy for the last live birth  | Percentage whose most recent live birth was protected against neonatal tetanus | Number of mothers  |
| **Age at birth** |  |  |  |
| <20 |  |  |  |
| 20-34 |  |  |  |
| 35-49 |  |  |  |
| **Birth order** |  |  |  |
| 1 |  |  |  |
| 2-3 |  |  |  |
| 4-5 |  |  |  |
| 6+ |  |  |  |
| **Residence** |  |  |  |
| Urban |  |  |  |
| Peri-urban |  |  |  |
| Informal settlement |  |  |  |
| Non-urban\* |  |  |  |
| **Province** |  |  |  |
| Western Cape |  |  |  |
| Eastern Cape |  |  |  |
| Northern Cape |  |  |  |
| Free State |  |  |  |
| KwaZulu-Natal |  |  |  |
| North West |  |  |  |
| Gauteng |  |  |  |
| Mpumalanga |  |  |  |
| Limpopo |  |  |  |
| **Education** |  |  |  |
| No education |  |  |  |
| Primary incomplete |  |  |  |
| Primary complete |  |  |  |
| Secondary incomplete |  |  |  |
| Secondary complete |  |  |  |
| More than secondary |  |  |  |
| **Wealth quintile** |  |  |  |
| Lowest |  |  |  |
| Second |  |  |  |
| Middle |  |  |  |
| Fourth |  |  |  |
| Highest |  |  |  |
|  |  |  |  |
| Total |  |  |  |

\*Should not include peri-urban areas.

Generating and analyzing this type of data would allow all concerned with the health and well-being of poor and marginalized populations to better understand what the health needs are and propose policy and programmatic solutions to address them.