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| Baseline health survey for displaced population in Daquq IDP camp, Daquq district, Kirkuk governate, Iraq. |
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**Study proposal**

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**Version 1.1**

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***Study design***  Simple random sampling

***Study type*** Cross-sectional observational study

***Study subjects*** Population living in the survey area

***Study period*** June - July

***Study site*** Daquq IDP camp Daquq District, Kirkuk Governorate, Iraq

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Contents

[Abbreviations 5](#_Toc481496064)

[1. Introduction 6](#_Toc481496065)

[1.1. Context 6](#_Toc481496066)

[1.2. Daquq camp 6](#_Toc481496067)

[1.3. Leylan 3 camp 7](#_Toc481496068)

[1.4. Justification 7](#_Toc481496069)

[2. Survey objectives 8](#_Toc481496070)

[2.1. Primary objective 8](#_Toc481496071)

[2.2. Secondary objective 8](#_Toc481496072)

[3. Methodology 8](#_Toc481496073)

[3.1. Study design and area 8](#_Toc481496074)

[3.2. Study Population: 8](#_Toc481496075)

[3.3. Definitions 8](#_Toc481496076)

[3.4. Eligibility criteria: 9](#_Toc481496077)

[3.5. Sample size: 9](#_Toc481496078)

[3.6. Sampling procedures 12](#_Toc481496079)

[4. Questionnaire 13](#_Toc481496080)

[4.1. Household information 13](#_Toc481496081)

[4.2. Demographics, morbidity and mortality 13](#_Toc481496082)

[4.3. Access to health care 13](#_Toc481496083)

[4.4. Chronic conditions 13](#_Toc481496084)

[4.5. Vaccination and Nutritional status (including pregnant & lactating women) 13](#_Toc481496085)

[4.6. Experience of violence/trauma 14](#_Toc481496086)

[4.7. Mental health status 14](#_Toc481496087)

[5. Implementation 15](#_Toc481496088)

[6. Data management 15](#_Toc481496089)

[7. Ethical considerations 16](#_Toc481496090)

[7.1. Informed consent 16](#_Toc481496091)

[7.2. Confidentiality 17](#_Toc481496092)

[7.3. Risks and benefits related to survey participation 17](#_Toc481496093)

[8. Collaboration 17](#_Toc481496094)

[9. Recruitment, training and logistics 18](#_Toc481496095)

[9.1. Selection and tasks of study teams 18](#_Toc481496096)

[9.2. Supervision 18](#_Toc481496097)

[9.3. Suggested MSF support in the field 18](#_Toc481496098)

[9.4. Training of study teams and pre-testing of the questionnaires 19](#_Toc481496099)

[9.5. Timeframe in the field 19](#_Toc481496100)

[10. Logistics 19](#_Toc481496101)

[10.1. Supplies required 19](#_Toc481496102)

[10.2. Transport 20](#_Toc481496103)

[Bibliography: 20](#_Toc481496104)

# Abbreviations

|  |  |
| --- | --- |
| **BCG** | Bacille Calmette Guerin |
| **CMR** | Crude mortality rate |
| **CRF** | Case report forms |
| **CVD** | Cardiovascular disease |
| **DoH** | Directorate of Health |
| **EmCO** | Emergency coordinator |
| **FinHRCo** | Coordinator - Finance and Human resources |
| **GAM** | Global acute malnutrition |
| **GIS** | Geographical information system |
| **GPS** | Global positioning system |
| **HoM** | Head of Mission |
| **IDP** | Internally displaced population |
| **IOM** | International organization for migration |
| **IQD** | Iraqi Dinar |
| **ISF** | Iraqi security forces |
| **ISIL** | Islamic state of Iraq and the Levant |
| **MAM** | Moderate acute malnutrition |
| **MDM** | Médecins du Monde |
| **MedCo** | Medical coordinator |
| **MSF** | Médecins Sans Frontières |
| **MTL** | Medical team leader |
| **NCD** | Non-communicable disease |
| **OCA** | Operational centre Amsterdam |
| **PC** | Project coordinator |
| **PMF** | Popular mobilization forces |
| **SAM** | Severe acute malnutrition |
| **U5MR** | Under 5 mortality rate |
| **WASH** | Water, sanitation and hygeine |
| **WHO** | World Health Organization |

# Introduction

## Context

Iraq continues to experience pervasive levels of violence and displacement with no end in sight. The country is undergoing a massive humanitarian crisis compounded by an uneven emergency response and critical access constraints hampering the delivery of assistance to millions of civilians in a violent environment(1,2). As of 02 March 2017, there were 3,062,808 internally displaced persons (510,468 families) displaced after January 2014, dispersed across 106 districts and 3,660 locations in Iraq(3).

Health facilities are struggling to deliver the required support in areas with high concentrations of displaced people. Overcrowding is a major problem in many communities. With estimated tuberculosis incidence of 16 per 1,000 populations in 2015, Iraq has one of the highest tuberculosis rates in the region. Drug resistant tuberculosis was reported to be 3.3 per 100,000 in the same year(4–6). Cholera is endemic and measles cases have been reported in all 18 governorates. The burden of cardiovascular disease (CVDs) and other non-communicable diseases (NCDs) like cancer, chronic obstructive lung disease and diabetes is considerable. In 2014, WHO reported 62% of all reported deaths were attributable to NCDs. An already fragile and superficially functioning health care system is now further weakened by huge and rapid influxes of displaced populations causing significant increases in patient loads and reduced access to primary, secondary & tertiary healthcare services(7,8).

Kirkuk governorate hosts an estimated 380,412 IDPS with a 4% increase (9,216 individuals) from February to March 2017 as a result of the ongoing military operations in Al Hawija district. The displacement caused by the military operations affected not only Kirkuk, but also neighbouring governorates. According to the International Organisation for Migration Displacement Tracking Matrix, as of 6 March 2017 the total number of IDPs from Al Hawija (monitored from the beginning of August 2016) stands at 88,950 individuals. The majority of IDPs from Al Hawija are currently displaced in Kirkuk, Salah al-Din and Erbil governorates. As of April 13, 2017, there are 6 IDP camps within Kirkuk (42,541 Iraqi IDPs) of which 5 (Yahyawa – 3,758; Nasarawa – 9,300; Laylan 1 – 10,998; Laylan 2 – 4,607;  Laylan 3 – 3,822) are 20km south east & 1 (Daquq – 9,631) is 44km south of Kirkuk city (15 km east of the IS-Peshmerga/ISF/PMF front line ).

## Daquq camp

Daquq camp opened in early October 2016 and is commonly referred to as the ‘Hawija camp. The camp population ~9,000 persons are confined without identification or means to leave the camp. Some of them are accused of having links with ISIL but the main reason seems to be to avoid more IDPs in the host community which can change the demography of the city. Daquq camp has reached maximum capacity and is using now the so called emergency tents; the camp was forced to open prematurely before any permanent health services were in place. At that time MDM offered mobile clinic 3 days per week and the DOH provide a PHC medication dispensing service several hours each day/5 days a week from a caravan. MSF took over all MdM activities, first PHC in December 2016 & Mental Health during January 2017. MSF runs mobile clinics 6 times per week & established a proper PHC, but since January 2017 the DoH opened their own PHC next to MSF and by mid-April 2017 MSF handed over the OPD consultations to DoH and changed focus to NCD. DoH mobile vaccination started catch up vaccination activities in the camp. There is no 24 hour medical service, but in the event of urgent medical care people are referred to Daquq Hospital for all their healthcare needs (if they are able to negotiate their exit). Non-emergency referrals for secondary and tertiary care are uncertain and very restricted.

## Leylan 3 camp

Leylan 3 started to receive IDPS on 08/02/2017, at that time the camp already contained 2500 tents and a population of 640 families (3553 individuals), meaning that 25.6% of its capacity was full. The second half of the camp (for a similar capacity) is under discussion by the governor & Municipality. Last population from camp manager on 16/03/2017 was 3822 people. DoH is reported to be in camp since 09/02/17 with mobile clinics, the families living there arrived from Maktab Khalid, Salah Al-Din (few) & Debes.

## Justification

At present, we have limited information on this Daquq camp population in terms of their demographic composition, health and vaccination status, vulnerable population and current access to healthcare. There is also limited information on the population of Leylan 3 camp and if access can be negotiated we propose to conduct this same baseline assessment there.

* The proposed survey will allow MSF to better understand the health situation of the population in this camp, in order to respond to their immediate healthcare and mental health needs.
* Reliable data on the underlying health conditions and the vaccination coverage of the population of interest would help in advocating and liaising with stakeholders for targeted interventions which would help in reducing morbidity and mortality in the population.
* The information will provide a baseline to conduct a future assessment to measure the impact of our activities in the camp.



Figure 1. Map of Iraq

# Survey objectives

## Primary objective

To estimate the vaccination coverage for key vaccine preventable diseases in children aged 6-59 months and the prevalence of key morbidities in the population.

## Secondary objective

* To describe the demographic characteristics of the population
* To estimate the global acute malnutrition (GAM) rate of in children aged 6-59 months and pregnant women
* To estimate the prevalence of self-reported major chronic diseases
* To estimate the prevalence of symptoms commonly associated with mental health distress
* To estimate the prevalence of violence/trauma experienced during the recall period
* To estimate the current and retrospective mortality during the recall period
* To determine the most common barriers to healthcare

# Methodology

## Study design and area

This will be a cross-sectional observational survey in the Daquq IDP camp, Iraq.

## Study Population:

The study population is the whole population residing in the Daquq IDP camp, Iraq.

## Definitions

***Household definitions***

A **household** isdefined asa group of people who live together under the same roof and are under the responsibility of one person (head of household). The whole household will be included, no matter the age of the household member or the relation with the other members. The household definition includes all individuals who have been living in the household at any time during the recall period, including those who arrived or departed within the recall period.

A **head of household** is defined as:

* adult household member aged 18 years or older, ***and***
* can give accurate information on all demographic issues in his/her household, ***and***
* has lived in the household the entire recall period, ***and***
* is present at the time of the survey.

A household will be excluded from the survey if none of the household members fulfil all these criteria.

***Recall period***

We will use a recall period of up to one year. The precise beginning of the recall period will be decided upon with the team in the field, considering the experience of the national staff. The aim is to understand the experience of the population both before and after displacement and its impact on health. The end of the recall period will be the day prior to the start of the interviews in the field. Together with the field team, an events calendar will be generated for the chosen recall period to determine more accurately the dates the deaths occurred.

## Eligibility criteria:

***Inclusion criteria:***

A person will be included in the survey if he / she satisfy the following criteria:

* Currently living in the randomly selected household\*

***AND***

* Informed consent for inclusion in the survey is provided by the head of the household.

\*NB The demographic, mortality and violence sections of the survey will also include all persons who had arrived, had left, were born or who had died in the household during the recall period of the survey.

***Exclusion criteria:***

A person will be excluded from the survey if he / she satisfy any one of the following criteria:

* Inability to locate the potential participant after two attempts of tracing

***OR***

* Refusal to participate in the survey.

## Sample size:

Sample sizes, assuming simple random sampling, were calculated for vaccination coverage, nutrition and mortality surveys (see Table 1). The sample size for vaccination coverage was powered on detecting a vaccination coverage of 50%. This coverage figure has been chosen based on the low coverage found during the December 2015 surveys of camps in the Sulaimaniyah Governorate.

Based on an average household size of six with 18% of children aged 6-59 months we can expect on average a frequency of 1.08 children aged 6-59 months per household. To measure vaccination coverage of 369 children aged 6-59 months, 399 households need to be included in the vaccination survey. Allowing for a 10% non-response rate a total of **439 households** will be included.

Additional sample size calculations for Leylan 3 camp will be made if access is granted and a survey is planned.

Table 1 Assumptions for sample size calculation

|  |  |  |
| --- | --- | --- |
| **Parameter** | **Value** | **Comment** |
| **Vaccination Survey Sampling A** | | |
| Estimated vaccination coverage (%) | 50 | Assumed low coverage for largest sample size |
| Desired Precision (%) | 5 |  |
| Design Effect | 1.0 | Population assumed homogenous |
| Average HH Size | 6 | Based on Sulaimaniyah survey |
| % of children 6-59 months | 18 | Based on Sulaimaniyah survey |
| % non-response rate | 10 | Unknown potential non response rate |
| **Children to be included** | **369** | Children |
| **Total Sample size** | **439** | Households |
| **Nutrition Survey Sampling B** |  |  |
| Estimated GAM Prevalence (%) | 15 | Emergency threshold |
| Desired Precision (%) | 5 |  |
| Design Effect | 1 | Population assumed homogenous |
| Average HH Size | 6 | Based on Sulaimaniyah survey |
| % of children 6-59 months | 18 | Based on Sulaimaniyah survey |
| % non-response HH | 10 | Unknown potential non response rate |
| **Total children to be included** | **213** | Children |
| **Total Sample size** | **244** | Households |
| **Mortality Survey Sampling B** |  |  |
| Estimated death rate per 10,000/day | 0.5 |  |
| Desired Precision (%) | 0.3 |  |
| Design Effect | 1 | Population assumed homogenous |
| Average HH size | 6 | Based on Sulaimaniyah survey |
| Recall period (days) | 365 |  |
| % non-response HH | 10 | Unknown potential non response rate |
| **Total sample population** | **637** |  |
| **Total HH to be included** | **118** |  |

A Sample size for the vaccination survey was calculated using OPENEpi (http://www.openepi.com/Menu/OE\_Menu.htm)

B Sample size for the nutrition and mortality survey was calculated using the Emergency Nutrition Assessment (ENA) for SMART 2011 software (version 9th July 2015).



Figure 2: Plan of Daquq IDP camp, Kirkuk (Source: UNHCR)

## Sampling procedures

Option 1: Random selection from household list method

This option may be used if a current camp household list is available. Random numbers (between 1 and the total number of households in the camp) are generated to obtain the target sample size of households. Only these households will be visited.

Option 2: GPS based sampling method

This option may be used if a current camp household list is not available. Using satellite imagery or conducting a perimeter walk around the camp and using GPS points, an electronic outline of the camp will be created. GIS software will be used to generate random points within the camp corresponding to the number of households to be visited. Teams using either GPS machines or Android phones with GPS localization functionality will visit the households physically closest to the randomly-generated points.

Ten field teams of two staff will be deployed for data collection. It has been estimated that twelve field teams will be able to complete 48 households per day, assuming a working day from 9.30 am to 4 pm. (Table 2). To reach the desired number of households (439) will take ten days.

Table 2. Assumptions for calculating number of households/team/day

|  |  |  |
| --- | --- | --- |
| **Activity** | **Estimated time (minutes)** | |
| Daily briefings/feedback | | 60 |
| Lunch and tea breaks | | 60 |
| Community engagement/feedback | | 15 |
| Time to complete survey & walk to next household | | 60 |
| Total time available/day (9.30am – 4pm) | | 390 |
| Time required for non-survey activities | | 165 |
| Time available for surveys | | 225 |
| Number of households/team/day | | 4 |

# Questionnaire

The household interviews will be based on a questionnaire that consists of 7 sections. MSF-OCA standardised templates with contextual modifications (where required) are used wherever possible. Further adjustments may be made after consultation with the survey team and the pilot field test.

## Household information

The respondent will be asked about the origin of the household, date of arrival in the camp, reasons for and number of times they have re-located.

## Demographics, morbidity and mortality

The respondent will be asked for demographic information about current household members and all persons who have arrived, have left, were born or who have died in the household during the recall period of the survey. The field team member will **not** read out the cause of death options, but will prompt the respondent to gain the most accurate information.

The ability to obtain and barriers preventing obtaining ID documentation for children under 3 years will be noted.

The respondent will be asked if any household members were sick in the last two weeks.

The field team member will **not** read out the list of symptoms/conditions, but will prompt the respondent to gain the most accurate information.

The list of illnesses was taken from the Irbid (Jordan) Access survey conducted in 2016, as they are more suited to the context than the standard template options.

## Access to health care

The respondent will be asked about the access to health care for the household member who was most recently sick using the standardized health seeking behaviour template MODULE 4.

This section does not relate to a specific recall period.

## Chronic conditions

The respondent will be asked about chronic conditions requiring ongoing care in all current household members.

## Vaccination and Nutritional status (including pregnant & lactating women)

Children aged 6-59 months will be assessed for polio and measles vaccination. Verification method will be recorded. They will also be assessed for BCG vaccination by the team field member examining the upper left arm for a vaccination scar.

Table 3. Iraq Routine Vaccination Schedule

|  |  |
| --- | --- |
| Age | Type of Vaccine |
| 0-1 week | HepB1 , BCG + OPV0dose |
| 2 months | HEXA 1,ROTA1 ,PREV13-1+OPV1 |
| 4 months | HEXA2,ROTA2,PREV13-2 + OPV2 |
| 6 months | HEXA3,ROTA3,PREV13-3 + OPV3 |
| 9 months | Measles + VIT A |
| 15 months | MMR(Measles , Mumps , Rubella) |
| 18 months | PENTA (DTP+IPV+Hib ) OPV + VIT A |
| 4-6 years | TETRA (DTaP +IVP ) + OPV + MMR |

*Oedema*

Children aged 6- 59 months will be assessed for bilateral oedema by a field team member applying a three second moderate thumb pressure to the anterior surface of both feet. If, after the pressure is released, a depression remains for a >3 seconds on each foot, the child is recorded as having bilateral oedema.

*Mid-Upper Arm Circumference (MUAC) -children*

Children aged 6 – 59 months will have a MUAC measurement taken at the mid-point of the left upper arm, using the standard MUAC tape, and recorded in millimetres.

*Mid-Upper Arm Circumference (MUAC) – pregnant women*

Women will have a MUAC measurement taken at the mid-point of the left upper arm, using the adult MUAC tape, and recorded in millimetres.

## Experience of violence/trauma

The respondent will be asked about each household members’ experience of violence/trauma during the recall period. Household members who have left or died during the recall period are to be included.

The standardized template MODULE: Violence will be used with context specific modifications.

## Mental health status

Mental health status for all current household members will be assessed using the WHO-UNHCR Schedule of Serious Symptoms in Humanitarian Settings (WASSS) (field-test version).9

# Implementation

In the households randomly selected according to the above methodology, the head of the household will be provided with an information sheet explaining the survey purpose, data to be collected, risks and benefits, how confidentiality will be maintained and how the data will be used. The trained survey staff will read and/or explain the information sheet if required and answer any questions in the language the head of household is familiar with.

Written consent will be sought from all heads of household participating in the survey. If they decline to participate this will be accepted, written down and the next household approached; the number of household refusals should be noted on the survey control form.

All eligible children (those aged between 6 and 59 months of age) in every selected household will be measured and the mortality questionnaire and other survey sections will be administered in each household, even those with no eligible children.

If an eligible child is absent at the time of the visit, it will be noted on the data collection and survey control forms and the team will revisit the household later in the day.

If a household is empty, the neighbours will be asked about the family that lives there. If the residents are likely to return that day the team should also return later in the day. If the residents do not return before the team leaves, a note will be made on the data collection and survey control forms. The household should not be replaced as a non-response rate was factored into the sample size calculations.

# Data management

Survey teams will meet each morning for briefing, feedback from the previous day and collection of tablet. At completion of the day the teams will return to hand in their tablets for upload of data and recharging

Data will be entered into EpiData by the study investigators if collected on paper forms. If collected electronically, databases will be automatically generated so EpiData will not be needed. All data will be anonymised (names are not being collected) and electronic files stored password-protected by MSF. Only study investigators will have access to these data files. Data cleaning will be done to check for inconsistencies in data entry and responses. Data analysis will be conducted using STATA 13 (StataCorp, College Station, TX, USA).

No identifiable (name-related) data will be collected during the survey and all GPS coordinates will be destroyed; reducing the risk that participants will be identifiable after the survey has been completed. The electronic database will be password protected. The paper versions of the questionnaires (if used), and the electronic database will be stored at the MSF-OCA headquarters or country management level for 5 years after the survey. Access to the electronic and paper version of the survey will be restricted to the co-investigators of the study and the Medical Coordinator. After 5 years, the paper copies of all the questionnaires will be destroyed.

All indicators (i.e. sex and age of the survey population) will be calculated as proportions with 95% confidence intervals (95%CI).

The end of the recall period will be calculated individually for each member of the household present at the start of the recall period or born within the recall period. The recall period will end either with the day of the study or the day of death of the household member. An average of all recall days will be taken.

Denominators for mortality rates will correspond to the mid-period population sizes, assumed to be the total population at the end of the period minus half of persons joining the sample during the recall period (newborns and new household members) plus half of persons leaving the sample during the recall period (deaths or departure). 95% CIs will be calculated and adjusted for the design effect.

# Ethical considerations

The study will be conducted in accordance with the Council for International Organisations of Medical Sciences (CIOMS) International Ethical Guidelines, 2016 and the World Medical Assembly (WMA) Helsinki Declaration on Ethical Principles for Medical Research Involving Human Subjects.

The protocol will be approved by the Ethical Review Board of Médecins san Frontières before implementation. In addition official permission will be requested from Directorate of Health, Kirkuk Governorate, Iraq.

The camp administrator and the relevant authorities (including identified community leaders) will receive a letter one week prior to the start of the survey explaining the purpose of the survey and its procedures, specifically also explaining how the survey ensures anonymity of respondents and their right to refuse participation in the interview.

The MSF medical responsible in the field will advise the study team on the referral practices when finding survey participant who show signs or symptoms of illness requiring immediate clinical attention, children or pregnant women identified as malnourished as well as the procedure regarding psychosocial issues or victims of violence.

## Informed consent

Heads of the selected households will receive an oral and written information about the survey objectives, study procedures and a clear explanation of the risks and benefits derived from participation in the research through a trained study staff. The trained survey staff will answer to any queries that the head of household may have regarding the same. Those willing to participate will be requested to give written consent.

Participants will be informed that they have the right to withdraw from the study at any time during the research.

## Confidentiality

No names will be collected and household identifiers will be delinked from the data collection tool after data has been collected and verified.

Verbatim quotation in dissemination material will be designated by the age group and category of the person (e.g. male aged 40 years, head of the household) to preserve anonymity.

Access to the study data will only be granted to authorized and trained staff.

## Risks and benefits related to survey participation

***Risk for the participants***

The study participation is not expected to convey any risks to the participants. The interview will be conducted in privacy by trained survey staff. The questionnaire has been designed to deal the sensitive topics delicately. However, the interviews will cover several sensitive topics which may cause some anxiety for the participants. We will try to mitigate this by ensuring that our interview teams are appropriately trained in psychological first aid. In the event of a visibly traumatized individual, the team will conclude the interview and will identify follow up measure to offer appropriate support in liaison with the MSF Mental health staff. Each respondent will be assured of the confidentiality and privacy of the interview, and informed that s/he is free to stop the interview at any time or refuse to answer any questions.

For MSF, the risk would be that the security situation may deteriorate to a level that we would not safely be able to deploy the survey team.

***Benefit for the participants***

The survey results are expected to inform MSF to make operational decisions better suited to the needs of the targeted population.

# Collaboration

This survey will be conducted by MSF OCA, with cooperation of the Directorate of Health, Kirkuk Governorate, Iraq.

MSF OCA is the study sponsor and is responsible for funding. It is in charge of the field part fo the study, the analysis and report writing. Permission for publication must be obtained from the MSF OCA and the Directorate of Health.

Study results will belong to MSF OCA and the Directorate of Health, Kirkuk Governorate, Iraq.

# Recruitment, training and logistics

## Selection and tasks of study teams

The task of the interviewers will be to collect the necessary data for the study.

Each survey team is composed of two interviewers. To finalise the field part in a reasonable time we need ten survey teams of two people each

General selection criteria for all interviewers:

* Able to read and write in English and/or Arabic *and*
* Fluent in the local language Arabic *and*
* Available for the ENTIRE time of the study (training and interview days), *and*
* Motivated to participate in the study, *and*
* Not biased in expectations of the outcome of the study
* Experience with interviews in difficult settings and study populations would be an advantage

In addition, two local supervisors will be employed to supervise the survey teams in the field.

## Supervision

The principal investigator is the overall responsible for the final version of the protocol, overall quality of the survey and data analysis, and the final report.

The principal investigator will ensure that the following tasks are performed:

* Preparation of all necessary documents (protocol, questionnaires, informed consent forms) for the study
* Preparation of the field component of the study (training of the study teams, logistics, materials) together with the MSF team in the field
* Follow-up of the field component of the study
* Data entry
* Data analysis
* Report writing

## Suggested MSF support in the field

* Administrative support for study preparation at the field level and during field part, such as obtaining permission from the Directorate of Health, Kirkuk Governorate and payment of study teams.
* Human resources support, such as hiring study team/interviewers, a translator for the principal investigator if needed
* Logistic support for study preparation at the field level and during field part, such as organizing sufficient cars including drivers for the field part of the study, providing communication tools and MSF ID (e. g. aprons, vests or arm bands) to the study teams, stationary, printing the consent forms

## Training of study teams and pre-testing of the questionnaires

Two days training will be given to all interviewers to familiarise them with the background of the study, the questionnaires, the information sheet and the informed consent form. The training will be given in English with translation if needed by the principal investigator. It consists of an intensive review of the questionnaires and the information sheet including role-plays. As the interviews will be held in the national language, the principal investigator should ensure that all interviewers are using the same and correct wording for providing information to the households and for the interviews.

The 2-days training will finish with a pilot study. The pilot study allows for the testing and possible final adaptation of the questionnaires and informed consent to field conditions.

## Timeframe in the field

Preliminary plan of the field component of the survey. Additional time for final study preparation and report writing will be required.

Table 4. Field activities and days required

|  |  |  |
| --- | --- | --- |
| Activity | | Number of days |
| Travel days for arrival | | 3 |
| Final preparation of the study | | 2 |
| Training including the pilot study | | 2 |
| Field data collection | | 9 |
| Buffer days / debriefing | | 2 |
| Travel days to return | | 3 |
| **TOTAL** | **21** | |

# Logistics

## Supplies required

Supplies for the conduct of the study will be purchased locally.See table 5 for a list of required supplies.

Some IT supplies may already be available within the Iraq mission.

Table 5. Supplies needed for the survey teams/supervisors

|  |  |  |  |
| --- | --- | --- | --- |
| Item | No. needed per team | No. needed per supervisor | No. needed for ten teams and two supervisors |
| Back pack/shoulder bag | 1 | 1 | 12 |
| Clipboard | 1 | 1 | 12 |
| Pencil | 3 | 2 | 34 |
| Rubber | 2 | 2 | 24 |
| Sharpener | 2 | 2 | 24 |
| Eraser | 2 | 2 | 24 |
| Aprons, vests, arm bands or similar with MSF identification / logo | 2 | 1 | 22 |
| Plastic sleeves (for protection of documents) | 3 | 3 | 36 |

Table 6. IT requirements

|  |  |  |
| --- | --- | --- |
| Item | Number required | For whom |
| Tablets & chargers for data entry | 10 (minimum) | Survey teams |
| Laptop | 1 | Field coordinator |
| GPS devices (if not a feature of tablets) | 10 (minimum) | Survey teams |

## Transport

Transport requirements will depend on where the field teams are recruited from; if they are from outside of the camp, 2 taxi minibuses will be required.

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