November, 2006

ANGOLA MALARIA INDICATOR SURVEY
HOUSEHOLD QUESTIONNAIRE

ANGOLA
COSEP – CONSULTORIA, LDA / CONSAUDE

IDENTIFICATION

PLACE NAME _____

NAME OF HOUSEHOLD HEAD _____

CLUSTER NUMBER .....

HOUSEHOLD NUMBER .....

REGION .....

URBAN/RURAL (URBAN=1, RURAL=2) .....

MALARIA ENDEMIC REGION .....
1 = Hyperendemic (Cabinda, Uige, K. Norte, Malange, L. Norte, L. Sul
2 = Mesoendemic Stable (Zaire, Luanda, Bengo, Benguela, K. Sul, Huambo, Bié)
3 = Mesoendemic Unstable (Moxico, K. Kubango, Kunene, Huila, Namibe)

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY / MONTH / YEAR
INTERVIEWER'S NAME				NAME
RESULT*				RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:

1	COMPLETED
2	NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT
3	ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME
4	POSTPONED
5	REFUSED
6	DWELLING VACANT OR ADDRESS NOT A DWELLING
7	DWELLING DESTROYED
8	DWELLING NOT FOUND
9	OTHER _____ (SPECIFY)

TOTAL PERSONS IN HOUSEHOLD

TOTAL ELIGIBLE WOMEN

LINE NUMBER OF RESPONDENT TO HOUSEHOLD QUESTIONNAIRE

SUPERVISOR	OFFICE EDITOR	KEYED BY
NAME _____		
DATE _____		

INFORMED CONSENT

Hello. My name is _____ and I am working with (NAME OF ORGANIZATION). We are conducting a national survey about malaria. We would very much appreciate your participation in this survey. The information you provide will help the government to plan health services. The survey usually takes about 20 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

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?
May I begin the interview now?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED..... 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIEWED .... 2 —▸END

HOUSEHOLD LISTING

Now we would like some information about the people who usually live in your household or who are staying with you now.

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	ELIGIBLE WOMEN	ELIGIBLE CHILDREN
	Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.	What is the relationship of (NAME) to the head of the household?*	Is (NAME) male or female?	Does (NAME) usually live here?	Did (NAME) stay here last night?	How old is (NAME)?	CIRCLE LINE NUMBER OF ALL WOMEN AGE 15-49	CIRCLE LINE NUMBER OF ALL CHILDREN AGE 0-5 YEARS
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
			M F	YES NO	YES NO	IN YEARS		
01			1 2	1 2	1 2		01	01
02			1 2	1 2	1 2		02	02
03			1 2	1 2	1 2		03	03
04			1 2	1 2	1 2		04	04
05			1 2	1 2	1 2		05	05
06			1 2	1 2	1 2		06	06
07			1 2	1 2	1 2		07	07
08			1 2	1 2	1 2		08	08
09			1 2	1 2	1 2		09	09
10			1 2	1 2	1 2		10	10

* CODES FOR Q.3 RELATIONSHIP TO HEAD OF HOUSEHOLD:
01 = HEAD
02 = WIFE/HUSBAND
03 = SON OR DAUGHTER
04 = SON-IN-LAW OR DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER OR SISTER
09 = OTHER RELATIVE
10 = ADOPTED/FOSTER/ STEPCHILD
11 = NOT RELATED
98 = DON'T KNOW

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	ELIGIBLE WOMEN	ELIGIBLE CHILDREN
	Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.	What is the relationship of (NAME) to the head of the household?*	Is (NAME) male or female?	Does (NAME) usually live here?	Did (NAME) stay here last night?	How old is (NAME)?	CIRCLE LINE NUMBER OF ALL WOMEN AGE 15-49	CIRCLE LINE NUMBER OF ALL CHILDREN AGE 0-5 YEARS
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
			M F	YES NO	YES NO	IN YEARS		
11			1 2	1 2	1 2		11	11
12			1 2	1 2	1 2		12	12
13			1 2	1 2	1 2		13	13
14			1 2	1 2	1 2		14	14
15			1 2	1 2	1 2		15	15
16			1 2	1 2	1 2		16	16
17			1 2	1 2	1 2		17	17
18			1 2	1 2	1 2		18	18
19			1 2	1 2	1 2		19	19
20			1 2	1 2	1 2		20	20

TICK HERE IF CONTINUATION SHEET USED ☐

Just to make sure that I have a complete listing:

1) Are there any other persons such as small children or infants that we have not listed? YES ☐→ ENTER EACH IN TABLE NO ☐

2) In addition, are there any other people who may not be members of your family, such as domestic servants, lodgers or friends who usually live here? YES ☐→ ENTER EACH IN TABLE NO ☐

3) Are there any guests or temporary visitors staying here, or anyone else who stayed here last night, who have not been listed? YES ☐→ ENTER EACH IN TABLE NO ☐

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
10	What is the main source of drinking water for members of your household?	PIPED WATER PIPED INTO DWELLING .....11 PIPED INTO YARD/PLOT.....12 PUBLIC TAP/STANDPIPE.....13 TUBE WELL OR BOREHOLE ..... 21 DUG WELL PROTECTED WELL .....31 UNPROTECTED WELL .....32 WATER FROM SPRING PROTECTED SPRING .....41 UNPROTECTED SPRING .....42 RAINWATER .....51 TANKER TRUCK .....61 CART WITH SMALL TANK .....71 SURFACE WATER (RIVER/DAM/ LAKE/POND/STREAM/CANAL/ IRRIGATION CHANNEL .....81 BOTTLED WATER.....91 OTHER _____ 96 (SPECIFY)	
11	What kind of toilet facilities does your household use?[1]	FLUSH OR POUR FLUSH TOILET FLUSH TO PIPED SEWER SYSTEM.....11 FLUSH TO SEPTIC TANK ..... 12 FLUSH TO PIT LATRINE..... 13 FLUSH TO SOMEWHERE ELSE . 14 FLUSH, DON'T KNOW WHERE . .... 15 PIT LATRINE VENTILATED IMPROVED PIT LATRINE (VIP)..... 21 PIT LATRINE WITH SLAB..... 22 PIT LATRINE WITHOUT SLAB/ OPEN PIT.....23 COMPOSTING TOILET.....31 BUCKET TOILET.....41 HANGING TOILET/HANGING LATRINE..... 51 NO FACILITY/BUSH/FIELD.....61 OTHER _____ 96 (SPECIFY)	
12	Does your household have: Public electricity? Alternative source of electricity (generator; solar panel)? A radio? A television? A telephone (fixed or mobile)? A refrigerator?	YES NO PUBLIC ELECTRICITY .....1 2 ALTERNATIVE ELECTRICITY ....1 2 RADIO .....1 2 TELEVISION .....1 2 TELEPHONE (FIXED).....1 2 TELEPHONE (MOBILE).....1 2 REFRIGERATOR.....1 2	
13	What type of fuel does your household mainly use for cooking?	ELECTRICITY .....01 LPG/NATURAL GAS.....02 OIL.....03 FIREWOOD.....04 COAL.....05 STRAW .....06 DUNG.....07 OTHER _____ 96 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
14	MAIN MATERIAL OF THE FLOOR. RECORD OBSERVATION.	NATURAL FLOOR EARTH/SAND ..... 11 DUNG ..... 12 RUDIMENTARY FLOOR WOOD PLANKS ..... 21 PALM/BAMBOO ..... 22 FINISHED FLOOR PARQUET OR POLISHED WOOD ..... 31 VINYL OR ASPHALT STRIPS ..... 32 CERAMIC TILES ..... 33 CEMENT ..... 34 CARPET ..... 35 OTHER _____ 96 (SPECIFY)	
15	Does any member of your household own: A bicycle? A motorcycle or motor scooter? A car or truck? A wagon? A horse/donkey?	YES NO BICYCLE ..... 1 2 MOTORCYCLE/SCOOTER ..... 1 2 CAR/TRUCK ..... 1 2 WAGON ..... 1 2 HORSE/DONKEY 1 2	
15A	At any time in the past 12 months, has anyone sprayed the interior walls of your dwelling against mosquitoes?	YES ..... 1 NO ..... 2 DON'T KNOW 8	→ 16
15B	How many months ago was the house sprayed? IF LESS THAN ONE MONTH, RECORD '00' MONTHS AGO.	MONTHS AGO ..... [ ][ ]	
15C	Who sprayed the house?[2]	GOVERNMENT WORKER/PROGRAM ..... 1 NAME OF PROGRAM (IF KNOWN) _____ PRIVATE COMPANY ..... 2 NAME OF COMPANY (IF KNOWN) _____ HOUSEHOLD MEMBER ..... 3 OTHER _____ 6 (SPECIFY) DON'T KNOW 8	
16	Does your household have any mosquito nets that can be used while sleeping?	YES ..... 1 NO 2	→ 27
17	How many mosquito nets does your household have? IF 7 OR MORE NETS, RECORD '7'.	NUMBER OF NETS ..... [ ]	

		NET # 1	NET #2	NET #3
18	ASK RESPONDENT TO SHOW YOU THE NET(S) IN THE HOUSEHOLD. IF MORE THAN THREE NETS, USE ADDITIONAL QUESTIONNAIRE(S).	OBSERVED .... 1 NOT OBSERVED 2	OBSERVED .... 1 NOT OBSERVED 2	OBSERVED .... 1 NOT OBSERVED 2
19	How long ago did your household obtain the mosquito net?	MOS AGO [ ][ ] MORE THAN 3 YEARS AGO 95	MOS AGO [ ][ ] MORE THAN 3 YEARS AGO 95	MOS AGO [ ][ ] MORE THAN 3 YEARS AGO……… 95
19a	(IF BETWEEN 0 AND 6 MONTHS) Did you obtain this mosquito net during the "*Viva a vida com saúde*" campaign?	YES ....1 NO ....2 DON'T KNOW 8	YES ....1 NO ....2 DON'T KNOW 8	YES ....1 NO ....2 DON'T KNOW 8
20	OBSERVE OR ASK THE BRAND OF MOSQUITO NET. IF BRAND IS UNKNOWN, AND YOU CANNOT OBSERVE THE NET, SHOW PICTURES OF TYPICAL NET TYPES/BRANDS TO RESPONDENT.	'PERMANENT' NET OLYSET ....11 PERMANET ....12 JOIA ....16 OTHER/DON'T KNOW BRAND 17 (SKIP TO 24) .... 'PRETREATED' NET BRAND C………...21 BRAND D………...22 OTHER ______________ 26 (SKIP TO 22) .... OTHER……………….31 DON'T KNOW BRAND……………..98	'PERMANENT' NET OLYSET ....11 PERMANET ....12 JOIA ....16 OTHER/DON'T KNOW BRAND 17 (SKIP TO 24) .... 'PRETREATED' NET BRAND C………...21 BRAND D………...22 OTHER ______________ 26 (SKIP TO 22) .... OTHER……………….31 DON'T KNOW BRAND……………..98	'PERMANENT' NET OLYSET ....11 PERMANET ....12 JOIA ....16 OTHER/DON'T KNOW BRAND 17 (SKIP TO 24) .... 'PRETREATED' NET BRAND C………...21 BRAND D………...22 OTHER ______________ 26 (SKIP TO 22) .... OTHER……………….31 DON'T KNOW BRAND……………..98
21	When you got the net, was it already factory-treated with an insecticide to kill or repel mosquitos?	YES ....1 NO ....2 NOT SURE 8	YES ....1 NO ....2 NOT SURE 8	YES ....1 NO ....2 NOT SURE 8
22	Since you got the mosquito net, was it ever soaked or dipped in a liquid to repel mosquitoes or bugs?	YES ....1 NO ....2 (SKIP TO 24) NOT SURE 8	YES ....1 NO ....2 (SKIP TO 24) NOT SURE 8	YES ....1 NO ....2 (SKIP TO 24) NOT SURE 8
23	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 EXACT NUMBER OF MONTHS.	MOS AGO [ ][ ] MORE THAN 2 YEARS AGO........... 95 NOT SURE 98	MOS AGO [ ][ ] MORE THAN 2 YEARS AGO .... 95 NOT SURE 98	MOS AGO [ ][ ] MORE THAN 2 YEARS AGO........... 95 NOT SURE 98
24	Did anyone sleep under this mosquito net last night?	YES ....1 NO ....2 (SKIP TO 26) NOT SURE 8	YES ....1 NO ....2 (SKIP TO 26) NOT SURE 8	YES ....1 NO ....2 (SKIP TO 26) NOT SURE 8

[1] "Permanent" is a factory treated net that does not require any further treatment.
[2] "Pretreated" is a net that has been pretreated, but requires further treatment after 6-12 months.

		NET # 1	NET #2	NET #3
25	Who slept under this mosquito net last night? RECORD THE RESPECTIVE LINE NUMBER FROM THE HOUSEHOLD SCHEDULE.	NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ]	NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ]	NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ] NAME ___________ LINE NO [ ][ ]
26		GO BACK TO 18 FOR NEXT NET; OR, IF NO MORE NETS, VERIFY IN HOUSEHOLD LISTING THE ELIGIBLE WOMEN, AND START A NEW INDIVIDUAL WOMAN'S QUESTIONNAIRE WITH EACH ELIGIBLE WOMAN.	GO BACK TO 18 FOR NEXT NET; OR, IF NO MORE NETS, VERIFY IN HOUSEHOLD LISTING THE ELIGIBLE WOMEN, AND START A NEW INDIVIDUAL WOMAN'S QUESTIONNAIRE WITH EACH ELIGIBLE WOMAN.	GO BACK TO 18 IN THE FIRST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE NETS, VERIFY IN HOUSEHOLD LISTING THE ELIGIBLE WOMEN, AND START A NEW INDIVIDUAL WOMAN'S QUESTIONNAIRE WITH EACH ELIGIBLE WOMAN.

HAEMOGLOBIN MEASUREMENT FOR CHILDREN UNDER 5 YEARS

CHECK COLUMN (7) OF HOUSEHOLD LISTING: RECORD THE LINE NUMBER, NAME AND AGE OF ALL CHILDREN UNDER 5 YEARS. THEN ASK THE DATE OF BIRTH.

CHILDREN UNDER AGE 6 YEARS					HAEMOGLOBIN MEASUREMENT OF CHILDREN BORN IN 2001 OR LATER			
LINE NUMBER FROM COL. (1)	NAME FROM COL. (2)	AGE FROM COL. (7)	What Is (NAME's) date of birth? FOR CHILDREN NOT INCLUDED IN ANY BIRTH HISTORY, ASK DAY, MONTH AND YEAR.	CHECK HERE IF CHILD IS ELIGIBLE FOR MEASURE-MENT (AGE 6-59 MONTHS)	LINE NUMBER OF PARENT/ADULT RESPONSIBLE FOR THE CHILD RECORD '00' IF NOT LISTED IN HOUSEHOLD SCHEDULE	READ CONSENT STATEMENT TO PARENT/ADULT RESPONSIBLE FOR THE CHILD CIRCLE CODE AND SIGN	RESULT 1 MEASURED 2 NOT PRESENT 3 REFUSED 4 OTHER ________ SPECIFY	HAEMOGLOBIN LEVEL (G/DL)
(27)	(28)	(29)	(30)	(31)	(32)	(33)	(34)	(35)
☐☐		☐☐	DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐	☐	☐☐	GRANTED REFUSED 1 SIGN__________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐☐ ☐☐ ☐☐☐☐	☐	☐☐	1 SIGN__________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐☐ ☐☐ ☐☐☐☐	☐	☐☐	1 SIGN__________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐☐ ☐☐ ☐☐☐☐	☐	☐☐	1 SIGN__________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐☐ ☐☐ ☐☐☐☐	☐	☐☐	1 SIGN__________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐☐ ☐☐ ☐☐☐☐	☐	☐☐	1 SIGN__________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐

TICK HERE IF CONTINUATION SHEET USED ☐

CONSENT STATEMENT: As part of this survey, we are studying anaemia among children under 5 years. Anaemia is a serious health problem that results from poor nutrition or diseases such as malaria. This survey will assist the government to develop programs to prevent and treat these important health problems.

We request that all children born in 2001 or later participate in the anaemia testing part of this survey and give a few drops of blood from a finger. The test uses disposable sterile instruments that are clean and completely safe. The blood will be analyzed with new equipment and the results of the test will be given to you right after the blood is taken. The results will be kept confidential.

May I now ask that (NAME OF CHILD[REN]) participate in the anaemia test. However, if you decide not to have him/her/them tested, it is your right and we will respect your decision. Now please tell me if you agree to have the test(s) done.

36	CHECK 34: NUMBER OF CHILDREN WITH HAEMOGLOBIN LEVEL BELOW 7 G/DL ONE OR MORE ☐ → GIVE EACH PARENT/ADULT RESPONSIBLE FOR THE CHILD THE RESULT OF THE HAEMOGLOBIN MEASUREMENT, AND CONTINUE WITH 36.[1] NONE ☐ → GIVE EACH PARENT/ADULT RESPONSIBLE FOR THE CHILD THE RESULT OF THE HAEMOGLOBIN MEASUREMENT AND END THE HOUSEHOLD INTERVIEW.
37	We detected a low level of haemoglobin in the blood of [NAME OF CHILD(REN)]. This indicates that (NAME OF CHILD(REN) has/have developed severe anaemia, which is a serious health problem. We suggest you go to _____ [THE NEAREST HEALTH FACILITY] to receive appropriate treatment for [NAME OF CHILD(REN)] condition. Do you agree to go to that facility to have [NAME OF CHILD(REN)'S] anemia treated?

NAME OF CHILD WITH HAEMOGLOBIN BELOW 7 G/DL	NAME OF PARENT/RESPONSIBLE ADULT	AGREES TO REFERRAL?
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2

[1] If more than one child is below 7 g/dl, read statement in Q.37 to each parent/adult responsible for a child who is below the cutoff point.

HAEMOGLOBIN MEASUREMENT FOR WOMEN 15-49 YEARS

CHECK COLUMN (7) OF HOUSEHOLD LISTING: RECORD THE LINE NUMBER, NAME AND AGE OF ALL WOMEN 15-49 YEARS OLD. THEN ASK THE DATE OF BIRTH.

WOMEN 15-49 YEARS				HAEMOGLOBIN MEASUREMENT OF WOMEN AGED 15-49 YEARS			
LINE NUMBER FROM COL. (1)	NAME FROM COL. (2)	AGE FROM COL. (7)	WOMAN IS PREGNANT YES..........1 NO............2	LINE NUMBER OF PARENT/ADULT RESPONSIBLE FOR THE WOMAN (FOR UNDER 18) RECORD '00' IF NOT LISTED IN HOUSEHOLD SCHEDULE	READ CONSENT STATEMENT TO WOMAN OR PARENT/ADULT RESPONSIBLE FOR THE WOMAN UNDER 18 CIRCLE CODE AND SIGN	RESULT 1 MEASURED 2 NOT PRESENT 3 REFUSED 4 OTHER SPECIFY _________	HAEMOGLOBIN LEVEL (G/DL)
(38)	(39)	(40)	(41)	(42)	(43)	(44)	(45)
☐☐		☐☐	☐	☐☐	GRANTED REFUSED 1 SIGN__________________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐	☐☐	1 SIGN__________________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐	☐☐	1 SIGN__________________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐	☐☐	1 SIGN__________________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐	☐☐	1 SIGN__________________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐
☐☐		☐☐	☐	☐☐	1 SIGN__________________ 2	☐ (IF 2-4-->NEXT)	☐☐.☐

TICK HERE IF CONTINUATION SHEET USED ☐

CONSENT STATEMENT: As part of this survey, we are studying anaemia among women between 15-49 years old. Anaemia is a serious health problem that results from poor nutrition or diseases such as malaria. This survey will assist the government to develop programs to prevent and treat these important health problems.

We request that all women aged 15-49 years participate in the anaemia testing part of this survey and give a few drops of blood from a finger. The test uses disposable sterile instruments that are clean and completely safe. The blood will be analyzed with new equipment and the results of the test will be given to you right after the blood is taken. The results will be kept confidential.

May I now ask that (NAME OF WOMEN) participate in the anaemia test. However, if you decide not to get tested [or have her/them tested], it is your right and we will respect your decision. Now please tell me if you agree to have the test(s) done.

46	CHECK 44 NUMBER OF WOMEN 15-49 YEARS WITH HAEMOGLOBIN LEVEL BELOW 7 G/DL ONE OR MORE ☐ → GIVE EACH WOMAN [OR PARENT/ADULT RESPONSIBLE FOR THE PERSON] THE RESULT OF THE HAEMOGLOBIN MEASUREMENT, AND CONTINUE WITH 46.[1] NONE ☐ → GIVE EACH WOMAN [PARENT/ADULT RESPONSIBLE FOR THE WOMAN] THE RESULT OF THE HB MEASUREMENT AND END THE HOUSEHOLD INTERVIEW.
47	We detected a low level of haemoglobin in the blood of [NAME OF WOMAN]. This indicates that (NAME OF WOMAN) has/have developed severe anaemia, which is a serious health problem. We suggest you go to _____ [THE NEAREST HEALTH FACILITY] to receive appropriate treatment for the condition. Do you agree to go to that facility to have [NAME OF WOMAN] anemia treated?

NAME OF WOMAN 15-49 YEARS WITH HAEMOGLOBIN BELOW 7 G/DL	NAME OF WOMAN OR PARENT/RESPONSIBLE ADULT	AGREES TO REFERRAL?
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2
		YES.....1 NO.....2

MALARIA TESTING—CHILDREN 6-59 MONTHS

CHECK COLUMN (7) OF HOUSEHOLD LISTING: RECORD THE LINE NUMBER, NAME AND AGE OF ALL CHILDREN 6-59 MONTHS THEN ASK THE DATE OF BIRTH.

CHILDREN 5-59 MONTHS			MALARIA TESTING OF CHILDREN AGE 6-59 MONTHS				
LINE NUMBER FROM COL. (9)	NAME FROM COL. (2)	LINE NUMBER OF PARENT/ ADULT RESPONSIBLE FOR THE CHILD RECORD '00' IF NOT LISTED IN HOUSEHOLD SCHEDULE	READ CONSENT STATEMENT TO PARENT/ADULT RESPONSIBLE FOR THE CHILD CIRCLE CODE AND SIGN	RESULT 1 TESTED 2 NOT PRESENT 3 REFUSED 4 OTHER	MALARIA RESULT 1 POSITIVE >> **READ PRESCRIPTION WARNINGS** 2 NEGATIVE 3 OTHER	BAR CODE LABEL PUT 1ST BAR CODE LABEL IN BOX BELOW. **PUT THE 2ND LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM**	TREATMENT OFFERED 1-ACCEPTED 2-DECLINED 3-CONTRA-INDICATED
(48)	(49)	(50)	(51)	(52)	(53)	(54)	(55)
☐☐		☐☐	GRANTED REFUSED 1 SIGN________________ 2	☐ (IF 2-4-->NEXT)	☐	PUT 1ST BAR CODE LABEL HERE	☐
☐☐		☐☐	1 SIGN________________ 2	☐ (IF 2-4-->NEXT)	☐	PUT 1ST BAR CODE LABEL HERE	☐
☐☐		☐☐	1 SIGN________________ 2	☐ (IF 2-4-->NEXT)	☐	PUT 1ST BAR CODE LABEL HERE	☐
☐☐		☐☐	1 SIGN________________ 2	☐ (IF 2-4-->NEXT)	☐	PUT 1ST BAR CODE LABEL HERE	☐
☐☐		☐☐	1 SIGN________________ 2	☐ (IF 2-4-->NEXT)	☐	PUT 1ST BAR CODE LABEL HERE	☐
☐☐		☐☐	1 SIGN________________ 2	☐ (IF 2-4-->NEXT)	☐	PUT 1ST BAR CODE LABEL HERE	☐

TICK HERE IF CONTINUATION SHEET USED ☐

CONSENT STATEMENT: As part of this survey, we are studying malaria among children and pregnant women. Malaria is a serious health problem caused by a parasite that is transmitted by a mosquito bite. This survey will assist the government to develop programs to prevent and treat malaria.

We request that all children born in 2001[1] or later participate in the malaria testing part of this survey and give a few drops of blood from a finger. The test uses disposable sterile instruments that are clean and completely safe. The blood will be analyzed with new equipment and the results of the test will be given to you right after the blood is taken. The results will be kept confidential.

May I now ask that (NAME OF CHILD[REN]) participate in the malaria test However, if you decide not to have him/her/them tested, it is your right and we will respect your decision. Now please tell me if you agree to have the test(s) done.

MALARIA TESTING—PREGNANT WOMEN

CHECK COLUMN (9) OF HOUSEHOLD LISTING: RECORD THE LINE NUMBER, NAME AND AGE OF ALL PREGNANT WOMEN.

PREGNANT WOMEN				MALARIA TESTING FOR PREGNANT WOMEN					
LINE NUMBER FROM COL. (8) AND PAGE 38 FOR ELIGIBLE PREGNANT WOMEN	NAME FROM PAGE 39	AGE FROM PAGE 40	How many months pregnant are you? [INDICATE GESTATIONAL AGE IN COMPLETE MONTHS AND WEEKS] RECORD GESTATIONAL AGE IN MONTHS AND WEEKS	LINE NUMBER OF WOMAN OR PARENT/ADULT RESPONSIBLE FOR THE PREGNANT WOMAN (IF UNDER 18) RECORD '00' IF NOT LISTED IN HOUSEHOLD SCHEDULE	READ CONSENT STATEMENT TO PREGNANT WOMAN OR PARENT/ADULT RESPONSIBLE FOR THE PREGNANT WOMAN CIRCLE CODE AND SIGN	RESULT 1 MEASURED 2 NOT PRESENT 3 REFUSED 4 OTHER	MALARIA RESULT 1 POSITIVE>> **READ PRESCRIPTION WARNINGS** 2 NEGATIVE 3 OTHER	IF POSITIVE AND PREGNANCY ≤ 3 MONTHS, CHECK BOX, AND **DO NOT** OFFER TREATMENT (MARK 3 IN (65))	TREATMENT OFFERED 1-ACCEPTED 2-DECLINED 3-CONTRA-INDICATED
(56)	(57)	(58)	(59)	(60)	(61)	(62)	(63)	(64)	(65)
			MONTHS WEEKS		GRANTED REFUSED 1 SIGN.________________ 2	(IF 2-4-->NEXT)			
			MONTHS WEEKS		1 SIGN.________________ 2	(IF 2-4-->NEXT)			
			MONTHS WEEKS		1 SIGN.________________ 2	(IF 2-4-->NEXT)			
			MONTHS WEEKS		1 SIGN.________________ 2	(IF 2-4-->NEXT)			
			MONTHS WEEKS		1 SIGN.________________ 2	(IF 2-4-->NEXT)			
			MONTHS WEEKS		1 SIGN.________________ 2	(IF 2-4-->NEXT)			

TICK HERE IF CONTINUATION SHEET USED ☐

CONSENT STATEMENT: As part of this survey, we are studying malaria among children and pregnant women. Malaria is a serious health problem caused by a parasite that is transmitted by a mosquito bite. This survey will assist the government to develop programs to prevent and treat malaria.

We request that all pregnant women participate in the malaria testing part of this survey and give a few drops of blood from a finger. The test uses disposable sterile instruments that are clean and completely safe. The blood will be analyzed with new equipment and the results of the test will be given to you right after the blood is taken. The results will be kept confidential.

May I now ask that (NAME OF PREGNANT WOMAN) participate in the malaria test However, if you decide not to test or have her/them tested, it is your right and we will respect your decision. Now please tell me if you agree to have the test(s) done.

MALARIA TESTING AND PRESCRIPTION

PRESCRIPTION WARNINGS FOR MALARIA POSITIVE CASES AMONG PREGNANT WOMEN:

READ THE STATEMENT FOR **PREGNANT** WOMEN
WHO RESULT POSITIVE WITH THE RAPID DIAGNOSTIC TEST

The test has given back a positive result. This means you seem to have active malaria. We can provide you with a full treatment free of charge with a medicine called quinine®. Quinine is an effective medication, and should help you to feel better in a few days. As with every medicine, this medicine may have undesired effects on you. The most common are headache, flushing and sweating, nausea, ringing in the ears, dizziness, blurred vision, and changes in seeing colors. There can be more severe symptoms, including disturbances in the heart rhythm, swelling and lack of blood coagulation. If any of these or other severe symptoms develop, they usually go if you stop taking the medication. If you are breastfeeding a baby, there should not be any problems with taking the medication.

Although you should feel better after the treatment, you have the right to decline receiving the treatment, with no repercussions to you. Please tell us whether you accept treatment or not.

MARK IN THE MALARIA TESTING SHEET WHETHER THE RESPONDENT AGREES TREATMENT FOR HER.

PRESCRIPTION OF QUININE

Give 650 mg of Quinine Sulfate (2 capsules of 324 mg each) every 8 hours (three times daily), preferably with food, for a total of 3 days (7 days?).

PRESCRIPTION WARNINGS FOR MALARIA POSITIVE CASES IN CHILDREN UNDER 5 YEARS:

READ THE STATEMENT FOR CHILDREN UNDER 5
WHO RESULT POSITIVE WITH THE RAPID DIAGNOSTIC TEST

The test has given back a positive result. This means your child[ren] seem[s] to have active malaria. We can provide him/her/them with a full treatment free of charge with a medicine called Coartem®. Coartem is very effective, and should in a few days rid him/her/them from fever and other symptoms. Coartem® is also very safe. However, as with every medicine, this medicine may have undesired effects. The most common are dizziness, fatigue, lack of appetite, palpitations. Coartem should not be taken by persons with severe heart problems or severe malaria (e.g. cerebral), or problems regulating their body salts [ASK IF THE CHILD[REN] HAS/HAVE ANY OF THESE PROBLEMS, THAT THEY ARE AWARE OF; IF SO, DO NOT OFFER COARTEM, EXPLAIN THE RISKS OF MALARIA, AND REFER HIM/HER/THEM TO NEAREST HEALTH FACILITY].

Although [NAME OF CHILD/REN] should feel better after the treatment, you have the right to decline GIVING THE CHILD/REN the treatment, with no repercussions to you [OR TO THE CHILD/REN]. Please tell us whether you accept treatment or not.

MARK IN THE MALARIA TESTING SHEET WHETHER THE RESPONDENT AGREES OR DECLINES TREATMENT FOR [EACH OF] HER CHILD[REN]

PRESCRIPTION OF COARTEM™

Weight (in Kg) – Approximate Age	Dosage *
5 to less than 15 – under 3 years of age	1 tablet twice daily for 3 days
15 to less than 25 – 3 to 8 years of age	2 tablets twice daily for 3 days
25 to less than 35 – 9 to 14 years of age	3 tablets twice daily for 3 days
35 or more (adults) – 15 + years of age	4 tables twice daily for 3 days

First day starts by taking first dose followed by the second one 8 hours later; on subsequent days the recommendation is simply “morning” and “evening” (usually around 12 hours apart).

ANGOLA MALARIA INDICATOR SURVEY
WOMEN'S QUESTIONNAIRE

ANGOLA
COSEP-CONSULTORIA, LDA/CONSAÚDE

IDENTIFICATION

PLACE NAME _____

NAME OF HOUSEHOLD HEAD _____

CLUSTER NUMBER .....

HOUSEHOLD NUMBER .....

REGION .....

URBAN/RURAL (URBAN=1, RURAL=2) .....

MALARIA ENDEMIC REGION .....
1 = Hyperendemic (Cabinda, Uige, K. Norte, Malange, L. Norte, L. Sul
2 = Mesoendemic Stable (Zaire, Luanda, Bengo, Benguela, K. Sul, Huambo, Bié)
3 = Mesoendemic Unstable (Moxico, K. Kubango, Kunene, Huila, Namibe)

NAME AND LINE NUMBER OF WOMAN _____

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE				DAY / MONTH / YEAR
INTERVIEWER'S NAME				NAME
RESULT*				RESULT
NEXT VISIT: DATE				TOTAL NO. OF VISITS
TIME				

*RESULT CODES:
1 COMPLETED
2 NOT AT HOME
3 POSTPONED
4 REFUSED
5 PARTLY COMPLETED
6 INCAPACITATED
7 OTHER _____ (SPECIFY)

COUNTRY-SPECIFIC INFORMATION: LANGUAGE OF QUESTIONNAIRE, LANGUAGE OF INTERVIEW, NATIVE LANGUAGE OF RESPONDENT, AND WHETHER TRANSLATOR USED

SUPERVISOR	OFFICE EDITOR	KEYED BY
NAME _____		
DATE _____		

SECTION 1. RESPONDENT'S BACKGROUND

INTRODUCTION AND CONSENT

INFORMED CONSENT

Hello. My name is _____ and I am working with (NAME OF ORGANIZATION). We are conducting a national survey about malaria. We would very much appreciate your participation in this survey. The information you provide will help the government to plan health services. The survey usually takes between 10 and 20 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

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?
May I begin the interview now?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED..... 1 ↓ RESPONDENT DOES NOT AGREE TO BE INTERVIEWED.... 2 —▸END

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME.	HOUR ..... ☐☐ MINUTES ..... ☐☐	
102	In what month and year were you born?	MONTH ..... ☐☐ DON'T KNOW MONTH ..... 98 YEAR ..... ☐☐☐☐ DON'T KNOW YEAR 9998	
103	How old were you at your last birthday? COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT.	AGE IN COMPLETED YEARS ☐☐	
104	Have you ever attended school?	YES ..... 1 NO 2	—▸108
105	What is the highest level of school you attended: primary, secondary, or higher?[1]	PRIMARY ..... 1 SECONDARY ..... 2 HIGHER 3	
106	What is the highest (grade/form/year) you completed at that level?[1]	GRADE ..... ☐☐	
107	CHECK 105: PRIMARY ☐ ↓ SECONDARY OR HIGHER ☐		—▸201
108	Now I would like you to read this sentence to me. SHOW CARD TO RESPONDENT. IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me?	CANNOT READ AT ALL ..... 1 ABLE TO READ ONLY PARTS OF SENTENCE ..... 2 ABLE TO READ WHOLE SENTENCE ..... 3 NO CARD WITH REQUIRED LANGUAGE _____ 4 (SPECIFY LANGUAGE) BLIND/VISUALLY IMPAIRED..... 5	

Section 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	Now I would like to ask about all the births you have had during your life. Have you ever given birth?	YES .....1 NO 2	→206
202	Do you have any sons or daughters to whom you have given birth who are now living with you?	YES .....1 NO 2	→204
203	How many sons live with you? And how many daughters live with you? IF NONE, RECORD '00'.	SONS AT HOME..... ☐☐ DAUGHTERS AT HOME..... ☐☐	
204	Do you have any sons or daughters to whom you have given birth who are alive but do not live with you?	YES .....1 NO 2	→206
205	How many sons are alive but do not live with you? And how many daughters are alive but do not live with you? IF NONE, RECORD '00'.	SONS ELSEWHERE..... ☐☐ DAUGHTERS ELSEWHERE... ☐☐	
206	Have you ever given birth to a boy or girl who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?	YES .....1 NO 2	→208
207	How many boys have died? And how many girls have died? IF NONE, RECORD '00'.	BOYS DEAD ..... ☐☐ GIRLS DEAD ..... ☐☐	
208	SUM ANSWERS TO 203, 205, AND 207, AND ENTER TOTAL.	NONE.....00 TOTAL..... ☐☐	→345
209	CHECK 208: Just to make sure that I have this right: you have had in TOTAL _____ births during your life. Is that correct? YES ☐ ↓ NO ☐→ PROBE AND CORRECT 201-208 AS NECESSARY.		
210	CHECK 208: ONE BIRTH ☐ ↓ Was this child born in the last six years? IF NO, CIRCLE '00.' TWO OR MORE BIRTHS ☐ How many of these children were born in the last six years?	NONE.....00 TOTAL IN LAST SIX YEARS..... ☐☐	→345

211 Now I would like to record the names of all your births in the last six years (since 2001), whether still alive or not, starting with the first one you had.
RECORD NAMES OF ALL THE BIRTHS IN THE LAST SIX YEARS IN 212. RECORD TWINS AND TRIPLETS ON SEPARATE LINES.

212 What name was given to your (first/ next) baby? (NAME)	213 Were any of these births twins?	214 Is (NAME) a boy or a girl?	215 In what month and year was (NAME) born? PROBE: What is his/her birthday?	216 Is (NAME) still alive?	217 IF ALIVE: How old was (NAME) at his/her last birthday? RECORD AGE IN COMPLETED YEARS	218 IF ALIVE Is (NAME) living with you?	219 IF ALIVE: RECORD HOUSEHOLD LINE NUMBER OF CHILD (RECORD '00' IF CHILD NOT LISTED IN HOUSEHOLD)	220 IF DEAD: How old was (NAME) when he/she died? IF '1 YR', PROBE: How many months old was (NAME)? RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.	221 Were there any other live births between (NAME OF PREVIOUS BIRTH) and (NAME)?
01	SING.....1 MULT.....2	BOY .... 1 GIRL.... 2	MONTH .... YEAR	YES..... 1 NO..... 2 → 220	AGE IN YEARS	YES.....1 NO.....2	LINE NUMBER → (NEXT BIRTH)	DAYS ..... 1 MONTHS ..... 2 YEARS..... 3	
02	SING.....1 MULT.....2	BOY .... 1 GIRL.... 2	MONTH .... YEAR	YES..... 1 NO..... 2 → 220	AGE IN YEARS	YES.....1 NO.....2	LINE NUMBER → (220)	DAYS ..... 1 MONTHS ..... 2 YEARS..... 3	YES.....1 NO.....2
03	SING.....1 MULT.....2	BOY .... 1 GIRL.... 2	MONTH .... YEAR	YES..... 1 NO..... 2 → 220	AGE IN YEARS	YES.....1 NO.....2	LINE NUMBER → (220)	DAYS ..... 1 MONTHS ..... 2 YEARS..... 3	YES.....1 NO.....2
04	SING.....1 MULT.....2	BOY .... 1 GIRL.... 2	MONTH .... YEAR	YES..... 1 NO..... 2 → 220	AGE IN YEARS	YES.....1 NO.....2	LINE NUMBER → (220)	DAYS ..... 1 MONTHS ..... 2 YEARS..... 3	YES.....1 NO.....2
05	SING.....1 MULT.....2	BOY .... 1 GIRL.... 2	MONTH .... YEAR	YES..... 1 NO..... 2 → 220	AGE IN YEARS	YES.....1 NO.....2	LINE NUMBER → (220)	DAYS ..... 1 MONTHS ..... 2 YEARS..... 3	YES.....1 NO.....2
06	SING.....1 MULT.....2	BOY .... 1 GIRL.... 2	MONTH .... YEAR	YES..... 1 NO..... 2 → 220	AGE IN YEARS	YES.....1 NO.....2	LINE NUMBER → (220)	DAYS ..... 1 MONTHS ..... 2 YEARS..... 3	YES.....1 NO.....2
07	SING.....1 MULT.....2	BOY .... 1 GIRL.... 2	MONTH .... YEAR	YES..... 1 NO..... 2 → 220	AGE IN YEARS	YES.....1 NO.....2	LINE NUMBER → (220)	DAYS ..... 1 MONTHS ..... 2 YEARS..... 3	YES.....1 NO.....2

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
222	Have you had any live births since the birth of (NAME OF MOST RECENT BIRTH)? IF YES, RECORD BIRTH(S) IN BIRTH TABLE.	YES.....1 NO.....2	
223	COMPARE 210 WITH NUMBER OF BIRTHS IN HISTORY ABOVE AND MARK: NUMBERS ARE SAME NUMBERS ARE DIFFERENT → (PROBE AND RECONCILE) CHECK: FOR EACH BIRTH: YEAR OF BIRTH IS RECORDED. FOR EACH LIVING CHILD: CURRENT AGE IS RECORDED.		
224	CHECK 215 AND ENTER THE NUMBER OF BIRTHS IN 2001 OR LATER. IF NONE, RECORD '0'.		
225	Are you pregnant now?	YES ..... 1 NO ..... 2 UNCERTAIN 8	→ 227
226	IF YES, RECORD NUMBER OF COMPLETED MONTHS AND WEEKS OF PREGNANCY.	☐☐ MONTHS ☐☐ WEEKS	
227	VERIFY 224: ONE OR MORE BIRTHS IN 2001 OR LATER NO BIRTHS IN 2001 OR LATER →		301
227A	VERIFY 215 AND 216: ONE OR MORE CHILDREN DEAD NONE →		301
227B	VERIFY Q.220 AND ENTER NUMBER OF CHILDREN WHO DIED BEFORE THE AGE OF 29 DAYS. IF NONE, ENTER '0.'		
227C	VERIFY Q.220 AND ENTER NUMBER OF CHILDREN WHO DIED BETWEEN THE AGE OF 29 DAYS AND FIVE YEARS. IF NONE, ENTER '0.'		

Section 3 - VERBAL AUTOPSY - DEATH OF A CHILD UNDER 29 DAYS

228 I would like to ask you some questions concerning symptoms that the deceased child(dren) who died before s/he (they) was (were) 29 days old had or showed when s/he was ill. Some of these questions may be painful and you can choose not to answer them; also they may not appear to be directly related to his/her death. Please bear with me and answer all the questions as best as you can. They will help us to get a clearer picture of all possible symptoms that the deceased had.

228A	WRITE THE NAME AND LINE NUMBER OF THE CHILD FROM Q. 212	LINE NUMBER ☐☐ NAME_____	LINE NUMBER ☐☐ NAME_____
228B	How is your health now?	FINE....1 SICK....2 OTHER....6	FINE....1 SICK....2 OTHER....6
228C	Was (NAME's) birth a difficult birth?	YES....1 NO....2	YES....1 NO....2
228D	Did you have fits before giving birth to (NAME)?	YES....1 NO....2	YES....1 NO....2
228E	Did/does you have high blood pressure?	YES....1 NO....2 DON'T KNOW....8	YES....1 NO....2 DON'T KNOW....8
228F	Did you have a febrile illness at the time of delivery of (NAME)?	YES....1 NO....2 DON'T KNOW....8	YES....1 NO....2 DON'T KNOW....8
228G	Did you suffer from any of the conditions during your pregnancy with (NAME)?	DIABETES: YES ☐ NO ☐ DK ☐ HEART DISEASE: YES ☐ NO ☐ DK ☐ TB: YES ☐ NO ☐ DK ☐ EPILEPSY: YES ☐ NO ☐ DK ☐	DIABETES: YES ☐ NO ☐ DK ☐ HEART DISEASE: YES ☐ NO ☐ DK ☐ TB: YES ☐ NO ☐ DK ☐ EPILEPSY: YES ☐ NO ☐ DK ☐
229	Did you have any antenatal care during your pregnancy with (NAME)?	YES....1 NO....2	YES....1 NO....2
229A	Where did you give birth to (NAME)?	HOME....1 HEALTH FACILITY....2 IN TRANSIT....3 OTHER PLACE....4	HOME....1 HEALTH FACILITY....2 IN TRANSIT....3 OTHER PLACE....4
229B	Who assisted the birth?	NO ONE....1 UNTRAINED TBA....2 HEALTH PROFESSIONAL....3 DON'T KNOW....9	NO ONE....1 UNTRAINED TBA....2 HEALTH PROFESSIONAL....3 DON'T KNOW....9
229C	Had you received TT vaccination when you were pregnant with (NAME)?	YES....1 NO....2 DON'T KNOW....8	YES....1 NO....2 DON'T KNOW....8
229D Filter	If yes, how many TT injections did you receive?	NUMBER OF VACCINES ☐☐	LINE NUMBER ☐☐
229E	Was (NAME) a singleton or a twin?	SINGLETON....1 TWIN....2	SINGLETON....1 TWIN....2
229F	Was it a forceps or vacuum delivery?	YES....1 NO....2 DON'T KNOW....8	YES....1 NO....2 DON'T KNOW....8

229G	Was it a caesarean delivery?	YES.....1 NO.....2	YES.....1 NO.....2
229H	How many hours was the labour?	HOURS…… ☐☐ DON'T KNOW.....8	HOURS…… ☐☐ DON'T KNOW.....8
229I	Did waters break 1 day or more before delivery of (NAME)?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
229J	Was (NAME) born premature?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
229K Filter	If yes, at how many months or weeks of pregnancy?	MONTHS…… ☐☐ WEEKS…… ☐☐	MONTHS…… ☐☐ WEEKS…… ☐☐
229L	Did (NAME) play or move in the womb before labour?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
229M Filter	If no, did (NAME) breathe at all after delivery?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
229N	Was (NAME) dead at birth?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
229O	Did the umbilical cord come before (NAME) was born?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
	ASK THESE QUESTIONS IF THE CHILD WAS BORN ALIVE		
230	Did (NAME) cry immediately after birth?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230A	Was(NAME) able to breastfeed soon after birth?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230B Filter	If no, was the problem with (NAME) or with you?	WITH THE MOTHER.....1 WITH THE CHILD.....2 OTHER_____ 8	WITH THE MOTHER.....1 WITH THE CHILD.....2 OTHER _____8
230C	Was (NAME) weighed after being born?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230D Filter	If yes, how much did (NAME) weigh?	WEIGHT IN GRAMS ☐☐☐	WEIGHT IN GRAMS ☐☐☐
230E	Were there any bruises or signs of injury on (NAME)'s body after birth?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230F	What was the colour of (NAME)'s skin after being born?	NORMAL.....1 PURPLE.....2 PALE.....3 DON'T KNOW.....9	NORMAL.....1 PURPLE.....2 PALE.....3 DON'T KNOW.....9
230G	Did (NAME)'s arms/legs have strength?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
213H	Did (NAME) have any malformation at birth?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8

230I	Did the eye color change to yellow (jaundice)?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230J Filter	If yes, how many days after being born?	DAYS AFTER ☐☐	DAYS AFTER ☐☐
230K	Did (NAME) have any problem with the umbilical cord?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230L	Did (NAME) have a fever?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230L2 Filter	If yes, for how many days?	DAYS OF FEVER ☐☐	DAYS OF FEVER ☐☐
230M	Did (NAME) have convulsions?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230N	During the period of illness did (NAME) have areas of skin that were red, peeling or skin rash with blisters containing pus?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230O	Was (NAME) coughing?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230P	Did (NAME) have difficulty breathing?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230Q Filter	If yes, did s/he have fast breathing?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230R Filter	Did s/he have in-drawing of the chest while breathing?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230S	Was (NAME) vomiting?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230T	Did s/he have diarrhea?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230U	Was (NAME) unable to breastfeed when s/he was ill?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230V	Was there a bulge in (NAME)'s fontanel?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
230W	Did (NAME) have an….	INJURY.....1 ACCIDENT.....2 NEITHER 1 OR 2.....3 DON'T KNOW.....8	INJURY.....1 ACCIDENT.....2 NEITHER 1 OR 2.....3 DON'T KNOW.....8
230X Filter	If the answer to question …is 1 or 2, what kind of injury or accident?	_____	_____
230Y	During the illness that led to death, did (NAME) become unconscious?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8

230Z	PLACE OF DEATH	HOME .....1 HEALTH FACILITY _____ 2 OTHER PLACE.....8	HOME .....1 HEALTH FACILITY _____2 OTHER PLACE.....8
230Z1	DATE OF DEATH	DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐	DAY ☐☐ MONTH ☐☐ YEAR ☐☐☐☐
230Y1	VERIFY 215, 216 AND 220:	ONE OR MORE CHILDREN WHO DIED BETWEEN 29 DAYS AND 5 YEARS → CONTINUE	NONE → 301
230Y2		VERIFY Q.220 AND WRITE THE NUMBER OF CHILDREN WHO DIED BETWEEN AGE 29 DAYS AND FIVE YEARS AND CONTINUE TO Q.231. IF NONE, WRITE '0' AND CONTINUE TO Q. 301	•••• • • ••••

Section 4 - VERBAL AUTOPSY - DEATH OF A CHILD AGED 29 DAYS TO UNDER 5 YEARS			
231	I would like to ask you some questions concerning symptoms that the deceased child(dren) (who died between 29 days old but before turning 5 years) had or showed when s/he was ill. Some of these questions may be painful and you can choose not to answer them; also they may not appear to be directly related to his/her death. Please bear with me and answer all the questions as best as you can. They will help us to get a clearer picture of all possible symptoms that the deceased had.		
232	WRITE THE NAME AND LINE NUMBER OF THE CHILD FROM Q. 212	LINE NUMBER ☐☐ NAME_____	LINE NUMBER ☐☐ NAME_____
		SYMPTOMS	
233	Was (NAME) small at birth?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
234	Was (NAME) born premature?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
235 Filter	If yes, how many months or weeks of pregnancy?	MONTHS ☐☐ WEEKS ☐☐ DON'T KNOW..... 98	MONTHS ☐☐ WEEKS ☐☐ DON'T KNOW 98
236	Was (NAME) breastfeeding?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
237 Filter	If yes, did (NAME) stop feeding just before death?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
238	Did s/he have fever?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
239 Filter	If yes, was the fever continuous or off and on?	CONTINUOUS..... 1 ON AND OFF.....2 DON'T KNOW.....8	CONTINUOUS ..... 1 ON AND OFF .....2 DON'T KNOW 8
240	Did s/he have convulsions?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
241	Did s/he have a cough?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
242	If yes, was the cough dry, productive or with blood?	DRY .....1 PRODUCTIVE .....2 WITH BLOOD.....3 DON'T KNOW.....8	DRY .....1 PRODUCTIVE .....2 WITH BLOOD.....3 DON'T KNOW 8
243	Did s/he have breathing difficulties?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
244 Filter	If yes, did s/he have fast breathing?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8

245 Filter	Did s/he have in-drawing of chest while breathing?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
246	Did s/he vomit?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
247 Filter	If yes, did s/he vomit blood?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
248	Did s/he have a mass in the abdomen?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
249	Did s/he have abdominal distension?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
250 Filter	If yes, did the distension start suddenly or gradually as the days went on?	SUDDENLY .....1 GRADUALLY.....2 DON'T KNOW.....8	SUDDENLY .....1 GRADUALLY.....2 DON'T KNOW 8
251	Did s/he have diarrhea?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
252 Filter	If yes, did s/he have bloody diarrhea?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
253	Did s/he have abdominal pain?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
254	Did s/he have weight loss?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
255	Did s/he have mouth sores?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
256	Did s/he look pale? (on fingers or feet soles)	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
257	Did the child's lips grow darker in color?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
258	Did s/he have puffiness of the face?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
259	Did s/he have swelling of the whole body	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
260	Did the eye color change to yellow (jaundice)?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
261	Did s/he have ankle swelling? (show that part of the body)	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
262	Did s/he have swelling of joints?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8

263	Did s/he have measles?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
264	Did s/he have any other skin disease?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
265	Was s/he unusually sleepy?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
266	Did s/he have neck pain?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
267	Did s/he have a headache?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
268	Did s/he develop stiffness of the whole body (before death)?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
269	Did s/he have loss of consciousness?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
270	Did s/he have fainting fits?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
271	Did s/he have paralysis of both legs?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
272	Was s/he unable to pass urine?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
273	Did s/he pass blood in urine?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
274	Did a dog bite him/her?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
275	Was s/he bitten by another animal or insect?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
276	If yes, what type of animal/insect? (Write the name)	_____	_____
277	Was s/he injured in a road accident?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
278	Did s/he suffer any other accidental injuries before death?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8
279	Was s/he injured intentionally by someone?	YES.....1 NO .....2 DON'T KNOW.....8	YES .....1 NO .....2 DON'T KNOW 8

Section 5. PREGNANCY AND INTERMITTENT PREVENTIVE TREATMENT

301	ENTER IN 302 THE NAME AND SURVIVAL STATUS OF THE MOST RECENT BIRTH. Now I would like to ask you some questions about your last pregnancy that ended in a live birth, in the last 6 years.		
302	FROM QUESTIONS 212 AND 213 (LINE 01)	LAST BIRTH NAME _____ LIVING ☐ DEAD ☐	
303	When you were pregnant with (NAME), did you see anyone for antenatal care?[1] IF YES: Whom did you see? Anyone else? PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS SEEN.	HEALTH PROFESSIONAL DOCTOR....A NURSE/MIDWIFE....B AUXILIARY MIDWIFE....C OTHER PERSON TRADITIONAL BIRTH ATTENDANT....D OTHER _____ X (SPECIFY) NO ONE....Y	
304	During this pregnancy, did you take any drugs in order to prevent you from getting malaria?	YES....1 NO....2 DON'T KNOW....8	☐→309A
305	Which drugs did you take to prevent malaria?[2] RECORD ALL MENTIONED. IF TYPE OF DRUG IS NOT DETERMINED, SHOW TYPICAL ANTIMALARIAL DRUGS TO RESPONDENT.	SP/FANSIDAR....A CHLOROQUINE....B OTHER _____ X (SPECIFY) DON'T KNOW....Z	
306	CHECK 305: DRUGS TAKEN FOR MALARIA PREVENTION	CODE "A" CIRCLED ☐ CODE "A" NOT CIRCLED ☐	→309A
307	How many times did you take SP/Fansidar during this pregnancy?	TIMES.... ☐☐	

308	CHECK 303: ANTENATAL CARE FROM A HEALTH PROFESSIONAL RECEIVED DURING THIS PREGNANCY?	CODE 'A', 'B', OR 'C' CIRCLED ☐ OTHER ☐_____	→309A
309	Did you get the SP/Fansidar during an antenatal visit, during another visit to a health facility, or from some other source?	ANTENATAL VISIT .....1 ANOTHER FACILITY VISIT .....2 OTHER SOURCE _____ 6 (SPECIFY)	
309A	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 PERSONNEL DOCTOR .....A NURSE/MIDWIFE .....B AUXILIARY MIDWIFE .....C OTHER PERSON TRADITIONAL BIRTH ATTENDANT .....D RELATIVE/FRIEND .....E OTHER SPECIFY _____X NO ONE .....Y	
309B	Where did you give birth to (NAME)? PROBE TO IDENTIFY THE TYPE OF PLACE AND CIRCLE THE APPROPRIATE CODE. IF UNABLE TO DETERMINE IF A HOSPITAL, HEALTH CENTER, OR CLINIC IS PUBLIC OR PRIVATE MEDICATL, WRITE THE NAME OF THE PLACE _____ (NAME OF THE PLACE)	HOME YOUR HOME .....11 OTHER HOME .....12 PUBLIC SECTOR GOVT. HOSPITAL .....21 GOVT. HEALTH CENTER .....22 GOVT. HEALTH POST .....23 OTHER PUBLIC _____ 26 (SPECIFY) PRIVATE MEDICAL SECTOR PVT. HOSPITAL/CLINIC .....31 OTHER PVT. MED. _____ 36 (SPECIFY) OTHER _____96 (SPECIFY)	
Now I would like to ask you some questions about "Paludismo"			
309C	Is there a difference between Paludismo and Malaria?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
309D	What is Paludismo? (DESCRIBE)	PALUDISMO IS ..... DON'T KNOW..... 8	
309D1	What is Malaria? (DESCRIBE)	MALARIA IS..... DON'T KNOW..... 8	
309E	Have you attended meetings in your community about the prevention of paludismo?	YES..... 1 NO..... 2 DON'T KNOW..... 8	
310	VERIFY IF RESPONDENT HAS A CHILD UNDER AGE 5 YEARS. IF YES, CONTINUE TO SECTION 6: FEVER IN CHILDREN.		

SECTION 6. FEVER IN CHILDREN

311	FROM Qs. 212 AND 213, ENTER IN THE TABLE THE LINE NUMBER AND NAME OF EACH LIVING CHILD BORN IN 2001[1] OR LATER. (IF THERE ARE MORE THAN 2 LIVING CHILDREN BORN IN 2001[1] OR LATER, USE ADDITIONAL QUESTIONNAIRES). Now I would like to ask you some questions about the health of all your children less than 5 years old. (We will talk about each one separately.)		
312	NAME AND LINE NUMBER FROM 212 AND 213	YOUNGEST CHILD LINE NUMBER ..... ☐☐ NAME _____	NEXT-TO-YOUNGEST CHILD LINE NUMBER ..... ☐☐ NAME _____
313	Has (NAME) been ill with a fever at any time in the last 2 weeks?	YES ..... 1 NO ..... 2 (GO TO 313 FOR NEXT CHILD OR, IF NO MORE CHILDREN, SKIP TO 345) DON'T KNOW 8	YES ..... 1 NO ..... 2 (GO BACK TO 313 FOR NEXT CHILD OR, IF NO MORE CHILDREN, SKIP TO 345) DON'T KNOW 8
314	How many days ago did the fever start? IF LESS THAN ONE DAY, RECORD '00'.	DAYS AGO ..... ☐☐ DON'T KNOW..... 98	DAYS AGO ..... ☐☐ DON'T KNOW..... 98
315	Did you seek advice or treatment for the fever from any source?	YES ..... 1 NO ..... 2 (SKIP TO 317)	YES ..... 1 NO ..... 2 (SKIP TO 317)
316	Where did you seek advice or treatment? Anywhere else? RECORD ALL SOURCES MENTIONED.	PUBLIC SECTOR GOVT. HOSPITAL ..... A GOVT. HEALTH CENTER ..... B GOVT. HEALTH POST ..... C MOBILE CLINIC ..... D CAMPAIGN WORKER ..... E PUBLIC COMPANY ..... F OTHER PUBLIC _____ G (SPECIFY) PRIVATE MEDICAL SECTOR PVT. HOSPITAL/CLINIC. ..... G PHARMACY ..... H PRIVATE DOCTOR ..... I MOBILE CLINIC ..... J CAMPAIGN WORKER ..... K OTHER PVT. MEDICAL _____ L (SPECIFY) OTHER SOURCE SHOP. ..... M TRAD. PRACTITIONER ..... N OTHER _____ X (SPECIFY)	PUBLIC SECTOR GOVT. HOSPITAL ..... A GOVT. HEALTH CENTER ..... B GOVT. HEALTH POST ..... C MOBILE CLINIC ..... D CAMPAIGN WORKER ..... E PUBLIC COMPANY ..... F OTHER PUBLIC _____ G (SPECIFY) PRIVATE MEDICAL SECTOR PVT. HOSPITAL/CLINIC. ..... G PHARMACY ..... H PRIVATE DOCTOR ..... I MOBILE CLINIC ..... J CAMPAIGN WORKER ..... K OTHER PVT. MEDICAL _____ L (SPECIFY) OTHER SOURCE SHOP. ..... M TRAD. PRACTITIONER ..... N OTHER _____ X (SPECIFY)

316 A	How many days after the fever began did you first seek treatment for (NAME)? IF THE SAME DAY, RECORD '00'.	DAYS ..... ☐☐	DAYS ..... ☐☐
		YOUNGEST CHILD NAME _____	NEXT-TO-YOUNGEST CHILD NAME _____
317	Is (NAME) still sick with a fever?	YES.....1 NO.....2 DON'T KNOW.....8	YES.....1 NO.....2 DON'T KNOW.....8
318	At any time during the illness, did (NAME) take any drugs for the fever?	YES.....1 NO.....2 (SKIP 344) ←┘ DON'T KNOW.....8	YES.....1 NO.....2 (SKIP 344) ←┘ DON'T KNOW.....8
319	What drugs did (NAME) take?[1] 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.	ANTIMALARIAL SP/FANSIDAR .....A CHLOROQUINE.....B AMODIAQUINE.....C QUININE .....D COARTEM .....E OTHER ANTIMALARIAL_____ F (SPECIFY) OTHER DRUGS ASPIRIN .....G ACETAMINOPHEN/ PARACETAMOL .....H IBUPROFEN ..... I OTHER _____ X (SPECIFY) DON'T KNOW..... Z	ANTIMALARIAL SP/FANSIDAR .....A CHLOROQUINE.....B AMODIAQUINE.....C QUININE .....D COARTEM .....E OTHER ANTIMALARIAL_____ F (SPECIFY) OTHER DRUGS ASPIRIN ..... G ACETAMINOPHEN/ PARACETAMOL.....H IBUPROFEN ..... I OTHER _____ X (SPECIFY) DON'T KNOW..... Z
320	CHECK 319: ANY CODE A-F CIRCLED?	YES ☐ NO ☐ (GO BACK TO 317 IN NEXT COLUMN; OR IF NO MORE BIRTHS, SKIP TO 344)	YES ☐ NO ☐ (GO BACK TO 317 IN NEXT COLUMN; OR IF NO MORE BIRTHS, SKIP TO 344)
320A	CHECK 319: SP/FANSIDAR ('A') GIVEN?	CODE 'A' CIRCLED ☐ CODE 'A' NOT CIRCLED ☐ (SKIP TO 324)	CODE 'A' CIRCLED ☐ CODE 'A' NOT CIRCLED ☐ (SKIP TO 324)
321	How long after the fever started did (NAME) first take SP/Fansidar?	SAME DAY..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW..... 8	SAME DAY..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW..... 8
		YOUNGEST CHILD NAME _____	NEXT-TO-YOUNGEST CHILD NAME _____

322	For how many days did (NAME) take the SP/Fansidar? IF 7 OR MORE DAYS, RECORD '7'.	DAYS ..... ☐☐ DON'T KNOW 8	DAYS..... ☐☐ DON'T KNOW 8
323	Did you have the SP/Fansidar at home or did you get it from somewhere else? IF SOMEWHERE ELSE, PROBE FOR SOURCE. IF MORE THAN ONE SOURCE MENTIONED, ASK: Where did you get the SP/Fansidar first?	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8
324	CHECK 319: WHICH MEDICINES?	CODE 'B' CIRCLED ☐ / CODE 'B' NOT CIRCLED ☐ (SKIP TO 328)	CODE 'B' CIRCLED ☐ / CODE 'B' NOT CIRCLED ☐ (SKIP TO 328)
325	How long after the fever started did (NAME) first take chloroquine?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8
326	For how many days did (NAME) take chloroquine? IF 7 OR MORE DAYS, RECORD '7'.	DAYS ..... ☐☐ DON'T KNOW 8	DAYS..... ☐☐ DON'T KNOW 8
327	Did you have the chloroquine at home or did you get it from somewhere else? IF SOMEWHERE ELSE, PROBE FOR SOURCE. IF MORE THAN ONE SOURCE MENTIONED, ASK: Where did you get the chloroquine first?	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8
328	CHECK 319: WHICH MEDICINES?	CODE 'C' CIRCLED ☐ / CODE 'C' NOT CIRCLED ☐ (SKIP TO 332)	CODE 'C' CIRCLED ☐ / CODE 'C' NOT CIRCLED ☐ (SKIP TO 332)
329	How long after the fever started did (NAME) first take Amodiaquine?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8
		YOUNGEST CHILD NAME _____	NEXT-TO-YOUNGEST CHILD NAME _____

330	For how many days did (NAME) take Amodiaquine? IF 7 OR MORE DAYS, RECORD '7'.	DAYS ..... ☐☐ DON'T KNOW 8	DAYS..... ☐☐ DON'T KNOW 8
331	Did you have the Amodiaquine at home or did you get it from somewhere else? IF SOMEWHERE ELSE, PROBE FOR SOURCE. IF MORE THAN ONE SOURCE MENTIONED, ASK: Where did you get the Amodiaquine first?	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8
332	CHECK 319: WHICH MEDICINES?	CODE 'D' CIRCLED ☐ CODE 'D' NOT CIRCLED ☐ (SKIP TO 336)	CODE 'D' CIRCLED ☐ CODE 'D' NOT CIRCLED ☐ (SKIP TO 336)
333	How long after the fever started did (NAME) first take Quinine?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8
334	For how many days did (NAME) take Quinine? IF 7 OR MORE DAYS, RECORD '7'.	DAYS ..... ☐☐ DON'T KNOW 8	DAYS..... ☐☐ DON'T KNOW 8
335	Did you have the Quinine at home or did you get it from somewhere else? IF SOMEWHERE ELSE, PROBE FOR SOURCE. IF MORE THAN ONE SOURCE MENTIONED, ASK: Where did you get the Quinine first?	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8
336	CHECK 319: WHICH MEDICINES?	CODE 'E' CIRCLED ☐ CODE 'E' NOT CIRCLED ☐ (SKIP TO 340)	CODE 'E' CIRCLED ☐ CODE 'E NOT CIRCLED ☐ (SKIP TO 340)
337	How long after the fever started did (NAME) first take Coartem?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8
		YOUNGEST CHILD NAME _____	NEXT-TO-YOUNGEST CHILD NAME _____

338	For how many days did (NAME) take Coartem? IF 7 OR MORE DAYS, RECORD '7'.	DAYS ..... ☐☐ DON'T KNOW 8	DAYS..... ☐☐ DON'T KNOW 8
339	Did you have the Coartem at home or did you get it from somewhere else? IF SOMEWHERE ELSE, PROBE FOR SOURCE. IF MORE THAN ONE SOURCE MENTIONED, ASK: Where did you get the ACT first?	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8
340	CHECK 319: WHICH MEDICINES?	CODE 'F' CIRCLED ☐ CODE 'F' NOT CIRCLED ☐ (SKIP TO 344)	CODE 'F' CIRCLED ☐ CODE 'F' NOT CIRCLED ☐ (SKIP TO 344)
341	How long after the fever started did (NAME) first take (NAME OF OTHER ANTIMALARIAL)?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER THE FEVER ..... 2 THREE DAYS AFTER THE FEVER..3 FOUR OR MORE DAYS AFTER THE FEVER ..... 4 DON'T KNOW 8
342	For how many days did (NAME) take (NAME OF OTHER ANTIMALARIAL)? IF 7 OR MORE DAYS, RECORD '7'.	DAYS ..... ☐☐ DON'T KNOW 8	DAYS..... ☐☐ DON'T KNOW 8
343	Did you have the (NAME OF OTHER ANTIMALARIAL) at home or did you get it from somewhere else? IF SOMEWHERE ELSE, PROBE FOR SOURCE. IF MORE THAN ONE SOURCE MENTIONED, ASK: Where did you get the (NAME OF OTHER ANTIMALARIAL) first?	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8	AT HOME ..... 1 GOVERNMENT HEALTH FACILITY/WORKER ..... 2 PRIVATE HEALTH FACILITY/WORKER ..... 3 SHOP ..... 4 OTHER_____ 6 (SPECIFY) DON'T KNOW 8
344		GO BACK TO 313 IN NEXT COLUMN, OR, IF NO MORE CHILDREN, GO TO 345.	GO BACK TO 313 IN FIRST COLUMN OF NEW QUESTIONNAIRE, OR, IF NO MORE CHILDREN, GO TO 345.
345	RECORD THE TIME.	HOUR ..... ☐☐ MINUTES ..... ☐☐	

GO BACK TO THE HOUSEHOLD QUESTIONNAIRE TO PROCEED WITH THE ANEMIA AND MALARIA TESTING, IF THERE ARE ELIGIBLE INDIVIDUALS. AFTER COMPLETING ALL TESTING, RETURN TO THE HOUSEHOLD QUESTIONNAIRE TO RECORD THE RESULTS OF YOUR VISIT.

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF THE SUPERVISOR:_____ DATE: _____