

2019 GHANA MALARIA INDICATOR SURVEY
 BIOMARKER QUESTIONNAIRE

MINISTRY OF HEALTH

GHANA STATISTICAL SERVICE

| IDENTIFICATION | | | | | |
|---|-------|---|-------|---|---|
| LOCALITY NAME _____ NAME OF HOUSEHOLD HEAD _____ CLUSTER NUMBER HOUSEHOLD NUMBER | | | | | |
| BIOMARKER TECHNICIAN VISITS | | | | | |
| | 1 | 2 | 3 | FINAL VISIT | |
| DATE | _____ | _____ | _____ | DAY | <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> |
| BIOMARKER TECH'S NAME | _____ | _____ | _____ | MONTH | <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> |
| | | | | YEAR | <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; text-align: center;">2</div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; text-align: center;">0</div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; text-align: center;">1</div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; text-align: center;">9</div> |
| NEXT VISIT: DATE | _____ | _____ | | TOTAL NUMBER OF VISITS | |
| TIME | _____ | _____ | | <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> | |
| NOTES: | | | | TOTAL ELIGIBLE CHILDREN | |
| _____ _____ _____ _____ _____ | | | | <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> | |
| LANGUAGE OF QUESTIONNAIRE** | | LANGUAGE OF INTERVIEW** | | NATIVE LANGUAGE OF RESPONDENT** | |
| <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; text-align: center;">0</div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; text-align: center;">1</div> | | <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> | | <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black;"></div> | |
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HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-5

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|-----|---|--|--|--|
| 101 | CHECK COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN 0-5 YEARS IN QUESTION 102; IF MORE THAN SIX CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S). | | | |
| | | CHILD 1 | CHILD 2 | CHILD 3 |
| 102 | CHECK HOUSEHOLD QUESTIONNAIRE: LINE NUMBER FROM COLUMN 9. | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ |
| 103 | COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM HOUSEHOLD SCHEDULE. IF COMPLETE DATE OF BIRTH NOT PROVIDED ASK: What is (NAME)'s date of birth? | DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| 104 | CHECK 103: CHILD BORN IN 2014-2019? | YES 1 NO 2 (SKIP TO 130) ← | YES 1 NO 2 (SKIP TO 130) ← | YES 1 NO 2 (SKIP TO 130) ← |
| 105 | CHECK 103: CHILD AGE 0-5 MONTHS, I.E., WAS CHILD BORN IN MONTH OF INTERVIEW OR 5 PREVIOUS MONTHS? | 0-5 MONTHS 1 (SKIP TO 130) ← OLDER 2 | 0-5 MONTHS 1 (SKIP TO 130) ← OLDER 2 | 0-5 MONTHS 1 (SKIP TO 130) ← OLDER 2 |
| 106 | NAME OF PARENT/OTHER ADULT RESPONSIBLE FOR THE CHILD. | NAME _____ _____ | NAME _____ _____ | NAME _____ _____ |
| 107 | ASK CONSENT FOR ANEMIA TEST FROM PARENT/OTHER ADULT. | <p>As part of this survey, we are asking children all over the country to take an anemia test. Anemia is a serious health problem that usually results from poor nutrition, infection, or chronic disease. This survey will assist the government to develop programs to prevent and treat anemia. We ask that all children born in 2014 or later take part in anemia testing in this survey and give a few drops of blood from a finger or heel. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after each test.</p> <p>The blood will be tested for anemia immediately, and the result will be told to you right away. The result will be kept strictly confidential and will not be shared with anyone other than members of our survey team.</p> <p>Do you have any questions? You can say yes or no. It is up to you to decide. Will you allow (NAME OF CHILD) to participate in the anemia test?</p> | | |
| 108 | CIRCLE THE CODE AND SIGN YOUR NAME. | GRANTED 1 _____ (SIGN) ← REFUSED 2 NOT PRESENT/OTHER . 3 | GRANTED 1 _____ (SIGN) ← REFUSED 2 NOT PRESENT/OTHER . 3 | GRANTED 1 _____ (SIGN) ← REFUSED 2 NOT PRESENT/OTHER . 3 |

HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-5

| | | CHILD 1 | CHILD 2 | CHILD 3 |
|-----|---|---|---|---|
| | CHECK HOUSEHOLD QUESTIONNAIRE: LINE NUMBER FROM COLUMN 9. | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ |
| 109 | ASK CONSENT FOR MALARIA TEST FROM PARENT/OTHER ADULT. | <p>As part of this survey, we are asking children all over the country to take a test to see if they have malaria. Malaria is a serious illness caused by a parasite transmitted by a mosquito bite. This survey will assist the government to develop programs to prevent malaria.</p> <p>We ask that all children born in 2014 or later take part in malaria testing in this survey and give a few drops of blood from a finger or heel. One blood drop will be tested for malaria immediately, and the result will be told to you right away. A few blood drops will be collected on slide(s) and taken to a laboratory for testing. You will not be told the results of the laboratory testing. All results will be kept strictly confidential and will not be shared with anyone other than members of our survey team.</p> <p>Do you have any questions? You can say yes or no. It is up to you to decide. Will you allow (NAME OF CHILD) to participate in the malaria test?</p> | | |
| 110 | CIRCLE THE CODE, SIGN YOUR NAME, AND ENTER YOUR FIELDWORKER NUMBER. | GRANTED 1 REFUSED 2 (SIGN AND ENTER YOUR FIELDWORKER NUMBER) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NOT PRESENT/OTHER . 3 | GRANTED 1 REFUSED 2 (SIGN AND ENTER YOUR FIELDWORKER NUMBER) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NOT PRESENT/OTHER . 3 | GRANTED 1 REFUSED 2 (SIGN AND ENTER YOUR FIELDWORKER NUMBER) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NOT PRESENT/OTHER . 3 |
| 111 | PREPARE EQUIPMENT AND SUPPLIES ONLY FOR THE TEST(S) FOR WHICH CONSENT HAS BEEN OBTAINED AND PROCEED WITH THE TEST(S). | | | |
| 112 | PLACE BAR CODE LABEL FOR MALARIA LAB TEST. | <div style="border: 1px dashed black; padding: 5px; text-align: center;">PUT THE 1ST BAR CODE LABEL HERE.</div> NOT PRESENT ... 99994 REFUSED 99995 OTHER 99996 PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. | <div style="border: 1px dashed black; padding: 5px; text-align: center;">PUT THE 1ST BAR CODE LABEL HERE.</div> NOT PRESENT ... 99994 REFUSED 99995 OTHER 99996 PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. | <div style="border: 1px dashed black; padding: 5px; text-align: center;">PUT THE 1ST BAR CODE LABEL HERE.</div> NOT PRESENT ... 99994 REFUSED 99995 OTHER 99996 PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. |
| 113 | RECORD HEMOGLOBIN LEVEL HERE AND IN THE ANEMIA AND MALARIA PAMPHLET. | G/DL <input type="text"/> <input type="text"/> . <input type="text"/> NOT PRESENT 994 REFUSED 995 OTHER 996 | G/DL <input type="text"/> <input type="text"/> . <input type="text"/> NOT PRESENT 994 REFUSED 995 OTHER 996 | G/DL <input type="text"/> <input type="text"/> . <input type="text"/> NOT PRESENT 994 REFUSED 995 OTHER 996 |
| 114 | CIRCLE THE CODE FOR THE MALARIA RDT. | TESTED 1 NOT PRESENT 2 REFUSED 3 OTHER 6 (SKIP TO 116) ← | TESTED 1 NOT PRESENT 2 REFUSED 3 OTHER 6 (SKIP TO 116) ← | TESTED 1 NOT PRESENT 2 REFUSED 3 OTHER 6 (SKIP TO 116) ← |

HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-5

| | | CHILD 1 | CHILD 2 | CHILD 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|---|--|---|---|----|---------------------|---|---|-------------------|---|---|-----------------------|---|---|--------------------|---|---|-------------|---|---|-------------|---|---|-------------|---|---|---------------|---|---|--|--|-----|----|---------------------|---|---|-------------------|---|---|-----------------------|---|---|--------------------|---|---|-------------|---|---|-------------|---|---|-------------|---|---|---------------|---|---|--|--|-----|----|---------------------|---|---|-------------------|---|---|-----------------------|---|---|--------------------|---|---|-------------|---|---|-------------|---|---|-------------|---|---|---------------|---|---|
| | CHECK HOUSEHOLD QUESTIONNAIRE: LINE NUMBER FROM COLUMN 9. | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 115 | RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANEMIA AND MALARIA PAMPHLET. | POSITIVE 1 (SKIP TO 118) ← NEGATIVE 2 OTHER 6 | POSITIVE 1 (SKIP TO 118) ← NEGATIVE 2 OTHER 6 | POSITIVE 1 (SKIP TO 118) ← NEGATIVE 2 OTHER 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 116 | CHECK 113: HEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 117 | <u>SEVERE ANEMIA REFERRAL</u> RECORD THE RESULT OF THE ANEMIA TEST ON THE REFERRAL FORM. | The anemia test shows that (NAME OF CHILD) has severe anemia. Your child is very ill and must be taken to a health facility immediately. (SKIP TO 130) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 118 | Does (NAME) suffer from any of the following illnesses or symptoms: a) Extreme weakness? b) Heart problems? c) Loss of consciousness? d) Rapid or difficult breathing? e) Seizures? f) Abnormal bleeding g) Jaundice or yellow skin? h) Dark urine? | <table border="0"> <tr><td></td><td>YES</td><td>NO</td></tr> <tr><td>a) EXTREME WEAKNESS</td><td>1</td><td>2</td></tr> <tr><td>b) HEART PROBLEMS</td><td>1</td><td>2</td></tr> <tr><td>c) LOSS OF CONSCIOUS.</td><td>1</td><td>2</td></tr> <tr><td>d) RAPID BREATHING</td><td>1</td><td>2</td></tr> <tr><td>e) SEIZURES</td><td>1</td><td>2</td></tr> <tr><td>f) BLEEDING</td><td>1</td><td>2</td></tr> <tr><td>g) JAUNDICE</td><td>1</td><td>2</td></tr> <tr><td>h) DARK URINE</td><td>1</td><td>2</td></tr> </table> | | YES | NO | a) EXTREME WEAKNESS | 1 | 2 | b) HEART PROBLEMS | 1 | 2 | c) LOSS OF CONSCIOUS. | 1 | 2 | d) RAPID BREATHING | 1 | 2 | e) SEIZURES | 1 | 2 | f) BLEEDING | 1 | 2 | g) JAUNDICE | 1 | 2 | h) DARK URINE | 1 | 2 | <table border="0"> <tr><td></td><td>YES</td><td>NO</td></tr> <tr><td>a) EXTREME WEAKNESS</td><td>1</td><td>2</td></tr> <tr><td>b) HEART PROBLEMS</td><td>1</td><td>2</td></tr> <tr><td>c) LOSS OF CONSCIOUS.</td><td>1</td><td>2</td></tr> <tr><td>d) RAPID BREATHING</td><td>1</td><td>2</td></tr> <tr><td>e) SEIZURES</td><td>1</td><td>2</td></tr> <tr><td>f) BLEEDING</td><td>1</td><td>2</td></tr> <tr><td>g) JAUNDICE</td><td>1</td><td>2</td></tr> <tr><td>h) DARK URINE</td><td>1</td><td>2</td></tr> </table> | | YES | NO | a) EXTREME WEAKNESS | 1 | 2 | b) HEART PROBLEMS | 1 | 2 | c) LOSS OF CONSCIOUS. | 1 | 2 | d) RAPID BREATHING | 1 | 2 | e) SEIZURES | 1 | 2 | f) BLEEDING | 1 | 2 | g) JAUNDICE | 1 | 2 | h) DARK URINE | 1 | 2 | <table border="0"> <tr><td></td><td>YES</td><td>NO</td></tr> <tr><td>a) EXTREME WEAKNESS</td><td>1</td><td>2</td></tr> <tr><td>b) HEART PROBLEMS</td><td>1</td><td>2</td></tr> <tr><td>c) LOSS OF CONSCIOUS.</td><td>1</td><td>2</td></tr> <tr><td>d) RAPID BREATHING</td><td>1</td><td>2</td></tr> <tr><td>e) SEIZURES</td><td>1</td><td>2</td></tr> <tr><td>f) BLEEDING</td><td>1</td><td>2</td></tr> <tr><td>g) JAUNDICE</td><td>1</td><td>2</td></tr> <tr><td>h) DARK URINE</td><td>1</td><td>2</td></tr> </table> | | YES | NO | a) EXTREME WEAKNESS | 1 | 2 | b) HEART PROBLEMS | 1 | 2 | c) LOSS OF CONSCIOUS. | 1 | 2 | d) RAPID BREATHING | 1 | 2 | e) SEIZURES | 1 | 2 | f) BLEEDING | 1 | 2 | g) JAUNDICE | 1 | 2 | h) DARK URINE | 1 | 2 |
| | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) EXTREME WEAKNESS | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b) HEART PROBLEMS | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c) LOSS OF CONSCIOUS. | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d) RAPID BREATHING | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e) SEIZURES | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f) BLEEDING | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g) JAUNDICE | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h) DARK URINE | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) EXTREME WEAKNESS | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b) HEART PROBLEMS | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c) LOSS OF CONSCIOUS. | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d) RAPID BREATHING | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e) SEIZURES | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f) BLEEDING | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g) JAUNDICE | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h) DARK URINE | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) EXTREME WEAKNESS | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b) HEART PROBLEMS | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c) LOSS OF CONSCIOUS. | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d) RAPID BREATHING | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e) SEIZURES | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f) BLEEDING | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| g) JAUNDICE | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| h) DARK URINE | 1 | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 119 | CHECK 118: ANY 'YES' CIRCLED? | NO YES <input type="checkbox"/> ↓ (SKIP TO 122) ← | NO YES <input type="checkbox"/> ↓ (SKIP TO 122) ← | NO YES <input type="checkbox"/> ↓ (SKIP TO 122) ← | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 120 | CHECK 113: HEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 (SKIP TO 122) ← 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 (SKIP TO 122) ← 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 (SKIP TO 122) ← 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 121 | In the past two weeks has (NAME) taken or is taking ACT given by a doctor or health professional to treat the malaria? VERIFY BY ASKING TO SEE TREATMENT | YES 1 (SKIP TO 123) ← NO 2 (SKIP TO 124) ← | YES 1 (SKIP TO 123) ← NO 2 (SKIP TO 124) ← | YES 1 (SKIP TO 123) ← NO 2 (SKIP TO 124) ← | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-5

| | | CHILD 1 | CHILD 2 | CHILD 3 |
|--|---|--|--|--|
| | CHECK HOUSEHOLD QUESTIONNAIRE: LINE NUMBER FROM COLUMN 9. | LINE NUMBER <input type="text"/> <input type="text"/> | LINE NUMBER <input type="text"/> <input type="text"/> | LINE NUMBER <input type="text"/> <input type="text"/> |
| | | NAME _____ | NAME _____ | NAME _____ |

| | | | | |
|-----|--|---|--|--|
| 122 | <u>SEVERE MALARIA REFERRAL</u> RECORD THE RESULT OF THE MALARIA RDT ON THE REFERRAL FORM. | The malaria test shows that (NAME OF CHILD) has malaria. Your child also has symptoms of severe malaria. The malaria treatment I have will not help your child, and I cannot give you the medication. Your child is very ill and must be taken to a health facility right away. (SKIP TO 128) | | |
| 123 | ALREADY TAKING ACT REFERRAL STATEMENT | You have told me that (NAME OF CHILD) had already received ACT for malaria. Therefore, I cannot give you additional ACT. However, the test shows that he/she has malaria. If your child has a fever for two days after the last dose of ACT, you should take the child to the nearest health facility for further examination. (SKIP TO 130) | | |
| 124 | READ INFORMATION FOR MALARIA TREATMENT AND CONSENT STATEMENT TO PARENT/OTHER | The malaria test shows that your child has malaria. We can give you free medicine. The medicine is called ACT. ACT is very effective and in a few days it should get rid of the fever and other symptoms. You do not have to give the child the medicine. This is up to you. Please tell me whether you accept the medicine or not. | | |
| 125 | CIRCLE THE APPROPRIATE CODE AND SIGN YOUR NAME. | ACCEPTED MEDICINE . 1 _____ (SIGN) REFUSED 2 OTHER 6 | ACCEPTED MEDICINE . 1 _____ (SIGN) REFUSED 2 OTHER 6 | ACCEPTED MEDICINE . 1 _____ (SIGN) REFUSED 2 OTHER 6 |
| 126 | CHECK 125: MEDICATION ACCEPTED | ACCEPTED MEDICINE . 1 REFUSED 2 OTHER 6 (SKIP TO 130) ← | ACCEPTED MEDICINE . 1 REFUSED 2 OTHER 6 (SKIP TO 130) ← | ACCEPTED MEDICINE . 1 REFUSED 2 OTHER 6 (SKIP TO 130) ← |
| 127 | READ INFORMATION FOR MALARIA TREATMENT AND CONSENT STATEMENT TO PARENT/OTHER ADULT. | TREATMENT WITH ARTESUNATE-AMODIAQUINE (AA) Weight (in kg) – Approximate age Dosage ≥4.5kg to 9kg (under 1 year) 1 tablet AS- AQ (25 mg/67.5 mg) daily for 3 days >9kg - <18kg (age 1-5 years) 1 tablet AS-AQ (50mg/135mg) daily for 3 days Give the child one tablet each day for three consecutive days. Take the medicine with fatty food or drinks like milk or breast milk. For smaller children, put the tablet in a little water, mix water and tablet well, and give to the child. If your child vomits within an hour of taking the medicine, repeat the dose and get additional tablets. ALSO TELL THE PARENT / OTHER ADULT: If (NAME OF CHILD) has any of the following symptoms, you should take him/her to a health professional for further assessment and treatment right away: -- A high temperature or fever -- Fast or difficulty breathing -- Not able to drink or breastfeed -- Gets sicker or does not get better in two days (SKIP TO 130) ← | | |
| 128 | CHECK 113: HEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANEMIA 1 8.0 G/DL OR ABOVE 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | BELOW 8.0 G/DL, SEVERE ANEMIA 1 8.0 G/DL OR ABOVE 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | BELOW 8.0 G/DL, SEVERE ANEMIA 1 8.0 G/DL OR ABOVE 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← |
| 129 | <u>SEVERE ANEMIA REFERRAL</u> RECORD THE RESULT OF THE ANEMIA TEST ON THE REFERRAL | The anemia test shows that (NAME OF CHILD) has severe anemia. Your child is very ill and must be taken to a health facility immediately. | | |
| 130 | GO BACK TO 103 IN NEXT COLUMN OF THIS QUESTIONNAIRE OR IN THE FIRST COLUMN OF THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW. | | | |

HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-5

| | | | | |
|-----|---|--|--|--|
| 101 | CHECK COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN 0-5 YEARS IN QUESTION 102; IF MORE THAN SIX CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S). | | | |
| | | CHILD 4 | CHILD 5 | CHILD 6 |
| 102 | CHECK HOUSEHOLD QUESTIONNAIRE: LINE NUMBER FROM COLUMN 9. | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ |
| 103 | COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM HOUSEHOLD SCHEDULE. IF COMPLETE DATE OF BIRTH NOT PROVIDED ASK: What is (NAME)'s date of birth? | DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR ... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| 104 | CHECK 103: CHILD BORN IN 2014-2019? | YES 1 NO 2 (SKIP TO 130) ← | YES 1 NO 2 (SKIP TO 130) ← | YES 1 NO 2 (SKIP TO 130) ← |
| 105 | CHECK 103: CHILD AGE 0-5 MONTHS, I.E., WAS CHILD BORN IN MONTH OF INTERVIEW OR 5 PREVIOUS MONTHS? | 0-5 MONTHS 1 (SKIP TO 130) ← OLDER 2 | 0-5 MONTHS 1 (SKIP TO 130) ← OLDER 2 | 0-5 MONTHS 1 (SKIP TO 130) ← OLDER 2 |
| 106 | NAME OF PARENT/OTHER ADULT RESPONSIBLE FOR THE CHILD. | NAME _____ _____ | NAME _____ _____ | NAME _____ _____ |
| 107 | ASK CONSENT FOR ANEMIA TEST FROM PARENT/OTHER ADULT. | <p>As part of this survey, we are asking children all over the country to take an anemia test. Anemia is a serious health problem that usually results from poor nutrition, infection, or chronic disease. This survey will assist the government to develop programs to prevent and treat anemia. We ask that all children born in 2014 or later take part in anemia testing in this survey and give a few drops of blood from a finger or heel. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after each test.</p> <p>The blood will be tested for anemia immediately, and the result will be told to you right away. The result will be kept strictly confidential and will not be shared with anyone other than members of our survey team.</p> <p>Do you have any questions? You can say yes or no. It is up to you to decide. Will you allow (NAME OF CHILD) to participate in the anemia test?</p> | | |
| 108 | CIRCLE THE CODE AND SIGN YOUR NAME. | GRANTED 1 _____ (SIGN) ← REFUSED 2 NOT PRESENT/OTHER . 3 | GRANTED 1 _____ (SIGN) ← REFUSED 2 NOT PRESENT/OTHER . 3 | GRANTED 1 _____ (SIGN) ← REFUSED 2 NOT PRESENT/OTHER . 3 |

HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-5

| | | CHILD 4 | CHILD 5 | CHILD 6 |
|-----|---|---|---|---|
| | CHECK HOUSEHOLD QUESTIONNAIRE: LINE NUMBER FROM COLUMN 9. | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ |
| 109 | ASK CONSENT FOR MALARIA TEST FROM PARENT/OTHER ADULT. | <p>As part of this survey, we are asking children all over the country to take a test to see if they have malaria. Malaria is a serious illness caused by a parasite transmitted by a mosquito bite. This survey will assist the government to develop programs to prevent malaria.</p> <p>We ask that all children born in 2014 or later take part in malaria testing in this survey and give a few drops of blood from a finger or heel. One blood drop will be tested for malaria immediately, and the result will be told to you right away. A few blood drops will be collected on slide(s) and taken to a laboratory for testing. You will not be told the results of the laboratory testing. All results will be kept strictly confidential and will not be shared with anyone other than members of our survey team.</p> <p>Do you have any questions? You can say yes or no. It is up to you to decide. Will you allow (NAME OF CHILD) to participate in the malaria test?</p> | | |
| 110 | CIRCLE THE CODE, SIGN YOUR NAME, AND ENTER YOUR FIELDWORKER NUMBER. | GRANTED 1 REFUSED 2 (SIGN AND ENTER YOUR FIELDWORKER NUMBER) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NOT PRESENT/OTHER . 3 | GRANTED 1 REFUSED 2 (SIGN AND ENTER YOUR FIELDWORKER NUMBER) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NOT PRESENT/OTHER . 3 | GRANTED 1 REFUSED 2 (SIGN AND ENTER YOUR FIELDWORKER NUMBER) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> NOT PRESENT/OTHER . 3 |
| 111 | PREPARE EQUIPMENT AND SUPPLIES ONLY FOR THE TEST(S) FOR WHICH CONSENT HAS BEEN OBTAINED AND PROCEED WITH THE TEST(S). | | | |
| 112 | PLACE BAR CODE LABEL FOR MALARIA LAB TEST. | <div style="border: 1px dashed black; padding: 5px; text-align: center;">PUT THE 1ST BAR CODE LABEL HERE.</div> NOT PRESENT ... 99994 REFUSED 99995 OTHER 99996 PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. | <div style="border: 1px dashed black; padding: 5px; text-align: center;">PUT THE 1ST BAR CODE LABEL HERE.</div> NOT PRESENT ... 99994 REFUSED 99995 OTHER 99996 PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. | <div style="border: 1px dashed black; padding: 5px; text-align: center;">PUT THE 1ST BAR CODE LABEL HERE.</div> NOT PRESENT ... 99994 REFUSED 99995 OTHER 99996 PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. |
| 113 | RECORD HEMOGLOBIN LEVEL HERE AND IN THE ANEMIA AND MALARIA PAMPHLET. | G/DL <input type="text"/> <input type="text"/> . <input type="text"/> NOT PRESENT 994 REFUSED 995 OTHER 996 | G/DL <input type="text"/> <input type="text"/> . <input type="text"/> NOT PRESENT 994 REFUSED 995 OTHER 996 | G/DL <input type="text"/> <input type="text"/> . <input type="text"/> NOT PRESENT 994 REFUSED 995 OTHER 996 |
| 114 | CIRCLE THE CODE FOR THE MALARIA RDT. | TESTED 1 NOT PRESENT 2 REFUSED 3 OTHER 6 (SKIP TO 116) ← | TESTED 1 NOT PRESENT 2 REFUSED 3 OTHER 6 (SKIP TO 116) ← | TESTED 1 NOT PRESENT 2 REFUSED 3 OTHER 6 (SKIP TO 116) ← |

HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-5

| | | CHILD 4 | CHILD 5 | CHILD 6 |
|--|--|---|---|---|
| | CHECK HOUSEHOLD QUESTIONNAIRE: LINE NUMBER FROM COLUMN 9. | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ | LINE NUMBER <input type="text"/> <input type="text"/> NAME _____ |

| | | | | |
|-----|---|---|---|---|
| 115 | RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANEMIA AND MALARIA PAMPHLET. | POSITIVE 1 (SKIP TO 118) ← NEGATIVE 2 OTHER 6 | POSITIVE 1 (SKIP TO 118) ← NEGATIVE 2 OTHER 6 | POSITIVE 1 (SKIP TO 118) ← NEGATIVE 2 OTHER 6 |
| 116 | CHECK 113: HEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← |
| 117 | <u>SEVERE ANEMIA REFERRAL</u> RECORD THE RESULT OF THE ANEMIA TEST ON THE REFERRAL FORM. | The anemia test shows that (NAME OF CHILD) has severe anemia. Your child is very ill and must be taken to a health facility immediately. (SKIP TO 130) | | |
| 118 | Does (NAME) suffer from any of the following illnesses or symptoms: a) Extreme weakness? b) Heart problems? c) Loss of consciousness? d) Rapid or difficult breathing? e) Seizures? f) Abnormal bleeding g) Jaundice or yellow skin? h) Dark urine? | YES NO a) EXTREME WEAKNESS 1 2 b) HEART PROBLEMS 1 2 c) LOSS OF CONSCIOUS. 1 2 d) RAPID BREATHING 1 2 e) SEIZURES 1 2 f) BLEEDING 1 2 g) JAUNDICE 1 2 h) DARK URINE 1 2 | YES NO a) EXTREME WEAKNESS 1 2 b) HEART PROBLEMS 1 2 c) LOSS OF CONSCIOUS. 1 2 d) RAPID BREATHING 1 2 e) SEIZURES 1 2 f) BLEEDING 1 2 g) JAUNDICE 1 2 h) DARK URINE 1 2 | YES NO a) EXTREME WEAKNESS 1 2 b) HEART PROBLEMS 1 2 c) LOSS OF CONSCIOUS. 1 2 d) RAPID BREATHING 1 2 e) SEIZURES 1 2 f) BLEEDING 1 2 g) JAUNDICE 1 2 h) DARK URINE 1 2 |
| 119 | CHECK 118: ANY 'YES' CIRCLED? | NO YES <input type="checkbox"/> ↓ (SKIP TO 122) ← | NO YES <input type="checkbox"/> ↓ (SKIP TO 122) ← | NO YES <input type="checkbox"/> ↓ (SKIP TO 122) ← |
| 120 | CHECK 113: HEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 (SKIP TO 122) ← 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 (SKIP TO 122) ← 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 | BELOW 8.0 G/DL, SEVERE ANEMIA ... 1 (SKIP TO 122) ← 8.0 G/DL OR ABOVE ... 2 NOT PRESENT 3 REFUSED 4 OTHER 6 |
| 121 | In the past two weeks has (NAME) taken or is taking ACT given by a doctor or health professional to treat the malaria? VERIFY BY ASKING TO SEE TREATMENT | YES 1 (SKIP TO 123) ← NO 2 (SKIP TO 124) ← | YES 1 (SKIP TO 123) ← NO 2 (SKIP TO 124) ← | YES 1 (SKIP TO 123) ← NO 2 (SKIP TO 124) ← |

HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-5

| | | CHILD 4 | CHILD 5 | CHILD 6 |
|--|---|--|--|--|
| | CHECK HOUSEHOLD QUESTIONNAIRE: LINE NUMBER FROM COLUMN 9. | LINE NUMBER <input type="text"/> <input type="text"/> | LINE NUMBER <input type="text"/> <input type="text"/> | LINE NUMBER <input type="text"/> <input type="text"/> |
| | | NAME _____ | NAME _____ | NAME _____ |

| | | | | |
|-----|--|---|--|--|
| 122 | <u>SEVERE MALARIA REFERRAL</u> RECORD THE RESULT OF THE MALARIA RDT ON THE REFERRAL FORM. | The malaria test shows that (NAME OF CHILD) has malaria. Your child also has symptoms of severe malaria. The malaria treatment I have will not help your child, and I cannot give you the medication. Your child is very ill and must be taken to a health facility right away. (SKIP TO 128) | | |
| 123 | ALREADY TAKING ACT REFERRAL STATEMENT | You have told me that (NAME OF CHILD) had already received ACT for malaria. Therefore, I cannot give you additional ACT. However, the test shows that he/she has malaria. If your child has a fever for two days after the last dose of ACT, you should take the child to the nearest health facility for further examination. (SKIP TO 130) | | |
| 124 | READ INFORMATION FOR MALARIA TREATMENT AND CONSENT STATEMENT TO PARENT/OTHER | The malaria test shows that your child has malaria. We can give you free medicine. The medicine is called ACT. ACT is very effective and in a few days it should get rid of the fever and other symptoms. You do not have to give the child the medicine. This is up to you. Please tell me whether you accept the medicine or not. | | |
| 125 | CIRCLE THE APPROPRIATE CODE AND SIGN YOUR NAME. | ACCEPTED MEDICINE . 1 _____ (SIGN) REFUSED 2 OTHER 6 | ACCEPTED MEDICINE . 1 _____ (SIGN) REFUSED 2 OTHER 6 | ACCEPTED MEDICINE . 1 _____ (SIGN) REFUSED 2 OTHER 6 |
| 126 | CHECK 125: MEDICATION ACCEPTED | ACCEPTED MEDICINE . 1 REFUSED 2 OTHER 6 (SKIP TO 130) ← | ACCEPTED MEDICINE . 1 REFUSED 2 OTHER 6 (SKIP TO 130) ← | ACCEPTED MEDICINE . 1 REFUSED 2 OTHER 6 (SKIP TO 130) ← |
| 127 | READ INFORMATION FOR MALARIA TREATMENT AND CONSENT STATEMENT TO PARENT/OTHER ADULT. | TREATMENT WITH ARTESUNATE-AMODIAQUINE (AA) Weight (in kg) – Approximate age Dosage ≥4.5kg to 9kg (under 1 year) 1 tablet AS- AQ (25 mg/67.5 mg) daily for 3 days >9kg - <18kg (age 1-5 years) 1 tablet AS-AQ (50mg/135mg) daily for 3 days Give the child one tablet each day for three consecutive days. Take the medicine with fatty food or drinks like milk or breast milk. For smaller children, put the tablet in a little water, mix water and tablet well, and give to the child. If your child vomits within an hour of taking the medicine, repeat the dose and get additional tablets. ALSO TELL THE PARENT / OTHER ADULT: If (NAME OF CHILD) has any of the following symptoms, you should take him/her to a health professional for further assessment and treatment right away: -- A high temperature or fever -- Fast or difficulty breathing -- Not able to drink or breastfeed -- Gets sicker or does not get better in two days (SKIP TO 130) ← | | |
| 128 | CHECK 113: HEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANEMIA 1 8.0 G/DL OR ABOVE 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | BELOW 8.0 G/DL, SEVERE ANEMIA 1 8.0 G/DL OR ABOVE 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← | BELOW 8.0 G/DL, SEVERE ANEMIA 1 8.0 G/DL OR ABOVE 2 NOT PRESENT 3 REFUSED 4 OTHER 6 (SKIP TO 130) ← |
| 129 | <u>SEVERE ANEMIA REFERRAL</u> RECORD THE RESULT OF THE ANEMIA TEST ON THE REFERRAL | The anemia test shows that (NAME OF CHILD) has severe anemia. Your child is very ill and must be taken to a health facility immediately. | | |
| 130 | GO BACK TO 103 IN NEXT COLUMN OF THIS QUESTIONNAIRE OR IN THE FIRST COLUMN OF THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW. | | | |

TO BE FILLED IN AFTER COMPLETING BIOMARKERS

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.
