NIGERIA MALARIA INDICATOR SURVEY
BIOMARKER QUESTIONNAIRE

NIGERIA
NATIONAL MALARIA ELIMINATION PROGRAMME
NATIONAL POPULATION COMMISSION

IDENTIFICATION		
STATE		
LOCAL GOV'T AREA		
LOCALITY		
ENUMERATION AREA		
NAME OF HOUSEHOLD HEAD		
CLUSTER NUMBER	....	
HOUSEHOLD NUMBER	....	

LABORATORY SCIENTIST'S VISITS

	1	2	3	FINAL VISIT
DATE				DAY
LABORATORY SCIENTIST'S NAME				MONTH
				YEAR
NEXT VISIT: DATE				TOTAL NUMBER OF VISITS
TIME				
NOTES:				TOTAL ELIGIBLE CHILDREN

LANGUAGE OF QUESTIONNAIRE** **0 1** LANGUAGE OF INTERVIEW** NATIVE LANGUAGE OF RESPONDENT** TRANSLATOR (YES = 1, NO = 2)

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:
01 ENGLISH 03 YORUBA 06 OTHER
02 HAUSA 04 IGBO

TEAM	TEAM SUPERVISOR	
NUMBER	NAME	NUMBER

| 101 | CHECK CAPI OUTPUT FOR "LIST ELIGIBLE INDIVIDUALS/BIOMARKERS" COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN AGE 0-5 YEARS IN QUESTION 102 ON THIS PAGE AND SUBSEQUENT PAGES STARTING WITH THE FIRST ONE LISTED. IF MORE THAN THREE CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S). | | |

		CHILD 1	SKIP
102	CHECK CAPI OUTPUT AND RECORD NAME AND LINE NUMBER OF CHILD. [RECORD NAME FROM COLUMN 2 IN HOUSEHOLD QUESTIONNAIRE; RECORD LINE NUMBER FROM COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE.]	NAME _____ LINE NUMBER . . . . . . ☐☐	
103	IF MOTHER INTERVIEWED: COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: What is (NAME)'s date of birth?	DAY . . . . ☐☐ MONTH . . . . ☐☐ YEAR . . . . ☐☐☐☐	
104	IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: How old was (NAME) at (NAME)'s last birthday? COMPARE AND CORRECT 103 AND/OR 104 IF INCONSISTENT.	AGE IN COMPLETED YEARS ☐	
105	CHECK 104: CHILD AGE 0-4 YEARS? YES ☐ NO ☐		→ 129
106	CHECK 103: IS THE CHILD AGE 0-5 MONTHS OR OLDER ☐ AGE 0-5 ☐ IS THE CHILD OLDER? MONTHS		→ 129
107	RECORD NAME OF PARENT/RESPONSIBLE ADULT FOR THE CHILD.	NAME _____ LINE NUMBER . . . . . . ☐☐	
108	ASK CONSENT FOR MALARIA AND ANEMIA TESTS FROM PARENT/RESPONSIBLE ADULT: As part of this survey, we are asking children all over the country to take a test to see if they have malaria and a test to see if they have anemia. Malaria is a serious illness caused by a parasite transmitted by a mosquito bite. Anemia is a serious health problem that usually results from poor nutrition, malaria and other infections, or chronic disease. This survey will assist the government to develop programs to prevent and treat malaria and anemia. We ask that all children age 6 months through 4 years take part in malaria and anemia testing. The tests require 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. The blood will be tested for malaria and anemia immediately, and the results will be told to you right away. A few blood drops will be collected on a slide 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. 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 and anemia tests?		
109	CIRCLE THE CODE.	GRANTED . . . . 1 REFUSED . . . . 2 NOT PRESENT/OTHER 3	→ 112
110	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER.	_____ (SIGN) ☐☐☐☐ LAB SCIENTIST NUMBER	

110A	ASK CONSENT FOR DRIED BLOOD SPOTS COLLECTION FROM PARENT/RESPONSIBLE ADULT: As part of the survey, we are also asking to collect blood samples on filter paper to send to the lab to test to determine if the antimalaria medicines are still able to kill the parasite. For this test, a few drops of blood will be collected on a filter paper card to test at a laboratory for the ability of the antimalarial medicine to kill the malaria parasite. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after we take your blood. 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. 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 collecting blood samples on filter paper?		
110B	CIRCLE THE CODE.	GRANTED . . . . 1 REFUSED . . . . 2 NOT PRESENT/OTHER 3	→ 112
110C	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER.	_____ (SIGN) ☐☐☐☐ LAB SCIENTIST NUMBER	
110D	ASK CONSENT FOR ADDITIONAL TESTING FROM PARENT/RESPONSIBLE ADULT: We ask you to allow the ANDI Centre of Excellence for Malaria Diagnosis, College of Medicine, University of Lagos to store part of the blood sample at the laboratory for additional malaria tests or research. We are not certain about what additional malaria tests might be done. The blood sample will not have any name or other data attached that could identify you. You do not have to agree. If you do not want the blood sample stored for additional testing, you can still participate in testing to see if malaria medicines are still effective. Will you allow us to keep the blood sample stored for additional testing?		
110E	CIRCLE THE CODE.	GRANTED . . . . 1 REFUSED . . . . 2 NOT PRESENT/OTHER 3	→ 112
110F	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER NUMBER.	_____ (SIGN) ☐☐☐☐ LAB SCIENTIST NUMBER	

HEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 6 MONTHS TO 4 YEARS

		CHILD 1	SKIP
111	IF CONSENT GRANTED, PREPARE EQUIPMENT AND SUPPLIES FOR THE TESTS AND PROCEED WITH THE TESTS.		
112	PLACE 1ST BAR CODE LABEL FOR MALARIA LAB TEST IN SPACE TO THE RIGHT. PUT THE 2ND BAR CODE LABEL ON THE SLIDE, THE 3RD ON THE FILTER PAPER, THE 4TH ON THE SLIDE TRANSMITTAL FORM AND THE 5TH ON THE DBS TRANSMITTAL FORM.	PUT THE 1ST BAR CODE LABEL HERE. NOT PRESENT .... 99994 REFUSED .... 99995 OTHER 99996	
113	RECORD HEMOGLOBIN LEVEL HERE AND IN THE ANEMIA AND MALARIA PAMPHLET.	G/DL .... ☐☐.☐ NOT PRESENT .... .994 REFUSED .... 995 OTHER 996	
114	RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANEMIA AND MALARIA PAMPHLET.	POSITIVE .... 1 NEGATIVE .... 2 NOT PRESENT .... 4 REFUSED .... 5 OTHER 6	→ 126 → 128 → 126
115	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? i) Vomiting? j) Pallor? k) Refusal to eat? l) Very cold hands and feet?	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 i)VOMITING .... 1 2 j) PALLOR .... 1 2 k) REFUSAL TO EAT ... 1 2 l) VERY COLD HANDS AND FEET 1 2	
116	CHECK 115: ANY 'YES' CIRCLED? NO ☐ YES ☐		→ 118
117	CHECK 113: HEMOGLOBIN RESULT	BELOW 8.0 G/DL, SEVERE ANEMIA .... 1 8.0 G/DL OR ABOVE .... 2 OTHER 6	→ 119
118	**SEVERE MALARIA REFERRAL** The malaria test shows that (NAME OF CHILD) has malaria. Your child also has symptoms suggestive of severe malaria. Due to the severity of your child's illness, the malaria treatment I have may 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. RECORD THE RESULT OF THE MALARIA RDT ON THE REFERRAL FORM.		→ 126
119	In the past 2 weeks has (NAME) taken or is (NAME) taking ACT given by a doctor or health center to treat the malaria? VERIFY BY ASKING TO SEE TREATMENT.	YES .... 1 NO 2	→ 121
120	**ALREADY TAKING ACT REFERRAL STATEMENT** You have told me that (NAME OF CHILD) had already received an 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 2 days after the last dose of ACT, you should take the child to the nearest health facility for further examination.		→ 128

		CHILD 1	SKIP
121	ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT: 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.		
122	CIRCLE THE APPROPRIATE CODE.	ACCEPTED MEDICINE .... 1 REFUSED MEDICINE .... 2 OTHER 6	→ 128
123	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER NUMBER.	_____ (SIGN) ☐☐☐☐ LAB SCIENTIST NUMBER	
124	CHECK 122: ACCEPTED MEDICINE? YES ☐ NO ☐		→ 128
125	PROVIDE DOSAGE INSTRUCTIONS TO PARENT/RESPONSIBLE ADULT. The second dose should be given 8 hours after the first dose on the day of commencement of treatment. TELL THE PARENT/RESPONSIBLE ADULT: If [NAME] has a high fever, fast or difficult breathing, is not able to drink or breastfeed, gets sicker or does not get better in 2 days, you should take him/her to a health professional for treatment right away. <table><tr><td colspan="3">TREATMENT WITH ACT</td></tr><tr><td>WEIGHT (in kg)</td><td>AGE</td><td>ARTEMETHER-LUMEFANTRINE</td></tr><tr><td>LESS THAN 5 KGS</td><td>NOTHING</td><td>NOTHING</td></tr><tr><td>5-14 KGS</td><td>6 MONTHS - 3 YEARS</td><td>1 TABLET TWICE A DAY FOR 3 DAYS</td></tr><tr><td>15-25 KGS</td><td>4 - 8 YEARS</td><td>2 TABLETS TWICE A DAY FOR 3 DAYS</td></tr><tr><td colspan="3">IF CHILD WEIGHS LESS THAN 5 KGS, DO NOT LEAVE DRUGS. TELL PARENTS TO TAKE CHILD TO HEALTH FACILITY.</td></tr></table>		→ 128
126	CHECK 113: HEMOGLOBIN RESULT	BELOW 8.0 G/DL, SEVERE ANEMIA .... 1 8.0 G/DL OR ABOVE .... 2 OTHER 6	→ 128
127	**SEVERE ANEMIA 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. RECORD THE RESULT OF THE ANEMIA TEST ON THE REFERRAL FORM.		
128	TODAY'S DATE:	DAY .... MONTH .... YEAR	
129	IF ANOTHER CHILD, GO TO 102 ON THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW.		

101	CHECK CAPI OUTPUT FOR "LIST ELIGIBLE INDIVIDUALS/BIOMARKERS" COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN AGE 0-5 YEARS IN QUESTION 102 ON THIS PAGE AND SUBSEQUENT PAGES STARTING WITH THE FIRST ONE LISTED. IF MORE THAN THREE CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S).		
		CHILD 2	SKIP
102	CHECK CAPI OUTPUT AND RECORD NAME AND LINE NUMBER OF CHILD. [RECORD NAME FROM COLUMN 2 IN HOUSEHOLD QUESTIONNAIRE; RECORD LINE NUMBER FROM COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE.]	NAME _____ LINE NUMBER ...... ☐☐	
103	IF MOTHER INTERVIEWED: COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: What is (NAME)'s date of birth?	DAY .... ☐☐ MONTH .... ☐☐ YEAR .... ☐☐☐☐	
104	IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: How old was (NAME) at (NAME)'s last birthday? COMPARE AND CORRECT 103 AND/OR 104 IF INCONSISTENT.	AGE IN COMPLETED YEARS ☐	
105	CHECK 104: CHILD AGE 0-4 YEARS?　　YES ☐　　　NO ☐		→ 129
106	CHECK 103: IS THE CHILD AGE 0-5 MONTHS OR IS THE CHILD OLDER?　　OLDER ☐　　AGE 0-5 MONTHS ☐		→ 129
107	RECORD NAME OF PARENT/RESPONSIBLE ADULT FOR THE CHILD.	NAME _____ LINE NUMBER ...... ☐☐	
108	ASK CONSENT FOR MALARIA AND ANEMIA TESTS FROM PARENT/RESPONSIBLE ADULT: As part of this survey, we are asking children all over the country to take a test to see if they have malaria and a test to see if they have anemia. Malaria is a serious illness caused by a parasite transmitted by a mosquito bite. Anemia is a serious health problem that usually results from poor nutrition, malaria and other infections, or chronic disease. This survey will assist the government to develop programs to prevent and treat malaria and anemia. We ask that all children age 6 months through 4 years take part in malaria and anemia testing. The tests require 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. The blood will be tested for malaria and anemia immediately, and the results will be told to you right away. A few blood drops will be collected on a slide 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. 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 and anemia tests?		
109	CIRCLE THE CODE.	GRANTED .... 1 REFUSED .... 2 NOT PRESENT/OTHER 3	→ 112
110	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER.	_____ (SIGN) ☐☐☐☐ LAB SCIENTIST NUMBER	

110A	ASK CONSENT FOR DRIED BLOOD SPOTS COLLECTION FROM PARENT/RESPONSIBLE ADULT: As part of the survey, we are also asking to collect blood samples on filter paper to send to the lab to test to determine if the antimalaria medicines are still able to kill the parasite. For this test, a few drops of blood will be collected on a filter paper card to test at a laboratory for the ability of the antimalarial medicine to kill the malaria parasite. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after we take your blood. 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. Do you have any questions? You can say yes or no. It is up to you to decide.	
110B	CIRCLE THE CODE.	GRANTED .... 1 REFUSED .... 2 NOT PRESENT/OTHER ..... 3 → 112
110C	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER.	_____ (SIGN) ▢▢▢▢ LAB SCIENTIST NUMBER
110D	ASK CONSENT FOR ADDITIONAL TESTING FROM PARENT/RESPONSIBLE ADULT: We ask you to allow the ANDI Centre of Excellence for Malaria Diagnosis, College of Medicine, University of Lagos to store part of the blood sample at the laboratory for additional malaria tests or research. We are not certain about what additional malaria tests might be done. The blood sample will not have any name or other data attached that could identify you. You do not have to agree. If you do not want the blood sample stored for additional testing, you can still participate in testing to see if malaria medicines are still effective. Will you allow us to keep the blood sample stored for additional testing?	
110E	CIRCLE THE CODE.	GRANTED .... 1 REFUSED .... 2 NOT PRESENT/OTHER ..... 3 → 112
110F	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER.	_____ (SIGN) ▢▢▢▢ LAB SCIENTIST NUMBER

		CHILD 2	SKIP
111	IF CONSENT GRANTED, PREPARE EQUIPMENT AND SUPPLIES FOR THE TESTS AND PROCEED WITH THE TESTS.		
112	PLACE 1ST BAR CODE LABEL FOR MALARIA LAB TEST IN SPACE TO THE RIGHT. PUT THE 2ND BAR CODE LABEL ON THE SLIDE, THE 3RD ON THE FILTER PAPER, THE 4TH ON THE SLIDE TRANSMITTAL FORM AND THE 5TH ON THE DBS TRANSMITTAL FORM.	PUT THE 1ST BAR CODE LABEL HERE. NOT PRESENT .... 99994 REFUSED .... 99995 OTHER 99996	
113	RECORD HEMOGLOBIN LEVEL HERE AND IN THE ANEMIA AND MALARIA PAMPHLET.	G/DL .... ☐☐.☐ NOT PRESENT .... .994 REFUSED .... .995 OTHER .... .996	
114	RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANEMIA AND MALARIA PAMPHLET.	POSITIVE .... 1 NEGATIVE .... 2 NOT PRESENT .... 4 REFUSED .... 5 OTHER 6	→ 126 → 128 → 126
115	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? i) Vomiting? j) Pallor? k) Refusal to eat? l) Very cold hands and feet?	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 i) VOMITING .... 1 2 j) PALLOR .... 1 2 k) REFUSAL TO EAT ... 1 2 l) VERY COLD HANDS AND FEET 1 2	
116	CHECK 115: ANY 'YES' CIRCLED? NO ☐ YES ☐		→ 118
117	CHECK 113: HEMOGLOBIN RESULT	BELOW 8.0 G/DL, SEVERE ANEMIA .... 1 8.0 G/DL OR ABOVE .... 2 OTHER 6	→ 119
118	**SEVERE MALARIA REFERRAL** The malaria test shows that (NAME OF CHILD) has malaria. Your child also has symptoms suggestive of severe malaria. Due to the severity of your child's illness, the malaria treatment I have may 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. RECORD THE RESULT OF THE MALARIA RDT ON THE REFERRAL FORM.		→ 126
119	In the past 2 weeks has (NAME) taken or is (NAME) taking ACT given by a doctor or health center to treat the malaria? VERIFY BY ASKING TO SEE TREATMENT.	YES .... 1 NO 2	→ 121
120	**ALREADY TAKING ACT REFERRAL STATEMENT** You have told me that (NAME OF CHILD) had already received an 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 2 days after the last dose of ACT, you should take the child to the nearest health facility for further examination.		→ 128

	CHILD 2		SKIP
121	ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT: 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.		
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123	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER.	_____ (SIGN) ☐☐☐☐ LAB SCIENTIST NUMBER	
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125	PROVIDE DOSAGE INSTRUCTIONS TO PARENT/RESPONSIBLE ADULT. The second dose should be given 8 hours after the first dose on the day of commencement of treatment. TELL THE PARENT/RESPONSIBLE ADULT: If [NAME] has a high fever, fast or difficult breathing, is not able to drink or breastfeed, gets sicker or does not get better in 2 days, you should take him/her to a health professional for treatment right away. **TREATMENT WITH ACT** | WEIGHT (in kg)	AGE	ARTEMETHER-LUMEFANTRINE
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LESS THAN 5 KGS	NOTHING	NOTHING
5-14 KGS	6 MONTHS - 3 YEARS	1 TABLET TWICE A DAY FOR 3 DAYS
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126	CHECK 113: HEMOGLOBIN RESULT	BELOW 8.0 G/DL, SEVERE ANEMIA .... 1 8.0 G/DL OR ABOVE .... 2 OTHER 6	→ 128
127	**SEVERE ANEMIA 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. RECORD THE RESULT OF THE ANEMIA TEST ON THE REFERRAL FORM.		
128	TODAY'S DATE:	DAY .... ☐☐ MONTH .... ☐☐ YEAR .... ☐☐☐☐	
129	IF ANOTHER CHILD, GO TO 102 ON THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW.		

101	CHECK CAPI OUTPUT FOR "LIST ELIGIBLE INDIVIDUALS/BIOMARKERS" COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN AGE 0-5 YEARS IN QUESTION 102 ON THIS PAGE AND SUBSEQUENT PAGES STARTING WITH THE FIRST ONE LISTED. IF MORE THAN THREE CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S).	

	CHILD 3	SKIP
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	CHILD 3	SKIP
111	IF CONSENT GRANTED, PREPARE EQUIPMENT AND SUPPLIES FOR THE TESTS AND PROCEED WITH THE TESTS.	
112	PLACE 1ST BAR CODE LABEL FOR MALARIA LAB TEST IN SPACE TO THE RIGHT. PUT THE 2ND BAR CODE LABEL ON THE SLIDE, THE 3RD ON THE FILTER PAPER, THE 4TH ON THE SLIDE TRANSMITTAL FORM AND THE 5TH ON THE DBS TRANSMITTAL FORM.	PUT THE 1ST BAR CODE LABEL HERE. NOT PRESENT . . . . 99994 REFUSED . . . . 99995 OTHER 99996	
113	RECORD HEMOGLOBIN LEVEL HERE AND IN THE ANEMIA AND MALARIA PAMPHLET.	G/DL . . . . ☐☐.☐ NOT PRESENT . . . . .994 REFUSED . . . . .995 OTHER 996	
114	RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANEMIA AND MALARIA PAMPHLET.	POSITIVE . . . . 1 NEGATIVE . . . . 2 NOT PRESENT . . . . 4 REFUSED . . . . 5 OTHER 6	→ 126 → 128 → 126
115	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? i) Vomiting? j) Pallor? k) Refusal to eat? l) Very cold hands and feet?	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 i)VOMITING . . . . 1 2 j) PALLOR . . . . 1 2 k) REFUSAL TO EAT . . . 1 2 l) VERY COLD HANDS AND FEET 1 2	
116	CHECK 115: ANY 'YES' CIRCLED? NO ☐ YES ☐	→ 118
117	CHECK 113: HEMOGLOBIN RESULT	BELOW 8.0 G/DL, SEVERE ANEMIA . . . . 1 8.0 G/DL OR ABOVE . . . . 2 OTHER 6	→ 119
118	**SEVERE MALARIA REFERRAL** The malaria test shows that (NAME OF CHILD) has malaria. Your child also has symptoms suggestive of severe malaria. Due to the severity of your child's illness, the malaria treatment I have may 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. RECORD THE RESULT OF THE MALARIA RDT ON THE REFERRAL FORM.	→ 126
119	In the past 2 weeks has (NAME) taken or is (NAME) taking ACT given by a doctor or health center to treat the malaria? VERIFY BY ASKING TO SEE TREATMENT.	YES . . . . 1 NO 2	→ 121
120	**ALREADY TAKING ACT REFERRAL STATEMENT** You have told me that (NAME OF CHILD) had already received an 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 2 days after the last dose of ACT, you should take the child to the nearest health facility for further examination.	→ 128

		CHILD 3		SKIP
121	ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT: 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.			
122	CIRCLE THE APPROPRIATE CODE.		ACCEPTED MEDICINE . . . . 1 REFUSED MEDICINE . . . . 2 OTHER 6	→ 128
123	SIGN NAME AND ENTER LABORATORY SCIENTIST NUMBER NUMBER.		_____ (SIGN) [ ][ ][ ][ ] LAB SCIENTIST NUMBER	
124	CHECK 122: ACCEPTED MEDICINE? YES [ ] NO [ ]			→ 128
125	PROVIDE DOSAGE INSTRUCTIONS TO PARENT/RESPONSIBLE ADULT. The second dose should be given 8 hours after the first dose on the day of commencement of treatment. TELL THE PARENT/RESPONSIBLE ADULT: If [NAME] has a high fever, fast or difficult breathing, is not able to drink or breastfeed, gets sicker or does not get better in 2 days, you should take him/her to a health professional for treatment right away. **TREATMENT WITH ACT** 	**WEIGHT (in kg)**	**AGE**	**ARTEMETHER-LUMEFANTRINE**
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LESS THAN 5 KGS	NOTHING	NOTHING
5-14 KGS	6 MONTHS - 3 YEARS	1 TABLET TWICE A DAY FOR 3 DAYS
15-25 KGS	4 - 8 YEARS	2 TABLETS TWICE A DAY FOR 3 DAYS | IF CHILD WEIGHS LESS THAN 5 KGS, DO NOT LEAVE DRUGS. TELL PARENTS TO TAKE CHILD TO HEALTH FACILITY.			→ 128
126	CHECK 113: HEMOGLOBIN RESULT		BELOW 8.0 G/DL, SEVERE ANEMIA . . . . 1 8.0 G/DL OR ABOVE . . . . 2 OTHER 6	→ 128
127	**SEVERE ANEMIA 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. RECORD THE RESULT OF THE ANEMIA TEST ON THE REFERRAL FORM.			
128	TODAY'S DATE:		DAY . . . . [ ][ ] MONTH . . . . [ ][ ] YEAR . . . . [ ][ ][ ][ ]	
129	IF ANOTHER CHILD, GO TO 102 IN ADDITIONAL QUESTIONNAIRE; IF NO MORE CHILDREN, END INTERVIEW.			

LABORATORY SCIENTIST'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING BIOMARKERS

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SUPERVISOR'S OBSERVATIONS

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