

D. MORBIDITY: REFERENCE CHILD

DIST: LOC: ALD: AF: p. 3

D01. REFERENCE CHILD _____

D02. AGE IN MONTHS

D03 Has the child been vaccinated against measles (*before today*) (0- No 1- Yes, checked on card 2- Yes, not verified) D04 *If Yes: When?* DATA: / /

D05 *If No and the child is older than 9 months:* Why not: _____

D06 Since the beginning of the year, has child _____ had measles? (0- No 1- Yes)

Box D1. Measles

Month caught	Lasted for how many days (see codes)	How many days were you unable to undertake normal activities due to the child's illness?	How many whole days did the child spend in bed?	Who was consulted and was the child given any medication to treat the illness?								If nobody was consulted: <i>Porqué?</i>		
				1 First consultation				2 Segunda Consulta						
D07	D08	D09	D10	D11	D12	D13	D14		D15	D16	D17	D18		D19

D20. During the last 2 weeks has the child had diarrhea? 0- No 1- Yes D21: *If yes:* When did it end? (Number of days ago) (00- Not yet ended) *Maximum number possible: 14*

Box D2. Gastro-Intestinal Symptoms

Gastro-Intestinal Symptoms				8 - Don't know		Did the child vomit at least once?	Was the amount of food or liquids ingested reduced?	Did the child have fever?
How many times a day did the child defecate in the beginning?	Did the diarrhea have mucus?	Fecal consistency: 1- very liquid 2- semi-liquid 3- pasty 8- don't know		Was there blood in the feces?				
D22	D23	D24		D25		D26	D27	D28

Box D3. Illness and treatment sought

How many days did it last? <i>Duration</i> (see codes)	How many days were you unable to undertake normal activities due to the child's illness?	How many whole days did the child spend in bed?	Who was consulted and was the child given any medication to treat the illness?								If nobody was consulted: <i>Why?</i>		
			1 First Consultation				2 Second Consultation						
D29	D30	D31	D32	D33	D34	D35		D36	D37	D38	D39		D40

*IF D32=OTHER, SPECIFY: _____

*IF D40=OTHER, SPECIFY: _____

D. MORBIDITY: REFERENCE CHILD, CONT.

DIST: LOC: ALD: AF: p.4
 0- No 1- Yes D42 When did it end?

D41 During the past 2 weeks has the child suffered from acute respiratory infection?

IF D41=1, FILL OUT BOXES D3 AND D4

(Number of days ago) (00- Not yet)
 Maximum number possible: 14

Box D3. Respiratory Symptoms

Respiratory Symptoms			8 - Don't know			How severe was the respiratory infection?			Fever?					
Cough?	Runny nose?	Rapid breathing?				1- Slight 2- Medium 3- Very			0- No 1- Low 2- High					
0- No 1- Yes	0- No 1- Yes	0- No 1- Yes												
D43			D44			D45			D46			D47		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Box D4. Illness and Treatment Sought

Illness or symptoms (see codes)	How many days did it last? (see codes)	How many days were you unable to undertake normal activities due to the child's illness?	How many whole days did the child spend in bed	Who was consulted and was the child given any medication to treat the illness?								If nobody was consulted: Why?
				1 First consultation				2 Second consultation				
				Who?	How many times?	Did the child take the medication?	Total cost of treatment? (CONTOS) (including transport costs)	Who?	How many times?	Did the child take the medication?	Total cost of treatment? (CONTOS) (including transport costs)	
				00- nobody		0- No 1- Yes		00- nobody		0- No 1- Yes		
D48	D49	D50	D51	D52	D53	D54	D55	D56	D57	D58	D59	D60
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

D61 During the past 2 weeks has the child suffered from fevers?

0- No 1- Yes

D62 If Yes: When did it end? (00- Not yet)

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

D63 During the past 2 weeks has the child suffered from any other disease?

0- No 1- Yes

D64 If Yes: When did it end? (00- Not yet)

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

IF D61=1 AND/OR D63=1, FILL-OUT BOX D5

Maximum amount possible: 14

Box D5. Illness and Treatment Sought

Illness or symptoms (see codes)	How many days did it last? (see codes)	How many days were you unable to undertake normal activities due to the child's illness?	How many whole days did the child spend in bed	Who was consulted and was the child given any medication to treat the illness?								If nobody was consulted: Why?
				1 First consultation				2 Second consultation				
				Who?	How many times?	Did the child take the medication?	Total cost of treatment? (CONTOS) (including transport costs)	Who?	How many times?	Did the child take the medication?	Total cost of treatment? (CONTOS) (including transport costs)	
				00- nobody		0- No 1- Yes		00- nobody		0- No 1- Yes		
D65	D66	D67	D68	D69	D70	D71	D72	D73	D74	D75	D76	D77
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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*IF D69=OTHER, SPECIFY:

*IF D77=OTHER, SPECIFY:

D. MORBIDITY: ALL OTHER MEMBERS OF THE HH

DIST: LOC: ALD: AF:

D78 Since the June this year has the reference child fallen ill with any serious disease (except for measles) for more than 3 days?

0- No 1- Yes 8- Don't know

Box D6. Illness and Treatment Sought

Fill out one line per disease in box D6

Identification number	Type of illness (see codes)	How many days did it last? (see codes)	When did it end? (number of days) 00- Not yet	How many days were you unable to undertake your normal activities due to the child's illness?	How many whole days did the child spend in bed?	Who was consulted and was the child given any medication to treat the illness?								If nobody was consulted: Why?	
						1 First consultation				2 Second consultation					
						Who? 00- nobody	How many times?	Did the child take the medication? 0- No 1- Yes	Total cost of treatment? (CONTOS) (including transport costs)	Who? 00- nobody	How many times?	Did the child take the medication? 0- No 1- Yes	Total cost of treatment? (CONTOS) (including transport costs)		
D79	D80	D81	D82	D83	D84	D85	D86	D87	D88	D89	D90	D91	D92	D93	

*IF D85=OTHER, SPECIFY: _____

*IF D93=OTHER, SPECIFY: _____

D94 During the past 2 weeks (14 days), has ANOTHER member of the HH had diarrhea?

0- No 1- Yes 8- Don't know

D95 During the past 2 weeks (14 days), has ANOTHER member of the HH had an acute respiratory infection?

0- No 1- Yes 8- Don't know

D96 During the past 2 weeks (14 days), has ANOTHER member of the HH had a fever (malaria)?

0- No 1- Yes 8- Don't know

D97 During the past 2 weeks (14 days), has ANOTHER member of the HH had any other disease?

0- No 1- Yes 8- Don't know

E. RADIO USAGE

We are thinking about putting programmes about dietary practices on the radio. We want to understand your radio usage to better plan it.

E01 Name of mother/principle caregiver of household _____

E02 Last month, how many times did you listen to the radio?

0- didn't listen last month 1- everyday 2- at least 3 times a week 3- 1-2 times a week 4- irregularly

E03 Normally, does the radio you listen to belong to a person in your HH or to someone else?

0- someone in my HH 1- someone else 9- Not applicable, don't listen to the radio

E04 What is the best time for you to listen to the radio on weekdays?

1 ⁰ 2 ⁰

1- Midnight 12:01 - 4:00 in the morning 4- Mid-morning 8:01 - 10:00am 7- Mid-afternoon 14:01 - 16:00 10- 20:01 - 22:00

E05 What is the best time for you to listen to the radio on Saturdays?

1 ⁰ 2 ⁰

2- Every morning 4:01-6:00 5- Late morning 10:01 - 12:00 8- Later afternoon 16:01 - 18:00 11- 22:01 - 24:00

E06 What is the best time for you to listen to the radio on Sundays?

1 ⁰ 2 ⁰

3- Early morning 6:01 - 8:00 6- Early afternoon 12:01 - 14:00 9- Evening: 18:01 - 20:00 99- Not Applicable

E07 What station do you listen to most?

1- Rádio Moçambique (RM) - Quelimar 2- RM- Beira 3- RM- Maputo 4- RM- Nampula 5- RTP- Portugal 6- Other: _____

F. CONSUMPTION OF VITAMIN A RICH FOODS AND DISTANCE TO SERVICES

DIST: LOC: ALD: AF: p. 6

REFERENCE CHILD

F01 Name: _____ ID:

F02 Are you breast feeding the child? 0- No 1- Yes

F03 IF YES: Yesterday, during the day was it more than 5 times? 0- No 1- Yes

F04 Did you breast feed at night? 0- No 1- Yes

F05 IF NOT: At what age did this child stop breast feeding? Years:

F06 [88- Don't know] Months:

IF THE CHILD IS YOUNGER THAN 2 YEARS: Why did it stop breast feeding?

 Probe!

Num.	NAME OF THE FOOD	NUMBER OF DAYS THE FOOD WAS CONSUMED OVER THE PAST 7 DAYS
		F07
15	Small fish FRESH (with intact liver)	<input type="checkbox"/>
16	Small fish DRIED (with intact liver)	<input type="checkbox"/>
17	Peanut or cashew nut	<input type="checkbox"/>
18	Orange-flesh sweet potato (OFSP)	<input type="checkbox"/>
19	Chicken	<input type="checkbox"/>
20	Pumpkin leaves	<input type="checkbox"/>
21	Liver - from any animal	<input type="checkbox"/>
22	Sweet potato leaves	<input type="checkbox"/>
23	Meat from cow/pig/sheep/rabbit/rat	<input type="checkbox"/>
24	Butter	<input type="checkbox"/>
25	Beans (all kinds)	<input type="checkbox"/>
26	Wheat/biscuits	<input type="checkbox"/>
27	Cod liver oil	<input type="checkbox"/>
28	Food cooked in oil	<input type="checkbox"/>
29	Cassava leaves	<input type="checkbox"/>
30	Food oil (after cooking)	<input type="checkbox"/>
31	Vitamin A fortified margarine	<input type="checkbox"/>
32	Prawn/crab	<input type="checkbox"/>
33	Coconut milk	<input type="checkbox"/>
34	Yellow-flesh sweet potato	<input type="checkbox"/>
35	Cerelac	<input type="checkbox"/>

Frequency of Consumption

During the past 7 days, how many days did the selected child eat (name of the food)?
 Meaning, how many days, starting with the last day (specify the day), did the child eat (food)?
 Explain to the mother that you want the number of DAYS, not the number of times. For example, if she gave the child maize and porridge twice on Wednesday it only counts as 1 day.

Num.	NAME OF THE FOOD	NUMBER OF DAYS THE FOOD WAS CONSUMED OVER THE PAST 7 DAYS
		F07
1	Cassava - fresh or flour	<input type="checkbox"/>
2	Whole chillies	<input type="checkbox"/>
3	Dark green leaves (of all kinds)	<input type="checkbox"/>
4	Cows milk/goats milk/powdered/condensed	<input type="checkbox"/>
5	Carrots	<input type="checkbox"/>
6	Ripe mango	<input type="checkbox"/>
7	Pumpkin	<input type="checkbox"/>
8	Pigeon pea leaves	<input type="checkbox"/>
9	Ripe papaya	<input type="checkbox"/>
10	Stiff porridge of sorghum/millet/maize	<input type="checkbox"/>
11	Rice	<input type="checkbox"/>
12	Pumpkin or cucumber seeds	<input type="checkbox"/>
13	White-flesh sweet potato	<input type="checkbox"/>
14	Eggs with yolk	<input type="checkbox"/>

F08 What is the health unit used most frequently when the child falls ill?

F09 What is the mode of transport most frequently used to get to that health unit?
 1- Foot 2- HH's Bicycle 3- Other's bicycle 4- Minibus 5- Other motorized transport 6- Other

F10 How much time is needed to reach the health unit? (Using the specified means of transportation)
 Hours: Minutes:

F11 Is there another health unit closer than the one used most frequently? 0- No 1- Yes
 If Yes: Why not use that unit? _____

F12 What is the location of the witchdoctor/tradition healer used most often by the family?
 0- Nobody goes to the witchdoctor 1- In the village 2- Outside the village 3- Outside the locality

F13 How long does it take to get to the witchdoctor/traditional healer used most often by your family?
 [Don't know: 8 /888] [N/A 9/999] Hours: Minutes:

H. ANTHROPOMETRY

INSTRUCTIONS:

Weigh all children between 0 to 59 months old.

For children under 4 months, only weigh them, (do not measure their length).

The child should be undressed when being weighed

Measure the length of children aged between 4 to 23 months old and the height of children thought to be older than 24 months.

TIME :

(If the child's age is unknown, measure its length (laying down), if it is less than 85 cm, register it, and if it is greater than or equal to 85 cm, measure the child's height.

Measure the height and weight of the mother and father or equivalent caregiver

DIST: LOC: ALD: AF: p. 8
MEASURER: _____ ASSISTANT _____

1. REFERENCE CHILD: (INFORMATION FROM THE PREVIOUS QUESTIONNAIRE)

MEM	Child's Name	Sex 1-M 2-F	Date of Birth 88- don't know			Age (in completed months)	Is he/she a twin? 0- No 1- Yes	Does he/she have a health card? 0- No 1- Yes	If yes: How many health visits are registered since February 2004?
HO1	H02	H03	H04	H05	H06	H07	H08	H09	H10
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. CHILD'S ARM CIRCUMFERENCE

ARM (0,1 CM)	
1 Measurement OF THE CHILD	2 Measurement OF THE CHILD
H11	H12
<input type="text"/>	<input type="text"/>

4. WEIGHT OF MOTHER AND CHILD

SUPERVISOR:

3. INFORMATION AND HEIGHT OF MOTHER OR PRIMARY CAREGIVER		WOMEN:			WEIGHT (0,1 kg)		Mother's clothes	Child's clothes	Child's WEIGHT
MEM	NAME	Is she pregnant? 0- No 1- Yes	If yes: How many months?	If yes: how many times has she had a prenatal check-up? (verify on the card)	1 Measurement Mother Alone	2 Measurement Child	1- Light weight (<0,5 kg) 2- Medium weight (0,5-1,5 kgs)	0- Undressed 1- Underwear 2- Light clothes	within normal limits 0- No 1- Yes
H13	H14	H15	H16	H17	H18	H19	H20	H21	H22
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. CHILD'S HEIGHT OR LENGTH

SUPERVISOR:

HEIGHT (0,1 CM) OR LENGTH		1- Length	Is the height or length of the child within normal limits
1 Measurement	2 Measurement	2- Height	0- No 1- Yes
H23	H24	H25	H26
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

SUPERVISOR:

If there is a measurement outside of normal limits, re-estimate date of birth		
Re-estimated date of birth		
DAY	MONTH	YEAR
H32	H33	H34
<input type="text"/>	<input type="text"/>	<input type="text"/>

REMEMBER THAT WE SHOULD MEASURE NEW CHILDREN (SECTION G)

6. HEIGHT AND WEIGHT OF THE FATHER OR MAIN MALE

MEN:

MEM	NAME	WEIGHT (0,1 kg)	HEIGHT (0,1 CM)	
H27	H28	H29	H30	H31
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Method Used

<input type="text"/>
