SUSTAINABLE NUTRITIONAL IMPROVEMENT: BASE INQUIERY: PART II: CHUABO: MAY/JUNE 2003

A. IDENTIFICATION OF HOUSEHOLD

A01. DISTRICT: A02. LOCALITY: A03. VILLAGE A04. HH:

A05. HEAD OF HOUSEHOLD:

A06. TYPE OF HOUSEHOLD HEAD: (1- MAN 2- WOMAN WITH SUPPORT 3- WOMAN WITHOUT SUPPORT):

A07.	DATE OF 1º INTERVIEW			/			A10. INVESTIGATOR				A13. DATA DE 1º DIGITAÇÃO			/		
A08.	TIME AT START			:			A11. CONTROLLER				A14. 1º DIGITADOR					
A09.	TIME AT END			:			A12. CALL-BACK? 0- No 1- Yes 2 Yes, only blood				A15. DATA DE 1º DIGITAÇÃO			/		
A09B.	DATE OF 2º INTERVIEW						A12B. INVESTIGATOR OF 2º				A16. 2º DIGITADOR					
PROBLEMS:							APPROVAL									

REFERENCE CHILD: BREAST FED AT FIRST INTERVIEW: (0- No 1- Yes):

RECEIVED CAPSULE: DATE RECEIVED:

MOTHER/CAREGIVER OF CHILD: FATHER/CAREGIVER OF CHILD: SIZE OF HH:

MEMBERS AGED 60 MONTHS OR MORE: (0- No 1- Yes)

#1 SEX: 0 RELATION: 0 AGE: 0 RESIDENT: 1 A17A. IS RESIDENT? |___| *IF LEFT:* WHY: _______________ |___|___|

#2 SEX: 0 RELATION: 0 AGE: 0 RESIDENT: 1 A17A. IS RESIDENT? |___| *IF LEFT:* WHY: _______________ |___|___|

#3 SEX: 0 RELATION: 0 AGE: 0 RESIDENT: 1 A17A. IS RESIDENT? |___| *IF LEFT:* WHY: _______________ |___|___|

#4 SEX: 0 RELATION: 0 AGE: 0 RESIDENT: 1 A17A. IS RESIDENT? |___| *IF LEFT:* WHY: _______________ |___|___|

#5 SEX: 0 RELATION: 0 AGE: 0 RESIDENT: 1 A17A. IS RESIDENT? |___| *IF LEFT:* WHY: _______________ |___|___|

#6 SEX: 0 RELATION: 0 AGE: 0 RESIDENT: 1 A17A. IS RESIDENT? |___| *IF LEFT:* WHY: _______________ |___|___|

#0 SEX: 0 RELATION: 0 AGE: 0 RESIDENT: 1 A17A. IS RESIDENT? |___| *IF LEFT:* WHY: _______________ |___|___|

#0 SEX: 0 RELATION: 0 AGE: 0 RESIDENT: 1 A17A. IS RESIDENT? |___| *IF LEFT:* WHY: _______________ |___|___|

MEMBERS YOUNGER THAN 60 MONTHS OLD:

0 SEX: 0 DATE OF BIRHT: DAY: MONTH: YEAR: 0 HAS HEALTH CARD? MOTHER'S ID NUM: ALTER.: 0 FATHER'S ID NUM: 0 ALTER.: 0

A18A. IS RESIDENT? |___| *IF LEFT:* WHY: ____________________________ |___|___|

0 SEX: 0 DATE OF BIRHT: DAY: MONTH: YEAR: 0 HAS HEALTH CARD? MOTHER'S ID NUM: ALTER.: 0 FATHER'S ID NUM: 0 ALTER.: 0

A18A. IS RESIDENT? |___| *IF LEFT:* WHY: ____________________________ |___|___|

0 SEX: 0 DATE OF BIRHT: DAY: MONTH: YEAR: 0 HAS HEALTH CARD? MOTHER'S ID NUM: ALTER.: 0 FATHER'S ID NUM: 0 ALTER.: 0

A18A. IS RESIDENT? |___| *IF LEFT:* WHY: ____________________________ |___|___|

0 SEX: 0 DATE OF BIRHT: DAY: MONTH: YEAR: 0 HAS HEALTH CARD? MOTHER'S ID NUM: ALTER.: 0 FATHER'S ID NUM: 0 ALTER.: 0

A18A. IS RESIDENT? |___| *IF LEFT:* WHY: ____________________________ |___|___|

A19A. MOTHER/CAREGIVER IS GROUP MEMEBER? (0-Não 1-Sim) |____| *If Yes:* A19B. NAME OF GROUP _______________|___|___|___|

A20A. ID NUMBER OF OTHER MEMBER OF THE GROUP? |___|___| *If Yes:* A20B. NAME OF GROUP: _______________|___|___|___|

B. NEW MEMBERS OF THE HH WHO ARE 60 MONTHS OLD OR ABOVE

DIST: ☐ LOC: ☐☐ ALD: ☐☐ AF: ☐☐

Has anyone else moved into this house since our last visit?

IF YES: FILL IN BOXES B AND C *IF NOT: FILL ID IN BOXES B AND C WITH 00*

B02

01- Self	Side of HH Head	Spouse´s side
02- Spouse	15- Sibling	25- Sibling
03- Son/daughter	16- Parent	26- Parent
04-Grandchild	17- Nephew/Niece	27- Nephew/Niece
30- No relation	18- Cousin	28- Cousin
	19- Other relatives	29- Other relatives

No.	Name	Sex 1-M 2-F	Relation to the head o the HH *see codes*	Age (in number of birthdays)	Has he/ she lived in this house since January 2003? 0- No 1- Yes	Does he/ she speak Portuguese? 0- No 1- Yes	Current Scholastic Level 0- Never Studied 01 ... 12 13- Tertiary education 19- Literate	*If he/she is younger than 30:* Is he/she currently studying? 0- No 1- Yes	Marital Status 1- Single 2- Married 3- Marital Union 4- Polygamous 5- Divorced or Separated 6- Widowed	Is agriculture his/her primary or secondary occupation? 0- N/A 1- Primary 2- Secondary	Since the start of 2003 has he/she: Sold agriculture and or livestock products? 0- No 1- Yes	Undertaken salaried employment? 0- No 1- Yes	Done casual labour? 0- No 1- Yes	Been involved in petty trade? 0- No 1- Yes	Been involved in some other self-employment activity (e.g. Fishing woodwork stonemason) 0- No 1- Yes
ID	NAME	B01	B02	B03	B04	B05	B06	B07	B08	B09	B10	B11	B12	B13	B14
☐☐															
☐☐															
☐☐															
☐☐															

C. NEW MEMBERS OF THE HH YOUNGER THAN 60 MONTHS OLD

Those entering the HH who are less than 5 years old

No.	Name	Sex 1-M 2- F	Date of Birth DAY	MONTH	YEAR (88- unknown)	Age (in months complet-ed)	Does he/ she have a health card? 0- No 1- Yes	*If yes:* How many registered health visits are there?	Mother of the Child: Name	Identification number or (*see Section B*) 40-Living but non-resident 50- Dead	*Se o zelador não for a mãe:* Núm. do zelador principal pela criança	Father of the Child: Name	Identification number or (*see Section B*) 40-Living but non-resident 50- Dead	*If the father is non-resident:* ID number of main male
ID	MEM	C01	C02	C03	C04	C05	C06	C07		C08	C09		C10	C11
☐☐														
☐☐														
☐☐														

D. MORBIDITY: REFERENCE CHILD

DIST: ☐ LOC: ☐☐ ALD: ☐☐ AF: ☐☐

D01. REFERENCE CHILD: _____ ☐☐

D02. Since birth, has the child spent at least one night in a health unit because of illness? 0- No ☐ D06 1- Yes

Has the child got at least one vaccination registered on his/her health card? ☐

0- No 1- Yes 2- Never received 3- Received but lost card/part of card

If Yes:
Fill-out the box

Time	How many days?	How old (in months) was the child?	What was the main illness
	D03	D04	D05
1 First	☐☐☐	☐☐☐	☐☐☐
2 Second	☐☐☐	☐☐☐	☐☐☐
3 Third	☐☐☐	☐☐☐	☐☐☐

If Yes
Not the quantity of vaccinations received of each type

VACCINATION	Maximum Possible	Quantity D07
1- BCG	1	☐☐☐
2- POLIO	4	☐☐☐
3- DPT-HEPB	3	☐☐☐
4- MEASLES	1	☐☐☐

D08. During the last two weeks, has the child had diarrhea? 0- No 1- Yes ☐ D09: If Yes: When did it end? (Number of days ago) (00- Not yet) ☐☐☐ *Maximum possible: 14*

Box D1. Gastro-Intestinal Symptoms

Gastro-Intestinal Symptoms 8 - Don´t know				Did the child vomit at least	Was the amount of food or	Did the child have fever?
How many times a day did the child defacate in the beginning?	Did the diarrhea have mucus? 0- No 1- Yes	Fecal consistency: 1- very liquid 2- semi-lliquid 3- pasty 8- don´t know	Was there blood in the feces? 0- No 1- Yes 8- Don´t know	once? 0- No 1- Yes 8- Don´t know	liquids ingested reduced? 0- No 1- A little 3- A lot	0- No 1- Slight 2- High
D10	D11	D12	D13	D14	D15	D16
☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐

Box D2. Illness and treatment sought

How many days did it last? *Duration* (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? 1First Consultation				2 Second Cosultation				*If nobody was consulted*
			Who? 00- nobody	How many times?	Did the child take the medication? 0- No 1- Yes	Total cost of the treatment? (CONTOS) (including transport costs)	Who? 00- nobody	How many times?	Did the child take the medication? 0- No 1- Yes	Total cost of the treatment? (CONTOS) (including transport costs)	Why?
D17	D18	D19	D20	D21	D22	D23	D24	D25	D26	D27	D28
☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐,☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐,☐☐	☐☐☐

IF D20=OTHER, SPECIFY: _____

**IF D28=OTHER, SPECIFY:* _____

D29. During the past 2 weeks has the child suffered from acute respiratory infection? 0- No 1- Yes D30 If Yes: When did it end? (Number of days ago) (00- Not yet)

IF D29=1, FILL-OUT BOXES D3 AND D4

Maximum number possible: 14

Box D3. Respiratory Symptoms

Respiratory Symptoms 8 - Don´t know			How severe was the	Fever?
Cough? 0- No 1- Yes	Runny nose? 0- No 1- Yes	Rapid breathing? 0- No 1- Yes	respiratory infection? 1- Slight 2- Medium 3- Very	0- No 1- Low 2- High
D31	D32	D33	D34	D35

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? 1 First consultation				2 Second consultation				*If nobody was consulted:*
				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)	Why?
D36	D37	D38	D39	D40	D41	D42	D43	D44	D45	D46	D47	D48
							,				,	

D49. During the past 2 weeks has the child suffered from fevers? 0- No 1- Yes

D50: *If Yes:* When did it end? (00- Not yet)

D51. During the past 2 weeks has the child suffered from any other disease? 0- No 1- Yes

D52: *If Yes:* When did it end? (00- Not yet)

IF D49=1 AND/OR D51=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? 1 First consultation				2 Second consultation				*If nobody was consulted:*
				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)	Why?
D53	D54	D56	D57	D58	D59	D60	D61	D62	D63	D64	D65	D66
							,				,	
							,				,	
							,				,	
							,				,	

**IF D58=OTHER, SPECIFY:* _____

**IF D66=OTHER, SPECIFY:* _____

D67. During the past 2 weeks (14 days), has ANOTHER member of the HH had diarrhea? …….. 0- No 1- Yes 8- Don´t know

D68. 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

D69. 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

D70. 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

Fill out one line per disease in box D6

Box D6. Illness and Treatment Sought

Identification number IDENTI-FICAÇÃO	Type of illness (see codes)	How many days did it last? (see codes)	When did it end? (number of days) 00- Not yet	*If the child is LESS* than 12 years old: How many days were you unable to undertake your normal activities due to the child´s illness?	*If patient is 12* years old or more How many days was the patient unable to under-take normal activities	How many whole days were spent in bed?	Who was consulted and was the child given any medication to treat the illness? 1 First consultation Who? 00- nobody	How many times?	Did he/she take the medication? 0- No 1- Yes	Total cost of treatment? (CONTOS) (including transport costs)	2 Second consultation Who? 00- nobody	How many times?	Did he/she take the medication? 0- No 1- Yes	Total cost of treatment? (CONTOS) (including transport costs)	*If not consulted* Why?
D71	D72	D73	D74	D75	D76	D77	D78	D79	D80	D81	D82	D83	D84	D85	D86
										,				,	
										,				,	
										,				,	
										,				,	
										,				,	
										,				,	
										,				,	
										,				,	

*IF *D72=OTHER, SPECIFY:* _____

IF D86=OTHER, SPECIFY: _____

D21	Doença		
0 1	Diarréia	1 6	Febre Tifoide
0 2	Desenteria	1 7	Tuberculose
0 3	Infecção Respiratória	1 8	SIDA
0 4	Tosse	1 9	Sarampo
0 5	Gripe Grave	2 0	Cólera
0 6	Febre	2 1	Têtano
0 7	Malária	2 2	Sarna
0 8	Constipação	2 3	Problema nos Olhos
0 9	Dores de Cabeça	2 4	Pneumonia
1 0	Problema de Estômago	2 5	Lombrigas/Parasitas
1 1	Problema de Ouvidos	2 6	Hepatite
1 2	Problema de Dentes	2 7	Vómitos
1 3	Anémia	2 8	Outra Dor
1 4	Pingo/Rinolreia	2 9	Paralisia
1 5	Rheumatismo	3 0	Problemas Mentais
		3 1	Marasmo
		3 2	Kwashiokhor
		3 3	Hemorragia
		3 4	Papera

D22	Duração
1	1 Dia
2	2 Dias
3	3 Dias
4	4 Dias
5	5 Dias
6	6 Dias
.	
.	
.	
9 0	90 Dias
9 1	3-6 meses
9 2	7-9 meses
9 3	9-12 meses
9 4	mais de um ano
9 5	mais de dois anos
9 6	mais de três anos
9 7	condição permanente
9 8	Não lembra/sabe

D26	A Quem Consultou?
D30	
0 0	Ninguém
0 1	Próprio
0 2	Posto de Saúde
0 3	Centro de Saúde
0 4	Hospital
0 5	Clínica Privada
0 6	Parteira Tradicional
0 7	Curandeiro/Médico tradicional
0 8	Tratamento particular
0 9	Farmácia
1 0	Loja Geral
1 1	Marido/Esposa
1 2	Pai/Mãe
1 3	Avó
1 4	Tia/Tio
1 5	Sogra/Sogro
1 6	Cunhado/Cunhada
1 7	Outro Parente
1 8	Voluntário/Extensionista de Saúde
1 9	Amigo/Amiga
2 0	Outro: Especificar

D34	Porquê não Consultou?
0 1	Falta de dinheiro
0 2	Falta de tempo
0 3	Reluctância do doente
0 4	Não sabe onde ir
0 5	Falta de facilidades próximas
0 6	Estradas pobres ou falta de transporte
0 7	Reluctância do membro da família
0 8	Doença grave--não pode andar
0 9	Não foi necessário
1 0	Outro, especificar
9 9	Não aplicável

E. CONSUMO DE ALIMENTOS RICOS EM VITAMINA A

DIST: ☐ LOC: ☐☐ ALD: ☐☐ AF: ☐☐

REFERENCE CHILD

E01 Name: _____ ID: ☐☐

E02 Are you breast feeding the child? …….. 0- No 1- Yes ☐

E03 *IF YES:* Yesterday, during the day was it more than 5 times? 0- No 1- Yes ☐

E04 Did you breast feed at night? 0- No 1- Yes ☐

E05A *IF NOT:* At what age did this child stop breast feeding? Years: ☐

E05B [88- Don´t know] Months: ☐☐

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

Frequency of Consumption

During the past 7 days, how many days did the selected child eat *(nome do alimento)* ?

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
		E12
1	Maize with bran	☐
2	Whole chillies	☐
3	Dark green leaves (of all types)	☐
4	Cows milk/goats milk/powdered/condensed	☐
5	Carrots	☐
6	Ripe mango	☐
7	Pumpkin	☐
8	Pigeon pea leaves	☐
9	Ripe papaya	☐
10	Stiff porridge of sorghum/millet/maize	☐
11	Rice	☐

Núm.	NAME OF THE FOOD	NUMBER OF DAYS THE FOOD WAS CONSUMED OVER THE PAST 7 DAYS
		E12
12	Pumpkin or cucumber seeds	☐
13	White-flesh sweet potato	☐
14	Small fish (with intact liver)	☐
15	Peanuts	☐
16	Orange-flesh sweet potato	☐
17	Chicken	☐
18	Pumpkin leaves	☐
19	Liver of any animal	☐
20	Sweet potato leaves	☐
21	Meat from cow/pig/sheep/rabbit/rat	☐
22	Butter	☐
23	Beans (all kinds)	☐
24	Wheat	☐
25	Cod liver oil	☐
26	Oil added to food	☐
27	Cassava leaves	☐
28	Food oil	☐
29	Vitamin A fortified margarine	☐
30	Prawn/Crab	☐
31	Coconut milk	☐
32	Yellow-flesh sweet potato	☐
33	Cerelac	☐

Diagnosis of child WITHOUT informing the caregiver:

E05C Does the child show signs of malnutrition 0- None 1- Some 2- Many ☐

E06 *If Yes:* Swollen stomach …….. 0- No 1-Yes ☐

E07 Swollen of other part of face or body …….. 0- No 1-Yes ☐

E08 Discolouration (lightening) of skin and hair …….. 0- No 1-Yes ☐

E09 Seem apathatic and without energy …….. 0- No 1-Yes ☐

E10 Extreme skin peeling or sores on the body …….. 0- No 1-Yes ☐

E11 Extremely thin body (showing bones) and loose skin …….. 0- No 1-Yes ☐

F. HISTORY OF FERTILITY OF MOTHER/CAREGIVER OF REFERENCE CHILD

DIST: ☐ LOC: ☐☐ ALD: ☐☐ AF: ☐☐

F01 WOMAN'S NAME: _____ IDNO: ☐☐

F02 At what age did she have her first child? …….. ☐☐ years

F03 How many live births has she had? …….. ☐☐ *If had live births:*

F04 How many of those children died in first 5 years? …….. ☐☐

F05 How many of these children were born prematurely? …….. ☐☐

F06 How many births has she had where the child was stillborn? …….. ☐☐

F07 What is the birthing order of the reference child _____ , *meaning, is he/she* the first, second, third…. last? …….. ☐☐

If wasn't the first born alive:

F08 What is the difference in age between the reference child and the child born before him/her? ☐☐ years ☐☐ months

Date of birth of reference child: ☐☐ / ☐☐ / ☐☐

Date of birht of older child: ☐☐ / ☐☐ / ☐☐

F09 At this moment, do you want more children? 0- No 1- Yes ☐ *If No:* F10 Why not? _____ ☐☐

If Yes: F11 How many do you want? …….. ☐☐

G. MOTHER AND CHILD'S HEMOGLOBIN

G01 MEASURER: _____ ☐☐ **G02** ASSISTANT: _____ ☐☐

1. MOTHER OR PRIMARY FEMALE CAREGIVER

2. REFERENCE CHILD

MOTHER OR PRIMARY CAREGIVER			CHILD						
ID INDIV	**NAME**	**HEMOGLOBIN g/dl**	ID NUM VILLAGE HH ID INDIV (Put on filter paper)	**NAME**	AGE Months	TEMPERATURE Degrees C	**Serum Retinol of the blood** completed? 0-No 1-Yes	**HEMOGLOBIN g/dl**
G02	**G03**	**G04**	G05	**G06**	G07	G08	**G09**	**G10**
☐☐		☐☐,☐	☐☐~☐☐~☐☐		☐☐	☐☐☐,☐	☐	☐☐,☐

CRITERIA FOR ADMINISTRATION OF THE CAPSULE

G11. Is the child over 6 months old? (0- No 1- Yes) ☐ *If No: Child won't receive the capsule today*

G12. Has the child NOT received the capsule in the past 5 months? (0- No 1- Yes) ☐ *If No: Child won't receive the capsule today*

G13. Child has NOT been ill over past 7 days? (0- No 1- Yes) D09>6 ☐ e D30>6 ☐ e D50>6 ☐ e D52>6 ☐ *If one of the boxes equals 0, evaluate the next criterion*

G14. Do we already have the 10% of the predicted sample of reference children that is not receiving the capsules for reasons of illness? ☐ *If G13=0 & G14=0: Child won't receive a capsule today*

G15. DID THE REFERENCE CHILD RECEIVE A CAPSULE TODAY? 0- No 1- Yes, Cápsula 2- Yes, Placebo ☐

If didn't receive: When the capsule be administered again? DAY ☐☐ / MONTH ☐☐ / YEAR ☐☐

Signature of person who decided: _____ ☐

H. ANTHROPOMETRY

DIST: ☐ LOC: ☐☐ ALD: ☐☐ AF: ☐☐

INSTRUCTIONS: DATE OF INTERVIEW ☐☐ / ☐☐ / ☐☐ MEASURER: _____ ☐☐ ASSISTANT: _____ ☐☐

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 heigth and weight of the mother and father or equivalent caregiver

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

MEM	ID INDIV	Child´s Name	Sex 1-M 2- F	Date of Birth 88- don´t know Day Month Year	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?	LAST DATE RECEIVED A VITAMIN A CAPSULE Day/Month/Year (see health card) 99/99/99: Doesn't remember (received) 88/88/88: Never received
HO1	H02	H03	H04	H05 H06 H07	H08	H08B	H09	H10	H11 H12 H13
☐☐	☐☐☐			☐☐ / ☐☐ / ☐☐	☐☐	☐	☐	☐☐	☐☐ / ☐☐ / ☐☐

3. PESO DA MÃE E CRIANÇA *SUPERVISOR:*

2. INFORMATION AND HEIGHT OF MOTHER OR PRIMARY CAREGIVER			WOMEN:			WEIGHT (0,1 kg)		Mother´s clothes 1- Light weight (<0,5 kg) 2- Medium weight (0,5-1,5 kgs)	Child's clothes 0- Undressed 1- Underwear 2- Light clothes	Child´s WEIGHT within normal limits 0- No 1- Yes
MEM	ID INDIV	NAME	Is she pregnant 0- No 1- Yes	*If yes:* How many months?	Has she taken her iron sulfate pill within the last 2 weeks 0- No 1- Yes	1 Measurement Mother Alone	2 Measurement Child			
H14	H15	H16	H17	H18	H19	H20	H21	H22	H23	H24
☐☐	☐☐☐		☐	☐☐	☐	☐☐☐,☐	☐☐☐,☐	☐	☐	☐

4. CHILD'S ARM CIRCUMFERENCE

ARM (0,1 CM)	
1 Measurement OF THE CHILD	2 Measurement OF THE CHILD
H25	H26
☐☐,☐	☐☐,☐

5. MOTHER'S HEIGHT

MOTHER'S HEIGHT:	
HEIGHT (0,1 CM)	
1 Measurement	2 Measurement
H27	H28
☐☐☐,☐	☐☐☐,☐

6. CHILD´S HEIGHT OR LENGTH *SUPERVISOR:*

HEIGHT (0,1 CM) OR LENGTH		1-Length 2-Height	Is the height or length of the child within normal limits 0- No 1- Yes
1 Measurement	2 Measurement		
H30	H31	H32	H33
☐☐☐,☐	☐☐☐,☐	☐	☐

SUPERVISOR:

If there is a measurement outside of normal limits, re-estimate date of birth

Re-estimated date of birth

DAY MONTH YEAR

H40 H41 H42

☐☐ / ☐☐ / ☐☐

Method Used

7. HEIGHT AND WEIGHT OF THE FATHER OR MAIN MALE

MEN:		
MEM	ID INDIV	NAME	WEIGHT (0,1 kg)	HEIGHT (0,1 CM)	
---	---	---	---	---	---
				1 Measurement	2 Measurement
H34	H35	H36	H37	H38	H39
☐☐	☐☐☐		☐☐☐,☐	☐☐☐,☐	☐☐☐,☐

NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐
NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐
NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐
NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐
NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐
NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐
NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐
NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐
NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐	NAME: ________ HEMOGLOBIN: ☐☐,☐

QUALITY CONTROL OF HEMACUE 2003

Q01 TEAM: ☐

DATE			WORK AREA	IDENTIFICATION NUMBER		MICROCUVETTE DO CONTROLO			CONTENTOR DO MICROCUVETTE						WORK AREA
			Disinfected at the beginning of the session	Máquina da Hemocue	Microcuvette do Controlo	Acceptable values (Série)	Value at the beginning of the day	Container Number	Date container was opened					Number of days container has been open	Disinfected at the end of the session
DAY		MOTNH	0- No 1-Yes						DAY		MONTH		YEAR		0- No 1-Yes
Q02		**Q03**	**Q05**	**Q06**	**Q07**	**Q08**	**Q09**	**Q10**	**Q11**		**Q12**		**Q13**	**Q14**	**Q15**
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			
	/						,			/		/			

What 3 varieties of sweet potato are most produced by this household? 5- Other: Specify

Name of Variety			Where does it come from? 1- Existed before independence 2- Distributed by government 3- Distributed by a NGO (e.g. World Vision) 4- Neighbour/friend in area	How many years have you cultivated this variety? 1- <1 year 2- 1 to 2 years 3- 3 to 4 years 4- 5 to 6 years 5- More than 6 years	Colour of flesh 1- pure white 2- cream 3- yellow 4- orange 5- other, explain	Colour of peel 1- pure white 2- cream 3- red 4- brown-ish 5- other, specify	Type of plant: 1- erect 2- semi-erect 3- prostrated	Type of leaf: 1- wide 2- thin	Flavour 1- Very bland 2- A little bland 3- Not bland	Resistant to drought? 0- No 1- Yes
K13			K14	K15	K16	K17	K18	K19	K20	K21

What 3 varieties of sweet potato are most produced by this household?

Name of Variety			Where does it come from? 1- Existed before independence 2- Distributed by government 3- Distributed by a NGO (e.g. World Vision) 4- Neighbour/friend in area	How many years have you cultivated this variety? 1- <1 year 2- 1 to 2 years 3- 3 to 4 years 4- 5 to 6 years 5- More than 6 years	Colour of flesh 1- pure white 2- cream 3- yellow 4- orange 5- other, explain	Colour of peel 1- pure white 2- cream 3- red 4- brown-ish 5- other, specify	Type of plant: 1- erect 2- semi-erect 3- prostrated	Type of leaf: 1- wide 2- thin	Flavour 1- Very bland 2- A little bland 3- Not bland	Resistant to drought? 0- No 1- Yes
K13			K14	K15	K16	K17	K18	K19	K20	K21