

# SUSTAINED NUTRITIONAL IMPROVEMENT: ROUND 3 NUTRITIONAL STATE: CHUABO: MAY/JUNE 2004

**A01. DISTRICT:** \_\_\_\_\_ **A02. LOCALITY:** \_\_\_\_\_ **A03. VILLAGE:** \_\_\_\_\_ **A04. HH:** \_\_\_\_\_  
**A05. HEAD OF HOUSEHOLD:** \_\_\_\_\_ **A06. CONFIRM HEAD OF HH:** \_\_\_\_\_  
**A07. TYPE OF HEAD CURRENTLY:** (1- MAN 2- WOMAN WITH SUPPORT 3- WOMAN WITHOUT SUPPORT): \_\_\_\_\_ **IN MID-TERM SURVEY WAS:** \_\_\_\_\_  
**A08. HAS CHILD CHANGED RESIDENCE SINCE MID-TERM (0- NO 1- YES)** \_\_\_\_\_ **IF MOVED: LOCAL:** \_\_\_\_\_ **VILLAGE:** \_\_\_\_\_

A09	DATE OF 1 <sup>st</sup> INTERVIEW												A13. INVESTIGATOR							A17. . DATE OF 1 <sup>st</sup> DATA ENTRY								
A10.	TIME AT START		:										A14. CONTROLLER							A18. 1 <sup>st</sup> DIGITIZER								
A11.	TIME AT END		:										A15. WAS THERE A CALL-BACK	0- No 1- Yes 2 Only blood					A19. DATE OF 2 <sup>nd</sup> DATA ENTRY									
A12	DATE OF 2 <sup>nd</sup> INTERVIEW												A16. INVESTIGATOR OF 2 <sup>nd</sup>						A20. 2 <sup>nd</sup> DIGITIZER									

**PROBLEMS:** \_\_\_\_\_ **A21. WHY NOT DONE: (0- WAS DONE)** \_\_\_\_\_

**REFERENCE CHILD:** \_\_\_\_\_ **CALCULATE AGE IN MONTHS:** \_\_\_\_\_ **BREAST FED IN MID-TERM: (0- No 1- Yes):** \_\_\_\_\_  
**MOTHER/CAREGIVER:** \_\_\_\_\_ **IF NEW FEMALE CARGIVER SINCE ROUND 2:** \_\_\_\_\_  
**CONFIRM MOTHER/CAREGIVER OF REFERENCE CHILD: #** \_\_\_\_\_ **NAME:** \_\_\_\_\_  
**NEW CHILD (YOUNGER, OF SAME MOTHER) IN ROUND 2:** \_\_\_\_\_ **GE OF NEW CHILD IN MONTHS:** \_\_\_\_\_  
**IF DIDN'T HAVE A NEW CHILD IN ROUND 2 BUT WAS BORN IN THE MEANTIME: #** \_\_\_\_\_ **NAME:** \_\_\_\_\_  
**MEMBERS AGED 60 MONTHS OR OLDER:** (0- No 1- Yes)

	RESIDENT IN MID-TERM:	22. IS RESIDENT?	IF LEFT :	WHY?	WHERE/WHY
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____
#0		_____	_____	_____	_____

**MEMBERS LESS THAN 60 MONTHS OLD**

#0	SEXO:	DATE OF BIRTH:	DAY:	MONTH:	YEAR:	RESIDENT IN MID-TERM?	ID MOTHER:	ALTER.:	ID FATHER:	ALTER.:
	<b>A23. IS RESIDENT?</b>	_____	_____	_____	_____	_____	_____	_____	_____	_____
										<b>IF LEFT: WHY:</b> _____
										<b>WHERE/WHY:</b> _____
#0	SEXO:	DATE OF BIRTH:	DAY:	MONTH:	YEAR:	RESIDENT IN MID-TERM?	ID MOTHER:	ALTER.:	ID FATHER:	ALTER.:
	<b>A23. IS RESIDENT?</b>	_____	_____	_____	_____	_____	_____	_____	_____	_____
										<b>IF LEFT: WHY:</b> _____
										<b>WHERE/WHY:</b> _____
#0	SEXO:	DATE OF BIRTH:	DAY:	MONTH:	YEAR:	RESIDENT IN MID-TERM?	ID MOTHER:	ALTER.:	ID FATHER:	ALTER.:
	<b>A23. IS RESIDENT?</b>	_____	_____	_____	_____	_____	_____	_____	_____	_____
										<b>IF LEFT: WHY:</b> _____
										<b>WHERE/WHY:</b> _____
#0	SEXO:	DATE OF BIRTH:	DAY:	MONTH:	YEAR:	RESIDENT IN MID-TERM?	ID MOTHER:	ALTER.:	ID FATHER:	ALTER.:
	<b>A23. IS RESIDENT?</b>	_____	_____	_____	_____	_____	_____	_____	_____	_____
										<b>IF LEFT: WHY:</b> _____
										<b>WHERE/WHY:</b> _____



**SE NÃO FOI FEITO (O INQUÉRITO): PORQUÊ?**

- 0- Inquérito foi feito
- 1- Criança de referência faleceu
- 2- Agregado familiar saiu de área
- 3- Não é membro do grupo
- 4- Recusou
- 5- Ausente quando tentou inquirir
- 6- Muito doente
- 7- Outro razão, especificar

**SE SAIU: PORQUÊ?**

- 01 Casamento
- 02 Doença
- 03 Arranjou emprego
- 04 Procurou emprego
- 05 Estudou
- 06 Divórcio/Separação
- 07 Faleceu por causa de acidente
- 08 Faleceu durante o acto de parto
- 09 Faleceu por causa de doença prolongada (pelo menos 3 meses)
- 10 Faleceu por causa de doença não prolongada (especificar doença)
- 11 Faleceu por causa de outra razão
- 12 Outro razão para sair, especificar

**ONDE/CAUSA**

- 01 QUELIMANE
- 02 BEIRA
- 03 MOCUBA
- 04 MAMUTHO
- 05 POSTO CAMPO
- 06 FALTA DE LEITE DO PEITO
- 07 SITAO
- 08 CHIMOIO
- 09 DUGUDIUA
- 10 SARAMPO
- 11 MAPUTO
- 12 NICURRUCUMA
- 13 NICOADALA
- 14 TOSSE
- 15 TUBERCULOSE
- 16 MACUSE
- 17 MACANA
- 18 FURQUIA
- 19 MAZARO
- 20 NAMATIDA RIO
- 21 YACOTA II
- 22 MEWENE
- 23 CONCAJU
- 24 CHANGAUE
- 25 HEPATITE
- 26 NAMARIA
- 27 POSTO CAMPO
- 28 DIARREIA
- 29 DESNUTRICAÇÃO
- 30 MALARIA
- 31 LICUAR
- 32 MANALE
- 33 FEBRES
- 34 ZONA
- 35 CUNDINE
- 36 MARROMEU
- 37 CHIMUARA
- 38 FUNGANHA
- 39 BRONCOPNEUMONIA
- 40 DORES DE CABECA
- 98 OUTRO, ESPECIFICAR

**F06**

**PORQUE DEIXOU DE MAMAR ?**

- 01 MAE FICOU GRAVIDA
- 02 MAE FICOU DOENTE
- 03 CRIANCA FICOU DOENTE
- 04 QUANDO A CRIANCA MAMAVA VOMITAVA
- 05 A CRIANCA DEIXOU SOZINHA
- 06 A CRIANCA ESTAVA A FICAR RAQUITICA
- 07 A CRIANCA MORDIA A MAMA DA MAE
- 08 A CRIANCA JA ESTAVA GRANDE
- 09 A MAE FALECEU
- 10 SAIA LEITE TURVO ( AMARELO )
- 11 O LEITE SAIA ESTRAGADO
- 12 A MAE FICOU LOUCA
- 14 FALTA DE LEITE NO PEITO DA MAE
- 15 AUSENCIA DA MAE POR MOTIVO DE ESCOLA
- 16 A CRIANCA NAO QUERIA COMER

**F08**

**PORQUE NÃO CONSUMIU BDPA?**

- 01 NÃO FOI DISPONÍVEL NA MACHAMBA
- 02 NÃO TEVE TEMPO PARA COLHER
- 03 CRIANÇA NÃO GOSTA DE COMER
  
- 10 OUTRO, ESPECIFICAR
- 88 NÃO SABE

**D. MORBIDITY: REFERENCE CHILD**

DIST:  LOC:   ALD:   AF:

D01. REFERENCE CHILD \_\_\_\_\_

D02. AGE IN MONTHS

D03 In your opinion is your child \_\_\_\_\_ (name) growing up strong and healthy? (0- No 1- Yes)

D04 Why? \_\_\_\_\_

D05 Since the beginning of 2004 did child \_\_\_\_\_ catch the measles? (0- No 1- Yes)

**Box M1. Measles**

Month caught	Year 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: 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							
D06	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?	Did the child breast feed?
How many times a day did the child defecate in the beginning?	Did the diarrhea have mucus?	Fecal consistency:	Was there blood in the feces?	0- No 1- Yes 8- Don't know	0- No 1- A little 3- A lot	0- No 1- Slight 2- High	0-No 1- A little 2- A lot 9- N/A (doesn't breast feed)
D22	D23	D24	D25	D26	D27	D28	D28B

**Box D3. 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?	Was the child given any treatment at home?	If yes: What was given? 1- rice water 2- water with salt and sugar 3- a packet of oral rehydration salts 4- traditional medicine 5- other (specify)	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 the treatment? (CONTOS) (including transport costs)	Who?	How many times?	Did the child take the medication?	Total cost of the treatment? (CONTOS) (including transport costs)		
00- nobody		0- No 1- Yes		00- nobody		0- No 1- Yes								
D29	D30	D31	D31B	D31C	D31D	D32	D33	D34	D35	D36	D37	D38	D39	D40

\*IF D11 OR D32=OTHER, SPECIFY: \_\_\_\_\_

\*IF D19 OR D40=OTHER, SPECIFY: \_\_\_\_\_

**D. MORBIDITY: REFERENCE CHILD, CONT.**

DIST:  LOC:  ALD:  AF:  p.4  
 0- No 1- Yes  D42 When did it end?   
 (Number of days ago) (00- Not yet)  
 Maximum number possible: 14

**D41 During the past 2 weeks has the child suffered from acute respiratory infection?**  
 IF D41=1, FILL OUT BOXES D3 AND D4

**Box D4. 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		

**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? 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)	
D48	D49	D50	D51	D52	D53	D54	D55	D56	D57	D58	D59	D60

**D61 During the past 2 weeks has the child suffered from fevers?** ..... 0- No 1- Yes   
**D63 During the past 2 weeks has the child suffered from any other disease?** .. 0- No 1- Yes

**D62 If Yes:** When did it end? (00- Not yet)   
**D64 If Yes:** When did it end? (00- Not yet)

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

Maximum amount possible: 14

**Box D6. 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? 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)	
D65	D66	D67	D68	D69	D70	D71	D72	D73	D74	D75	D76	D77

IF D52 OR D69=OTHER, SPECIFY: \_\_\_\_\_

IF D60 OR D77=OTHER, SPECIFY: \_\_\_\_\_

**D. MORBIDITY OF THE REFERENCE CHILD: SERIOUS ILLNESSES SINCE JANUARY 2004**

DIST:  LOC:   ALD:   AF:

**D78** Since the January 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 D7. Illness and Treatment Sought**

*Fill out one line per disease in box D7*

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: \_\_\_\_\_

**E. MORBIDITY OF THE OTHER MEMBERS OF THE HOUSEHOLD DURING THE PAST 2 WEEKS**

**E01** During the past 2 weeks (14 days), has ANOTHER member of the HH had diarrhea? ..... 0- No 1- Yes 8- Don't know

**E02** 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

**E03** 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

**E04** 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

**Box E1. Illness and Treatment Sought**

*If the ill person is LESS than 12*

*If the ill person is MORE than 12*

**FILL OUT BOX E1 WHEN E01, E02, E03 OR E04=1.**

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 days were you unable to undertake your normal activities?	How many whole days were spent 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)	
E05	E06	E07	E08	E09	E10	E11	E12	E13	E14	E15	E16	E17	E18	E19	E20

\*IF E12=OTHER, SPECIFY: \_\_\_\_\_

\*IF E20=OTHER, SPECIFY: \_\_\_\_\_

<b>D21</b>	<b>Doença</b>			<b>D22</b>	<b>Duração</b>	<b>D26</b>	<b>A Quem Consultou?</b>	<b>D34</b>	<b>Porquê não Consultou?</b>
0 1	Diarréia	1 6	Febre Tifoide	1	1 Dia	<b>D30</b>		0 1	Falta de dinheiro
0 2	Desenteria	1 7	Tuberculose	2	2 Dias	0 0	Ninguém	0 2	Falta de tempo
0 3	Infecção Respiratória	1 8	SIDA	3	3 Dias	0 1	Próprio	0 3	Reluctância do doente
0 4	Tosse	1 9	Sarampo	4	4 Dias	0 2	Posto de Saúde	0 4	Não sabe onde ir
0 5	Gripe Grave	2 0	Cólera	5	5 Dias	0 3	Centro de Saúde	0 5	Falta de facilidades próximas
0 6	Febre	2 1	Tétano	6	6 Dias	0 4	Hospital	0 6	Estradas pobres ou falta de transporte
0 7	Malária	2 2	Sarna	.	.	0 5	Clínica Privada	0 7	Reluctância do membro da família
0 8	Constipação	2 3	Problema nos Olhos	.	.	0 6	Parteira Tradicional	0 8	Doença grave--não pode andar
0 9	Dores de Cabeça	2 4	Pneumonia	.	.	0 7	Curandeiro/Médico tradicional	0 9	Não foi necessário
1 0	Problema de Estômago	2 5	Lombrigas/Parasitas	9 0	90 Dias	0 8	Tratamento particular	1 0	Outro, especificar
1 1	Problema de Ouvidos	2 6	Hepatite			0 9	Farmácia	9 9	Não aplicável
1 2	Problema de Dentes	2 7	Vómitos	9 1	3-6 meses	1 0	Loja Geral		
1 3	Anémia	2 8	Outra Dor	9 2	7-9 meses	1 1	Marido/Esposa		
1 4	Pingo/Rinolreia	2 9	Paralisia	9 3	9-12 meses	1 2	Pai/Mãe		
1 5	Rheumatismo	3 0	Problemas Mentais	9 4	mais de um ano	1 3	Avó		
		3 1	Marasmo	9 5	mais de dois anos	1 4	Tia/Tio		
		3 2	Kwashiokhor	9 6	mais de três anos	1 5	Sogra/Sogro		
		3 3	Hemorragia	9 7	condição permanente	1 6	Cunhado/Cunhada		
		3 4	Papera	9 8	Não lembra/sabe	1 7	Outro Parente		
		3 5	Acidente			1 8	Voluntário/Extensionista de Saúde		
		3 6	Outro, especificar			1 9	Amigo/Amiga		
						2 0	Outro: Especificar		

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

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!

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"/>	<input type="checkbox"/>
2	Whole chillies	<input type="checkbox"/>	<input type="checkbox"/>
3	Dark green leaves (of all kinds)	<input type="checkbox"/>	<input type="checkbox"/>
4	Cows milk/goats milk/powdered/condensed	<input type="checkbox"/>	<input type="checkbox"/>
5	Carrots	<input type="checkbox"/>	<input type="checkbox"/>
6	Ripe mango	<input type="checkbox"/>	<input type="checkbox"/>
7	Pumpkin	<input type="checkbox"/>	<input type="checkbox"/>
8	Pigeon pea leaves	<input type="checkbox"/>	<input type="checkbox"/>
9	Ripe papaya	<input type="checkbox"/>	<input type="checkbox"/>
10	Stiff porridge of sorghum/millet/maize	<input type="checkbox"/>	<input type="checkbox"/>
11	Rice	<input type="checkbox"/>	<input type="checkbox"/>
12	Pumpkin or cucumber seeds	<input type="checkbox"/>	<input type="checkbox"/>
13	White-flesh sweet potato	<input type="checkbox"/>	<input type="checkbox"/>
14	Eggs with yolk	<input type="checkbox"/>	<input type="checkbox"/>

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

If you did not give either orange-flesh or yellow-flesh sweet potato:  
 F08 Why did the child not eat orange-flesh or yellow-flesh sweet potato in the last 7 days?

\_\_\_\_\_  
 \_\_\_\_\_

I. RADIO USAGE

I01 Name of Interviewee \_\_\_\_\_

I02 Last month, how many times did you listen to the radio? \_\_\_\_\_ 0- didn't listen to the radio last month .....

1- everyday      2- at least 3 times a week      3- 1-2 times a week      4- irregularly

I03 If listened to the radio: Did you listen to a program that mentioned Vitamin A or orange-flesh sweet potato?  
 ..... 0- No 1-Yes



**J. DESCRIPTION OF THE CONSUMPTION PATTERN OF A NEW CHILD**

*NEW CHILD SINCE JANUARY 2003. VERIFY WHETHER THERE IS A NEW CHILD WITHIN THE HH BORN AFTER THE REFERENCE CHILD OF THE SAME MOTHER*

DIST:  LOC:  ALD:  AF:  p. 7

J01 Name: \_\_\_\_\_ ID:

J02 Are you breast feeding the child? ..... 0- No 1- Yes

J03 *IF YES:* Yesterday, during the day was it more than 5 times? 0- No 1- Yes

J04 Did you breast feed at night? ..... 0- No 1- Yes

J05 *IF NOT:* At what age did this child stop breast feeding? ..... Years:

J06 0- No 1- Yes Months:

J07 *IF THE CHILD IS YOUNGER THAN 2 YEARS: Why did it stop breast feeding?*

*Probe!*

J08 *If it was due to illness of the child:* What illness? .....

J09 *If it was due to the illness of the mother:* What illness? .....

J10 When the child was born, did you give it the first milk (colostrum)? 0- No 1- Yes

J11 *IF NOT:* Why?

J12 What were the other liquids or traditional medicines given to the child during its first week of life other than breast milk?

J12A #1

J12B #2

J12C #3

J13 Why?

*If it was based on somebody's recommendation, explain who this person is:*

J14 Has the child started eating? ..... 0- No 1- Yes

J15A *IF NOT:* Why not?

*IF YES:* When did he/she start eating? J15B Month  J15C Year

J16 Once the child started eating, what would the mother feed it most often (LIST INGREDIENTS)

J16A #1

J16B #2

J16C #3

J17 *If the new child is over 2 months old, ask the mother:*

Your child is already \_\_\_\_\_ months old. How many times a day do you think he/she should eat?

J18 Has the child gotten ill since it was born? ..... 0- No 1- Yes  *(IF NO, SKIP TO THE NEXT PAGE)*

J19 *IF YES:* Has it ever had diarrhea that lasted for more than 1 day? ..... 0- No 1- Yes

J20 *IF YES:* How many times has he/she had diarrhea that lasted for more than 3 days?

J21 *IF YES:* Any of the times that the child got diarrhea, did the mother treat it at home? 0- No 1- Yes

J22 *IF YES:* Describe the most recent treatment for diarrhea

J23 Was the treatment successful? .... 0- No 1- Yes

J24 *IF NO:* Why?

J25 *IF YES:* Did the child continue breast feeding last time it had diarrhea? ..... 0- No 1- Yes

J26 *IF YES:* Did he/she breast feed the same as before, more than before or less than before? 1- same 2- more 3- less .....

J27 *IF NO:* Why?

J28 *IF YES:* Durante as duas semanas depois de parar a diarreia mais recente, que quantidade de comida dava-- same as before, more than before or less than before 1- same 2- more 3- less .....

J29 *IF YES:* While having diarrhea did the child maintain a good appetite? 0- No 1- Yes

*Before* J30 *IF NO:* What did you do?

*J28*

J31 *IF DIDN'T DO ANYTHING:* Why?

**J. PRACTICES (CONT.) AND CONSUMPTION OF THE NEW CHILD YESTERDAY**

*We are still talking about the new child, not the reference child*

J32 Since the birth of this child, has the mother gotten ill for more than one day while the child was breast feeding? ..... 0- Não 1- Sim

J33 IF YES: Did she continue to breast feed the child? ..... 0- Não 1- Sim

J34 IF YES: Did she breast feed more than before, same as before or less than before?  
1- same 2- more 3- less .....

J35 In your opinion, is this child growing up strong and healthy? ..... 0- Não 1- Sim

J36 Why \_\_\_\_\_

J37 Comparing \_\_\_\_\_ (new child) and \_\_\_\_\_ (reference child)  
when they were of the same age, which does the mother think is growing up better? .....   
0- No difference 1- New child 2- Reference child?

J38 Why? \_\_\_\_\_

DIST:  LOC:  ALD:  AF:  p. 8

**K. CONSUMPTION OF THE NEW CHILD YESTERDAY**

Now we are going to talk about what the new child ate yesterday  
We are not including other family members, just this child

<b>BREAKFAST</b>									
(and all foods eaten yesterday morning)									
<b>7. What dish(es) did he/she eat yesterday morning?</b>									
<i>List all the dishes (e.g. porridges) eaten yesterday at breakfast and during the course of the morning</i>									
M01						M04			
M02						M05			
<b>14. What foods were used to to make the dish _____ ?</b>									
<i>List all the ingredients of all the dishes mentioned above</i>									
M11						M17			
M12						M18			
M13						M19			
<b>9. Did he/she consume any other food or drink at breakfast or during the course of the rest of the morning (p.e. fruta, sumo)</b>									
M31						M47			
M32						M48			

<b>LUNCH</b> (and all foods eaten yesterday afternoon)					<b>DINNER</b> (and all foods eaten yesterday night)				
<b>10. What dish(es) were eaten at lunch yesterday?</b>					<b>13. What dish(es) were eaten for dinner yesterday?</b>				
<i>List all dishes (e.g. porridges) eaten yesterday at lunch and during the course of the afternoon</i>					<i>List all dishes (e.g. stiff porridge) eaten yesterday dinner and during the course of the night</i>				
A01				A04	J01				J04
A02				A05	J02				J05
<b>11. What foods were used to to make the dish _____ ?</b>					<b>14. What foods were used to to make the dish _____ ?</b>				
<i>List all the ingredients of all the dishes mentioned above</i>					<i>List all the ingredients of all the dishes mentioned above</i>				
A11				A17	J11				J17
A12				A18	J12				J18
A13				A19	J13				J19
<b>12. Did you consume any other food or drink at lunch or the during the course of yesterday afternoon? (e.g. fruit, juice)</b>					<b>15. Did you consume any other food or drink at lunch or during the course of yesterday night? (e.g. fruit, juice)</b>				
A31				A47	J31				J47
A32				A48	J32				J48

## CÓDIGOS DE CONSUMO

### CEREAIS

101 FARINHA DE MILHO  
 102 FARINHA DE TRIGO  
 103 FARINHA DE ARROZ  
 104 FARINHA DE MAPIRA  
 111 MILHO SECO (em grão)  
 113 ARROZ SECO  
 114 MAPIRA SECA  
 115 MEXOEIRA  
 121 MAÇAROCA  
 124 MAPIRA FRESCA  
 131 FARELO DE MILHO  
 151 PÃO  
 152 MASSA  
 190 OUTROS CEREAIS

### TUBÉRCULOS

201 MANDIOCA SECA  
 202 FARINHA DE MANDIOCA  
 203 MANDIOCA FRESCA  
 211 BATATA DOCE - POLPA BRANCA  
 212 BATATA DOCE - POLPA AMARELA  
 213 BATATA DOCE - POLPA ALARANJADA  
 221 BATATA RENO  
 230 INHAME (TARO)  
 290 OUTROS TUBÉRCULOS

### FEIJÕES

301 FEIJÃO NEMBA, SECO  
 302 FEIJÃO MANTEIGA, SECO  
 303 FEIJÃO BOER, SECO  
 304 FEIJÃO OLOCO, SECO  
 309 OUTRO FEIJÃO, SECO  
 311 FEIJÃO NEMBA, FRESCO  
 312 FEIJÃO MANTEIGA, FRESCO  
 313 FEIJÃO BOER, FRESCO  
 319 OUTRO FEIJÃO, FRESCO  
 321 ERVILHA, SECA  
 322 FAVA, SECA  
 329 OUTRA LEGUMINOSA, SECA  
 331 ERVILHA, FRESCA  
 332 FAVA, FRESCA  
 339 OUTRA LEGUMINOSA, FRESCA

### AMÊNDOAS E SEMENTES

401 AMENDOIM SECO  
 402 AMENDOIM FRESCO  
 403 GERGELIM  
 404 GIRASSOL  
 405 CASTANHA DE CAJU  
 411 SEMENTES DE ABÓBORA  
 412 SEMENTES DE PEPINO  
 490 OUTRAS AMÊNDOAS OU SEMENTES

### PRODUTOS ANIMAIS

501 PEIXE SECO  
 502 PEIXE FRESCO  
 503 PEIXE EMLATADO  
 504 CAMARÃO FRESCO  
 505 CAMARÃO SECO  
 506 CARANGUEJO  
 507 LULAS FRESCAS  
 508 LULAS SECAS  
 509 OUTROS MARISCOS  
 521 GALINHA  
 522 PASSARINHO  
 523 POMBO  
 524 PATO  
 525 OUTRAS AVES  
 531 CARNE DE BOVINO  
 532 CARNE DE SUINO  
 533 CARNE DE CAPRINO  
 534 CARNE DE CAÇA  
 539 OUTRAS CARNES  
 541 RATO/RATAZANA  
 542 MACACO  
 543 COELHO  
 544 SAPO  
 549 OUTROS ANIMAIS DO MATO  
 551 GAFANHOTO  
 552 CARACOL  
 553 OUTROS INSECTOS  
 561 OVOS

### PRODUTOS ANIMAIS (CONT)

571 LEITE FRESCO  
 572 LEITE EM PÓ  
 573 LEITE CONDENSADO  
 574 IOGURT  
 575 QUEIJO  
 579 OUTROS PRODUTOS LACTICINIOS

### VEGETAIS

601 COUVE  
 602 ALFACE  
 603 REPOLHO  
 604 FOLHA DE ABÓBORA  
 605 FOLHA DE MANDIOCA  
 606 FOLHA DE FEIJÃO  
 607 FOLHA DE BATATA DOCE  
 608 FOLHA DE AMARANTES  
 609 OUTRA S FOLHAS  
 611 ABÓBORA  
 612 PEPINO  
 613 PIRI PIRI  
 614 PIMENTO  
 615 CENOURA  
 616 TOMATE  
 621 CEBOLA  
 622 ALHO  
 623 COGUMELO  
 624 QUIABO  
 625 BERINGELA  
 629 OUTRO VEGETAL

### FRUTAS (OU SUMO DE FRUTA)

701 BANANA  
 702 PAPAIA  
 703 MANGA  
 704 LARANJA  
 705 TANGERINA  
 706 TORANJA  
 707 LIMÃO  
 708 ANANAS  
 709 ABACATE  
 710 ATA

### FRUTAS (CONT)

711 MAÇÃ  
 712 MARACUJÃ  
 713 GOIABA  
 714 MELANCIA  
 715 MAÇANICA  
 716 FRUTO DE CAJÚ  
 717 COCO/LEITE DE COCO  
 718 LANTHÃO  
 719 FRUTOS SILVESTRES  
 720 OUTRAS FRUTAS

### OUTROS PRODUTOS

801 AÇÚCAR  
 802 CANA DE AÇUCAR  
 803 REBUÇADO  
 804 MEL  
 805 JAM  
 811 BOLACHA  
 812 BOLO  
 821 ÓLEO  
 822 MANTEIGA  
 831 CERVEJA EM GARRAFA OU LATA  
 832 VINHO EM GARRAFA  
 833 REFRESCO EM GARRAFA  
 834 AGUARDENTE  
 835 BEBIDA DE CANA  
 836 BEBIDA DE CAJÚ  
 837 BEBIDA DE FARELO  
 838 SURA (COQUEIRO)  
 839 OUTRA BEBIDA ALCOÓLICA (TRADICIONAL)  
 849 OUTRO REFRESCO  
 850 SUMO DE BATATA DOCE  
 851 CAFÉ  
 852 CHÁ  
 861 SAL  
 870 AGUA

### PRATOS

901 CHIMA  
 902 CARIL  
 903 MUCUANE  
 904 MUCUANE COM FEIJÃO  
 905 MANDIOCA COM FEIJÃO  
 906 CHÁ COM AÇÚCAR  
 907 PAPAS



## 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).

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

(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.

DIST:  LOC:  ALD:  AF:  p. 10  
ASSISTANT:

The child should be undressed when being weighed

TIME  :

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

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

MEM	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?
HO1	H02	H03	H04	H05	H06	H07	H08	H09	H10

### 2. CHILD'S ARM CIRCUMFERENCE

ARM (0,1 CM)	
1 Measurement OF THE CHILD	2 Measurement OF THE CHILD
H11	H12

### 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 prenatal check-up? (verify on the card)	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- Despida 1- Calcinhas 2- Roupa Ligeira	within normal limits 0- No 1- Yes
H13	H14	H15	H16	H17	H18	H19	H20	H21	H22

### 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 0- No 1- Yes
1 Measurement	2 Measurement	2- Height	
H23	H24	H25	H26

### 6. HEIGHT AND WEIGHT OF THE FATHER OR PRINCIPAL MALE

### MEN:

MEM	NAME	WEIGHT (0,1 kg)	HEIGHT (0,1 CM)	
			1 Measurement	2 Measurement
H27	H28	H29	H30	H31

### 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

/  /

Method Used

REMEMBER THAT WE SHOULD MEASURE NEW CHILDREN (SECTION G)