

CHAIN Number

[1][0][0][0][1][ ][ ][ ]

Eligibility Checklist		
Age between 2 months and before 2 <sup>nd</sup> birthday	Y	N - ineligible
Being admitted to hospital because of acute illness	Y	N- ineligible
Parent or guardian able and available to consent	Y	N- ineligible
Able to feed orally in usual state of health	Y	N- ineligible
Known congenital syndrome	Y- ineligible	N
Cleft palate	Y- ineligible	N
Known congenital cardiac disease	Y- ineligible	N
Known terminal illness e.g. cancer	Y- ineligible	N
Admission for surgery, or likely to require surgery within 6m	Y- ineligible	N
Admission for trauma?	Y- ineligible	N
Sibling enrolled in study	Y- ineligible	N
Previously enrolled	Y- ineligible	N

## Part 1

## Admission to Hospital and Study Enrolment

<b>DATE arrived at the hospital</b>	___/___/___ <i>DD/MM/YYYY</i>	<b>TIME arrived at the hospital</b>	__:__ <i>24h Clock</i>	<input type="checkbox"/> Arrival time unknown	
<b>DATE of enrolment</b> i.e. date consented and seen by research team	___/___/___ <i>DD/MM/YYYY</i>	<b>TIME of enrolment</b>	__:__ <i>24h Clock</i>	<b>Sex</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>DOB</b>	___/___/___ <i>DD/MM/YYYY</i>	<b>Is the DOB:</b>	<input type="checkbox"/> True <input type="checkbox"/> Estimated*	<b>Child's Initials</b>	___
<b>Brought into hospital by:</b> <i>Select all that apply</i>	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle	
	<input type="checkbox"/> Sibling <18	<input type="checkbox"/> Sibling >18	<input type="checkbox"/> Carer (care home)	<input type="checkbox"/> Other _____	

\*if DOB is estimated, and the day is uncertain, write '15' for DD

## Presenting Complaints

<input type="checkbox"/> Fever / Hotness of body	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Lethargy
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Diarrhoea <14 days	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Cough<14 days	<input type="checkbox"/> Diarrhoea >14 days	<input type="checkbox"/> Altered consciousness
<input type="checkbox"/> Cough>14days	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Not feeding
<input type="checkbox"/> Poor feeding/ Weight loss	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Body swelling / limb swelling/ Oedema
<input type="checkbox"/> Rash/ skin lesion	<input type="checkbox"/> Other ( <i>only one complaint, if not covered by above options</i> )	

CHAIN Number

[1][0][0][0][1][ ][ ][ ]

Initial Observations (to be taken at time of examination by research team)			
<b>Axillary temperature</b>	_____ . _____ °C	<b>Respiratory rate</b> Count for 1 minute	_____ /minute
<b>Heart rate</b> Count for 1 minute	_____ /minute		
<b>SaO2</b> To be taken from finger or toe using pulse oximeter	_____ % Write 000 if unrecordable	<input type="checkbox"/> Measured in Oxygen	<input type="checkbox"/> Measured in Room Air <input type="checkbox"/> Unrecordable

Anthropometry					
<b>Weight</b> to be taken using SECA scales for CHAIN study	_____ . _____ kg		<b>Length</b> to be taken using SECA 416 infantometer provided for CHAIN study	Measurer 1	_____ . _____ cm
				Measurer 2	_____ . _____ cm
<b>MUAC</b> To be taken using MUAC tape for CHAIN study	Measurer 1	_____ . _____ cm	<b>Head circumference</b> To be taken using CHAIN measuring tape	Measurer 1	_____ . _____ cm
	Measurer 2	_____ . _____ cm		Measurer 2	_____ . _____ cm
<b>Oedema</b>	<input type="checkbox"/> None <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++	<b>Initials</b>		Measurer 1	Measurer 2
				_____	_____

NB: If the child is unwell the Length and Head Circumference can be taken at a later time.

Current Health	
<b>Previously admitted to hospital.</b> Include other hospitals / health centres. Select 1	<input type="checkbox"/> No <input type="checkbox"/> < 1 week ago <input type="checkbox"/> 1 weeks-1month ago <input type="checkbox"/> >1month ago
<b>Any medication last 7 days.</b> Select all that apply	<input type="checkbox"/> No medication <input type="checkbox"/> Antibiotic <input type="checkbox"/> Antimalarial <input type="checkbox"/> Traditional <input type="checkbox"/> Deworming <input type="checkbox"/> Vitamin <input type="checkbox"/> Paracetamol or Ibuprofen <input type="checkbox"/> Yes, but unknown <input type="checkbox"/> Other
<b>Urine volume in last 24hrs?</b> Select 1	<input type="checkbox"/> Not passing urine <input type="checkbox"/> Less than normal <input type="checkbox"/> Normal or greater <input type="checkbox"/> Unknown

Feeding			
<b>Currently in outpatient nutrition program?</b> Select one.	<input type="checkbox"/> Supplementary (corn soy blend, RUSF, khichuri, halwa)	<input type="checkbox"/> Therapeutic (RUTF, Plumpy-nut)	<input type="checkbox"/> None
<b>Has the child eaten these nutrition products in the last 3 days?</b>	<input type="checkbox"/> Supplementary	<input type="checkbox"/> Therapeutic	<input type="checkbox"/> None
<b>Currently Breastfeeding?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>If yes is the child taking anything else (exclude medicine)?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A

CHAIN Number

[1][0][0][0][1][ ][ ][ ]

<b>If NO breastfeeding at all, age stopped in months?</b> <i>(select one)</i>	<input type="checkbox"/> 0-3m	<input type="checkbox"/> 4-6m	<input type="checkbox"/> 7-12m	<input type="checkbox"/> >12m	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
<b>What did the child receive other than breast milk in the first 3 days of life?</b> <i>Select all that apply</i> <i>Do not include medications e.g. ARV.</i>	<input type="checkbox"/> Sweetened/sugar water	<input type="checkbox"/> Formula/powder milk	<input type="checkbox"/> Animal milk	<input type="checkbox"/> Fruit Juice	<input type="checkbox"/> Tea	<input type="checkbox"/> Other
	<input type="checkbox"/> Water	<input type="checkbox"/> Porridge/pulp	<input type="checkbox"/> Gutthi / gripe water	<input type="checkbox"/> Pure Honey	<input type="checkbox"/> Glycerine	<input type="checkbox"/> Nothing

CHAIN Number

[1][0][0][0][1][ ][ ][ ]

## Examination

*Examination should be performed by CHAIN study clinician trained in clinical examination of children, and able to formulate a diagnosis based on clinical history and findings. Refer to Clinical Examination SOP*

<b>Airway</b> <i>(select one)</i>	<input type="checkbox"/> Clear	<input type="checkbox"/> Needs active support	<input type="checkbox"/> Obstructed/Stridor
<b>Breathing</b> <i>(select all that apply)</i>	<input type="checkbox"/> <b>Normal – no concerns</b> , (move to circulation)		
	<input type="checkbox"/> Central cyanosis	<input type="checkbox"/> Nasal flaring	<input type="checkbox"/> Reduced air-entry
	<input type="checkbox"/> Wheeze	<input type="checkbox"/> Acidotic Breathing	<input type="checkbox"/> Grunting
	<input type="checkbox"/> Lower chest wall indrawing	<input type="checkbox"/> Crackles	<input type="checkbox"/> Dull to percussion
			<input type="checkbox"/> Head nodding
<b>Circulation:</b>			
<b>Cap Refill</b> (select one)	<input type="checkbox"/> >3s	<input type="checkbox"/> 2-3s	<input type="checkbox"/> <2s
<b>Cold Peripheries</b> (select one)	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hand
			<input type="checkbox"/> Warm peripheries
<b>Disability:</b>			
<b>Conscious level</b> (select one)	<input type="checkbox"/> Alert	<input type="checkbox"/> Voice	<input type="checkbox"/> Pain
			<input type="checkbox"/> Unresponsive
<b>Fontanelle</b> (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Bulging	<input type="checkbox"/> Sunken
			<input type="checkbox"/> Not present
<b>Tone</b> (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Hypertonic	<input type="checkbox"/> Hypotonic
<b>Posture</b> (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Decorticate	<input type="checkbox"/> Decerebrate
<b>Activity</b> (select one)	<input type="checkbox"/> Normal	<input type="checkbox"/> Irritable/Agitated	<input type="checkbox"/> Lethargic
<b>Dehydration:</b>			
<b>Sunken eyes?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
<b>Skin pinch</b> (select one)	<input type="checkbox"/> >2 seconds	<input type="checkbox"/> <2 seconds	<input type="checkbox"/> Immediate
<b>Drinking/Breastfeeding</b> <i>(Select one)</i>	<input type="checkbox"/> Normal	<input type="checkbox"/> Poorly	<input type="checkbox"/> Not drinking
			<input type="checkbox"/> Eager / Thirsty
<b>Abdomen</b> <i>(select any that apply)</i>	<input type="checkbox"/> Normal – no concerns	<input type="checkbox"/> Distension	<input type="checkbox"/> Hepatomegaly
	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Splenomegaly	<input type="checkbox"/> Other abdominal mass
<b>Signs of Rickets</b>	<input type="checkbox"/> None	<input type="checkbox"/> Wrist widening	<input type="checkbox"/> Rachitic rosary
			<input type="checkbox"/> Swollen knees
			<input type="checkbox"/> Bow legs
			<input type="checkbox"/> Frontal bossing
<b>Jaundice</b> (Select one)	<input type="checkbox"/> Not jaundiced	<input type="checkbox"/> +	<input type="checkbox"/> ++
			<input type="checkbox"/> +++
<b>ENT/Oral/Eyes</b> <i>(select any that apply)</i>	<input type="checkbox"/> Mouth Normal	<input type="checkbox"/> Ears Normal	<input type="checkbox"/> Eyes Normal
	<input type="checkbox"/> Oral ulceration	<input type="checkbox"/> Pus from ear	<input type="checkbox"/> Conjunctivitis
	<input type="checkbox"/> Oral candidiasis	<input type="checkbox"/> Tender swelling behind ear (mastoiditis)	<input type="checkbox"/> Eye discharge
	<input type="checkbox"/> Stomatitis	<input type="checkbox"/> Lymphadenopathy	<input type="checkbox"/> Visual impairment
<b>Skin</b> <i>(select any that apply)</i>	<input type="checkbox"/> Normal	<input type="checkbox"/> Hyperpigmentation	<input type="checkbox"/> Depigmentation
	<input type="checkbox"/> Broken skin/excoriation	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> 'Flaky paint'
	<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Impetigo	<input type="checkbox"/> Pustules
	<input type="checkbox"/> Vesicles	<input type="checkbox"/> Desquamation	<input type="checkbox"/> Macular or papular
<b>Site of skin lesions.</b> <i>(select any that apply)</i>	<input type="checkbox"/> Not applicable (No rash)	<input type="checkbox"/> Trunk	<input type="checkbox"/> Face / scalp
	<input type="checkbox"/> Palms / soles	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Arms
			<input type="checkbox"/> Legs
			<input type="checkbox"/> Perineum



CHAIN Number  
[1][0][0][0][1][ ][ ][ ]

Suspected Chronic Conditions			
Select confirmed, suspected or none for all conditions:	Confirmed (diagnosed previously/ recorded)	Suspected (clinician's impression)	None
Cerebral palsy/neurological problem/ epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell disease family history, crisis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thalassaemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual problem / Blindness Not fixing and following	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Losing weight or not gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TB Screening							
Known TB (on treatment)		Child has cough >14 days		Household contact has TB, or cough >14 days		Child has suspected extra-pulmonary TB	
Y	N	Y	N	Y	N	Y	N

Immediate Clinical Investigations and HIV status							
<b>Malaria RDT</b> <i>circle result</i>		Positive		Negative		Not done	
<b>Blood glucose</b>		_____ . _____ mmol/L		<b>Time glucose measured</b>		_____ : _____ 24h clock <input type="checkbox"/>	
<b>Urine Dipstick</b> <i>(can be done at any time during admission)</i>		Protein	Nitrites	Leucocytes	Blood	Ketones	Glucose
<b>Urine sample stored?</b>		Y	N				
<input type="checkbox"/> Not done <input type="checkbox"/> Bag <input type="checkbox"/> Clean catch		None + ++ +++	Pos Neg	None + ++ +++	None + ++ +++	None + ++ +++	None + ++ +++
<b>HIV status known?</b>		<input type="checkbox"/> Yes, known PCR positive <input type="checkbox"/> Yes, antibody positive, unknown PCR status		<input type="checkbox"/> Yes, known exposed, known PCR negative (children under 18m with PCR result SEEN BY RESEARCH TEAM. If not seen select below and perform HIV RDT			
		<input type="checkbox"/> No, known to be HIV exposed, but child untested		<input type="checkbox"/> No, child not tested, not known to be exposed			
<b>If child known HIV positive or exposed</b>	<b>On any ART?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown		<b>If on treatment,</b>		<b>If on prophylaxis</b>	
	<b>Co-trimoxazole select one</b>	<input type="checkbox"/> On prophylactic dose co-trimoxazole <input type="checkbox"/> On high dose co-trimoxazole		ARV 1 _____ ARV 2 _____ ARV 3 _____		<input type="checkbox"/> Nevirapine prophylaxis only <input type="checkbox"/> AZT + NVP prophylaxis <input type="checkbox"/> Caregiver unsure	
<b>If not known positive</b>	<b>HIV RDT now select one</b>	<input type="checkbox"/> Reactive / positive <input type="checkbox"/> Non-Reactive / Negative		<input type="checkbox"/> Declined			
		PCR sent: <input type="checkbox"/> Y <input type="checkbox"/> N					
<b>HIV test offered to caregiver?</b>		<input type="checkbox"/> Yes, Reactive	<input type="checkbox"/> Yes, Non-reactive	<input type="checkbox"/> Yes, but Declined	<input type="checkbox"/> No, Caregiver is known positive	<input type="checkbox"/> Missed	<input type="checkbox"/> N/A child in care home
<b>Did the mother have interventions or medication during delivery to prevent transmission of HIV to baby?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			



CHAIN Number

[1][0][0][0][1][ ][ ][ ]

Vaccinations – Ask carer or check book / card if available							
<b>BCG scar</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Rotavirus</b>	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	<b>Doses received:</b> 3 2 1 <input type="checkbox"/> Unknown
<b>Measles</b>	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<b>Pneumococcus</b>	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	<b>Doses received:</b> 3 2 1 <input type="checkbox"/> Unknown
			<b>DTP/Penta</b>	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	<b>Doses received:</b> 3 2 1 <input type="checkbox"/> Unknown
	<input type="checkbox"/> Not received	<input type="checkbox"/> Unknown	<b>Polio</b>	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	<input type="checkbox"/> Unknown
			<b>MenAfriVac</b>	<input type="checkbox"/> Book	<input type="checkbox"/> Self report	<input type="checkbox"/> Not received	<input type="checkbox"/> Unknown

Suspected Initial Diagnoses: <i>Clinical diagnosis should be based on examination and investigation findings. Tick the <u>three</u> most likely diagnoses.</i>		
<b>Respiratory</b>	<b>Infection</b>	<b>CNS</b>
<input type="checkbox"/> LRTI/pneumonia <input type="checkbox"/> Bronchiolitis <input type="checkbox"/> URTI <input type="checkbox"/> Pulmonary TB <input type="checkbox"/> Otitis media <input type="checkbox"/> Asthma	<input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Sepsis <input type="checkbox"/> Malaria <input type="checkbox"/> Extra pulmonary TB <input type="checkbox"/> Soft tissue infection <input type="checkbox"/> UTI <input type="checkbox"/> HIV related illness <input type="checkbox"/> Measles <input type="checkbox"/> Varicella <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Febrile illness unspecified <input type="checkbox"/> Enteric fever	<input type="checkbox"/> Febrile convulsions <input type="checkbox"/> Epilepsy <input type="checkbox"/> Probable meningitis <input type="checkbox"/> Other encephalopathy <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Developmental delay <input type="checkbox"/> Cerebral palsy
<b>General</b>		<b>Other suspected diagnosis:</b>
<input type="checkbox"/> Anaemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Thalassaemia <input type="checkbox"/> Renal impairment <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Nephritis <input type="checkbox"/> Liver dysfunction <input type="checkbox"/> Ileus <input type="checkbox"/> Congenital cardiac disease		<input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Failed appetite test only

CLINICIANS IMPRESSION OF RISK						
<i>How likely does the clinical team think this child is to die during this admission? Select one</i>						
<input type="checkbox"/> Almost certainly not	<input type="checkbox"/> Very unlikely	<input type="checkbox"/> Quite unlikely	<input type="checkbox"/> Unsure	<input type="checkbox"/> Quite likely	<input type="checkbox"/> Very likely	<input type="checkbox"/> Almost certainly



CHAIN Number  
[1][0][0][0][1][ ][ ][ ]

INITIAL TREATMENT		
<b>Admitted to:</b> <i>select one</i>	<input type="checkbox"/> Admission to ward	<input type="checkbox"/> Admission to HDU <input type="checkbox"/> Admission to ICU
<b>Date and time First antibiotics given</b>	___/___/_____ <i>24h clock</i>	____:____ <input type="checkbox"/> Not given
<b>Intravenous Antibiotics Given?</b> <input type="checkbox"/> Not given	<input type="checkbox"/> Benzylpenicillin <input type="checkbox"/> Co-amoxiclav/ Augmentin <input type="checkbox"/> Ampicillin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Ceftazidime <input type="checkbox"/> Other _____	<input type="checkbox"/> Gentamicin <input type="checkbox"/> Flu/Cloxacillin <input type="checkbox"/> Amikacin <input type="checkbox"/> Vancomycin <input type="checkbox"/> Pivmecillinam <input type="checkbox"/> Ceftriaxone / Cefotaxime <input type="checkbox"/> Chloramphenicol <input type="checkbox"/> Meropenem / Imipenem <input type="checkbox"/> Metronidazole
<b>Oral Antibiotics Given?</b> <input type="checkbox"/> Not given	<input type="checkbox"/> Amoxicillin <input type="checkbox"/> Co-trimoxazole <input type="checkbox"/> Cefalexin / cefaclor <input type="checkbox"/> Penicillin <input type="checkbox"/> Other _____	<input type="checkbox"/> Erythromycin <input type="checkbox"/> Metronidazole <input type="checkbox"/> Co-amoxiclav / Augmentin <input type="checkbox"/> Flucloxacillin <input type="checkbox"/> Azithromycin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Nalidixic acid <input type="checkbox"/> Levofloxacin
<b>Initial treatment given</b> <i>First 6 hours.</i> <i>Select any that apply.</i>	<input type="checkbox"/> IV Fluid Bolus	<input type="checkbox"/> IV Maintenance Fluids
	<input type="checkbox"/> Oxygen	<input type="checkbox"/> CPAP
	<input type="checkbox"/> IV Glucose <input type="checkbox"/> Oral Glucose	<input type="checkbox"/> Warmth (heater, warmed fluids)
	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Commercial F75
	<input type="checkbox"/> Phenobarbitone	<input type="checkbox"/> Commercial F100
	<input type="checkbox"/> Diazepam	<input type="checkbox"/> Locally prepared F75/ milk suji
	<input type="checkbox"/> Paracetamol	<input type="checkbox"/> Local prepared F100 / milk suji 100
	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Expressed breast milk
	<input type="checkbox"/> Diclofenac	<input type="checkbox"/> Dilute F100/ dilute milk or formula
	<input type="checkbox"/> Salbutamol / atrovent / other bronchodilator	<input type="checkbox"/> Other milk/ formula/ feed
	<input type="checkbox"/> Prednisolone/ dexamethasone/ hydrocortisone	<input type="checkbox"/> RUTF
	<input type="checkbox"/> Adrenaline	<input type="checkbox"/> Nasogastric tube
	<input type="checkbox"/> Zinc	<input type="checkbox"/> Multivitamin
	<input type="checkbox"/> Folic acid	<input type="checkbox"/> Micronutrients
	<input type="checkbox"/> Antimalarial (any)	<input type="checkbox"/> Vitamin A
	<input type="checkbox"/> ReSoMal	<input type="checkbox"/> Albendazole / deworming
<input type="checkbox"/> ORS	<input type="checkbox"/> Other _____	

Admission Core Cohort Investigations and Sample Collection				
<b>CBC taken</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<b>Plain Blood (serum)</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Clinical chemistry taken</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<b>Blood spot taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>EDTA 2ml blood taken</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<b>Blood culture taken (if available at site)</b>	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> Y AFTER ABX <input type="checkbox"/> N



CHAIN Number

[1][0][0][0][1][ ][ ][ ]

<b>EDTA 0.5ml blood taken</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<b>Blood gas taken</b> <i>(if available at site)</i>	<input type="checkbox"/> Capillary <input type="checkbox"/> N <input type="checkbox"/> Venous
<b>Date Taken</b>	Date taken _____ Time taken _____: _____ <i>D D / M M / Y Y Y Y</i>		
<b>Unable to take blood samples, why?</b>	<input type="checkbox"/> Difficult venepuncture <input type="checkbox"/> Child uncooperative <input type="checkbox"/> Parent refused <input type="checkbox"/> Other		
<b>Rectal swabs taken</b>	<input type="checkbox"/> Y BEFORE ABX <input type="checkbox"/> Y AFTER ABX	<input type="checkbox"/> N      Number taken <input type="checkbox"/> 1 <input type="checkbox"/> 2	Time taken _____: _____
<b>Stool sample</b>	Taken in first 24h? <input type="checkbox"/> Y <input type="checkbox"/> N	Date taken _____: _____ <i>D D / M M / Y Y Y Y</i>	Time taken _____: _____

<b>Chest x-ray indicated</b> <i>(respiratory signs symptoms)</i>	<input type="checkbox"/> Yes, but too unwell <input type="checkbox"/> Yes, done <input type="checkbox"/> Indicated but not done, unclear <input type="checkbox"/> Not indicated
<b>Lumbar puncture indicated</b> <i>(signs of meningitis documented)</i>	<input type="checkbox"/> Yes, but too unwell <input type="checkbox"/> Yes, done <input type="checkbox"/> Not indicated

<b>Blood Samples taken by (initials)</b>	_____
<b>Rectal Swabs taken by (initials)</b>	_____

<b>CRF Completed by (Initials) – to be signed when complete.</b> <i>Do not sign if any fields are empty</i>	_____	Date _____/_____/_____ <i>D D / M M / Y Y Y Y</i>	Time _____:_____
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CHAIN Number

[1][0][0][0][1][ ][ ][ ]

**PART 2****CHAIN ADMISSION CRF: SOCIAL INFORMATION.**

*To be completed within 48h of admission when child is stable. This should ideally be done in a conversational and unhurried way, with the interviewer sitting with the caregiver.*

Initials of person interviewing caregiver and completing part 2  _____	Date  ____/____/_____ D D / M M / Y Y Y Y
<input type="checkbox"/> Doctor <input type="checkbox"/> Clinical officer <input type="checkbox"/> Nurse <input type="checkbox"/> Field worker <input type="checkbox"/> Research Assistant <input type="checkbox"/> Other	Time  ____:____

**Who is being interviewed?**

<input type="checkbox"/> Primary caregiver only	<input type="checkbox"/> Care home staff	<input type="checkbox"/> Primary caregiver and one other person	<input type="checkbox"/> Primary caregiver and more than one other person	<input type="checkbox"/> One person who is not the primary caregiver	<input type="checkbox"/> More than one person who is not the primary caregiver
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**Care-seeking Behaviour**

<b>Was the child in generally good health before this illness?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>If No, how long has the child had this problem of generally bad health?</b>	____ weeks	<input type="checkbox"/> N/A	
<b>Does the child have health insurance?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>What was the main reason for bringing the child to this hospital today? <i>Reasons given, select one</i></b>			
<input type="checkbox"/> Referred by health care worker	<input type="checkbox"/> Caregiver concern of child's condition	<input type="checkbox"/> Received money for transport to hospital (e.g. from family, neighbour, paid work)?	
<input type="checkbox"/> Relative / neighbour concern of child's condition	<input type="checkbox"/> Primary caregiver returned home e.g. if working away	<input type="checkbox"/> Other	
<b>How did you travel to the hospital? <i>Select all that apply</i></b>			
<input type="checkbox"/> Car/ Taxi	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Bus	<input type="checkbox"/> Motorbike
<input type="checkbox"/> Tuk-tuk /CNG	<input type="checkbox"/> Cycle rickshaw	<input type="checkbox"/> Train	<input type="checkbox"/> Walking
<input type="checkbox"/> Other			
<b>How long did it take you to travel to hospital?</b>	<input type="checkbox"/> <1h	<input type="checkbox"/> 1- < 2h	<input type="checkbox"/> 2-4h
	<input type="checkbox"/> >4h	<input type="checkbox"/> > 1 day	
<b>How much did it cost the family to travel to hospital today (in local currency)? <i>Estimate amount. If walked, drove own car or free ambulance write</i></b>	_____		
<b>Have you sought treatment for this illness prior to coming to hospital? <i>Select all that apply</i></b>			
<input type="checkbox"/> No treatment sought	<input type="checkbox"/> Shop	<input type="checkbox"/> Government hospital	<input type="checkbox"/> Government dispensary
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Private Medical Facility/ NGO	<input type="checkbox"/> Herbalist	<input type="checkbox"/> Homeopathist
<input type="checkbox"/> Other			
<b>Received treatment from traditional healer, homeopathist or herbalist in last 4 weeks?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	
<b>Child's Health Status Before Admission</b>			
<b>Before this illness, how did this child's health compare to other children of similar age in your neighbourhood? <i>Select one</i></b>			
<input type="checkbox"/> Similar	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Don't know
<b>Before this illness, how did this child's health compare to his/her siblings at a similar age? <i>Select one</i></b>			
<input type="checkbox"/> Similar	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Don't know
			<input type="checkbox"/> N/A only child

CHAIN Number  
[1][0][0][0][1][ ][ ][ ]

Birth History				
<b>Source of information</b>	<input type="checkbox"/> Maternal/caregiver recall		<input type="checkbox"/> Book/medical records	
<b>Birth weight</b>	___ . ___ ___ kg		<input type="checkbox"/> Unknown	
<b>Birth details</b> <i>Select any that apply</i>	<input type="checkbox"/> Premature <input type="checkbox"/> Born small <2.5kg <input type="checkbox"/> Twin/multiple birth <input type="checkbox"/> Born at term <input type="checkbox"/> Unknown			
<b>Delivery location</b> <i>Select one</i>	<input type="checkbox"/> Born in hospital <input type="checkbox"/> Community facility/clinic with midwife/nurse midwife/doctor <input type="checkbox"/> Home without birth attendant <input type="checkbox"/> Home with traditional birth attendant (untrained) <input type="checkbox"/> Home with midwife/nurse <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
<b>Delivery details</b> <i>Select all that apply</i>	<input type="checkbox"/> Normal, spontaneous vaginal delivery <input type="checkbox"/> Assisted delivery (forceps, ventouse) <input type="checkbox"/> Caesarean section <input type="checkbox"/> Admitted neonatal unit <input type="checkbox"/> Mother admitted to hospital >48h <input type="checkbox"/> Unknown			
<b>Mother's age at first pregnancy</b>	___ years <input type="checkbox"/> unknown		<b>Mother's age now</b>	___ years <input type="checkbox"/> unknown
<b>Participant birth order</b>	___ of ___ total live births <i>(e.g. if youngest of 3 children 3 of 3, if oldest of 3 children 1 of 3)</i>			
<b>Are the biological parents of this child consanguineous?</b> <i>Ask if parents have relatives in common or are related.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

CHAIN Number

[1][0][0][0][1][ ][ ][ ]

**Primary Caregiver Information**

*This is the person who has responsibility for day to day care of the child, but is not a substitute carer such as childminder or grandparent who cares for child whilst, for example, mother is at work.*

<b>Who is the Primary Caregiver?</b> <i>Select one</i>	<input type="checkbox"/> Biological Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Aunt / Uncle / Cousin <input type="checkbox"/> Stepmother / father <input type="checkbox"/> Care home /orphanage <input type="checkbox"/> Other/ Unclear		
<b>Is the child's biological father alive?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	<b>Is the child's biological mother alive?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown
<b>Primary Care Giver Age</b> <i>Select one</i>	<input type="checkbox"/> <18years <input type="checkbox"/> >=18 years <input type="checkbox"/> >50years <input type="checkbox"/> N/A (care home or unclear)		
<b>Primary Care Giver Sex</b> <i>Select one</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> N/A	<b>Primary caregiver present at admission?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Has the primary caregiver lived in the same household as the child for the last 2 months?</b>			<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A (care home)
<b>Marital status of primary caregiver</b> <i>Select one</i>	<input type="checkbox"/> Married/ monogamous <input type="checkbox"/> Married polygamous <input type="checkbox"/> Single <input type="checkbox"/> Separated / divorced <input type="checkbox"/> Widowed <input type="checkbox"/> N/A		
<b>If not present at admission, where is the primary caregiver?</b> <i>Select one</i>			
<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> N/A			
<b>If the primary caregiver is present, caregiver anthropometry:</b>			
<i>Use locally available adult scales and stadiometer, and adult MUAC tapes provided by CHAIN.</i>			
<input type="checkbox"/> <b>Primary caregiver not present during admission, or care home</b>			
<b>Weight</b> _____ kg	<b>MUAC</b> _____ cm	<b>Height:</b> _____ cm	
<b>Education:</b> <i>Select highest level of education achieved</i>	<input type="checkbox"/> None <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Above secondary <input type="checkbox"/> Unknown <input type="checkbox"/> N/A care home		
<b>Able to read?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	<b>Is the primary caregiver primarily responsible for financial support and providing for the child?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>Primary caregiver HIV status in last 6 months</b> <i>Select one</i>	<input type="checkbox"/> Tested Positive <input type="checkbox"/> Tested Negative <input type="checkbox"/> Not tested or unknown		
<b>Have there been ANY changes to the child's social situation in the last 2 MONTHS?</b> <i>Select any that apply,</i>			
<b>Child moved to a different household</b>	Y    N	<b>Relocation from rural to urban setting</b> <i>Select 'yes' even if this is temporary</i>	Y    N
		<b>Relocation from urban to rural setting</b> <i>Select 'yes' even if this is temporary</i>	Y    N
		<b>Relocation to live with different caregiver</b> <i>Select 'yes' even if this is temporary</i>	Y    N
<b>Mother sick</b>	Y    N	<b>Mother Died</b>	Y    N
<b>Father sick</b>	Y    N	<b>Father Died</b>	Y    N
<b>Other primary caregiver sick</b>	Y    N    N/A	<b>Other primary caregiver died</b>	Y    N    N/A
<b>Primary caregiver changed</b>	Y    N	<b>Child went into care home</b>	Y    N
<b>Primary caregiver started employment / returned to school</b>	Y    N	<b>Person providing for the child has lost income</b>	Y    N
<b>Primary caregiver divorced / separated from partner</b>	Y    N	<b>Primary caregiver in new relationship</b>	Y    N
<b>Mother is pregnant</b>	Y    N	<b>Mother gave birth</b>	Y    N
<b>Other primary caregiver pregnant?</b>	Y    N    N/A	<b>Other primary caregiver gave birth</b>	Y    N    N/A
<b>If primary caregiver has changed in the last 2 months, who was the child's previous primary caregiver?</b> <i>Select one</i>			
<input type="checkbox"/> Biologic Mother <input type="checkbox"/> Biologic Father <input type="checkbox"/> Sibling ≥18 years old <input type="checkbox"/> Sibling <18 years old <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle/Cousin <input type="checkbox"/> Other <input type="checkbox"/> N/A			

**Primary caregiver earns an income now?** *Ask the person accompanying the child and select one*

Employed full time by someone else     Employed part time by someone else

CHAIN Number

[1][0][0][0][1][ ][ ][ ]

<input type="checkbox"/> Works for self	<input type="checkbox"/> No work income
<input type="checkbox"/> Works casually/irregularly for someone	<input type="checkbox"/> Don't know
If works casually, Occupation:	<input type="checkbox"/> N/A care home
<b>How many days worked a week? Select one</b>	<input type="checkbox"/> <3 <input type="checkbox"/> 3-5 <input type="checkbox"/> >5 <input type="checkbox"/> N/A, does not work for income
<b>If the primary caregiver earns, main source of income? Select one</b>	
<input type="checkbox"/> Farmer	<input type="checkbox"/> Business/trader
<input type="checkbox"/> Other private sector employment	<input type="checkbox"/> Public sector employment
<input type="checkbox"/> Begging	<input type="checkbox"/> Other _____
<input type="checkbox"/> Labourer	<input type="checkbox"/> Retired with pension income
<input type="checkbox"/> Domestic work	<input type="checkbox"/> N/A
<b>If the primary caregiver works (earning or non-earning), main place of work? Select one</b>	
<input type="checkbox"/> In/around home (where child lives)	<input type="checkbox"/> Away for <4 hours per day
<input type="checkbox"/> Away > 8h a day but returns home daily	<input type="checkbox"/> Away >1 day, comes home weekly
<input type="checkbox"/> Primary caregiver lives and works away	<input type="checkbox"/> Don't know
<input type="checkbox"/> Away >4 hours but comes home daily	<input type="checkbox"/> Away comes home, less than weekly
<input type="checkbox"/> N/A	

<b>The person primarily providing financial support to this child is this child's: Select one</b>			
<input type="checkbox"/> Biologic Mother	<input type="checkbox"/> Biologic Father	<input type="checkbox"/> Stepfather	<input type="checkbox"/> Stepmother
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Sibling ≥18 years old	<input type="checkbox"/> Sibling <18 years old	<input type="checkbox"/> Aunt/Uncle/Cousin
<input type="checkbox"/> More than one person responsible, unclear	<input type="checkbox"/> Unsupported / care home	<input type="checkbox"/> Other -specify _____	
<b>Person responsible for providing financial support to child, place of usual residence? Select one</b>			
<input type="checkbox"/> Always sleeps at home	<input type="checkbox"/> Sleeps away but returns weekly		
<input type="checkbox"/> Sleeps away for > two months per year	<input type="checkbox"/> Works and lives abroad, contact with child once a year or less		
<input type="checkbox"/> Sleeps away but return monthly or less often	<input type="checkbox"/> Don't know		
<input type="checkbox"/> Other _____	<input type="checkbox"/> N/A (e.g. care home, unsupported)		
<b>What is the Father or person responsible for providing financial support to child source of income? Select one. If the primary carer is also the person providing financial support do not complete this section.</b>			
<input type="checkbox"/> Farmer	<input type="checkbox"/> Business/trader	<input type="checkbox"/> Labourer	<input type="checkbox"/> Domestic work
<input type="checkbox"/> Other private sector employment	<input type="checkbox"/> Public sector employment	<input type="checkbox"/> Retired with pension income	
<input type="checkbox"/> Begging	<input type="checkbox"/> None	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
			<input type="checkbox"/> N/A



CHAIN Number  
[1][0][0][0][1][ ][ ][ ]

Substitute Care:					
<i>Who usually looks after child when primary caretaker is working or away? Select all that apply</i>					
<input type="checkbox"/> Not applicable, caregiver looks after child full time		<input type="checkbox"/> Not applicable, child accompanies caregiver to work			
<input type="checkbox"/> No substitute care, child left alone		<input type="checkbox"/> No substitute care / unclear		<input type="checkbox"/> Child in care home	
<input type="checkbox"/> Biological Mother	<input type="checkbox"/> Biological Father	<input type="checkbox"/> Sibling <18 years old		<input type="checkbox"/> Sibling ≥18 years old	
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle/Cousin	<input type="checkbox"/> Childcare facility outside home		<input type="checkbox"/> Childminder/ day care at home	
<b>How many days a week is the child in day care?</b>	<input type="checkbox"/> N/A	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> >6
<b>How many hours per day is the child in day care?</b>	<input type="checkbox"/> N/A	<input type="checkbox"/> 1-4h	<input type="checkbox"/> 5-8h	<input type="checkbox"/> 9-12h	<input type="checkbox"/> >12h
<b>How many children are looked after at this day care?</b>	<input type="checkbox"/> <3	<input type="checkbox"/> 4-6	<input type="checkbox"/> 7-10	<input type="checkbox"/> >10	<input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<b>How many of these are under 2y?</b>	<input type="checkbox"/> <3	<input type="checkbox"/> 4-6	<input type="checkbox"/> 7-10	<input type="checkbox"/> >10	<input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<b>How many adults look after these children?</b>	<input type="checkbox"/> 1	<input type="checkbox"/> 2-4	<input type="checkbox"/> 5-10	<input type="checkbox"/> >10	<input type="checkbox"/> N/A
<b>Do you feel the day care is good?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> N/A		
<b>Who provides food for the child at day care? Select one</b>					
<input type="checkbox"/> Caregiver provides food for the child	<input type="checkbox"/> Day care provides food for the child	<input type="checkbox"/> Someone else provides food for the child	<input type="checkbox"/> Don't know	<input type="checkbox"/> N/A	
<b>Is feeding supervised / assisted at day care?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A	

Household Food Security		
<i>(if child in care home include children in the care home only)</i>		
<b>During the past 7 DAYS</b> has ANY member of the household missed a meal due to food shortage?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
<b>During the past 4 WEEKS</b> Did you worry that your household would not have enough food?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Were any of your household unable to eat the kinds of food preferred because of a lack of resources?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household had to eat a limited variety of food due to lack of resources?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household eaten some foods that you really didn't want to eat because of lack of resources?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Have any of your household eaten fewer meals in a day because there was not enough food?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Did household members go to sleep at night hungry because there was not enough food?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Did you or your household members go a whole day and night without eating anything because there was not enough food?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown

CHAIN Number

[1][0][0][0][1][ ][ ][ ]

### Child Dietary Diversity

#### What does the child eat on a typical day?

- Ask this as an open question and select all that the caregiver mentions.
- Do not present the caregiver with this list.
- You may prompt the caregiver with open questions, e.g. What does your child usually eat for breakfast

**Milk and Milk Products:** Fresh/fermented milk, cheese, yogurt, or other milk products

**Breast milk**

**Cereals and Cereal Products:** Maize, rice, pasta, porridge, bread, biscuits, millet, sorghum, wheat, locally available grains

**Fish and Sea Foods:** fresh or dried fish or shellfish

**Roots and Tubers:** potatoes, sweet potatoes, yams, cassava, or foods made from roots or wild roots and tubers

**Vegetables:** Cabbages, carrots, spinach, and any other locally available vegetables including wild vegetables

**Fruits:** Oranges, bananas, mangoes, avocados, apples, grapes etc

**Meats and Poultry:** Camel, beef, lamb, goat, rabbit, wild game, chicken or other birds, liver, kidney, heart or other organ meats or blood-based foods

**Eggs:** Hen or other bird eggs

**Pulses / Legumes / Nuts and Seeds:** Beans, peas, lentils, nuts, seeds or foods made from these

**Fats and Oils:** Oil, fats, ghee, margarine or butter added to food or used for cooking

**Sugars / Honey and Commercial Juices:** Sugar in tea, honey, sweetened soda, juices, chocolates, sweets or candies

**Miscellaneous:** Spices, unsweetened beverages

**UNKNOWN**

### Feeding practices

#### How is food USUALLY given to the child? Select one

Fed by adult

Child feeds self, unsupervised

Child feeds self, supervised by adult

Fed from common plate or bowl

Child feeds self, supervised by older children

Child exclusively breastfed

Unknown

Other



CHAIN Number

[1][0][0][0][1][ ][ ][ ]

<b>Assessment of household wealth</b> (DHS 7 questionnaire. Please answer all questions, for all participants, including children in care homes)			
<b>What is the main source of drinking water for members of your household? Choose one</b>			
<input type="checkbox"/> Piped water to dwelling	<input type="checkbox"/> Cart with small tank	<input type="checkbox"/> from vendor	
<input type="checkbox"/> Piped water to yard / plot	<input type="checkbox"/> Tanker truck	<input type="checkbox"/> Rainwater	
<input type="checkbox"/> Piped to neighbour	<input type="checkbox"/> Bottled water	<input type="checkbox"/> Stream/river/lake/pond/dam	
<input type="checkbox"/> Public tap/ Standpipe	<input type="checkbox"/> Protected spring	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Protected well / borehole	<input type="checkbox"/> Unprotected spring		
<input type="checkbox"/> Unprotected well	<input type="checkbox"/> Other		
<b>What is the MAIN source of water used by your household for other purposes such as cooking and handwashing? SELECT ONE ONLY</b>			
<input type="checkbox"/> Piped water to dwelling	<input type="checkbox"/> Cart with small tank	<input type="checkbox"/> Bought from vendor	
<input type="checkbox"/> Piped water to yard / plot	<input type="checkbox"/> Tanker truck	<input type="checkbox"/> Rainwater	
<input type="checkbox"/> Piped to neighbour	<input type="checkbox"/> Bottled water	<input type="checkbox"/> Stream/river/lake/pond/dam	
<input type="checkbox"/> Public tap/ Standpipe	<input type="checkbox"/> Protected spring	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Protected well / borehole	<input type="checkbox"/> Unprotected spring		
<input type="checkbox"/> Unprotected well	<input type="checkbox"/> Other		
<b>How long does it take to get DRINKING water and come back? (State 0 if water supplied within home or compound)</b>	___ ___ ___ minutes	<input type="checkbox"/> Don't know	
<b>In the past 2 weeks was the water from this source not available for at least one full day?</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Unknown	
<b>Do you usually do anything to the water to make it safer to drink? Select all that apply</b>			
<input type="checkbox"/> None	<input type="checkbox"/> Bleach/ chlorine	<input type="checkbox"/> Strain through a cloth	<input type="checkbox"/> Let it stand and settle
<input type="checkbox"/> Use water filter (ceramic/sand/composite etc)	<input type="checkbox"/> Solar disinfection	<input type="checkbox"/> Boil	<input type="checkbox"/> Other

CHAIN Number

[1][0][0][0][1][ ][ ][ ]

<b>What kind of toilet facility do members of your household usually use? <i>Select one</i></b>			
<input type="checkbox"/> Flush or pour flush toilet to piped sewer	<input type="checkbox"/> Flush to septic tank	<input type="checkbox"/> Ventilated improved pit latrine	
<input type="checkbox"/> Flush to pit latrine	<input type="checkbox"/> Flush to somewhere else	<input type="checkbox"/> Open pit / Pit latrine without slab	
<input type="checkbox"/> Flush don't know where	<input type="checkbox"/> Composting toilet	<input type="checkbox"/> Bucket toilet	
<input type="checkbox"/> Pit latrine with slab	<input type="checkbox"/> Hanging toilet / hanging latrine	<input type="checkbox"/> No facility / bush/ field	
<input type="checkbox"/> Unknown			
<b>Do you share this toilet facility with other households?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>If Yes, including your own household, how many households use this toilet facility?</b>	Number if <10__	<input type="checkbox"/> >10 households	<input type="checkbox"/> Unknown <input type="checkbox"/> N/A
<b>Where is this toilet facility located?</b>	<input type="checkbox"/> In own dwelling	<input type="checkbox"/> In own yard / plot	<input type="checkbox"/> Elsewhere
<b>How many rooms are there in the household for SLEEPING?</b>	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> >2
<b>What is the MAIN FLOOR material of the rooms in this household? <i>Select one only</i></b>			
<input type="checkbox"/> Cement	<input type="checkbox"/> Earth/sand	<input type="checkbox"/> Wood	
<input type="checkbox"/> Dung	<input type="checkbox"/> Lives on boat	<input type="checkbox"/> Tiles	
<input type="checkbox"/> Carpet	<input type="checkbox"/> Other (specify)_____	<input type="checkbox"/> Unknown	
<b>What is the MAIN WALL material of the rooms in this household? <i>Select one only</i></b>			
<input type="checkbox"/> Grass/straw/makuti	<input type="checkbox"/> Stone	<input type="checkbox"/> Wood	<input type="checkbox"/> Unknown
<input type="checkbox"/> Corrugated iron sheet/ Tin	<input type="checkbox"/> Mud/wood	<input type="checkbox"/> Brick/block	
<input type="checkbox"/> Planks/shingles	<input type="checkbox"/> No wall	<input type="checkbox"/> Other (specify) _____	
<b>What is the MAIN ROOF material of the house in this household? <i>Select one only</i></b>			
<input type="checkbox"/> Grass/Thatch	<input type="checkbox"/> Tiles/Asbestos sheets	<input type="checkbox"/> Corrugated iron/ Tins	
<input type="checkbox"/> Mud	<input type="checkbox"/> Nylon papers/clothes	<input type="checkbox"/> Concrete	
<input type="checkbox"/> Other (specify) _____		<input type="checkbox"/> Unknown	
<b>What is the MAIN cooking fuel used in this household? <i>Select one only</i></b>			
<input type="checkbox"/> Electricity	<input type="checkbox"/> LPG /Natural gas/Biogas	<input type="checkbox"/> Paraffin	
<input type="checkbox"/> Coal / Lignite	<input type="checkbox"/> Charcoal	<input type="checkbox"/> Firewood	
<input type="checkbox"/> Straw/shrubs/grass	<input type="checkbox"/> Agricultural crop	<input type="checkbox"/> Animal Dung	
<input type="checkbox"/> No food cooked in household	<input type="checkbox"/> Other (specify)_____	<input type="checkbox"/> Unknown	
<b>Do you have a separate room which is used as a kitchen?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>Where is this household's cooking area located?</b>			
<input type="checkbox"/> In the house	<input type="checkbox"/> Outdoors	<input type="checkbox"/> In a separate building	<input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown





CHAIN Number  
[1][0][0][0][1][ ][ ][ ]

<b>Does this household own any livestock, herds, other farm animals or poultry</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>If yes, how many of the following animals does this household own?</b>			
Cows/bulls__ __	Sheep__ __		
Horses/Donkeys/Mules__ __	Goats__ __		
Chickens or Ducks__ __	Other _____	number__ __	<input type="checkbox"/> N/A
<b>Does any member of this household own land?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>If "Yes" How many acres of land does this household own?</b>	____Acres	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
<b>Does this household have a bank account?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>Does this household have electricity</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>Does this household own a radio?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>Does this household own a television?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>Does this household own a computer?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>Does this household own a refrigerator?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>Does any member of this household own:</b>			
<b>A watch</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>A mobile phone?</b>	<input type="checkbox"/> Y Standard phone	<input type="checkbox"/> Y smartphone	<input type="checkbox"/> N <input type="checkbox"/> Unknown
<b>An animal-drawn cart?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>A bicycle?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>A motorcycle / scooter?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>A car or truck?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
<b>A boat with a motor?</b>	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown

<b>CRF Completed by (Initials) – to be signed when complete.</b> <i>Do not sign if any fields are empty</i>		Date	Time
	____	____/____/____ D D / M M / Y Y Y Y	____:____

END