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ENGLISH LANGUAGE: 9 Jan 2020

KENYA MALARIA INDICATOR SURVEY
BIOMARKER QUESTIONNAIRE

Division of National Malaria Programme
Kenya National Bureau of Statistics

**IDENTIFICATION**

PLACE NAME _____

NAME OF HOUSEHOLD HEAD _____

CLUSTER NUMBER . . . . . | | | | |

HOUSEHOLD NUMBER . . . . . | | | | |

**HEALTH TECH VISITS**

| | 1 | 2 | 3 | FINAL VISIT |
|---|---|---|---|---|
| DATE | | | | DAY |
| | | | | MONTH |
| HEALTH TECH'S NAME | | | | YEAR |
| NEXT VISIT: DATE | | | | TOTAL NUMBER OF VISITS |
| TIME | | | | |

NOTES:

TOTAL ELIGIBLE CHILDREN

LANGUAGE OF QUESTIONNAIRE** 0 1

LANGUAGE OF INTERVIEW**

NATIVE LANGUAGE OF RESPONDENT**

TRANSLATOR (YES = 1, NO = 2)

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:

| | | | |
|---|---|---|---|
| 01 ENGLISH | 06 KAMBA | 11 LUO | 16 SOMALI |
| 02 KISWAHILI | 07 KIKUYU | 12 MAASAI | 17 TURKANA |
| 03 BORANA | 08 KISII | 13 MERU | 96 OTHER |
| 04 EMBU | 09 LUHYA | 14 MIJIKENDA | |
| 05 KALENJIN | 10 MARAGOLI | 15 POKOT | SPECIFY |

| SUPERVISOR | | HOUSEHOLD INTERVIEWER | |
|---|---|---|---|
| NAME | NUMBER | NAME | NUMBER |

HAEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-14 YEARS

| | | | |
|---|---|---|---|
| 101 | CHECK CAPI OUTPUT FOR "LIST ELIGIBLE INDIVIDUALS/BIOMARKERS" [COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE]. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN 0-14 YEARS IN QUESTION 102 ON THIS PAGE AND SUBSEQUENT PAGES STARTING WITH THE FIRST ONE LISTED. IF MORE THAN THREE CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S). | | |
| | CHILD 1 | | SKIP |
| 102 | CHECK CAPI OUTPUT AND RECORD LINE NUMBER AND NAME OF CHILD.<br><br>[RECORD LINE NUMBER FROM COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE; RECORD NAME FROM COLUMN 2 IN HOUSEHOLD QUESTIONNAIRE.] | LINE NUMBER . . . . . ☐☐<br>NAME _____ | |
| 103 | IF MOTHER INTERVIEWED: COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM BIRTH HISTORY.<br><br>IF MOTHER NOT INTERVIEWED ASK:<br>What is (NAME)'s date of birth? | DAY . . . . . ☐☐<br>MONTH . . . . . ☐☐<br>YEAR . . . . . ☐☐☐☐ | |
| 104 | IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY.<br><br>IF MOTHER NOT INTERVIEWED ASK:<br>How old was (NAME) at (NAME)'s last birthday?<br><br>COMPARE AND CORRECT 103 AND/OR 104 IF INCONSISTENT. | AGE IN COMPLETED YEARS ☐☐ | |
| 105 | CHECK 104: CHILD AGE 0-14 YEARS? YES ☐ | NO ☐ → | 129 |
| 106 | CHECK 103: IS THE CHILD AGE 0-5 MONTHS OR IS THE CHILD OLDER? OLDER ☐ | AGE 0-5 MONTHS ☐ → | 129 |
| 107 | NAME OF PARENT/RESPONSIBLE ADULT FOR THE CHILD. | NAME _____ | |
| 108 | CONSENT | | |
| 109 | CIRCLE THE CODE. | GRANTED . . . . . 1<br>REFUSED . . . . . 2<br>NOT PRESENT/OTHER . . . . . 3 → | 112 |
| 110 | SIGN NAME AND ENTER HEALTH TECH NUMBER. | _____ (SIGN)<br>☐☐☐☐ HEALTH TECH NUMBER | |

HAEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-14 YEARS

| | CHILD 1 | | SKIP |
|---|---|---|---|
| 111 | IF CONSENT GRANTED, PREPARE EQUIPMENT AND SUPPLIES FOR THE TESTS AND PROCEED WITH THE TESTS. | | |
| 112 | PLACE 1ST BAR CODE LABEL FOR MALARIA LAB TEST IN SPACE TO THE RIGHT. PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. | PUT THE 1ST BAR CODE LABEL HERE.<br>NOT PRESENT . . . . . 99994<br>REFUSED . . . . . 99995<br>OTHER . . . . . 99996 | |
| 113 | RECORD HAEMOGLOBIN LEVEL HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET. | G/DL . . . . . ☐☐.☐<br>NOT PRESENT . . . . . 994<br>REFUSED . . . . . 995<br>OTHER . . . . . 996 | |
| 114 | RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET. | POSITIVE . . . . . 1<br>NEGATIVE . . . . . 2 → 126<br>NOT PRESENT . . . . . 4 → 128<br>REFUSED . . . . . 5<br>OTHER . . . . . 6 → 126 | |
| 115 | Does (NAME) suffer from any of the following illnesses or symptoms:<br>a) Extreme weakness?<br>b) Heart problems?<br>c) Loss of consciousness?<br>d) Rapid or difficult breathing?<br>e) Seizures?<br>f) Abnormal bleeding?<br>g) Jaundice or yellow skin?<br>h) Dark urine? | YES NO<br>a) EXTREME WEAKNESS 1 2<br>b) HEART PROBLEMS . 1 2<br>c) LOSS OF CONSCIOUS 1 2<br>d) RAPID BREATHING . 1 2<br>e) SEIZURES . . . . . 1 2<br>f) BLEEDING . . . . . 1 2<br>g) JAUNDICE . . . . . 1 2<br>h) DARK URINE . . . . . 1 2 | |
| 116 | CHECK 115: ANY 'YES' CIRCLED? NO ☐ YES ☐ | | → 118 |
| 117 | CHECK 113: HAEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANAEMIA . . . . . 1<br>8.0 G/DL OR ABOVE . . . . . 2 → 119<br>OTHER . . . . . 6 | |
| 118 | **SEVERE MALARIA REFERRAL**<br>The malaria test shows that (NAME OF CHILD) has malaria. Your child also has symptoms of severe malaria. The malaria treatment I have will not help your child, and I cannot give you the medication. Your child is very ill and must be taken to a health facility right away.<br><br>RECORD THE RESULT OF THE MALARIA RDT ON THE REFERRAL FORM. | | → 126 |
| 119 | In the past two weeks has (NAME) taken or is taking ACTs given by a doctor or health centre to treat the malaria?<br><br>VERIFY BY ASKING TO SEE TREATMENT. | YES . . . . . 1<br>NO . . . . . 2 → 121 | |
| 120 | **ALREADY TAKING [FIRST LINE MEDICATION] REFERRAL STATEMENT**<br>You have told me that (NAME OF CHILD) had already received ACTs for malaria. Therefore, I cannot give you additional ACTs. However, the test shows that he/she has malaria. If your child has a fever for two days after the last dose of ACTs, you should take the child to the nearest health facility for further examination. | | → 128 |

HAEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-14 YEARS

| | CHILD 1 | | SKIP |
|---|---|---|---|
| 121 | ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT:<br><br>The malaria test shows that your child has malaria. We can give you free medicine. The medicine is called ACT. ACT is very effective and in a few days it should get rid of the fever and other symptoms. You do not have to give the child the medicine. This is up to you. Please tell me whether you accept the medicine or not. | | |
| 122 | CIRCLE THE APPROPRIATE CODE. | ACCEPTED MEDICINE . . . . . 1<br>REFUSED MEDICINE . . . . . 2<br>OTHER . . . . . 6 | → 128 |
| 123 | SIGN NAME AND ENTER HEALTH TECH NUMBER. | _____<br>(SIGN)<br><br>☐☐☐☐<br>HEALTH TECH NUMBER | |
| 124 | CHECK 122: ACCEPTED MEDICINE? YES ☐ NO ☐ | | → 128 |
| 125 | TELL THE PARENT/OTHER ADULT: If your child has a fever for two days after the last dose of ACTs, you should take the child to the nearest health facility for further examination. If [NAME] has a high fever, fast or difficult breathing, is not able to drink or breastfeed, gets sicker or does not get better in two days, you should take him/her to a health professional for treatment right away.<br><br>IF CHILD WEIGHS LESS THAN 5 KGS., DO NOT LEAVE DRUGS. TELL PARENT TO TAKE CHILD TO HEALTH FACILITY.<br><br>First day starts by taking first dose followed by the second dose 8 hours later. On subsequent days, the recommendation is simply "morning" and "evening" (around 12 hours apart). Take the medicine (crushed for small children) with high fat foods or drinks like milk.<br><br>Make sure the full 3 days treatment is taken at the recommended times, otherwise the infection may return.<br><br>If your child vomits within an hour of taking the medicine, you will need to get additional tablets and repeat the dose. | | → 128 |
| 126 | CHECK 113: HAEMOGLOBIN RESULT | BELOW 8.0 G/DL,<br>SEVERE ANAEMIA . . . . . 1<br>8.0 G/DL OR ABOVE . . . . . 2<br>OTHER . . . . . 6 | → 128 |
| 127 | **SEVERE ANAEMIA REFERRAL**<br>The anaemia test shows that (NAME OF CHILD) has severe anaemia. Your child is very ill and must be taken to a health facility immediately.<br><br>RECORD THE RESULT OF THE ANAEMIA TEST ON THE REFERRAL FORM. | | |
| 128 | TODAY'S DATE: | DAY . . . . . ☐☐<br>MONTH . . . . . ☐☐<br>YEAR . . . . . ☐☐☐☐ | |
| 129 | IF ANOTHER CHILD, GO TO 103 ON THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW. | | |

DOSING SCHEDULE WITH ARTEMETHER-LUMEFANTRINE (AL)

| WEIGHT IN KG | AGE IN YEARS | NUMBER OF TABLETS PER DOSE | | | | | |
|---|---|---|---|---|---|---|---|
| | | DAY 1 | | DAY 2 | | DAY 3 | |
| | | 1st dose | 8 hours | 24 hours | 36 hours | 48 hours | 60 hours |
| 5-14 | 5mos-<3yrs | 1 | 1 | 1 | 1 | 1 | 1 |
| 15-24 | 3-7yrs | 2 | 2 | 2 | 2 | 2 | 2 |
| 25-34 | 8-11yrs | 3 | 3 | 3 | 3 | 3 | 3 |
| 35 and above | ≥12yrs | 4 | 4 | 4 | 4 | 4 | 4 |

HAEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-14 YEARS

| | | | |
|---|---|---|---|
| 101 | CHECK CAPI OUTPUT FOR "LIST ELIGIBLE INDIVIDUALS/BIOMARKERS" [COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE]. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN 0-14 YEARS IN QUESTION 102 ON THIS PAGE AND SUBSEQUENT PAGES STARTING WITH THE FIRST ONE LISTED. IF MORE THAN THREE CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S). | | |
| | CHILD 2 | | SKIP |
| 102 | CHECK CAPI OUTPUT AND RECORD LINE NUMBER AND NAME OF CHILD.<br><br>[RECORD LINE NUMBER FROM COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE; RECORD NAME FROM COLUMN 2 IN HOUSEHOLD QUESTIONNAIRE.] | LINE NUMBER . . . . . ☐☐<br>NAME _____ | |
| 103 | IF MOTHER INTERVIEWED: COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM BIRTH HISTORY.<br><br>IF MOTHER NOT INTERVIEWED ASK:<br>What is (NAME)'s date of birth? | DAY . . . . . ☐☐<br>MONTH . . . . . ☐☐<br>YEAR . . . . . ☐☐☐☐ | |
| 104 | IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY.<br><br>IF MOTHER NOT INTERVIEWED ASK:<br>How old was (NAME) at (NAME)'s last birthday?<br><br>COMPARE AND CORRECT 103 AND/OR 104 IF INCONSISTENT. | AGE IN COMPLETED YEARS ☐☐ | |
| 105 | CHECK 104: CHILD AGE 0-14 YEARS? YES ☐ | NO ☐ | → 129 |
| 106 | CHECK 103: IS THE CHILD AGE 0-5 MONTHS OR IS THE CHILD OLDER? OLDER ☐ | AGE 0-5 MONTHS ☐ | → 129 |
| 107 | NAME OF PARENT/RESPONSIBLE ADULT FOR THE CHILD. | NAME _____ | |
| 108 | CONSENT | | |
| 109 | CIRCLE THE CODE. | GRANTED . . . . . 1<br>REFUSED . . . . . 2<br>NOT PRESENT/OTHER . . . . . 3 | → 112 |
| 110 | SIGN NAME AND ENTER HEALTH TECH NUMBER. | _____ (SIGN)<br>☐☐☐☐ HEALTH TECH NUMBER | |

HAEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-14 YEARS

| | CHILD 2 | | SKIP |
|---|---|---|---|
| 111 | IF CONSENT GRANTED, PREPARE EQUIPMENT AND SUPPLIES FOR THE TESTS AND PROCEED WITH THE TESTS. | | |
| 112 | PLACE 1ST BAR CODE LABEL FOR MALARIA LAB TEST IN SPACE TO THE RIGHT. PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. | PUT THE 1ST BAR CODE LABEL HERE.<br>NOT PRESENT . . . . . 99994<br>REFUSED . . . . . 99995<br>OTHER . . . . . 99996 | |
| 113 | RECORD HAEMOGLOBIN LEVEL HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET. | G/DL . . . . . ☐☐.☐<br>NOT PRESENT . . . . . 994<br>REFUSED . . . . . 995<br>OTHER . . . . . 996 | |
| 114 | RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET. | POSITIVE . . . . . 1<br>NEGATIVE . . . . . 2<br>NOT PRESENT . . . . . 4<br>REFUSED . . . . . 5<br>OTHER . . . . . 6 | → 126<br>→ 128<br>→ 126 |
| 115 | Does (NAME) suffer from any of the following illnesses or symptoms:<br>a) Extreme weakness?<br>b) Heart problems?<br>c) Loss of consciousness?<br>d) Rapid or difficult breathing?<br>e) Seizures?<br>f) Abnormal bleeding?<br>g) Jaundice or yellow skin?<br>h) Dark urine? | YES NO<br>a) EXTREME WEAKNESS 1 2<br>b) HEART PROBLEMS . 1 2<br>c) LOSS OF CONSCIOUS 1 2<br>d) RAPID BREATHING . 1 2<br>e) SEIZURES . . . . . 1 2<br>f) BLEEDING . . . . . 1 2<br>g) JAUNDICE . . . . . 1 2<br>h) DARK URINE . . . . . 1 2 | |
| 116 | CHECK 115: ANY 'YES' CIRCLED? NO ☐ YES ☐ | | → 118 |
| 117 | CHECK 113: HAEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANAEMIA . . . . . 1<br>8.0 G/DL OR ABOVE . . . . . 2<br>OTHER . . . . . 6 | → 119 |
| 118 | **SEVERE MALARIA REFERRAL**<br>The malaria test shows that (NAME OF CHILD) has malaria. Your child also has symptoms of severe malaria. The malaria treatment I have will not help your child, and I cannot give you the medication. Your child is very ill and must be taken to a health facility right away.<br><br>RECORD THE RESULT OF THE MALARIA RDT ON THE REFERRAL FORM. | | → 126 |
| 119 | In the past two weeks has (NAME) taken or is taking ACTs given by a doctor or health centre to treat the malaria?<br><br>VERIFY BY ASKING TO SEE TREATMENT. | YES . . . . . 1<br>NO . . . . . 2 | → 121 |
| 120 | **ALREADY TAKING [FIRST LINE MEDICATION] REFERRAL STATEMENT**<br>You have told me that (NAME OF CHILD) had already received ACTs for malaria. Therefore, I cannot give you additional ACTs. However, the test shows that he/she has malaria. If your child has a fever for two days after the last dose of ACTs, you should take the child to the nearest health facility for further examination. | | → 128 |

HAEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-14 YEARS

| | CHILD 2 | | SKIP |
|---|---|---|---|
| 121 | ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT:<br><br>The malaria test shows that your child has malaria. We can give you free medicine. The medicine is called ACT. ACT is very effective and in a few days it should get rid of the fever and other symptoms. You do not have to give the child the medicine. This is up to you. Please tell me whether you accept the medicine or not. | | |
| 122 | CIRCLE THE APPROPRIATE CODE. | ACCEPTED MEDICINE . . . . . 1<br>REFUSED MEDICINE . . . . . 2<br>OTHER . . . . . 6 | → 128 |
| 123 | SIGN NAME AND ENTER HEALTH TECH NUMBER. | _____<br>(SIGN)<br><br>☐☐☐☐<br>HEALTH TECH NUMBER | |
| 124 | CHECK 122: ACCEPTED MEDICINE? YES ☐ NO ☐ | | → 128 |
| 125 | TELL THE PARENT/OTHER ADULT: If your child has a fever for two days after the last dose of ACTs, you should take the child to the nearest health facility for further examination. If [NAME] has a high fever, fast or difficult breathing, is not able to drink or breastfeed, gets sicker or does not get better in two days, you should take him/her to a health professional for treatment right away.<br><br>IF CHILD WEIGHS LESS THAN 5 KGS., DO NOT LEAVE DRUGS. TELL PARENT TO TAKE CHILD TO HEALTH FACILITY.<br><br>First day starts by taking first dose followed by the second dose 8 hours later. On subsequent days, the recommendation is simply "morning" and "evening" (around 12 hours apart). Take the medicine (crushed for small children) with high fat foods or drinks like milk.<br><br>Make sure the full 3 days treatment is taken at the recommended times, otherwise the infection may return.<br><br>If your child vomits within an hour of taking the medicine, you will need to get additional tablets and repeat the dose. | | → 128 |
| 126 | CHECK 113: HAEMOGLOBIN RESULT | BELOW 8.0 G/DL,<br>SEVERE ANAEMIA . . . . . 1<br>8.0 G/DL OR ABOVE . . . . . 2<br>OTHER . . . . . 6 | → 128 |
| 127 | **SEVERE ANAEMIA REFERRAL**<br>The anaemia test shows that (NAME OF CHILD) has severe anaemia. Your child is very ill and must be taken to a health facility immediately.<br><br>RECORD THE RESULT OF THE ANAEMIA TEST ON THE REFERRAL FORM. | | |
| 128 | TODAY'S DATE: | DAY . . . . . ☐☐<br>MONTH . . . . . ☐☐<br>YEAR . . . . . ☐☐☐☐ | |
| 129 | IF ANOTHER CHILD, GO TO 103 ON THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW. | | |

DOSING SCHEDULE WITH ARTEMETHER-LUMEFANTRINE (AL)

| WEIGHT IN KG | AGE IN YEARS | NUMBER OF TABLETS PER DOSE | | | | | |
|---|---|---|---|---|---|---|---|
| | | DAY 1 | | DAY 2 | | DAY 3 | |
| | | 1st dose | 8 hours | 24 hours | 36 hours | 48 hours | 60 hours |
| 5-14 | 5mos-<3yrs | 1 | 1 | 1 | 1 | 1 | 1 |
| 15-24 | 3-7yrs | 2 | 2 | 2 | 2 | 2 | 2 |
| 25-34 | 8-11yrs | 3 | 3 | 3 | 3 | 3 | 3 |
| 35 and above | >12yrs | 4 | 4 | 4 | 4 | 4 | 4 |

| | | | |
|---|---|---|---|
| 101 | CHECK CAPI OUTPUT FOR "LIST ELIGIBLE INDIVIDUALS/BIOMARKERS" [COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE]. RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN 0-14 YEARS IN QUESTION 102 ON THIS PAGE AND SUBSEQUENT PAGES STARTING WITH THE FIRST ONE LISTED. IF MORE THAN THREE CHILDREN, USE ADDITIONAL QUESTIONNAIRE(S). | | |
| | CHILD 3 | | SKIP |
| 102 | CHECK CAPI OUTPUT AND RECORD LINE NUMBER AND NAME OF CHILD.<br><br>[RECORD LINE NUMBER FROM COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE; RECORD NAME FROM COLUMN 2 IN HOUSEHOLD QUESTIONNAIRE.] | LINE NUMBER . . . . . ☐☐<br>NAME _____ | |
| 103 | IF MOTHER INTERVIEWED: COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM BIRTH HISTORY.<br><br>IF MOTHER NOT INTERVIEWED ASK:<br>What is (NAME)'s date of birth? | DAY . . . . . ☐☐<br>MONTH . . . . . ☐☐<br>YEAR . . . . . ☐☐☐☐ | |
| 104 | IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY.<br><br>IF MOTHER NOT INTERVIEWED ASK:<br>How old was (NAME) at (NAME)'s last birthday?<br><br>COMPARE AND CORRECT 103 AND/OR 104 IF INCONSISTENT. | AGE IN COMPLETED YEARS ☐☐ | |
| 105 | CHECK 104: CHILD AGE 0-14 YEARS? YES ☐ | NO ☐ | → 129 |
| 106 | CHECK 103: IS THE CHILD AGE 0-5 MONTHS OR IS THE CHILD OLDER? OLDER ☐ | AGE 0-5 MONTHS ☐ | → 129 |
| 107 | NAME OF PARENT/RESPONSIBLE ADULT FOR THE CHILD. | NAME _____ | |
| 108 | CONSENT | | |
| 109 | CIRCLE THE CODE. | GRANTED . . . . . 1<br>REFUSED . . . . . 2<br>NOT PRESENT/OTHER . . . . . 3 | → 112 |
| 110 | SIGN NAME AND ENTER HEALTH TECH NUMBER. | _____ (SIGN)<br>☐☐☐☐ HEALTH TECH NUMBER | |

HAEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-14 YEARS

| | CHILD 3 | | SKIP |
|---|---|---|---|
| 111 | IF CONSENT GRANTED, PREPARE EQUIPMENT AND SUPPLIES FOR THE TESTS AND PROCEED WITH THE TESTS. | | |
| 112 | PLACE 1ST BAR CODE LABEL FOR MALARIA LAB TEST IN SPACE TO THE RIGHT. PUT THE 2ND BAR CODE LABEL ON THE SLIDE AND THE 3RD ON THE TRANSMITTAL FORM. | PUT THE 1ST BAR CODE LABEL HERE.<br>NOT PRESENT . . . . . 99994<br>REFUSED . . . . . 99995<br>OTHER . . . . . 99996 | |
| 113 | RECORD HAEMOGLOBIN LEVEL HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET. | G/DL . . . . . ☐☐.☐<br>NOT PRESENT . . . . . 994<br>REFUSED . . . . . 995<br>OTHER . . . . . 996 | |
| 114 | RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET. | POSITIVE . . . . . 1<br>NEGATIVE . . . . . 2<br>NOT PRESENT . . . . . 4<br>REFUSED . . . . . 5<br>OTHER . . . . . 6 | → 126<br>→ 128<br>→ 126 |
| 115 | Does (NAME) suffer from any of the following illnesses or symptoms:<br>a) Extreme weakness?<br>b) Heart problems?<br>c) Loss of consciousness?<br>d) Rapid or difficult breathing?<br>e) Seizures?<br>f) Abnormal bleeding?<br>g) Jaundice or yellow skin?<br>h) Dark urine? | YES NO<br>a) EXTREME WEAKNESS 1 2<br>b) HEART PROBLEMS . 1 2<br>c) LOSS OF CONSCIOUS 1 2<br>d) RAPID BREATHING . 1 2<br>e) SEIZURES . . . . . 1 2<br>f) BLEEDING . . . . . 1 2<br>g) JAUNDICE . . . . . 1 2<br>h) DARK URINE . . . . . 1 2 | |
| 116 | CHECK 115: ANY 'YES' CIRCLED? NO ☐ YES ☐ | | → 118 |
| 117 | CHECK 113: HAEMOGLOBIN RESULT | BELOW 8.0 G/DL, SEVERE ANAEMIA . . . . . 1<br>8.0 G/DL OR ABOVE . . . . . 2<br>OTHER . . . . . 6 | → 119 |
| 118 | **SEVERE MALARIA REFERRAL**<br>The malaria test shows that (NAME OF CHILD) has malaria. Your child also has symptoms of severe malaria. The malaria treatment I have will not help your child, and I cannot give you the medication. Your child is very ill and must be taken to a health facility right away.<br><br>RECORD THE RESULT OF THE MALARIA RDT ON THE REFERRAL FORM. | | → 126 |
| 119 | In the past two weeks has (NAME) taken or is taking ACTs given by a doctor or health centre to treat the malaria?<br><br>VERIFY BY ASKING TO SEE TREATMENT. | YES . . . . . 1<br>NO . . . . . 2 | → 121 |
| 120 | **ALREADY TAKING [FIRST LINE MEDICATION] REFERRAL STATEMENT**<br>You have told me that (NAME OF CHILD) had already received ACTs for malaria. Therefore, I cannot give you additional ACTs. However, the test shows that he/she has malaria. If your child has a fever for two days after the last dose of ACTs, you should take the child to the nearest health facility for further examination. | | → 128 |

HAEMOGLOBIN MEASUREMENT AND MALARIA TESTING FOR CHILDREN AGE 0-14 YEARS

| | CHILD 3 | | SKIP |
|---|---|---|---|
| 121 | ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT:<br><br>The malaria test shows that your child has malaria. We can give you free medicine. The medicine is called ACT. ACT is very effective and in a few days it should get rid of the fever and other symptoms. You do not have to give the child the medicine. This is up to you. Please tell me whether you accept the medicine or not. | | |
| 122 | CIRCLE THE APPROPRIATE CODE. | ACCEPTED MEDICINE . . . . . 1<br>REFUSED MEDICINE . . . . . 2<br>OTHER . . . . . 6 | → 128 |
| 123 | SIGN NAME AND ENTER HEALTH TECH NUMBER. | _____<br>(SIGN)<br><br>☐☐☐☐<br>HEALTH TECH NUMBER | |
| 124 | CHECK 122: ACCEPTED MEDICINE? YES ☐ NO ☐ | | → 128 |
| 125 | TELL THE PARENT/OTHER ADULT: If your child has a fever for two days after the last dose of ACTs, you should take the child to the nearest health facility for further examination. If [NAME] has a high fever, fast or difficult breathing, is not able to drink or breastfeed, gets sicker or does not get better in two days, you should take him/her to a health professional for treatment right away.<br><br>IF CHILD WEIGHS LESS THAN 5 KGS., DO NOT LEAVE DRUGS. TELL PARENT TO TAKE CHILD TO HEALTH FACILITY.<br><br>First day starts by taking first dose followed by the second dose 8 hours later. On subsequent days, the recommendation is simply "morning" and "evening" (around 12 hours apart). Take the medicine (crushed for small children) with high fat foods or drinks like milk.<br><br>Make sure the full 3 days treatment is taken at the recommended times, otherwise the infection may return.<br><br>If your child vomits within an hour of taking the medicine, you will need to get additional tablets and repeat the dose. | | → 128 |
| 126 | CHECK 113: HAEMOGLOBIN RESULT | BELOW 8.0 G/DL,<br>SEVERE ANAEMIA . . . . . 1<br>8.0 G/DL OR ABOVE . . . . . 2<br>OTHER . . . . . 6 | → 128 |
| 127 | **SEVERE ANAEMIA REFERRAL**<br>The anaemia test shows that (NAME OF CHILD) has severe anaemia. Your child is very ill and must be taken to a health facility immediately.<br><br>RECORD THE RESULT OF THE ANAEMIA TEST ON THE REFERRAL FORM. | | |
| 128 | TODAY'S DATE: | DAY . . . . . ☐☐<br>MONTH . . . . . ☐☐<br>YEAR . . . . . ☐☐☐☐ | |
| 129 | IF ANOTHER CHILD, GO TO 103 IN ADDITIONAL QUESTIONNAIRE; IF NO MORE CHILDREN, END INTERVIEW. | | |

DOSING SCHEDULE WITH ARTEMETHER-LUMEFANTRINE (AL)

| WEIGHT IN KG | AGE IN YEARS | NUMBER OF TABLETS PER DOSE | | | | | |
|---|---|---|---|---|---|---|---|
| | | DAY 1 | | DAY 2 | | DAY 3 | |
| | | 1st dose | 8 hours | 24 hours | 36 hours | 48 hours | 60 hours |
| 5-14 | 5mos-<3yrs | 1 | 1 | 1 | 1 | 1 | 1 |
| 15-24 | 3-7yrs | 2 | 2 | 2 | 2 | 2 | 2 |
| 25-34 | 8-11yrs | 3 | 3 | 3 | 3 | 3 | 3 |
| 35 and above | ≥12yrs | 4 | 4 | 4 | 4 | 4 | 4 |

HEALTH TECH'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING BIOMARKERS

SUPERVISOR'S OBSERVATIONS