

QUESTIONNAIRE FOR CHILDREN UNDER FIVE

UNDER-FIVE CHILD INFORMATION PANEL		UF
<p><i>This questionnaire is to be administered to all mothers or caretakers (see household listing, column HL8) who care for a child that lives with them and is under the age of 5 years (see household listing, column HL5).</i></p> <p><i>A separate questionnaire should be used for each eligible child.</i></p> <p><i>Fill in the cluster and household number, and names and line numbers of the child and the mother/caretaker in the space below. Insert your own name and number, and the date.</i></p>		
UF1. Cluster number: _____	UF2. Household number: _____	
UF3. Child's Name:	UF4. Child's Line Number: _____	
UF5. Mother's/Caretaker's Name:	UF6. Mother's/Caretaker's Line Number: _____	
UF7. Interviewer name and number: _____	UF8. Day/Month/Year of interview: ____/____/_____	
UF9. Result of interview for children under 5 (Codes refer to mother/caretaker.)	Completed1 Not at home2 Refused3 Partly completed4 Incapacitated5 Other (specify)6	

Repeat greeting if not already read to this respondent:

WE ARE FROM (country-specific affiliation). WE ARE WORKING ON A PROJECT CONCERNED WITH FAMILY HEALTH AND EDUCATION. I WOULD LIKE TO TALK TO YOU ABOUT THIS. THE INTERVIEW WILL TAKE ABOUT (45) MINUTES. ALL THE INFORMATION WE OBTAIN WILL REMAIN STRICTLY CONFIDENTIAL AND YOUR ANSWERS WILL NEVER BE IDENTIFIED. ALSO, YOU ARE NOT OBLIGED TO ANSWER ANY QUESTION YOU DON'T WANT TO, AND YOU MAY WITHDRAW FROM THE INTERVIEW AT ANY TIME. MAY I START NOW?

If permission is given, begin the interview. If the respondent does not agree to continue, thank him/her and go to the next interview. Discuss this result with your supervisor for a future revisit.

UF10. NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH OF EACH CHILD UNDER THE AGE OF 5 IN YOUR CARE, WHO LIVES WITH YOU NOW. NOW I WANT TO ASK YOU ABOUT (name). IN WHAT MONTH AND YEAR WAS (name) BORN? <i>Probe:</i> WHAT IS HIS/HER BIRTHDAY? <i>If the mother/caretaker knows the exact birth date, also enter the day; otherwise, circle 98 for day.</i>	Date of birth: Day DK day98 Month..... Year.....	
UF11. HOW OLD WAS (name) AT HIS/HER LAST BIRTHDAY? <i>Record age in completed years.</i>	Age in completed years.....	

BIRTH REGISTRATION AND EARLY LEARNING MODULE		BR
BR1. DOES (name) HAVE A BIRTH CERTIFICATE? MAY I SEE IT?	Yes, seen.....1 Yes, not seen.....2 No.....3 DK.....8	1⇒BR5 3⇒BR3
BR2. HAS (name's) BIRTH BEEN REGISTERED WITH A NOTARY OR THE MUNICIPALITY? OR ANY OTHER AUTHORITIES?	Notary.....1 Municipality.....2 Othe.....3 No.....4 DK.....8	1⇒BR5 2⇒BR5 3⇒BR5 4⇒BR3 8⇒BR5
BR3. WHY IS (name's) BIRTH NOT REGISTERED?	Costs too much.....1 Must travel too far.....2 Did not know it should be registered.....3 Does not know where to register.....5 Do not see the need to.....7 Other (specify).....6 DK.....8	
BR5. Check age of child in UF11: Child is 3 or 4 years old? <input type="checkbox"/> Yes. ⇒ Continue with BR6 <input type="checkbox"/> No. ⇒ Go to BR8		
BR6. DOES (name) ATTEND ANY ORGANIZED LEARNING OR EARLY CHILDHOOD EDUCATION PROGRAMME, SUCH AS A PRIVATE OR GOVERNMENT FACILITY, INCLUDING KINDERGARTEN OR COMMUNITY CHILD CARE?	Yes.....1 No.....2 DK.....8	2⇒BR8 8⇒BR8
BR7. WITHIN THE LAST SEVEN DAYS, ABOUT HOW MANY HOURS DID (name) ATTEND?	No. of hours.....__ __	
BR8. IN THE PAST 3 DAYS, DID YOU OR ANY HOUSEHOLD MEMBER OVER 15 YEARS OF AGE ENGAGE IN ANY OF THE FOLLOWING ACTIVITIES WITH (name): <i>If yes, ask: WHO ENGAGED IN THIS ACTIVITY WITH THE CHILD - THE MOTHER, THE CHILD'S FATHER OR ANOTHER ADULT MEMBER OF THE HOUSEHOLD (INCLUDING THE CARETAKER/RESPONDENT)?</i> <i>Circle all that apply.</i>		
BR8A. READ BOOKS OR LOOK AT PICTURE BOOKS WITH (name)?	Books	Mother Father Other No one A B X Y
BR8B. TELL STORIES TO (name)?	Stories	A B X Y
BR8C. SING SONGS WITH (name)?	Songs	A B X Y
BR8D. TAKE (name) OUTSIDE THE HOME, COMPOUND, YARD OR ENCLOSURE?	Take outside	A B X Y
BR8E. PLAY WITH (name)?	Play with	A B X Y
BR8F. SPEND TIME WITH (name) NAMING, COUNTING, AND/OR DRAWING THINGS?	Spend time with	A B X Y

VITAMIN A MODULE		VA
VA1. HAS (<i>name</i>) EVER RECEIVED A VITAMIN A CAPSULE (SUPPLEMENT) LIKE THIS ONE? <i>Show capsule or dispenser for different doses – 100,000 IU for those 6-11 months old, 200,000 IU for those 12-59 months old.</i>	Yes.....1 No.....2 DK.....8	2⇒NEXT MODULE 8⇒NEXT MODULE
VA2. HOW MANY MONTHS AGO DID (<i>name</i>) TAKE THE LAST DOSE?	Months ago..... DK.....98	
VA3. WHERE DID (<i>name</i>) GET THIS LAST DOSE?	On routine visit to health facility1 Sick child visit to health facility2 National Immunization Day campaign.....3 Other (<i>specify</i>)6 DK.....8	

BREASTFEEDING MODULE		BF
BF1. HAS (<i>name</i>) EVER BEEN BREASTFED?	Yes.....1 No.....2 DK.....8	2⇒BF3 8⇒BF3
BF2. IS HE/SHE STILL BEING BREASTFED?	Yes.....1 No.....2 DK.....8	
BF3. SINCE THIS TIME YESTERDAY, DID HE/SHE RECEIVE ANY OF THE FOLLOWING: <i>Read each item aloud and record response before proceeding to the next item.</i>		Y N DK
BF3A. VITAMIN, MINERAL SUPPLEMENTS OR MEDICINE?	A. Vitamin supplements.....1 2 8	
BF3B. PLAIN WATER?	B. Plain water.....1 2 8	
BF3C. SWEETENED, FLAVOURED WATER OR FRUIT JUICE OR TEA OR INFUSION?	C. Sweetened water or juice1 2 8	
BF3D. ORAL REHYDRATION SOLUTION (ORS)?	D. ORS.....1 2 8	
BF3E. INFANT FORMULA?	E. Infant formula1 2 8	
BF3F. TINNED, POWDERED OR FRESH MILK?	F. Milk1 2 8	
BF3G. ANY OTHER LIQUIDS?	G. Other liquids.....1 2 8	
BF3H. SOLID OR SEMI-SOLID (MUSHY) FOOD?	H. Solid or semi-solid food.....1 2 8	
BF4. Check BF3H: Child received solid or semi-solid (mushy) food? <input type="checkbox"/> Yes. ⇒ Continue with BF5 <input type="checkbox"/> No or DK. ⇒ Go to Next Module		
BF5. SINCE THIS TIME YESTERDAY, HOW MANY TIMES DID (<i>name</i>) EAT SOLID, SEMISOLID, OR SOFT FOODS OTHER THAN LIQUIDS? <i>If 7 or more times, record '7'.</i>	No. of times..... Don't know8	

CARE OF ILLNESS MODULE		CA
CA1. HAS (name) HAD DIARRHOEA IN THE LAST TWO WEEKS, THAT IS, SINCE (day of the week) OF THE WEEK BEFORE LAST? <i>Diarrhoea is determined as perceived by mother or caretaker, or as three or more loose or watery stools per day, or blood in stool.</i>	Yes.....1 No.....2 DK.....8	2⇒CA5 8⇒CA5
CA1A. WAS BLOOD EVER PRESENT IN THIS DIARRHOEA?	Yes.....1 No.....2 DK.....8	
CA2. DURING THIS LAST EPISODE OF DIARRHOEA, DID (name) DRINK ANY OF THE FOLLOWING: <i>Read each item aloud and record response before proceeding to the next item.</i>		
CA2A. A FLUID MADE FROM A SPECIAL PACKET CALLED (<i>local name for ORS packet solution</i>)? CA2B. GOVERNMENT-RECOMMENDED HOMEMADE FLUID (SUCH AS SUGAR – SALT SOLUTION, RICE WATER ETC.)? CA2C. A PRE-PACKAGED ORS FLUID FOR DIARRHOEA?	Yes No DK A. Fluid from ORS packet..... 1 2 8 B. Recommended homemade fluid 1 2 8 C. Pre-packaged ORS fluid 1 2 8	
CA3 A. DURING (name's) ILLNESS, DID HE/SHE BREASTFEED?	Yes.....1 No.....2 DK.....8	
CA3. DURING (name's) ILLNESS, DID HE/SHE DRINK MUCH LESS, ABOUT THE SAME, OR MORE THAN USUAL?	Much less or none1 About the same (or somewhat less)2 More3 DK.....8	
CA4. DURING (name's) ILLNESS, DID HE/SHE EAT LESS, ABOUT THE SAME, OR MORE FOOD THAN USUAL? <i>If "less", probe: MUCH LESS OR A LITTLE LESS?</i>	None.....1 Much less.....2 Somewhat less3 About the same.....4 More5 DK.....8	
CA5. HAS (name) HAD AN ILLNESS WITH A COUGH AT ANY TIME IN THE LAST TWO WEEKS, THAT IS, SINCE (day of the week) OF THE WEEK BEFORE LAST?	Yes.....1 No.....2 DK.....8	2⇒CA12 8⇒CA12
CA6. WHEN (name) HAD AN ILLNESS WITH A COUGH, DID HE/SHE BREATHE FASTER THAN USUAL WITH SHORT, QUICK BREATHS OR HAVE DIFFICULTY BREATHING?	Yes.....1 No.....2 DK.....8	2⇒CA12 8⇒CA12
CA7. WERE THE SYMPTOMS DUE TO A PROBLEM IN THE CHEST OR A BLOCKED NOSE?	Problem in chest1 Blocked nose2 Both3 Other (<i>specify</i>)6 DK.....8	2⇒CA12 6⇒CA12
CA8. DID YOU SEEK ADVICE OR TREATMENT FOR THE ILLNESS OUTSIDE THE HOME?	Yes.....1 No.....2 DK.....8	2⇒CA10 8⇒CA10

<p>CA9. FROM WHERE DID YOU SEEK CARE?</p> <p>ANYWHERE ELSE?</p> <p>Circle all providers mentioned, but do NOT prompt with any suggestions.</p> <p>If source is hospital, health center, or clinic, write the name of the place below. Probe to identify the type of source and circle the appropriate code.</p> <p>_____</p> <p>(Name of place)</p>	<p>Public sector</p> <p>Govt. hospital A</p> <p>Govt. health centre B</p> <p>Govt. health post C</p> <p>Village health worker D</p> <p>Other public (<i>specify</i>) H</p> <p>Private medical sector</p> <p>Private hospital/clinic I</p> <p>Private physician J</p> <p>Private pharmacy K</p> <p>Other private</p> <p>_____ medical (<i>specify</i>) O</p> <p>Other source</p> <p>Relative or friend P</p> <p>Shop Q</p> <p>Traditional practitioner R</p> <p>Other (<i>specify</i>) X</p>	
<p>CA10. WAS (<i>name</i>) GIVEN MEDICINE TO TREAT THIS ILLNESS?</p>	<p>Yes 1</p> <p>No 2</p> <p>DK 8</p>	<p>2⇒CA12</p> <p>8⇒CA12</p>
<p>CA11. WHAT MEDICINE WAS (<i>name</i>) GIVEN?</p> <p>Circle all medicines given.</p>	<p>Antibiotic A</p> <p>Paracetamol/Panadol/Acetaminophen P</p> <p>Aspirin Q</p> <p>Ibuprofen R</p> <p>Other (<i>specify</i>) X</p> <p>DK Z</p>	
<p>CA12. Check UF11: Child aged under 3?</p> <p><input type="checkbox"/> Yes. ⇒ Continue with CA13</p> <p><input type="checkbox"/> No. ⇒ Go to CA14</p>		
<p>CA13. THE LAST TIME (<i>name</i>) PASSED STOOLS, WHAT WAS DONE TO DISPOSE OF THE STOOLS?</p>	<p>Child used toilet/latrine 01</p> <p>Put/rinsed into toilet or latrine 02</p> <p>Put/rinsed into drain or ditch 03</p> <p>Thrown into garbage (solid waste) 04</p> <p>Buried 05</p> <p>Left in the open 06</p> <p>Other (<i>specify</i>) 96</p> <p>DK 98</p>	

ASK THE FOLLOWING QUESTIONS (CA 14, CA15) ONLY ONCE FOR EACH MOTHER/CARETAKER		
<p>CA14. SOMETIMES CHILDREN HAVE SEVERE ILLNESSES AND SHOULD BE TAKEN IMMEDIATELY TO A HEALTH FACILITY. WHAT TYPES OF SYMPTOMS WOULD CAUSE YOU TO TAKE YOUR CHILD TO A HEALTH FACILITY RIGHT AWAY?</p> <p><i>Keep asking for more signs or symptoms until the mother/caretaker cannot recall any additional symptoms. Circle all symptoms mentioned, But do NOT prompt with any suggestions</i></p>	<p>Child not able to drink or breastfeedA Child becomes sicker B Child develops a fever.....C Child has fast breathingD Child has difficult breathing..... E Child has blood in stoolF Child is drinking poorly.....G Child is coughing H Child has diarrhea.....I</p> <p>Other (specify) _____ X</p> <p>DK.....Z</p>	
<p>CA15. What ARE THE SYMPTOMS OR SIGNS OF MALARIA?</p> <p><i>Circle all symptoms mentioned.</i></p>	<p>Fever/sweats.....A Headaches.....B Chills/shivers.....C Neckache.....D Weakness/tiredness.....E Loss of appetite.....F Bitterness in the mouth.....G Vomiting/Nausea.....H</p> <p>Others (specify).....X</p> <p>DK.....Z</p>	
MALARIA MODULE FOR UNDER-FIVES		ML
<p>ML1. IN THE LAST TWO WEEKS, THAT IS, SINCE (<i>day of the week</i>) OF THE WEEK BEFORE LAST, HAS (<i>name</i>) BEEN ILL WITH A FEVER?</p>	<p>Yes.....1 No.....2 DK.....8</p>	<p>2⇒ML10 8⇒ML10</p>
<p>ML2. WAS (<i>name</i>) SEEN AT A HEALTH FACILITY DURING THIS ILLNESS?</p>	<p>Yes.....1 No.....2 DK.....8</p>	<p>2⇒ML10 8⇒ML10</p>
<p>ML3. DID (<i>name</i>) TAKE A MEDICINE FOR FEVER OR MALARIA THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY?</p>	<p>Yes.....1 No.....2 DK.....8</p>	<p>2⇒ML10 8⇒ML10</p>
<p>ML4. WHAT MEDICINE DID (<i>name</i>) TAKE THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY?</p> <p><i>Circle all medicines mentioned.</i></p>	<p>ANTIMALARIALS: SP/FANSIDAR A CHLOROQUINE B AMODIAQUINE C QUININE D ARTEMISININ-BASED COMBINATIONS..... E OTHER ANTI-MALARIAL (SPECIFY) _____ H</p> <p>OTHER MEDICATIONS: PARACETAMOL/PANADOL/ACETAMINOPHEN P ASPIRIN Q IBUPROFEN R</p> <p>OTHER (SPECIFY) _____ X DK.....Z</p>	

<p>ML8. Check ML4 : Anti-malarial mentioned (codes A - H)?</p> <p><input type="checkbox"/> Yes. ⇒ Continue with ML9</p> <p><input type="checkbox"/> No. ⇒ Go to ML10</p>		
<p>ML9. HOW LONG AFTER THE FEVER STARTED DID (name) FIRST TAKE (name of anti-malarial from ML4)?</p> <p><i>If multiple anti-malarials mentioned in ML4 name all anti-malarial medicines mentioned.</i></p> <p><i>Record the code for the day on which the first anti-malarial was given.</i></p>	<p>Same day0</p> <p>Next day1</p> <p>2 days after the fever2</p> <p>3 days after the fever3</p> <p>4 or more days after the fever.....4</p> <p>DK.....8</p>	
<p>ML9A . WHERE DID YOU GET THE (name of anti-malarial from ML4)?</p> <p>IF MORE THAN ONE ANTI-MALARIAL IS MENTIONED IN ML4, REFER TO THE FIRST ANTI-MALARIAL GIVEN FOR THE FEVER (THE ANTI-MALARIAL GIVEN ON THE DAY RECORDED IN ML9).</p>	<p>PUBLIC SECTOR</p> <p>GOVT. HOSPITAL11</p> <p>GOVT. HEALTH CENTRE12</p> <p>GOVT. HEALTH POST.....13</p> <p>VILLAGE HEALTH WORKER.....14</p> <p>MOBILE/OUTREACH CLINIC.....15</p> <p>OTHER PUBLIC (SPECIFY).....16</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/CLINIC.....21</p> <p>PRIVATE PHYSICIAN22</p> <p>PRIVATE PHARMACY23</p> <p>MOBILE CLINIC24</p> <p>OTHER PRIVATE MEDICAL (SPECIFY)26</p> <p>OTHER SOURCE</p> <p>RELATIVE OR FRIEND31</p> <p>SHOP32</p> <p>TRADITIONAL PRACTITIONER33</p> <p>OTHER (SPECIFY).....96</p> <p>DK.....98</p>	
<p>ML10. DID (name) SLEEP UNDER A MOSQUITO NET LAST NIGHT?</p>	<p>Yes.....1</p> <p>No.....2</p> <p>DK.....8</p>	<p>2⇒NEXT MODULE</p> <p>8⇒NEXT MODULE</p>
<p>ML10A. WHAT TYPE IS THIS NET?</p> <p><i>If the respondent does not know the TYPE of the net, show pictorials, or if possible, observe the net.</i></p> <p>LONG LASTING TREATED NETS:</p> <p>PRE-TREATED NETS:</p> <p>OTHER NETS:</p>	<p>Long lasting treated net 1</p> <p>Pre-treated net:2</p> <p>Other net:3</p> <p>DK brand.....98</p>	

IMMUNIZATION MODULE							IM
<p>If an immunization card is available, copy the dates in IM2-IM8 for each type of immunization or vitamin A dose recorded on the card. IM10-IM18 are for recording vaccinations that are not recorded on the card. IM10-IM18 will only be asked when a card is not available.</p>							
IM1. IS THERE A VACCINATION CARD FOR (name)?		Yes, seen.....1 Yes, not seen.....2 No.....3				2⇒IM10 3⇒IM10	
(a) Copy dates for each vaccination from the card. (b) Write '44' in day column if card shows that vaccination was given but no date recorded.		Date of Immunization					
		DAY:	MONTH :	YEAR:			
IM2. BCG	BCG						
IM3A. POLIO AT BIRTH	OPV0						
IM3B. POLIO 1	OPV1						
IM3C. POLIO 2	OPV2						
IM3D. POLIO 3	OPV3						
IM4A. DPT1	DPT1						
IM4B. DPT2	DPT2						
IM4C. DPT3	DPT3						
IM6. MEASLES (OR MMR)	MEASLES						
IM8A. VITAMIN A (1)	VIT A1						
IM8B. VITAMIN A (2)	VIT A2						
IM9. IN ADDITION TO THE VACCINATIONS AND VITAMIN A CAPSULES SHOWN ON THIS CARD, DID (name) RECEIVE ANY OTHER VACCINATIONS – INCLUDING VACCINATIONS RECEIVED IN CAMPAIGNS OR IMMUNIZATION DAYS? <i>Record 'Yes' only if respondent mentions BCG, OPV 0-3, DPT 1-3, Hepatitis B 1-3, Measles, Yellow Fever vaccine(s), or Vitamin A supplements.</i>		Yes.....1 <i>(Probe for vaccinations and write '66' in the corresponding day column on IM2 to IM8B.)</i> No.....2 DK.....8				1⇒IM18A 2⇒IM18A 8⇒IM18A	
IM10. HAS (name) EVER RECEIVED ANY VACCINATIONS TO PREVENT HIM/HER FROM GETTING DISEASES, INCLUDING VACCINATIONS RECEIVED IN A CAMPAIGN OR IMMUNIZATION DAY?		Yes.....1 No.....2 DK.....8				2⇒IM18A 8⇒IM18A	
IM11. HAS (name) EVER BEEN GIVEN A BCG VACCINATION AGAINST TUBERCULOSIS – THAT IS, AN INJECTION IN THE ARM OR SHOULDER THAT CAUSED A SCAR?		Yes.....1 No.....2 DK.....8					
IM12. HAS (name) EVER BEEN GIVEN ANY “VACCINATION DROPS IN THE MOUTH” TO PROTECT HIM/HER FROM GETTING DISEASES – THAT IS, POLIO?		Yes.....1 No.....2 DK.....8				2⇒IM15 8⇒IM15	
IM13. HOW OLD WAS HE/SHE WHEN THE FIRST DOSE WAS GIVEN – JUST AFTER BIRTH (WITHIN TWO WEEKS) OR LATER?		Just after birth (within two weeks).....1 Later.....2					

IM14. HOW MANY TIMES HAS HE/SHE BEEN GIVEN THESE DROPS?	No. of times.....__ __	
IM15. HAS (<i>name</i>) EVER BEEN GIVEN "DPT VACCINATION INJECTIONS" – THAT IS, AN INJECTION IN THE THIGH OR BUTTOCKS – TO PREVENT HIM/HER FROM GETTING TETANUS, WHOOPING COUGH, DIPHTHERIA? (SOMETIMES GIVEN AT THE SAME TIME AS POLIO)	Yes.....1 No.....2 DK.....8	2⇒IM17 8⇒IM17
IM16. HOW MANY TIMES?	No. of times.....__ __	
IM17. HAS (<i>name</i>) EVER BEEN GIVEN "MEASLES VACCINATION INJECTIONS" OR MMR – THAT IS, A SHOT IN THE ARM AT THE AGE OF 9 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING MEASLES?	Yes.....1 No.....2 DK.....8	
<i>Ask the following questions (IM 18A, IM 18B, IM 18C IM18D) only once for each mother/caretaker</i>		
IM 18 A. HAVE YOU EVER HEARD OF A DISEASE CALLED POLIO?	YES.....1 NO.....2 DK.....8	2⇒IM18D 8⇒IM18D
IM 18B. DO YOU AGREE TO RECEIVING REPEAT DOSES OF POLIO VACCINES EVERY MONTH?	YES.....1 NO.....2 DK.....8	
IM 18C. HAVE YOU EVER REFUSED TO VACCINATE ONE OF YOUR CHILDREN AGAINST POLIO DISEASE?	NEVER.....1 ONCE.....2 SEVERAL TIMES.....3	
IM18D. WHO IN THE HOUSEHOLD TAKES THE DECISION TO VACCINATE THE CHILD?	Father.....A Mother.....B Grandparents.....C Others (specify).....D	

IM20. Does another eligible child reside in the household for whom this respondent is mother/caretaker?
Check household listing, column HL8.

Yes. ⇒ End the current questionnaire and then

Go to QUESTIONNAIRE FOR CHILDREN UNDER FIVE to administer the questionnaire for the next eligible child.

No. ⇒ End the interview with this respondent by thanking him/her for his/her cooperation.

If this is the last eligible child in the household, go on to ANTHROPOMETRY MODULE.

ANTHROPOMETRY MODULE		AN
<p>After questionnaires for all children are complete, the measurer weighs and measures each child. Record weight and length/height below, taking care to record the measurements on the correct questionnaire for each child. Check the child's name and line number on the household listing before recording measurements.</p>		
AN1. Child's weight.	Kilograms (kg)..... _ _ . _	
AN2. Child's length or height. Check age of child in UF11: <input type="checkbox"/> Child under 2 years old. ⇒ Measure length (lying down). <input type="checkbox"/> Child age 2 or more years. ⇒ Measure height (standing up).	Length (cm) Lying down.....1 _ _ _ . _ Height (cm) Standing up.....2 _ _ _ . _	
AN3. Measurer's identification code.	Measurer code _ _	
AN4. Result of measurement.	Measured.....1 Not present.....2 Refused.....3 Other (specify)6	

AN5. Is there another child in the household who is eligible for measurement? <input type="checkbox"/> Yes. ⇒ Record measurements for next child. <input type="checkbox"/> No. ⇒ End the interview with this household by thanking all participants for their cooperation. Gather together all questionnaires for this household and check that all identification numbers are inserted on each page. Tally on the Household Information Panel the number of interviews completed.
