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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 HEALTH TECH'S NAME	______ ______	______ ______	______ ______	DAY [ ][ ] MONTH [ ][ ] YEAR [ ][ ][ ][ ]
NEXT VISIT: DATE TIME	______ ______	______ ______		TOTAL NUMBER OF VISITS [ ]

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. [RECORD LINE NUMBER FROM COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE; RECORD NAME FROM COLUMN 2 IN HOUSEHOLD QUESTIONNAIRE.]	LINE NUMBER . . . . . [ ][ ] NAME ______________	
103	IF MOTHER INTERVIEWED: COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: What is (NAME)'s date of birth?	DAY . . . . [ ][ ] MONTH . . . . [ ][ ] YEAR . . . . . . [ ][ ][ ][ ]	
104	IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: How old was (NAME) at (NAME)'s last birthday? 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 REFUSED . . . . 2 NOT PRESENT/OTHER 3	 → 112
110	SIGN NAME AND ENTER HEALTH TECH NUMBER.	______________ (SIGN) [ ][ ][ ][ ] 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. NOT PRESENT . . . . 99994 REFUSED . . . . 99995 OTHER 99996	
113	RECORD HAEMOGLOBIN LEVEL HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET.	G/DL . . . . [ ][ ].[ ] NOT PRESENT . . . . 994 REFUSED . . . . 995 OTHER 996	
114	RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET.	POSITIVE . . . . 1 NEGATIVE . . . . 2 NOT PRESENT . . . . 4 REFUSED . . . . 5 OTHER 6	 → 126]→ 128 → 126
115	Does (NAME) suffer from any of the following illnesses or symptoms: a) Extreme weakness? b) Heart problems? c) Loss of consciousness? d) Rapid or difficult breathing? e) Seizures? f) Abnormal bleeding? g) Jaundice or yellow skin? h) Dark urine?	YES NO a) EXTREME WEAKNESS 1 2 b) HEART PROBLEMS . 1 2 c) LOSS OF CONSCIOUS 1 2 d) RAPID BREATHING . 1 2 e) SEIZURES . . . . 1 2 f) BLEEDING . . . . 1 2 g) JAUNDICE . . . . 1 2 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 8.0 G/DL OR ABOVE . . . . . . 2 OTHER 6	]→ 119
118	**SEVERE MALARIA REFERRAL** 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. 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? VERIFY BY ASKING TO SEE TREATMENT.	YES . . . . 1 NO 2	 → 121
120	**ALREADY TAKING [FIRST LINE MEDICATION] REFERRAL STATEMENT** 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

	CHILD 1		SKIP
121	ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT: 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 REFUSED MEDICINE . . . . 2 OTHER 6	→ 128
123	SIGN NAME AND ENTER HEALTH TECH NUMBER.	________________ (SIGN) [ ][ ][ ][ ] 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. IF CHILD WEIGHS LESS THAN 5 KGS., DO NOT LEAVE DRUGS. TELL PARENT TO TAKE CHILD TO HEALTH FACILITY. 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. Make sure the full 3 days treatment is taken at the recommended times, otherwise the infection may return. If your child vomits within an hour of taking the medicine, you will need to get additional tablets and repeat the dose.		→ 128

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

			SKIP
126	CHECK 113: HAEMOGLOBIN RESULT	BELOW 8.0 G/DL, SEVERE ANAEMIA . . . . . . 1 8.0 G/DL OR ABOVE . . . . . . 2 OTHER 6	2, 6 → 128
127	**SEVERE ANAEMIA REFERRAL** 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. RECORD THE RESULT OF THE ANAEMIA TEST ON THE REFERRAL FORM.		
128	TODAY'S DATE:	DAY . . . . [ ][ ] MONTH . . . . [ ][ ] YEAR . . . . [ ][ ][ ][ ]	
129	IF ANOTHER CHILD, GO TO 103 ON THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW.		

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. [RECORD LINE NUMBER FROM COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE; RECORD NAME FROM COLUMN 2 IN HOUSEHOLD QUESTIONNAIRE.]	LINE NUMBER . . . . . ☐☐ NAME ______________	
103	IF MOTHER INTERVIEWED: COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: What is (NAME)'s date of birth?	DAY . . . . ☐☐ MONTH . . . . ☐☐ YEAR . . . . . . ☐☐☐☐	
104	IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: How old was (NAME) at (NAME)'s last birthday? 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 REFUSED . . . . 2 NOT PRESENT/OTHER 3	 3 → 112
110	SIGN NAME AND ENTER HEALTH TECH NUMBER.	______________ (SIGN) ☐☐☐☐ 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. NOT PRESENT . . . . 99994 REFUSED . . . . 99995 OTHER 99996	
113	RECORD HAEMOGLOBIN LEVEL HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET.	G/DL . . . . [ ][ ].[ ] NOT PRESENT . . . . 994 REFUSED . . . . 995 OTHER 996	
114	RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET.	POSITIVE . . . . 1 NEGATIVE . . . . 2 NOT PRESENT . . . . 4 REFUSED . . . . 5 OTHER 6	 → 126] → 128 → 126
115	Does (NAME) suffer from any of the following illnesses or symptoms: a) Extreme weakness? b) Heart problems? c) Loss of consciousness? d) Rapid or difficult breathing? e) Seizures? f) Abnormal bleeding? g) Jaundice or yellow skin? h) Dark urine?	YES NO a) EXTREME WEAKNESS 1 2 b) HEART PROBLEMS . 1 2 c) LOSS OF CONSCIOUS 1 2 d) RAPID BREATHING . 1 2 e) SEIZURES . . . . 1 2 f) BLEEDING . . . . 1 2 g) JAUNDICE . . . . 1 2 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 8.0 G/DL OR ABOVE . . . . . . 2 OTHER 6	] → 119
118	**SEVERE MALARIA REFERRAL** 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. 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? VERIFY BY ASKING TO SEE TREATMENT.	YES . . . . 1 NO 2	 → 121
120	**ALREADY TAKING [FIRST LINE MEDICATION] REFERRAL STATEMENT** 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

	CHILD 2		SKIP
121	ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT: 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 REFUSED MEDICINE . . . . 2 OTHER 6	→ 128
123	SIGN NAME AND ENTER HEALTH TECH NUMBER.	(SIGN) 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. IF CHILD WEIGHS LESS THAN 5 KGS., DO NOT LEAVE DRUGS. TELL PARENT TO TAKE CHILD TO HEALTH FACILITY. 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. Make sure the full 3 days treatment is taken at the recommended times, otherwise the infection may return. If your child vomits within an hour of taking the medicine, you will need to get additional tablets and repeat the dose.		→ 128

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

126	CHECK 113: HAEMOGLOBIN RESULT	BELOW 8.0 G/DL, SEVERE ANAEMIA . . . . . . 1 8.0 G/DL OR ABOVE . . . . . . 2 OTHER 6	(2, 6) → 128
127	**SEVERE ANAEMIA REFERRAL** 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. RECORD THE RESULT OF THE ANAEMIA TEST ON THE REFERRAL FORM.		
128	TODAY'S DATE:	DAY . . . . ☐☐ MONTH . . . . ☐☐ YEAR . . . . ☐☐☐☐	
129	IF ANOTHER CHILD, GO TO 103 ON THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW.		

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 3		SKIP
102	CHECK CAPI OUTPUT AND RECORD LINE NUMBER AND NAME OF CHILD. [RECORD LINE NUMBER FROM COLUMN 9 IN HOUSEHOLD QUESTIONNAIRE; RECORD NAME FROM COLUMN 2 IN HOUSEHOLD QUESTIONNAIRE.]	LINE NUMBER . . . . . ☐☐ NAME ________	
103	IF MOTHER INTERVIEWED: COPY CHILD'S DATE OF BIRTH (DAY, MONTH, AND YEAR) FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: What is (NAME)'s date of birth?	DAY . . . . ☐☐ MONTH . . . . ☐☐ YEAR . . . . . . ☐☐☐☐	
104	IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: How old was (NAME) at (NAME)'s last birthday? 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 REFUSED . . . . 2 NOT PRESENT/OTHER 3	112
110	SIGN NAME AND ENTER HEALTH TECH NUMBER.	________ (SIGN) ☐☐☐☐ 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. NOT PRESENT .... 99994 REFUSED .... 99995 OTHER 99996	
113	RECORD HAEMOGLOBIN LEVEL HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET.	G/DL .... [ ][ ].[ ] NOT PRESENT .... 994 REFUSED .... 995 OTHER 996	
114	RECORD THE RESULT OF THE MALARIA RDT HERE AND IN THE ANAEMIA AND MALARIA PAMPHLET.	POSITIVE .... 1 NEGATIVE .... 2 NOT PRESENT .... 4 REFUSED .... 5 OTHER 6	 → 126] → 128 → 126
115	Does (NAME) suffer from any of the following illnesses or symptoms: a) Extreme weakness? b) Heart problems? c) Loss of consciousness? d) Rapid or difficult breathing? e) Seizures? f) Abnormal bleeding? g) Jaundice or yellow skin? h) Dark urine?	YES NO a) EXTREME WEAKNESS 1 2 b) HEART PROBLEMS . 1 2 c) LOSS OF CONSCIOUS 1 2 d) RAPID BREATHING . 1 2 e) SEIZURES .... 1 2 f) BLEEDING .... 1 2 g) JAUNDICE .... 1 2 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 8.0 G/DL OR ABOVE ...... 2 OTHER 6	] → 119
118	**SEVERE MALARIA REFERRAL** 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. 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? VERIFY BY ASKING TO SEE TREATMENT.	YES .... 1 NO 2	 → 121
120	**ALREADY TAKING [FIRST LINE MEDICATION] REFERRAL STATEMENT** 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

	CHILD 3		SKIP
121	ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT: 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 REFUSED MEDICINE . . . . 2 OTHER 6	 → 128
123	SIGN NAME AND ENTER HEALTH TECH NUMBER.	____________________ (SIGN) [ ][ ][ ][ ] 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. IF CHILD WEIGHS LESS THAN 5 KGS., DO NOT LEAVE DRUGS. TELL PARENT TO TAKE CHILD TO HEALTH FACILITY. 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. Make sure the full 3 days treatment is taken at the recommended times, otherwise the infection may return. If your child vomits within an hour of taking the medicine, you will need to get additional tablets and repeat the dose.		→ 128

DOSING SCHEDULE WITH ARTEMETHER-LUMEFANTRINE (AL)

WEIGHT IN KG	AGE IN YEARS	NUMBER OF TABLETS PER DOSE					
		DAY 1		DAY 2		DAY 3	
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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

			SKIP
126	CHECK 113: HAEMOGLOBIN RESULT	BELOW 8.0 G/DL, SEVERE ANAEMIA . . . . . . 1 8.0 G/DL OR ABOVE . . . . . . 2 OTHER 6	 } → 128
127	**SEVERE ANAEMIA REFERRAL** 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. RECORD THE RESULT OF THE ANAEMIA TEST ON THE REFERRAL FORM.		
128	TODAY'S DATE:	DAY . . . . [ ][ ] MONTH . . . . [ ][ ] YEAR . . . . [ ][ ][ ][ ]	
129	IF ANOTHER CHILD, GO TO 103 IN ADDITIONAL QUESTIONNAIRE; IF NO MORE CHILDREN, END INTERVIEW.		

HEALTH TECH'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING BIOMARKERS

SUPERVISOR'S OBSERVATIONS