

MALARIA INDICATOR SURVEY
 MODEL BIOMARKER QUESTIONNAIRE

[NAME OF COUNTRY]
 [NAME OF ORGANIZATION]

IDENTIFICATION (1)																				
PLACE NAME _____																				
NAME OF HOUSEHOLD HEAD _____																				
CLUSTER NUMBER				<table border="1" style="width: 100%; height: 20px;"> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>																
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[FIELDWORKER] VISITS																				
	1	2	3	FINAL VISIT																
DATE	_____	_____	_____	DAY <table border="1" style="width: 40px; height: 20px; float: right;"></table>																
[FIELDWORKER'S] NAME	_____	_____	_____	MONTH <table border="1" style="width: 40px; height: 20px; float: right;"></table>																
				YEAR <table border="1" style="width: 40px; height: 20px; float: right;"></table>																
NEXT VISIT: DATE	_____	_____		TOTAL NUMBER OF VISITS <table border="1" style="width: 40px; height: 20px; float: right;"></table>																
TIME	_____	_____																		
NOTES: _____ _____ _____ _____ _____				TOTAL ELIGIBLE CHILDREN <table border="1" style="width: 40px; height: 20px; float: right;"></table>																
LANGUAGE OF QUESTIONNAIRE**	<table border="1" style="width: 40px; height: 20px;"><tr><td>0</td><td>1</td></tr></table>	0	1	LANGUAGE OF INTERVIEW**	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			NATIVE LANGUAGE OF RESPONDENT**	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			TRANSLATOR (YES = 1, NO = 2)	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td></tr></table>							
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LANGUAGE OF QUESTIONNAIRE**	ENGLISH		**LANGUAGE CODES:																	
			01 ENGLISH	03 LANGUAGE 3	05 LANGUAGE 5															
			02 LANGUAGE 2	04 LANGUAGE 4	06 LANGUAGE 6															
TEAM	TEAM SUPERVISOR		CAPI SUPERVISOR (2)																	
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NUMBER		NUMBER		NUMBER		NUMBER														

Note: Brackets [] indicate items that should be adapted on a country-specific basis. Curly brackets { } indicate dynamic text that will be automatically filled by CSPro and should not be changed.

MALARIA TESTING FOR CHILDREN AGE 6 MONTHS TO 4 YEARS

101	CHECK CAPI OUTPUT FOR "LIST ELIGIBLE INDIVIDUALS/BIOMARKERS". RECORD THE LINE NUMBER AND NAME FOR ALL ELIGIBLE CHILDREN AGE 0-5 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		
102	CHECK CAPI OUTPUT AND RECORD NAME AND LINE NUMBER OF CHILD.	NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>
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 OF CHILD}'s date of birth?	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/>
104	IF MOTHER INTERVIEWED: COPY CHILD'S AGE FROM BIRTH HISTORY. IF MOTHER NOT INTERVIEWED ASK: How old was {NAME OF CHILD} at {NAME OF CHILD}'s last birthday? COMPARE AND CORRECT 103 AND/OR 104 IF INCONSISTENT.	AGE IN COMPLETED YEARS <input type="text"/>
105	CHECK 104: CHILD AGE 0-4 YEARS? YES <input type="checkbox"/> NO <input type="checkbox"/>	→ 135
106	CHECK 103: IS THE CHILD AGE 0-5 MONTHS OR OLDER <input type="checkbox"/> AGE 0-5 MONTHS <input type="checkbox"/>	→ 135

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
118	RECORD NAME OF PARENT/RESPONSIBLE ADULT FOR THE CHILD.	NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>	
120	ASK CONSENT FOR MALARIA TEST FROM PARENT/RESPONSIBLE ADULT: As part of this survey, we are asking children all over the country to take a test to see if they have malaria. Malaria is a serious illness caused by a parasite transmitted by a mosquito bite. This survey will assist the government to develop programs to prevent and treat malaria. We ask that all children age 6 months through 4 years take part in malaria testing. The tests require a few drops of blood from a finger or heel. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after each test. The blood will be tested for malaria immediately, and the results will be told to you right away. [A few blood drops will be collected on slide(s) and taken to a laboratory for testing. You will not be told the results of the laboratory testing.] All results will be kept strictly confidential and will not be shared with anyone other than members of our survey team. Do you have any questions? You can say yes or no. It is up to you to decide. Will you allow {NAME OF CHILD} to participate in the malaria test?	GRANTED 1 REFUSED 2 NOT PRESENT/OTHER 3	
121	RECORD [FIELDWORKER] NUMBER.	_____ (SIGN) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [FIELDWORKER] NUMBER	
122	CHECK 120: CONSENT GRANTED <input type="checkbox"/> CONSENT REFUSED OR NOT PRESENT/OTHER <input type="checkbox"/>	→ 135	

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123 (3)	PREPARE EQUIPMENT AND SUPPLIES FOR THE TEST(S) AND PROCEED WITH TESTING. 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.	<div style="border: 1px dashed black; padding: 5px; text-align: center;"> PUT THE 1ST BAR CODE LABEL HERE. </div> REFUSED 99995 OTHER 99996	→ 135																											
124	CONDUCT TEST AND RECORD RESULT OF THE MALARIA RDT HERE AND IN THE [INFORMATIONAL PAMPHLET].	[TEST POSITIVE] 1 [TEST NEGATIVE] 2 NOT PRESENT 4 REFUSED 5 OTHER 6	→ 135																											
125	Does {NAME OF CHILD} 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?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>a) EXTREME WEAKNESS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>b) HEART PROBLEMS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>c) LOSS OF CONSCIOUS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>d) RAPID BREATHING</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>e) SEIZURES</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>f) BLEEDING</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>g) JAUNDICE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>h) DARK URINE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		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	
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126	CHECK 125: ANY 'YES' CIRCLED? YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 128																											
127	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.	SEVERE MALARIA REFERRAL PROVIDED 1 SEVERE MALARIA REFERRAL NOT PROVIDED 2	→ 135																											
128	In the past 2 weeks has {NAME OF CHILD} taken or is {NAME OF CHILD} taking [FIRST LINE MEDICATION] given by a doctor or health center to treat the malaria? VERIFY BY ASKING TO SEE TREATMENT.	YES 1 NO 2	→ 131																											

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
129	ALREADY TAKING [FIRST LINE MEDICATION] REFERRAL STATEMENT You have told me that {NAME OF CHILD} had already received [FIRST LINE OF MEDICATION] for malaria. Therefore, I cannot give you additional [FIRST LINE OF MEDICATION]. However, the test shows that he/she has malaria. If your child has a fever for 2 days after the last dose of [FIRST LINE MEDICATION], you should take the child to the nearest health facility for further examination.		
130	CHECK 128:	NO <input type="checkbox"/> YES <input type="checkbox"/>	→ 135
131	ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT: The malaria test shows that {NAME OF CHILD} has malaria. We can give you free medicine. The medicine is called [FIRST LINE OF MEDICATION]. [FIRST LINE OF MEDICATION] is very effective and in a few days it should get rid of the fever and other symptoms. You do not have to give {NAME OF CHILD} the medicine. This is up to you. Please tell me whether you accept the medicine or not.	ACCEPTED MEDICINE 1 REFUSED MEDICINE 2 OTHER 6	
132	RECORD [FIELDWORKER] NUMBER.	<div style="border: 1px solid black; display: inline-block; padding: 2px;"> </div> [FIELDWORKER] NUMBER	
133	CHECK 131: ACCEPTED MEDICINE?	ACCEPTED MEDICINE <input type="checkbox"/> REFUSED MEDICINE OR OTHER <input type="checkbox"/>	→ 135
134	PROVIDE DOSAGE INSTRUCTIONS TO PARENT/RESPONSIBLE ADULT. [INSERT INSTRUCTIONS HERE:] TELL THE PARENT/RESPONSIBLE ADULT: If {NAME OF CHILD} has a high fever, fast or difficult breathing, is not able to drink or breastfeed, gets sicker or does not get better in 2 days, you should take him/her to a health professional for treatment right away.		
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136	IF ANOTHER CHILD, GO TO 102 ON THE NEXT PAGE; IF NO MORE CHILDREN, END INTERVIEW.		

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CHILD 2		
102	CHECK CAPI OUTPUT AND RECORD NAME AND LINE NUMBER OF CHILD.	NAME _____ LINE NUMBER <input type="text"/> <input type="text"/>
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 OF CHILD}'s date of birth?	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/>
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123 (3)	PREPARE EQUIPMENT AND SUPPLIES FOR THE TEST(S) AND PROCEED WITH TESTING. 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.	<div style="border: 1px dashed black; padding: 5px; text-align: center;"> PUT THE 1ST BAR CODE LABEL HERE. </div> REFUSED 99995 OTHER 99996	→ 135																											
124	CONDUCT TEST AND RECORD RESULT OF THE MALARIA RDT HERE AND IN THE [INFORMATIONAL PAMPHLET].	[TEST POSITIVE] 1 [TEST NEGATIVE] 2 NOT PRESENT 4 REFUSED 5 OTHER 6	→ 135																											
125	Does {NAME OF CHILD} 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?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>a) EXTREME WEAKNESS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>b) HEART PROBLEMS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>c) LOSS OF CONSCIOUS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>d) RAPID BREATHING</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>e) SEIZURES</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>f) BLEEDING</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>g) JAUNDICE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>h) DARK URINE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		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	
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126	CHECK 125: ANY 'YES' CIRCLED? YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 128																											
127	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.	SEVERE MALARIA REFERRAL PROVIDED 1 SEVERE MALARIA REFERRAL NOT PROVIDED 2	→ 135																											
128	In the past 2 weeks has {NAME OF CHILD} taken or is {NAME OF CHILD} taking [FIRST LINE MEDICATION] given by a doctor or health center to treat the malaria? VERIFY BY ASKING TO SEE TREATMENT.	YES 1 NO 2	→ 131																											

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
129	<p>ALREADY TAKING [FIRST LINE MEDICATION] REFERRAL STATEMENT</p> <p>You have told me that {NAME OF CHILD} had already received [FIRST LINE OF MEDICATION] for malaria. Therefore, I cannot give you additional [FIRST LINE OF MEDICATION]. However, the test shows that he/she has malaria. If your child has a fever for 2 days after the last dose of [FIRST LINE MEDICATION], you should take the child to the nearest health facility for further examination.</p>		
130	<p>CHECK 128:</p> <p style="text-align: center;">NO <input type="checkbox"/> YES <input type="checkbox"/></p> <p style="text-align: right;">→ 135</p>		
131	<p>ASK CONSENT FOR MALARIA TREATMENT FROM PARENT/RESPONSIBLE ADULT:</p> <p>The malaria test shows that {NAME OF CHILD} has malaria. We can give you free medicine. The medicine is called [FIRST LINE OF MEDICATION]. [FIRST LINE OF MEDICATION] is very effective and in a few days it should get rid of the fever and other symptoms. You do not have to give {NAME OF CHILD} the medicine. This is up to you. Please tell me whether you accept the medicine or not.</p>	<p>ACCEPTED MEDICINE 1 REFUSED MEDICINE 2 OTHER 6</p>	
132	<p>RECORD [FIELDWORKER] NUMBER.</p>	<p style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> [FIELDWORKER] NUMBER </p>	
133	<p>CHECK 131: ACCEPTED MEDICINE?</p> <p style="text-align: center;">ACCEPTED MEDICINE <input type="checkbox"/> REFUSED MEDICINE OR OTHER <input type="checkbox"/></p> <p style="text-align: right;">→ 135</p>		
134	<p>PROVIDE DOSAGE INSTRUCTIONS TO PARENT/RESPONSIBLE ADULT. [INSERT INSTRUCTIONS HERE:]</p> <p>TELL THE PARENT/RESPONSIBLE ADULT: If {NAME OF CHILD} has a high fever, fast or difficult breathing, is not able to drink or breastfeed, gets sicker or does not get better in 2 days, you should take him/her to a health professional for treatment right away.</p>		
135	<p>RECORD DATE:</p>	<p>DAY <input type="text"/> <input type="text"/></p> <p>MONTH <input type="text"/> <input type="text"/></p> <p>YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	
136	<p>IF ANOTHER CHILD, GO TO 102 IN ADDITIONAL QUESTIONNAIRE; IF NO MORE CHILDREN, END INTERVIEW.</p>		

BIOMARKER: FOOTNOTES

- (1) This section should be adapted for country-specific survey design.
- (2) Remove the section for recording the name and ID number of the CAPI supervisor if the survey does not have CAPI supervisors who are separate from the team supervisors.
- (3) If the survey does not include blood smears, delete this question.