



Eligibility Criteria		
Age between 7 days and before 2 <sup>nd</sup> birthday	Y	N - ineligible
Living in same community as a hospitalised participant	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
Required hospital admission within the last 2 weeks (if under 2 weeks old, hospital admission since discharge home after birth)	Y- ineligible	N
Known but untreated TB or HIV	Y- ineligible	N
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
Sibling enrolled in study	Y- ineligible	N
Previously enrolled	Y- ineligible	N

Initials of person interviewing caregiver _____  <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	Date ____/____/_____ <i>D D / M M / Y Y Y Y</i>  Time ____:____
<b>Who is being interviewed?</b> <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	

Enrolment					
<b>Date of Enrolment</b> <i>i.e. date consented and seen by research team in hospital</i>	____/____/_____ <i>D D / M M / Y Y Y Y</i>	<b>Time of enrolment</b> <i>24H Clock</i>	____:____	<b>Sex circle</b>	Male    Female
<b>Date approached in community</b>	____/____/_____ <i>D D / M M / Y Y Y Y</i>	<b>Date of informed consent</b>		____/____/_____ <i>D D / M M / Y Y Y Y</i>	
<b>DOB</b>	____/____/_____ <i>D D / M M / Y Y Y Y</i>	<b>DOB</b>	<input type="checkbox"/> True  <input type="checkbox"/> Estimated	<b>Child Initials</b>	_____





GPS LOCATION OF HOUSEHOLD	
<i>Tick + or – to indicate N/S and W/E</i>	
Latitude: <input type="checkbox"/> + <input type="checkbox"/> –    _____ . _____	
Longitude <input type="checkbox"/> + <input type="checkbox"/> –    _____ . _____	
<i>NOTE: GPS must be set to decimal degrees DDD.DDDDDD (not degrees, minutes and seconds).</i>	

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





Anthropometry and Nutrition				
<b>Weight</b> <i>to be taken using SECA scales for CHAIN study</i>	____ ____ . ____ kg		<b>Length</b> <i>to be taken using SECA 416 infantometer provided for CHAIN study</i>	Measurer 1 _____ . _____ cm
				Measurer 2 _____ . _____ cm
<b>MUAC</b> <i>To be taken using MUAC tape for CHAIN study</i>	Measurer 1 _____ . _____ cm	<b>Head circumference</b> <i>To be taken using CHAIN measuring tape</i>	Measurer 1 _____ . _____ cm	Measurer 2 _____ . _____ 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    _____			

Current Health	
<b>Previously admitted to hospital.</b> <i>Include other hospitals / health centres. Select 1</i>	<input type="checkbox"/> No <input type="checkbox"/> 2 weeks-1month ago <input type="checkbox"/> >1month ago
<b>Any medication last 7 days.</b> <i>Select all that apply</i>	<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"/> Yes, but unknown <input type="checkbox"/> Other
<b>Urine volume in last 24hrs?</b> <i>Select 1</i>	<input type="checkbox"/> Not passing urine <input type="checkbox"/> Less than normal <input type="checkbox"/> Normal or greater <input type="checkbox"/> Unknown





<p><i>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</i></p>	
<p><b>Airway</b> (select one)</p>	<input type="checkbox"/> Clear <input type="checkbox"/> Needs active support <input type="checkbox"/> Obstructed/Stridor
<p><b>Breathing</b> (select all that apply)</p>	<input type="checkbox"/> Normal – no concerns, (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
<p><b>Circulation:</b> Cap Refill (select one) Cold Peripheries(select one)</p>	<input type="checkbox"/> >3s <input type="checkbox"/> 2-3s <input type="checkbox"/> <2s <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Hand <input type="checkbox"/> Warm peripheries
<p><b>Disability:</b> Conscious level(select one) Fontanelle(select one) Tone(select one) Posture(select one) Activity(select one)</p>	<input type="checkbox"/> Alert <input type="checkbox"/> Voice <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive <input type="checkbox"/> Normal <input type="checkbox"/> Bulging <input type="checkbox"/> Sunken <input type="checkbox"/> Not present <input type="checkbox"/> Normal <input type="checkbox"/> Hypertonic <input type="checkbox"/> Hypotonic <input type="checkbox"/> Normal <input type="checkbox"/> Decorticate <input type="checkbox"/> Decerebrate <input type="checkbox"/> Normal <input type="checkbox"/> Irritable/Agitated <input type="checkbox"/> Lethargic
<p><b>Dehydration:</b> Sunken eyes?</p>	<input type="checkbox"/> Y <input type="checkbox"/> N
<p><b>Skin pinch</b> (select one)</p>	<input type="checkbox"/> >2 seconds <input type="checkbox"/> <2 seconds <input type="checkbox"/> Immediate
<p><b>Drinking/Breastfeeding</b> (Select one)</p>	<input type="checkbox"/> Normal <input type="checkbox"/> Poorly <input type="checkbox"/> Not drinking <input type="checkbox"/> Eager / Thirsty
<p><b>Abdomen</b> (select any that apply)</p>	<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
<p><b>Signs of Rickets</b></p>	<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
<p><b>Jaundice</b> (Select one)</p>	<input type="checkbox"/> Not jaundiced <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++
<p><b>ENT/Oral/Eyes</b> (select any that apply)</p>	<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
<p><b>Skin</b> (select any that apply)</p>	<input type="checkbox"/> Normal <input type="checkbox"/> Hyperpigmentation <input type="checkbox"/> Depigmentation <input type="checkbox"/> Broken skin <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 <input type="checkbox"/> Not applicable <input type="checkbox"/> Trunk <input type="checkbox"/> Face / scalp <input type="checkbox"/> Legs





<b>Site of skin lesions.</b> <i>(select any that apply)</i>	(No rash) <input type="checkbox"/> Buttocks <input type="checkbox"/> Arms <input type="checkbox"/> Perineum
	<input type="checkbox"/> Palms / soles

**Suspected Chronic Conditions**

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

**Feeding**

<b>Currently in outpatient nutrition program?</b> <i>Select one.</i>	<input type="checkbox"/> Supplementary <i>(corn soy blend, RUSF, khichuri, halwa)</i>			<input type="checkbox"/> Therapeutic <i>(RUTF, Plumpy-nut)</i>		<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		
<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"/> Sweetened/sugar water <input type="checkbox"/> Fruit Juice		<input type="checkbox"/> Formula/powder milk <input type="checkbox"/> Tea		<input type="checkbox"/> Animal milk <input type="checkbox"/> Other	





<b>What did the child receive other than breast milk in the first 3 days of life? Select all that apply.</b>	<input type="checkbox"/> Water	<input type="checkbox"/> Porridge/pulp	<input type="checkbox"/> Nothing
	<input type="checkbox"/> Pure Honey	<input type="checkbox"/> Glycerine	

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

Child Health		
Is the child in generally good health?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
If No, how long has he child had this problem of generally bad health?	<input type="checkbox"/> < since birth	<input type="checkbox"/> <1month <input type="checkbox"/> > 1month
Does the child have health insurance?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Received medication from traditional healer, homeopathist or herbalist in last 4 weeks? Y N		
Child's Health Status		
How does this child's health compare to other children of similar age in your neighbourhood? Select one		
<input type="checkbox"/> Similar <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Don't know		
How did this child's health compare to his/her siblings at a similar age? Select one		
<input type="checkbox"/> Similar <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Don't know <input type="checkbox"/> Not applicable, only child		





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 underweight (<2.5kg)	
		<input type="checkbox"/> Twin/multiple birth		<input type="checkbox"/> Born at term	
<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			
<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		





Primary Caregiver Information									
<i>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.</i>									
Who is the Primary Caregiver? <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				
Is the child's biological father alive?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown	Is the child's biological mother alive?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown		
Primary Care Giver Age <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)			
Primary Care Giver Sex <i>Select one</i>	<input type="checkbox"/> Male		<input type="checkbox"/> Female	<input type="checkbox"/> N/A	Primary caregiver present at admission?	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Has the primary caregiver lived in the same household as the child for the last 2 months?						<input type="checkbox"/> Y	<input type="checkbox"/> N		
						<input type="checkbox"/> N/A/ care home			
Marital status of primary caregiver <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		
If not present at admission, where is the primary caregiver? <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									
If the primary caregiver is present, caregiver anthropometry: <i>Use locally available adult scales and stadiometer, and adult MUAC tapes provided by CHAIN.</i>									
<input type="checkbox"/> Primary caregiver not present during admission or care home									
Weight	_____ kg	MUAC	_____ cm	Height:	_____ cm				
Education: <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		
Able to read?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown	Is the primary caregiver primarily responsible for financial support and providing for the child?	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Primary caregiver HIV status in last 6 months <i>Select one</i>	<input type="checkbox"/> Tested Positive		<input type="checkbox"/> Tested Negative		<input type="checkbox"/> Not tested or unknown				
Have there been changes to the child's social situation in the last 2 MONTHS? <i>Select any that apply</i>									
Child moved to a different household	Y	N	Relocation from rural to urban setting			Y	N		
			Relocation from urban to rural setting			Y	N		
			Relocation to live with different caregiver			Y	N		
Mother sick	Y	N	Mother Died			Y	N		
Father sick	Y	N	Father Died			Y	N		
Other primary caregiver sick	Y	N	N/A	Other primary caregiver died			Y	N	N/A
Primary caregiver changed	Y	N	Child went into care home			Y	N		
Primary caregiver started employment / returned to school	Y	N	Person providing for the child has lost income			Y	N		
Primary caregiver divorced / separated from partner	Y	N	Primary caregiver in new relationship			Y	N		
Mother is pregnant	Y	N	Mother gave birth			Y	N		
Other primary caregiver pregnant?	Y	N	N/A	Other primary caregiver gave birth			Y	N	N/A





Community Enrolment V1.62

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

**If primary caregiver has changed in the last 2 months, who was the child's previous primary caregiver?**  
*Select one*

<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*

<input type="checkbox"/> Employed full time by someone else	<input type="checkbox"/> Employed part time by someone else
<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 checked="" type="checkbox"/> N/A care home

**How many days worked a week?** *Select one*

<input type="checkbox"/> <3	<input type="checkbox"/> 3-5	<input type="checkbox"/> >5	<input type="checkbox"/> N/A, does not work for income
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**If the primary caregiver earns, main source of income?** *Select one*

<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"/> Other _____	<input type="checkbox"/> N/A	

**If the primary caregiver works (earning or non-earning), main place of work?** *Select one*

<input type="checkbox"/> In/around home (where child lives)	<input type="checkbox"/> Away for <4 hours per day	<input type="checkbox"/> Away >4 hours but comes home daily
<input type="checkbox"/> Away > 8h a day but returns home daily	<input type="checkbox"/> Away >1 day, comes home weekly	<input type="checkbox"/> Away comes home, less than weekly
<input type="checkbox"/> Primary caregiver lives and works away	<input type="checkbox"/> Don't know	<input type="checkbox"/> N/A

**The person primarily providing financial support to this child is this child's:** *Select one*

<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 checked="" type="checkbox"/> Unsupported / care home	<input type="checkbox"/> Other -specify _____	

**Person responsible for providing financial support to child, place of usual residence?** *Select one*

<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 checked="" type="checkbox"/> N/A (e.g. care home, unsupported)

**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.*

<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 checked="" type="checkbox"/> N/A





<b>Substitute Care:</b>	
<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"/> Biological Mother	<input type="checkbox"/> Biological Father
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Aunt/Uncle/Cousin
<input type="checkbox"/> Sibling <18 years old	<input type="checkbox"/> Sibling ≥18 years old
<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

<b>11. Household Food Security</b>	
<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





Community Enrolment V1.62

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



23. Child Dietary Diversity
<p><b>What does the child eat on a typical day?</b></p> <ul style="list-style-type: none"> <li>Ask this as an open question and select all that the caregiver mentions.</li> <li>Do not present the caregiver with this list.</li> <li>You may prompt the caregiver with open questions, e.g. What does your child usually eat for breakfast</li> </ul>
<input type="checkbox"/> <b>Milk and Milk Products:</b> Fresh/fermented milk, cheese, yogurt, or other milk products
<input type="checkbox"/> <b>Breast milk</b>
<input type="checkbox"/> <b>Cereals and Cereal Products:</b> Maize, rice, pasta, porridge, bread, biscuits, millet, sorghum, wheat, locally available grains
<input type="checkbox"/> <b>Fish and Sea Foods:</b> fresh or dried fish or shellfish
<input type="checkbox"/> <b>Roots and Tubers:</b> potatoes, sweet potatoes, yams, cassava, or foods made from roots or wild roots and tubers
<input type="checkbox"/> <b>Vegetables:</b> Cabbages, carrots, spinach, and any other locally available vegetables including wild vegetables
<input type="checkbox"/> <b>Fruits:</b> Oranges, bananas, mangoes, avocados, apples, grapes etc
<input type="checkbox"/> <b>Meats and Poultry:</b> Camel, beef, lamb, goat, rabbit, wild game, chicken or other birds, liver, kidney, heart or other organ meats or blood-based foods
<input type="checkbox"/> <b>Eggs:</b> Hen or other bird eggs
<input type="checkbox"/> <b>Pulses / Legumes / Nuts and Seeds:</b> Beans, peas, lentils, nuts, seeds or foods made from these
<input type="checkbox"/> <b>Fats and Oils:</b> Oil, fats, ghee, margarine or butter added to food or used for cooking
<input type="checkbox"/> <b>Sugars / Honey and Commercial Juices:</b> Sugar in tea, honey, sweetened soda, juices, chocolates, sweets or candies
<input type="checkbox"/> <b>Miscellaneous:</b> Spices, unsweetened beverages
<input type="checkbox"/> <b>UNKNOWN</b>

Feeding Practices	
<b>How is food USUALLY given to the child? Select one</b>	
<input type="checkbox"/> Fed by adult	<input type="checkbox"/> Child feeds self, unsupervised
<input type="checkbox"/> Child feeds self, supervised by adult	<input type="checkbox"/> Fed from common plate or bowl
<input type="checkbox"/> Child feeds self, supervised by older children	<input type="checkbox"/> Child exclusively breastfed

household wealth (DHS 7 questionnaire. Please answer all questions)		
<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"/> 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	



Community Enrolment V1.62

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

<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 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

<b>What kind of toilet facility do members of your household usually use? Select one</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? Select one only</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? Select one only</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? Select one only</b>			





Community Enrolment V1.62

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

<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 <u>MAIN</u> 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





<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



11. 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"/> Unknown	
<b>Urine Dipstick</b> <i>(can be done at any time during admission)</i> <input type="checkbox"/> Not done <input type="checkbox"/> Bag <input type="checkbox"/> Clean catch	Protein	Nitrites	Leucocytes	Blood	Ketones	Glucose
	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> ARV 1 _____ ARV 2 _____ ARV 3 _____	<b>If on prophylaxis</b> <input type="checkbox"/> Nevirapine prophylaxis only <input type="checkbox"/> AZT + NVP prophylaxis <input type="checkbox"/> Caregiver unsure	
	<b>Co-trimoxazole</b> <i>select one</i>	<input type="checkbox"/> On prophylactic dose co-trimoxazole <input type="checkbox"/> On high dose co-trimoxazole		<input type="checkbox"/> Not on co-trimoxazole	<input type="checkbox"/> Caregiver unsure	
<b>If not known positive</b>	<b>HIV RDT now</b> <i>select one</i>	<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>Referred to HIV clinic</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No (select 'No' if referral not indicated)					
<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					



11. Admission Core Cohort Investigations and Sample Collection				
CBC taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Plain Blood (serum)	<input type="checkbox"/> Y <input type="checkbox"/> N
Clinical chemistry taken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood spot taken	<input type="checkbox"/> Y <input type="checkbox"/> N
EDTA 2ml blood taken	<input type="checkbox"/> Y	<input type="checkbox"/> N		
EDTA 0.5ml blood taken	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Date Taken	Date taken _____ Time taken _____: _____ D D / M M / Y Y Y Y			
Unable to take blood samples, why?	<input type="checkbox"/> Difficult venepuncture <input type="checkbox"/> Child uncooperative <input type="checkbox"/> Parent refused <input type="checkbox"/> Other			
Rectal swabs taken	<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 _____: _____
Stool sample	Taken in first 24h? <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> N	Date taken _____ D D / M M / Y Y Y Y	Time taken _____: _____

Blood Samples taken by (initials)	_____
Rectal Swabs taken by (initials)	_____

<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	_____ : _____

