



Household Visit V1.63

CHAIN Number [5][0][0][0][1][][][]

Homestead visit					
Date of visit	___/___/_____ D D / M M / Y Y Y Y	Time arrived at household	__:__	Accompanied child home from hospital?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is this the same homestead the child was admitted from?	<input type="checkbox"/> Y <input type="checkbox"/> N	Do the caregiver and child intend to stay at this homestead until the next follow-up visit?		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown	
How long did it take to get to the household?	___Hrs ___Min	How did you travel to the household?	<input type="checkbox"/> Car/ Taxi <input type="checkbox"/> Bus <input type="checkbox"/> Motorbike <input type="checkbox"/> Walking <input type="checkbox"/> Tuk-tuk <input type="checkbox"/> Cycle rickshaw <input type="checkbox"/> Train <input type="checkbox"/> Other		

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>	

Household Information					
Number of adults (over 18y) living in this household NOW	___	Number of children 5-18y living in household NOW	___	Number of children under 5 living in household NOW	___
Who lives in this household? Select all that apply					
<input type="checkbox"/> Biological Mother	<input type="checkbox"/> Biological father	<input type="checkbox"/> Brother	<input type="checkbox"/> Sister	<input type="checkbox"/> Grandmother	<input type="checkbox"/> Grandfather
<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Stepmother / stepfather	<input type="checkbox"/> Other	





Household Visit V1.63

CHAIN Number [5][0][0][0][1][][][]

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
If primary caregiver has changed in the last 2 months, who was the child's previous primary caregiver? <i>Select one</i>					
<input type="checkbox"/> Biologic Mother		<input type="checkbox"/> Biologic Father		<input type="checkbox"/> Sibling ≥18 years old	
<input type="checkbox"/> Grandparent		<input type="checkbox"/> Aunt/Uncle/Cousin		<input type="checkbox"/> Sibling <18 years old	
		<input type="checkbox"/> Other		<input type="checkbox"/> N/A	

Primary caregiver earns an income now? <i>Ask the person accompanying the child and select one</i>			
<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 type="checkbox"/> N/A care home	
How many days worked a week? <i>Select one</i>			<input type="checkbox"/> N/A, does not work for income
		<input type="checkbox"/> <3	<input type="checkbox"/> 3-5
		<input type="checkbox"/> >5	
If the primary caregiver earns, main source of income? <i>Select one</i>			
<input type="checkbox"/> Farmer		<input type="checkbox"/> Business/trader	
<input type="checkbox"/> Other private sector employment		<input type="checkbox"/> Labourer	
<input type="checkbox"/> Begging		<input type="checkbox"/> Domestic work	
		<input type="checkbox"/> Public sector employment	
		<input type="checkbox"/> Retired with pension income	
		<input type="checkbox"/> Other _____	
		<input type="checkbox"/> N/A	
If the primary caregiver works (earning or non-earning), main place of work? <i>Select one</i>			
<input type="checkbox"/> In/around home (where child lives)		<input type="checkbox"/> Away for <4 hours per day	
<input type="checkbox"/> Away > 8h a day but returns home daily		<input type="checkbox"/> Away >4 hours but comes home daily	
<input type="checkbox"/> Primary caregiver lives and works away		<input type="checkbox"/> Away >1 day, comes home weekly	
		<input type="checkbox"/> Away comes home, less than weekly	
		<input type="checkbox"/> Don't know	
		<input type="checkbox"/> N/A	
The person primarily providing financial support to this child is this child's: <i>Select one</i>			
<input type="checkbox"/> Biologic Mother		<input type="checkbox"/> Biologic Father	
<input type="checkbox"/> Grandparent		<input type="checkbox"/> Stepfather	
<input type="checkbox"/> More than one person responsible, unclear		<input type="checkbox"/> Stepmother	
		<input type="checkbox"/> Sibling ≥18 years old	
		<input type="checkbox"/> Sibling <18 years old	
		<input type="checkbox"/> Aunt/Uncle/Cousin	
		<input type="checkbox"/> Unsupported / care home	
		<input type="checkbox"/> Other -specify _____	





Household Visit V1.63

CHAIN Number [5][0][0][0][1][][][]

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 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 type="checkbox"/> N/A

Substitute Care:					
<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"/> Child in care home			
<input type="checkbox"/> Biological Mother	<input type="checkbox"/> Biological 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"/> Childcare facility outside home	<input type="checkbox"/> Childminder/ day care at home		
How many days a week is the child in day care?	<input type="checkbox"/> N/A	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-6	<input type="checkbox"/> >6
How many hours per day is the child in day care?	<input type="checkbox"/> N/A	<input type="checkbox"/> 1-4h	<input type="checkbox"/> 5-8h	<input type="checkbox"/> 9-12h	<input type="checkbox"/> >12h
How many children are looked after at this day care?	<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
How many of these are under 2y?	<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
How many adults look after these children?	<input type="checkbox"/> 1	<input type="checkbox"/> 2-4	<input type="checkbox"/> 5-10	<input type="checkbox"/> >10	<input type="checkbox"/> N/A
Do you feel the day care is good?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> N/A		
Who provides food for the child at day care? Select one					
<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	
Is feeding supervised / assisted at day care?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A	





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CHAIN Number [5][0][0][0][1][][][]

Feeding practices	
How is food USUALLY given to the child? Select one	
<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 Food Security	
If the child is in a care home, this should be asked regarding the other children in the care home, not members of staff	
During the past 7 DAYS 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
During the past 4 WEEKS	
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

Child Dietary Diversity
What does the child eat on a typical day?
<ul style="list-style-type: none"> Ask this as an open question and select all that the caregiver mentions. Do not present the caregiver with this list. You may prompt the caregiver with open questions, e.g. What does your child usually eat for breakfast
<input type="checkbox"/> Milk and Milk Products: Fresh/fermented milk, cheese, yogurt, or other milk products
<input type="checkbox"/> Breast milk
<input type="checkbox"/> Cereals and Cereal Products: Maize, rice, pasta, porridge, bread, biscuits, millet, sorghum, wheat, locally available grains
<input type="checkbox"/> Fish and Sea Foods: fresh or dried fish or shellfish
<input type="checkbox"/> Roots and Tubers: potatoes, sweet potatoes, yams, cassava, or foods made from roots or wild roots and tubers
<input type="checkbox"/> Vegetables: Cabbages, carrots, spinach, and any other locally available vegetables including wild vegetables
<input type="checkbox"/> Fruits: Oranges, bananas, mangoes, avocados, apples, grapes etc





Household Visit V1.63

CHAIN Number [5][0][0][0][1][][][]

<input type="checkbox"/> Meats and Poultry: 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"/> Eggs: Hen or other bird eggs
<input type="checkbox"/> Pulses / Legumes / Nuts and Seeds: Beans, peas, lentils, nuts, seeds or foods made from these
<input type="checkbox"/> Fats and Oils: Oil, fats, ghee, margarine or butter added to food or used for cooking
<input type="checkbox"/> Sugars / Honey and Commercial Juices: Sugar in tea, honey, sweetened soda, juices, chocolates, sweets or candies
<input type="checkbox"/> Miscellaneous: Spices, unsweetened beverages

Assessment of household wealth (DHS 7 questionnaire. Please answer all questions) This should be completed for all children, including those in care homes			
What is the main source of drinking water for members of your household? Choose one			
<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 _____		
What is the MAIN source of water used by your household for other purposes such as cooking and handwashing? SELECT ONE ONLY			
<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 _____		
How long does it take to get water and come back? (State 0 if water supplied within home or compound)	__ __ __ minutes	<input type="checkbox"/> Don't know	
In the past 2 weeks was the water from this source not available for at least one full day?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Unknown	
Do you usually do anything to the water to make it safer to drink? Select all that apply			
<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
What kind of toilet facility do members of your household usually use? Select one			





Household Visit V1.63

CHAIN Number [5][0][0][0][1][][][]

<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		
Do you share this toilet facility with other households?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
If Yes, including your own household, how many households use this toilet facility?	Number if <10__	<input type="checkbox"/> >10 households <input type="checkbox"/> Unknown <input type="checkbox"/> N/A
Where is this toilet facility located?	<input type="checkbox"/> In own dwelling	<input type="checkbox"/> In own yard / plot <input type="checkbox"/> Elsewhere
How many rooms are there in the household for SLEEPING?	<input type="checkbox"/> 1	<input type="checkbox"/> 2 <input type="checkbox"/> >2
What is the MAIN FLOOR material of the rooms in this household? <i>Select one only</i>		
<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
What is the MAIN WALL material of the rooms in this household? <i>Select one only</i>		
<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) _____
What is the MAIN ROOF material of the house in this household? <i>Select one only</i>		
<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
What is the MAIN cooking fuel used in this household? <i>Select one only</i>		
<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
Do you have a separate room which is used as a kitchen?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Unknown
Where is this household's cooking area located?		
<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





Household Visit V1.63

CHAIN Number [5][0][0][0][1][][][]

Does this household own any livestock, herds, other farm animals or poultry		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
If yes, how many of the following animals does this household own?				
Cows/bulls__ __	Sheep__ __			
Horses/Donkeys/Mules__ __	Goats__ __			
Chickens or Ducks__ __	Other _____	number __ __	<input type="checkbox"/> N/A	
Does any member of this this household own land?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
If "Yes" How many acres of land does this household own?		__ __ Acres	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
Does this household have a bank account?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household have electricity		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household own a radio?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household own a television?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household own a computer?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does this household own a refrigerator?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
Does any member of this household own:				
A watch		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A mobile phone?	<input type="checkbox"/> Y Standard phone	<input type="checkbox"/> Y smartphone	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
An animal-drawn cart?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A bicycle?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A motorcycle / scooter?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A car or truck?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown
A boat with a motor?		<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Unknown

CRF Completed by (Initials) – to be signed when complete. <i>Do not sign if any fields are empty</i>	_____	Date	Time
	_____	__ __ / __ __ / __ __ __ __ <i>D D / M M / Y Y Y Y</i>	__ __ : __ __

