State Name: _____

District Name: _____

Block Name: _____

Village Name: _____

HHID of Main Qre:

GP Code: ⬜⬜⬜⬜⬜⬜⬜

W S P   I M P A C T   E V A L U A T I O N – **ANTHROP QRE**

Baseline 2009

Name of Head of the HH and Detailed Address

HH Name:

⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜

Address:

⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜

⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜

Land Mark:

⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜⬜

Please gove a brief introduction to study and remind the primary care giver/mother of the main survey the team had done. Explain to her that Anthropometric is a part of that survey. Take consent for this section. Answer any questions.

*** Address is required to facilitate Anthro Team to visit a household multiple times in case respondent/child not available

This Page is Intentionally Left Blank

HOUSE HOLD IDENTIFICATION NUMBER

WSP IMPACT EVALUATION – BASE LINE 2009

HOUSEHOLD QUESTIONNAIRE

IDENTIFICATION

A. STATE _____

   DISTRICT _____

   TEHSIL/TALUK/COMMUNITY DEVELOPMENT BLOCK/MANDAL_____

   PSU (GP) _____

   PSU POPULATION AS PER 2001 CENSUS _____

   NO. OF SEGMENT CREATED IN GP _____

   NO OF SEGMENT SELECTED_____

   NAME OF VILLAGE IN THE GP_____

   NAME OF HEAD OF THE HOUSEHOLD_____

     ADDRESS _____

    _____

(TO BE ENTERED AT OFFICE)

IDENTIFICATION NUMBER OF THE COMMUNITY

QUESTIONNAIRE……………………………………………………

SERIAL NUMBER OF THE HOUSEHOLD QUESTIONNAIRE.………..………….…….…………..

B. RESULT STATUS OF THE HOUSEHOLD QUESTIONNAIRE

COMPLETED………………………………….. 1
PARTLY COMPLETED………………………... 2
   HOUSE HOLD PRESENT BUT NO
COMPETENT RESP. AT HOME……………….3
HOUSEHOLD ABSENT……………………….. 4
REFUSED…………………………………..….. 5

DWELLING VACANT/ADDRESS
NOT A DWELLING………………..… 6
DWELLING DESTROYED……………7
DWELLING NOT FOUND………….… 8
OTHER_____ 9
    (SPECIFY)

INTERVIEW DATE

DATE	MONTH	YEAR

Total <5 Yrs child in the HH

C. LINE NUMBER OF RESPONDENT IN HOUSEHOLD SCHEDULE

NUMBER OF VISITS MADE

	First Visit	Second Visit	Third Visit
Date			
Time Begun			
Time Ended			
Duration			
Result	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

NTOTALPERSONSIN HOUSEHOLD

F2. TOTAL MALE

F3. TOTAL FEMALE

G1. SPOT CHECKED BY	**G2.** FIELD EDITED BY	**G3.** OFF. EDITED BY	KEYED BY
NAME& DATE _____	CODE	CODE	CODE
NAME OF THE INVESTIGATOR	CODE	SIGNATURE OF THE INVESTIGATOR	

This Page is Intentionally Left Blank

14. Observations of Children (JC, LF/TK)

Direct observation. ONLY FOR CHILDREN **UNDER FIVE YEARS** (up to, but not after, the child's fifth birthday)

G.14.1. COPY THE ID CODE AND NAME OF EACH CHILD **LESS THAN FIVE YEARS OLD** IN THE HOUSEHOLD. (USE THE ID CODES FROM THE ROSTER ON PAGE 1.)		G.14.2. 👁 IS [NAME] RELATIVELY CLEAN, WITH NO OFFENSIVE ODOR? YES ....1 NO.................2 COULD NOT OBSERVE....-99	G.14.3. 👁 DOES [NAME] HAVE DIRTY HANDS? YES............... 1 NO .... 2 COULD NOT OBSERVE....-99	G.14.4. 👁 DOES [NAME] HAVE SOIL OR MUD IN FINGER NAILS? YES ....1 NO.................2 COULD NOT OBSERVE....-99	G.14.5. 👁 IS [NAME]'S FACE DIRTY? YES...............1 NO ....2 COULD NOT OBSERVE....-99	G.14.6. 👁 IS [NAME] WEARING CLOTHES? NO .... 2 YES, TOP ONLY 3 YES, BOTTOMS ONLY 4 YES, TOP AND BOTTOM 5 COULD NOT OBSERVE....-99	G.14.7. 👁 ARE [NAME]'S CLOTHES DIRTY? YES ....1 NO.................2 COULD NOT OBSERVE....-99	G.14.8. 👁 DOES [NAME] HAVE A POT-BELLY? YES............... 1 NO .... 2 COULD NOT OBSERVE....-99	G.14.9. 👁 IS [NAME] WEARING FOOTWARE (CHAPPALS /SANDLES / SHOES)? YES...............1 NO.................2 COULD NOT OBSERVE....-99
ID CODE	NAME								
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99
		1 2 -99	1 2 -99	1 2 -99	1 2 -99	2 3 4 5 -99	1 2 -99	1 2 -99	1 2 -99

19.   Child Health Calendar (4 copies – fill one for each child under 5)
EACH primary caregiver of children under 5

N.19.0 PCG ID CODE: [_____]   G.19.0 CHILD ID CODE: [_____]   Child NAME _____ Now I would like to ask about the health of [NAME] in the last 14 days.

In the last 14 days, did he/she have: _ _ _ _	G.19.1 Fever?	G.19.2 Constant Cough?	G.19.3 Congestion?	G.19.4 Panting/ wheezing/ difficulty breathing?	G.19.5 Stomach pain or cramps?	G.19.6 Nausea?	G.19.7 Vomit?	G.19.8 3 or more bowel movements in one day and one night?	G.19.9 Watery or soft stool?	G.19.10 Mucus or Blood in the stool?	G.19.11 Refuse to feed / eat?	G.19.12 Abrasion, scrapes or bruising?	G.19.13 Skin itching on the body or scalp?	G.19.14 Do you think that these Symptoms are / were serious?
DK : -99 / YES : 1 / NO : 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	
When did (_____) begin? **Days ago 1** OR **weeks ago 2**	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	-99 / Y N / 1 2
How many days did (SYMPTOM) last?	First put X on No of days when symptom started. Then count downwards the number of days the symptom lasted. Count the day with X mark as first day and then go down. Put Second X where you end with the counting. Join these two X with a line. If symptom lasts only 2 days then you will get X on two adjacent rows; in this case, join X even if they are close to each other. In some cases, the symptom will last only for 1 day; in this case, put only one X on the day started which is same as day ended but circle this X so we know it was only 1-day symptom. Each child can have multiple episodes in past 14 days and you need to record X for all of them. If symptom started before 14 days then put first X in 14 row and follow your training.													
days ago 14														14
13														13
12														12
11														11
10														10
9														9
8														8
7														7
6														6
5														5
4														4
3														3
2														2
Yester. 1														1
Today 0														0
Total No of Episodes	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]

Copy 2 for second U5 child

N.19.0 PCG ID CODE: [_____]   G.19.0 CHILD ID CODE: [_____]   Child NAME _____ Now I would like to ask about the health of [NAME] in the last 14 days.

In the last 14 days, did he/she have: _ _ _ _	G.19.1 Fever?	G.19.2 Constant Cough?	G.19.3 Congestion?	G.19.4 Panting/ wheezing/ difficulty breathing?	G.19.5 Stomach pain or cramps?	G.19.6 Nausea?	G.19.7 Vomit?	G.19.8 3 or more bowel movements in one day and one night?	G.19.9 Watery or soft stool?	G.19.10 Mucus or Blood in the stool?	G.19.11 Refuse to feed / eat?	G.19.12 Abrasion, scrapes or bruising?	G.19.13 Skin itching on the body or scalp?	G.19.14 Do you think that these Symptoms are / were serious?
DK : -99 YES : 1 NO : 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2
When did (____) begin? **Days ago 1** OR **weeks ago 2**	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	1 [_][_] 2 [_][_]	
How many days did (SYMPTOM) last?	First put X on No of days when symptom started. Then count downwards the number of days the symptom lasted. Count the day with X mark as first day and then go down. Put Second X where you end with the counting. Join these two X with a line. If symptom lasts only 2 days then you will get X on two adjacent rows; in this case, join X even if they are close to each other. In some cases, the symptom will last only for 1 day; in this case, put only one X on the day started which is same as day ended but circle this X so we know it was only 1-day symptom. Each child can have multiple episodes in past 14 days and you need to record X for all of them. If symptom started before 14 days then put first X in 14 row and follow your training.													
days ago 14														14
13														13
12														12
11														11
10														10
9														9
8														8
7														7
6														6
5														5
4														4
3														3
2														2
Yester. 1														1
Today 0														0
Total No of Episodes	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	

Copy 3 for third U5 child

N.19.0 PCG ID CODE: [_____] G.19.0 CHILD ID CODE: [_____] Child NAME _____ Now I would like to ask about the health of [NAME] in the last 14 days.

In the last 14 days, did he/she have: _ _ _ _	G.19.1 Fever?	G.19.2 Constant Cough?	G.19.3 Congestion?	G.19.4 Panting/ wheezing/ difficulty breathing?	G.19.5 Stomach pain or cramps?	G.19.6 Nausea?	G.19.7 Vomit?	G.19.8 3 or more bowel movements in one day and one night?	G.19.9 Watery or soft stool?	G.19.10 Mucus or Blood in the stool?	G.19.11 Refuse to feed / eat?	G.19.12 Abrasion, scrapes or bruising?	G.19.13 Skin itching on the body or scalp?	G.19.14 Do you think that these Symptoms are / were serious?
DK : -99 / YES : 1 / NO : 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2	-99 / Y N / 1 2
When did (_____) begin? **Days ago 1** OR **weeks ago 2**	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	
How many days did (SYMPTOM) last?	First put X on No of days when symptom started. Then count downwards the number of days the symptom lasted. Count the day with X mark as first day and then go down. Put Second X where you end with the counting. Join these two X with a line. If symptom lasts only 2 days then you will get X on two adjacent rows; in this case, join X even if they are close to each other. In some cases, the symptom will last only for 1 day; in this case, put only one X on the day started which is same as day ended but circle this X so we know it was only 1-day symptom. Each child can have multiple episodes in past 14 days and you need to record X for all of them. If symptom started before 14 days then put first X in 14 row and follow your training.													
days ago 14														14
13														13
12														12
11														11
10														10
9														9
8														8
7														7
6														6
5														5
4														4
3														3
2														2
Yester. 1														1
Today 0														0
Total No of Episodes	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	

Copy 4 for fourth U5 child

N.19.0 PCG ID CODE: [_____]   G.19.0 CHILD ID CODE: [_____]   Child NAME _____ Now I would like to ask about the health of [NAME] in the last 14 days.

In the last 14 days, did he/she have: _ _ _ _	G.19.1 Fever?	G.19.2 Constant Cough?	G.19.3 Congestion?	G.19.4 Panting/ wheezing/ difficulty breathing?	G.19.5 Stomach pain or cramps?	G.19.6 Nausea?	G.19.7 Vomit?	G.19.8 3 or more bowel movements in one day and one night?	G.19.9 Watery or soft stool?	G.19.10 Mucus or Blood in the stool?	G.19.11 Refuse to feed / eat?	G.19.12 Abrasion, scrapes or bruising?	G.19.13 Skin itching on the body or scalp?	G.19.14 Do you think that these Symptoms are / were serious?
DK : -99 YES : 1 NO : 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2	-99 Y N 1 2
When did (_____) begin? **Days ago 1** OR **weeks ago 2**	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	1 [__][__] 2 [__][__]	
How many days did (SYMPTOM) last?	First put X on No of days when symptom started. Then count downwards the number of days the symptom lasted. Count the day with X mark as first day and then go down. Put Second X where you end with the counting. Join these two X with a line. If symptom lasts only 2 days then you will get X on two adjacent rows; in this case, join X even if they are close to each other. In some cases, the symptom will last only for 1 day; in this case, put only one X on the day started which is same as day ended but circle this X so we know it was only 1-day symptom. Each child can have multiple episodes in past 14 days and you need to record X for all of them. If symptom started before 14 days then put first X in 14 row and follow your training.													
days ago 14														14
13														13
12														12
11														11
10														10
9														9
8														8
7														7
6														6
5														5
4														4
3														3
2														2
Yester. 1														1
Today 0														0
Total No of Episodes	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	[___]	

20. Child Health Calendar Summary (1 of 2)

Direct observation. ONLY FOR CHILDREN **UNDER FIVE YEARS**

CAREGIVER CODE	G.20.1. LIST THE ID CODES AND NAMES FOR EVERY CHILD **LESS THAN 5 YEARS OLD**.		G.20.2. (PLEASE CHECK: G.19.2. – G.19.4) ANY "YES" TO COUGH, CONGESTION, WHEEZING, OR DIFFICULTY BREATHING FOR THIS CHILD? YES...1 NO.....2 **[>>G.20.6.]**	G.20.3. 👁 MEASURE THE NUMBER OF CHEST RISES FOR CHILD OVER 30 SECONDS. COULD NOT OBSERVE.......-99 REFUSED.......-98 CHILD NOT PRESENT.......-95 **[>>G.20.6]** **BREATHS / 30 SECONDS**	G.20.4. 👁 DO YOU OBSERVE LOWER CHEST WALL INDRAWING? YES...................1 NO.....................2 REFUSED TO BE OBSERVED....-98 COULD NOT OBSERVE.......-99	G.20.5. 👁 DO YOU HEAR THE CHILD WHEEZING OR WHISTLING UPON **INHALATION**? YES...................1 NO.....................2 REFUSED TO BE OBSERVED....-98 COULD NOT OBSERVE......-99	G.20.6. (PLEASE CHECK: G.19.1.– G.19.11) ANY "YES" TO DIARRHEA OR RESPIRATORY SYMPTOMS FOR THIS CHILD? YES....1 NO......2 **[>> G.20.9.]**	G.20.7. In the past 14 days did you show [NAME] to anyone for diagnosis / advise? If so, what type? No.................1 **[>>G.20.9.]** Day visit to doctor........... 2 Overnight stay at hospital or clinic......... 3 Pharmacist...................... 4 Traditional Healer............ 5 Herbalist.......................... 6 Other (specify) _____ -96 DON'T KNOW...............-99	G.20.8. Was this person(s) government or private? Public.............. 1 Private............ 2 Both................. 3 DON'T KNOW...-99
	ID CODE	NAME							
			1 2		1 2 -98 -99	1 2 -98 -99	1 2	1 2 3 4 5 6 -96 -99	1 2 3 -99
			1 2		1 2 -98 -99	1 2 -98 -99	1 2	1 2 3 4 5 6 -96 -99	1 2 3 -99
			1 2		1 2 -98 -99	1 2 -98 -99	1 2	1 2 3 4 5 6 -96 -99	1 2 3 -99
			1 2		1 2 -98 -99	1 2 -98 -99	1 2	1 2 3 4 5 6 -96 -99	1 2 3 -99
			1 2		1 2 -98 -99	1 2 -98 -99	1 2	1 2 3 4 5 6 -96 -99	1 2 3 -99
			1 2		1 2 -98 -99	1 2 -98 -99	1 2	1 2 3 4 5 6 -96 -99	1 2 3 -99

20. Child Health Calendar Summary (2 of 2)

Direct observation. ONLY FOR CHILDREN **UNDER FIVE YEARS**

G.20.9. LIST THE ID CODES AND NAMES FOR EVERY CHILD **LESS THAN 5 YEARS OLD**.		G.20.10. (PLEASE CHECK: G.19.2. – G.19.4) ANY "YES" TO COUGH, CONGESTION, ETC. FOR THIS CHILD? YES.....1 NO.......2 **>> G.20.13.]**	G.20.11. Did you do anything to treat [NAME]'s respiratory problems? No treatment..1 **[>>G.20.13.]** Pill or syrup........................2 Injection.............................3 Intravenous fluid (IV)........4 Traditional remedies..........5 Other (Specify) _____-96 DON'T KNOW.................-99 CIRCLE ALL THAT APPLY	G.20.12. How much did you spend on treatments and advice for [NAME]? (Please include transport, food, doctor fees, medicine, etc) Did not pay......... 0 DON'T KNOW….....-99 CURRENCY	G.20.13. (PLEASE CHECK: G.19.5. – G.19.11.) ANY "YES" TO STOMACH PROBLEMS OR DIARRHEA IN FOR THIS CHILD? YES.....1 NO.......2 **[>> G.20.16.]**	G.20.14. Did you do anything to treat [NAME]'s stomach or diarrhea symptoms? No treatment...........1 **[>> G.20.16.]** Pill or syrup............................2 Injection..................................3 Intravenous fluid (IV)...............4 Traditional remedies................5 Oral Rehydration Solution.......6 Homemade sugar/salt water...7 Other (Specify) _____ -96 DON'T KNOW........................-99	G.20.15. How much did you spend on treatments and advice for (NAME)? (Please include transport, food, doctor fees, medicine, etc) Did not pay.......... 0 DON'T KNOW ....-99 CURRENCY	G.20.16. In the **past 14 days**, how much time were household members unable to work or go to school because they were caring for [NAME]? ENTER INFORMATION FOR THE TWO HOUSEHOLD MEMBERS WHO SPENT THE MOST TIME CARING FOR THIS CHILD. PUT ZERO HOURS IF THEY SPENT TIME CARING FOR THE CHILD WITHOUT MISSING ANY WORK OR SCHOOL.					
ID CODE	NAME							ID CODE	Hours	Days	ID CODE	Hours	Days
		1 2	1 2 3 4 5 -96 -99		1 2	1 2 3 4 5 6 7 -96 -99							
		1 2	1 2 3 4 5 -96 -99		1 2	1 2 3 4 5 6 7 -96 -99							
		1 2	1 2 3 4 5 -96 -99		1 2	1 2 3 4 5 6 7 -96 -99							
		1 2	1 2 3 4 5 -96 -99		1 2	1 2 3 4 5 6 7 -96 -99							
		1 2	1 2 3 4 5 -96 -99		1 2	1 2 3 4 5 6 7 -96 -99							
		1 2	1 2 3 4 5 -96 -99		1 2	1 2 3 4 5 6 7 -96 -99							
00	Totals												

33. Anothropometry and Anemia (1 of 2)

Direct observation. ONLY FOR CHILDREN **UNDER 2 YEARS**

G.33.1. PLEASE LIST ALL THE CHILDREN **UNDER 2 YEARS OF AGE**. (USE THE ID CODE FROM THE ROSTER ON PAGE 1.)		G.33.2. What was [NAME]'s weight at birth? IF KNOWN, RECORD WEIGHT, AND SKIP TO [>>G.33.4] DON'T KNOW ....-99	G.33.3. Was [NAME] unusually small at birth? Yes, quite small ....1 No, close to normal size.......2	G.33.4. In last 1 year, at least 6 times, is your child measured for weight and/or height at a clinic, at home, or somewhere else? Yes,.......1 No..........4 **[>>G.33.5]**	N.33.20 Where did you measure the weight and / or height? (Multiple Code) At a clinic ....1 At home ....2 Some other place................3 At Anganwadi.....................4	N.33.21 How many times did you in total weight or measure the child in past 1 year?	G.33.5. WEIGH EACH CHILD. (TO NEAREST 0.1 KG)	
ID CODE	NAME	Kilogram				No of times	Measure 1: In Kg	Measure 2: In Kg
			1 2	1 4	1 2 3 4		__ __ . __	__ __ . __
			1 2	1 4	1 2 3 4		__ __ . __	__ __ . __
			1 2	1 4	1 2 3 4		__ __ . __	__ __ . __
			1 2	1 4	1 2 3 4		__ __ . __	__ __ . __
			1 2	1 4	1 2 3 4		__ __ . __	__ __ . __
			1 2	1 4	1 2 3 4		__ __ . __	__ __ . __
00	Totals						__ __ . __	__ __ . __

33.   Anothropometry and Anemia (2 of 2)

Direct observation. ONLY FOR CHILDREN **UNDER 2 YEARS**

ID CODE	NAME	G.33.9. MEASURE THE **HEIGHT OR LENGTH** OF EACH CHILD. (TO NEAREST 0.1 CM) — cm	G.33.10. MEASURE THE **ARM** CIRCUMFERENCE OF EACH CHILD. (TO NEAREST 0.1 CM) — cm	G.33.11. MEASURE THE **HEAD** CIRCUMFERENCE OF EACH CHILD. (TO NEAREST 0.1 CM) — cm	G.33.13. FOR CHILDREN From 6 MONTHS 0 DAYS to 23 MONTHS 29 DAYS OF AGE: READ CONSENT STATEMENT BELOW FOR THE CHILD. CIRCLE CODE AND **SIGN** YOUR NAME. GRANTED.....1 REFUSED.....2	G.33.14. RECORD HEMOGLOBIN LEVEL HERE. (TO NEAREST 0.1) g / dl	G33.15 RESULT OF HEMOGLOBIN MEASUREMENT MEASURED.....1 REFUSED.....-98 NOT PRESENT.....-95
		__ __.__	__ __.__	__ __.__	1 2 _____	__ __.__	1 -98 -95
		__ __.__	__ __.__	__ __.__	1 2 _____	__ __.__	1 -98 -95
		__ __.__	__ __.__	__ __.__	1 2 _____	__ __.__	1 -98 -95
		__ __.__	__ __.__	__ __.__	1 2 _____	__ __.__	1 -98 -95
		__ __.__	__ __.__	__ __.__	1 2 _____	__ __.__	1 -98 -95
		__ __.__	__ __.__	__ __.__	1 2 _____	__ __.__	1 -98 -95
00	Totals						

G.33.8

PLEASE LIST ALL THE CHILDREN **UNDER 2 YEARS OF AGE**.

(USE THE ID CODE FROM THE ROSTER ON PAGE 1.)

CONSENT STATEMENT FOR ANEMIA TEST FOR CHILDREN
As part of this survey, we are asking people all over the country to take an anemia test. Anemia is a serious health problem that usually results from poor nutrition, infection, or chronic disease. This survey will assist the government to develop programs to prevent and treat anemia. You can agree to let us test blod by a minor finger prick which is most lilely not painful or very mildly painful or you can refuse this test. Will you allow [NAME(S) OF CHILD(REN)] to participate in the anemia test?

NOTE: YOU MUST OBTAIN CONSENT FOR ANY CHILD RECEIVING AN ANEMIA TEST.