

<input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
Site	Center	Child ID	Day	Month	Year

DATE

Section 1: Demographic and Epidemiological Information1. What is your relationship to [Child's Name]? **RELATIONSHIP**

- | | | | |
|----------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> 1 Mother | <input type="checkbox"/> 2 Father | <input type="checkbox"/> 3 Sister | <input type="checkbox"/> 4 Brother |
| <input type="checkbox"/> 5 Grandmother | <input type="checkbox"/> 6 Grandfather | <input type="checkbox"/> 7 Aunt | <input type="checkbox"/> 8 Uncle |
| <input type="checkbox"/> 9 No relation | <input type="checkbox"/> 10 Other relation by blood or marriage, specify RELATION_SEPC _____ | | |

2. Where does [Child's Name]'s mother live? **MOM_LIVE**

- | | | |
|-------------------------------------------------------|------------------------------------------------|---------------------------------|
| <input type="checkbox"/> 1 Living in household | <input type="checkbox"/> 3 Abroad | <input type="checkbox"/> 5 Died |
| <input type="checkbox"/> 2 Lives outside of household | <input type="checkbox"/> 4 Whereabouts unknown | |

3. Where does [Child's Name]'s father live? **DAD_LIVE**

- | | | |
|------------------------------------------------------------------|------------------------------------------------|---------------------------------|
| <input type="checkbox"/> 1 Living in household | <input type="checkbox"/> 3 Abroad or far away | <input type="checkbox"/> 5 Died |
| <input type="checkbox"/> 2 Lives outside of household but nearby | <input type="checkbox"/> 4 Whereabouts unknown | |

4. How far did the child's primary caretaker go in school? **PRIM_SCHL**

- | | |
|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> 1 No formal schooling | <input type="checkbox"/> 4 Completed secondary |
| <input type="checkbox"/> 2 Less than primary | <input type="checkbox"/> 5 Post-secondary |
| <input type="checkbox"/> 3 Completed primary | <input type="checkbox"/> 6 Religious education only |
| <input type="checkbox"/> 7 Don't know | |

5. How many people have been living regularly in your household for the past 6 months?

PPL_HOUSE

6. How many people have been sleeping regularly in your household for the past 6 months?

PPL_SLEEP7. How many children younger than 60 months live in the household? **YNG_CHILDREN**8. How many rooms in your household are used for sleeping? **SLP_ROOMS**

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9. What is the predominant floor in the house of [Child's Name]?

Natural Floor**NATFL**☐ 1 Earth/Sand☐ 2 DungRudimentary Floor**RUDFL**☐ 1 Wood planks☐ 2 Palm/bambooFinished Floor**FINFL**☐ 1 Parquet or polished wood☐ 2 Vinyl or asphalt strips☐ 3 Ceramic tile☐ 4 Cement☐ 5 Carpet☐ Other, specify **OTHFL** _____

10. Does your household have the following? [Must be functioning; "X" all that apply.]

☐ **HOUSE_ELEC**☐ Electricity☐ **HOUSE_TELE**☐ Television☐ **HOUSE_SCOOT**☐ Motorcycle/scooter☐ **HOUSE_RADIO**☐ Radio☐ **HOUSE_BIKE**☐ Bicycle/rickshaw☐ **HOUSE_CAR**☐ Car/truck☐ **HOUSE_FRIDGE**☐ Refrigerator☐ **HOUSE_BOAT**☐ Boat with a motor☐ **HOUSE_PHONE**☐ Telephone (mobile or non-mobile)☐ **HOUSE_CART**☐ Animal-drawn cart☐ **HOUSE_AGLAND**☐ Agricultural land☐ **HOUSE_NONE**☐ None of the above

11. What type of cooking fuel does your household use? ["X" all that apply.]

☐ **FUEL_ELEC**☐ Electricity☐ **FUEL_PROpane**☐ Liquid Propane Gas☐ **FUEL_NATGAS**☐ Natural Gas☐ **FUEL_KERO**☐ Kerosene☐ **FUEL_OTHER**☐ Other, specify **FUEL_OTHER_SPEC** _____☐ **FUEL_BIOGAS**☐ Biogas☐ **FUEL_COAL**☐ Coal/lignite☐ **FUEL_CHARCOAL**☐ Charcoal☐ **FUEL_WOOD**☐ Wood☐ **FUEL_GRASS**☐ Straw/shrubs/grass☐ **FUEL_DUNG**☐ Animal dung☐ **FUEL_CROP**☐ Agricultural crop residue☐ **FUEL_BUT**☐ Butane gas

12. Do the following animals live in the compound where [Child's Name] lives? ["X" all that apply.]

☐ Goat **ANI_GOAT**☐ Cow **ANI_COW**☐ Donkey **ANI_DONK**☐ Sheep **ANI_SHEEP**☐ Rodents **ANI_RODENTS**☐ Horses **ANI_HORS**☐ Dog **ANI_DOG**☐ Fowl (chicken, duck or other birds)**ANI_FOWL**☐ No Animals **ANI_NO**☐ Cat **ANI_CAT**☐ Pig **ANI_PIG**☐ Other, specify **ANI_SPEC** _____
ANI_OTHER

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13. During the last two weeks, has your household ever obtained drinking water from any of the following sources? [*“X” all that apply.*]

☐ Piped into house **WATER_HOUSE**☐ Piped into yard **WATER_YARD**☐ Public tap **WATER_PUBTAP**☐ Open well in house or yard **WATER_WELL**☐ Open public well **WATER_PUBWELL**☐ Stream **WATER_STR**☐ Dam or earth **WATER_DAM**☐ Deep tube well **WATER_DEEPWELL**☐ Bought (tank, bottles, etc) **WATER_BOUGHT**☐ Other, specify **WATER_OTHER WATER_SPEC**☐ Covered well in house or yard **WATER_COVWELL**☐ Covered public well **WATER_COVPWELL**☐ Protected spring **WATER_PROSPRING**☐ Unprotected spring **WATER_UNSPRING**☐ River **WATER_RIV**☐ Pond or lake **WATER_POND**☐ Rainwater **WATER_RAIN**☐ Shallow tube well **WATER_SHALLWELL**☐ Bore hole **WATER_BORE**

14. During the last two weeks, what was the **main source** of drinking water for the members of your household? [*“X” only one response that relates to the main source of drinking water.*] **MS_WATER**

☐ **1** Piped into house [*Go to Q17*]☐ **2** Piped into yard [*Go to Q17*]☐ **3** Public tap☐ **4** Open well in house or yard [*Go to Q17*]☐ **5** Open public well☐ **19** Stream☐ **14** Dam or earth☐ **7** Deep tube well☐ **16** Bought (tank, bottles, etc)☐ **18** Other, specify **MS_SPEC**☐ **9** Covered well in house or yard [*Go to Q17*]☐ **10** Covered public well☐ **11** Protected spring☐ **12** Unprotected spring☐ **13** River☐ **6** Pond or lake☐ **15** Rainwater [*Go to Q17*]☐ **8** Shallow tube well☐ **17** Bore hole

[Use your response from Question 14 to answer Questions 15 and 16. If the response to Question 14 is “piped into house/yard”, “open or covered well in house/yard” or “rainwater”, then go to Question 17. Otherwise continue.]

15. How long does it take to go there, get water, and come back? **TIME_WATER**

☐ **1** Less than 15 minutes☐ **2** 15 to 29 minutes☐ **3** 30 to 59 minutes☐ **4** 1 to 3 hours☐ **5** More than 3 hours

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16. Do you or other members from your household go and fetch drinking water for the household every day? **FETCH_WATER**

No Yes

☐0 ☐1

[If “Yes”, go to Question 16a, if “No” go to Question 16b.]

16a. On average, how many trips do you and members from your household make to fetch water each day?

Number of trips/day

TRIP_DAY

16b. On average, how many trips do you and members from your household make to fetch water each week?

Number of trips/week

TRIP_WEEK

[If no trips are made, complete as “00”.]

17. In the last two weeks, how often has water been available from this main source? **WATER_AVAIL**

☐1 All the time

☐3 A few times per week

☐2 Several hours every day

☐4 Less frequent than a few times per week

18. In the last two weeks, did you give *[Child’s Name]* stored water for drinking?

No Yes

☐0 ☐1 **STORE_WATER**

19. What kind of facility does your household most commonly use to dispose of human fecal waste?

[Show pictures to confirm the identity of the facility used. “X” only one response.] **MAIN_WASTE**

☐1 Flush or pour-flush toilet to:

- piped sewer system
- septic tank
- pit latrine

☐4 Ventilated improved pit (VIP) latrine

☐5 Pit latrine with slab

☐6 Pit latrine without slab or open pit

☐7 Composting toilet

☐2 Flush or pour-flush toilet to elsewhere

☐8 Hanging toilet or hanging latrine

☐3 Bucket

☐9 No facility: Bush/Field/Ground/Stream/Open sewer

☐10 Other, specify **WASTE_SPEC** _____

[If “No facility” selected, go to Question 21]

20. How many households (other than your own) share this facility?

 SHARE_FAC

[Respond with a number; code “00” for none.]

Section 2: Clinical Information

21. Breast Feeding

a. Since becoming ill with diarrhea, what has your child been eating and drinking?

	No	Yes	DK	
Breast milk	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9	CUR_BMILK
Drinking water	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9	CUR_H2O
Other foods or drinks	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 9	CUR_FDRK

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b. During the week **before** becoming ill with diarrhea, what was your child eating and drinking

	No	Yes	DK	
Breast milk	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>	PRI_BMILK
Drinking water	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>	PRI_H2O
Other foods or drinks	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>	PRI_FDRK

22. How many days including today has this episode of diarrhea lasted?

--	--

days DRH_DAYS

a. Date of onset of diarrhea:

--	--

--	--

2	0		
---	---	--	--

DRH_DATE

Day

Month

Year

23. Since [Child's Name] became ill with diarrhea, how would you best describe the stool? DRH_STOOLS
[“X” the most common.]
 Simple watery
 Rice watery stool
 Sticky/mucoid
 Bloody
[If the response is “Bloody,” go back to CRF 03 and ensure child was properly enrolled.]

24. During the illness, what was the maximum number of loose stools that [Child's Name] passed in a day (24-hour period)? [“X” only one response.] DAILY_MAX

 3
 4-5
 6 to 10 times per day
 More than 10 times per day

25. Has [Child's Name] experienced any of the following since this illness began?

	No	Yes	DK
a. Blood in stools DRH_BLOOD	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
b. Very thirsty DRH_THIRST	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
c. Drank much less than usual DRH_LESSDRINK	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
d. Not able to drink DRH_UNDRINK	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
e. Belly pain DRH_BELLYPAIN	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
f. Fever measured <u>at least</u> 38°C or parental perception DRH_FEVER	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
g. Irritable or restless DRH_RESTLESS	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
h. Decreased activity or lethargy DRH_LETHRGY	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
i. Loss of consciousness DRH_CONSC	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
j. Rectal straining DRH_STRAIN	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
k. Rectal prolapse DRH_PROLAPSE	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
l. Cough DRH_COUGH	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
m. Difficulty breathing DRH_BREATH	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>
n. Convulsion DRH_CONV	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text" value="9"/>

[If response to question 25a is “Yes,” go back to CRF 03 and ensure child was properly enrolled.]

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26. Did [Child's Name] vomit? **ANY_VOMIT** ☐ No ☐ Yes
[If 'No', go to Question 27. If 'Yes', continue.]

a. On the worst day, how many times did s/he vomit? ☐ 1 ☐ 2-4 ☐ 5 or more **FREQ_VOMIT**

b. How many days did the child have vomiting including today .days **DAYS_VOMIT**

27. Right now, does your child have any of the following?

	No	Yes	DK
a. Very thirsty CUR_THIRSTY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Drinks poorly or not able to drink CUR_NODRINK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Sunken eyes CUR_SUNKEYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Wrinkled skin CUR_SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Irritable or restless CUR_RESTLESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Lethargy or loss of consciousness CUR_LETHRGY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Dry mouth CUR_DRYMOUTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Fast breathing CUR_FASTBREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

~~27x. Is the child a VIDA-Plus case? ☐ No ☐ Yes~~

IF THE CHILD IS A VIDA-PLUS CASE, GO TO SECTION 4

28. Before coming to this hospital/health center, was [Child's Name] given any of the following to treat his/her diarrhea? [*"X" all that apply. Start with open-ended question; then probe options if not mentioned by the caretaker.*]

☐ A fluid made from a special packet called ORALITE or ORS? **HOMETRT_ORS**

☐ Homemade fluid (e.g., Thin watery porridge made from maize, rice or wheat, soup, sugar salt water solution, Yogurt based drink) **HOMETRT_MAIZE**

HOMETRT_MILK

☐ Special milk or infant formula

☐ Any other liquids, specify **HOMETRT_OTHRLIQ**

HOMETRT_HERB

☐ Home remedy/Herbal medication

☐ Antibiotics, specify **HOMETRT_AB**

HOMETRT_ZINC

☐ Zinc (tablet/syrup)

☐ Other (1), specify **HOMETRT_OTHR1**

HOMETRT_NONE

☐ No special remedies given

☐ Other (2), specify **HOMETRT_OTHR2**

29. Since [Child's Name] developed diarrhea, how much have you been offering [Child's Name] to drink? **OFFR_DRINK**

☐ More than usual

☐ Much less than usual

☐ Usual

☐ Nothing to drink

☐ Somewhat less than usual

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30. Since *[Child's Name]* developed diarrhea, how much have you been offering *[Child's Name]* to eat?

OFFR_EAT☐ **1** More than usual☐ **4** Much less than usual☐ **2** Usual☐ **5** Nothing to eat☐ **3** Somewhat less than usual**Section 3: Health care utilization before this visit to this hospital/health center**

31. Before coming to this hospital/health center, did you seek care for *[Child's Name]* outside your household for this illness? **SEEK_OUTSIDE**

☐ **0** No *[Go to Question 33]*☐ **1** Yes

32. If you previously sought care for *[Child's Name]* for this illness, where did you go? *[Use the Health Facility Coding List to code the center(s) of choice. "X" all that apply.]*

☐ Pharmacy **SEEK_PHARM**☐ Friend/relative **SEEK_FRIEND**☐ Traditional healer **SEEK_HEALER**☐ Unlicensed practitioner/village doctor/bush doctor/village health worker **SEEK_DOC**☐ Licensed practitioner/private doctor (not at hospital) **SEEK_PRIVDOC**☐ Bought a remedy/medicine at the shop/market, specify remedy/drug **SEEK_REMDY_SPEC**☐ Hospital/Center of first choice **SEEK_CTR1** **SEEK_CTR1_CODE**☐ Hospital/Center of second choice **SEEK_CTR2** **SEEK_CTR2_CODE**☐ Hospital/Center of third choice **SEEK_CTR3** **SEEK_CTR3_CODE**☐ Other Hospital/Center, specify **SEEK_OTHER** **SEEK_OTHER_SPEC**

ALL VARIABLE NAMES PREFACED WITH F4A_
VIDA - CRF 04A - ENROLLMENT FOR CASES – CLINICAL/EPIDEMIOLOGICAL HISTORY

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Section 4: Immunizations

The following information must be transmitted from the DSS database or entered onto this CRF during the interview:

33. Has your child received any vaccinations? No ☐ Yes ☐ **REC_VAX**

34. Immunization card: No ☐ Yes ☐ **If yes, please attach photograph of immunization card. VAX_CARD**

35. If immunization card was not available, was vaccine data available from another source? **VAX_SOURCE**

☐ No

☐ Yes, DSS

☐ Yes, RVS

☐ Yes, Other, Specify: **VAX_SOTH**

36. Vaccine Given?	Date	Name of health center	Health center code
a. DPT/Pentavalent #1	DPT1_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> DPT1	<input type="text"/> dd/MMM/yyyy	DPT1_HC	<input type="text"/> DPT1_HCID DK <input type="checkbox"/> DPT1_DK
DPT/Pentavalent #2	DPT2_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> DPT2	<input type="text"/> dd/MMM/yyyy	DPT2_HC	<input type="text"/> DPT2_HCID DK <input type="checkbox"/> DPT2_DK
DPT/Pentavalent #3	DPT3_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> DPT3	<input type="text"/> dd/MMM/yyyy	DPT3_HC	<input type="text"/> DPT3_HCID DK <input type="checkbox"/> DPT3_DK
If yes, which vaccine was given: <input type="checkbox"/> DPT <input type="checkbox"/> Pentavalent <input type="checkbox"/> Don't know DPT_TYPE			
b. Rotavirus vaccine #1	ROT1_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> ROT1	<input type="text"/> dd/MMM/yyyy	ROT1_HC	<input type="text"/> ROT1_HCID DK <input type="checkbox"/> ROT1_DK
Rotavirus vaccine #2	ROT2_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> ROT2	<input type="text"/> dd/MMM/yyyy	ROT2_HC	<input type="text"/> ROT2_HCID DK <input type="checkbox"/> ROT2_DK
Rotavirus vaccine #3	ROT3_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> ROT3	<input type="text"/> dd/MMM/yyyy	ROT3_HC	<input type="text"/> ROT3_HCID DK <input type="checkbox"/> ROT3_DK
c. Oral polio vaccine #1	OPV1_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> OPV1	<input type="text"/> dd/MMM/yyyy	OPV1_HC	<input type="text"/> OPV1_HCID DK <input type="checkbox"/> OPV1_DK
Oral polio vaccine #2	OPV2_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> OPV2	<input type="text"/> dd/MMM/yyyy	OPV2_HC	<input type="text"/> OPV2_HCID DK <input type="checkbox"/> OPV2_DK
Oral polio vaccine #3	OPV3_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> OPV3	<input type="text"/> dd/MMM/yyyy	OPV3_HC	<input type="text"/> OPV3_HCID DK <input type="checkbox"/> OPV3_DK
d. Inactivated polio vaccine #1	IPV1_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> IPV1	<input type="text"/> dd/MMM/yyyy	IPV1_HC	<input type="text"/> IPV1_HCID DK <input type="checkbox"/> IPV1_DK
Inactivated polio vaccine #2	IPV2_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> IPV2	<input type="text"/> dd/MMM/yyyy	IPV2_HC	<input type="text"/> IPV2_HCID DK <input type="checkbox"/> IPV2_DK
Inactivated polio vaccine #3	IPV3_DATE		
No <input type="checkbox"/> Yes <input type="checkbox"/> DK <input type="checkbox"/> IPV3	<input type="text"/> dd/MMM/yyyy	IPV3_HC	<input type="text"/> IPV3_HCID DK <input type="checkbox"/> IPV3_DK

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END OF THE INTERVIEW.

THANK THE RESPONDENT(S) FOR THEIR COOPERATION.

37. Specimen ID:

SPEC_ID

Place sticker of Specimen ID here.

Notes or comments *[Initial and date notes]* **COMMENT**

Interviewer's Name **INTVWR**

INT_CODE

Staff code

Quality Control's Name **QC**

Staff code

QC_CODE

Day

QC_DATE

Month

Year