

Survey Team No. \_\_\_\_\_

School Information

Surveyer ID \_\_\_\_\_

A	School name, Union, Upazila ▶								
B	School code ▶	<input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>							
C	Date of visit DD-MM-YY ▶	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>							
D	Name & Position of Respondent ▶								
<b>REGISTER INFORMATION</b>		<b>Total</b>	<b>Boys</b>	<b>Girls</b>	<b>Section</b>	<b>Repetition Rate</b>		<b>drop out as of Jan 2011</b>	
E	Enrolled in Pre-School in 2011 ▶	<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"/> Boys	<input type="text"/> Girls	<input type="text"/> Boys	<input type="text"/> Girls
F	Enrolled in Class 1 in 2011 ▶	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>				
G	<b>Attendance Class1</b>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>				
H	Enrolled in Class 2 in 2011 ▶	<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"/>
I	<b>Attendance Class2</b>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>				
I	Enrolled in Class 3 in 2011 ▶	<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"/>
J	<b>Attendance Class3</b>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>				
K	Enrolled in Class 4 in 2011 ▶	<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"/>
L	<b>Attendance Class4</b>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>				
M	Enrolled in Class 5 in 2011 ▶	<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"/>
N	<b>Attendance Class5</b>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>				
<b>Question</b>		<b>Data</b>				<b>Coding</b>		<b>Verify</b>	
1	How many positions for teachers are there?	<input type="text"/> <input type="text"/>				Enter number or 00			
2	How many serving male and female teachers are here <b>excluding</b> those on long-term leave?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Enter number or 00			
3	How many vacant positions are there?	<input type="text"/> <input type="text"/>				Enter number or 00			
4	How many serving para teachers are there?	<input type="text"/> <input type="text"/> male <input type="text"/> <input type="text"/> Cls1&2 <input type="text"/> <input type="text"/> Cls3 <input type="text"/> <input type="text"/> Cls4 <input type="text"/> <input type="text"/> Cls5 <input type="text"/>				Enter number or 00			
5	When does the classes take place for each class?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				1=AM; 2=PM; 3=AM&PM			
6	Does the school have PTA?	<input type="text"/>				1=Yes; 2=No			
7	Has the school been a target of any NGO project?	<input type="text"/>				1=Yes; 2=No			
7.1	If "Yes", please specify:	<input type="text"/> [ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ]							
8	How many de-worming drug distributions have taken place this year at the school?	<input type="text"/>				Enter number or 0			
9	What is the official grade of the school?	<input type="text"/>				1=A; 2=B; 3=C			
10	How many SMC male and female members?	<input type="text"/> <input type="text"/> M <input type="text"/> <input type="text"/> Cls1&2 <input type="text"/> <input type="text"/> Cls3 <input type="text"/> <input type="text"/> Cls4 <input type="text"/> <input type="text"/> Cls5 <input type="text"/> F <input type="text"/> <input type="text"/>				Enter number or 0 for <b>no SMC</b>			
11	Is the SMC chairperson male or female?	<input type="text"/>				1=Male; 2=Female			
12	How many times did the SMC meet this year?	<input type="text"/> <input type="text"/>				Enter number			
13	What is the SMC's 3 priority issues?	<input type="text"/> [ 1. <input type="text"/> 2. <input type="text"/> 3. <input type="text"/> ]							
14	Has the SMC/school executed any health or hygiene related activity this year? (e.g., hand-washing day; cleaning event)	<input type="text"/>				1=Yes; 2=No			

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14	If "Yes," what did the SMC execute?	[ ]	Government	SMC Member	Community
15	How much funds did the SMC receive from the government and community/SMC member this year?	[ ] taka	[ ] taka	[ ] taka	[ ] taka
16	How much funds did the SMC use for health and hygiene matters this year (e.g., soap, event) ?	[ ] in kind			

	Question & Observation	Data	Coding	Verify
17	How many latrines and urinals are there?	latrine <input type="checkbox"/> <input type="checkbox"/> boys <input type="checkbox"/> girls <input type="checkbox"/> urinal <input type="checkbox"/> <input type="checkbox"/> comm. <input type="checkbox"/>	Enter number or 00	<input type="checkbox"/>
18	How many <b>separate latrines for boys/girls</b> , and <b>how many communal latrines for both boys &amp; girls</b> are there?	boys <input type="checkbox"/> girls <input type="checkbox"/> comm. <input type="checkbox"/>	Enter number or 0	<input type="checkbox"/> p
18	Of these, how many latrines function properly?	boys <input type="checkbox"/> girls <input type="checkbox"/> comm. <input type="checkbox"/>	Enter number or 0	<input type="checkbox"/>
18	Of these, how many latrines are locked during school hours?	boys <input type="checkbox"/> girls <input type="checkbox"/> comm. <input type="checkbox"/>	Enter number or 0	<input type="checkbox"/>
18	Are these latrine pit water sealed?	boys <input type="checkbox"/> girls <input type="checkbox"/> comm. <input type="checkbox"/>	1=Yes; 2=No; 3=Some	<input type="checkbox"/>
18	Are these latrines clean?	male <input type="checkbox"/> female <input type="checkbox"/> comm. <input type="checkbox"/>	1=Yes; 2=No; 3=Somewhat	<input type="checkbox"/> p
19	Are there latrines <b>exclusively for teachers</b> (male, female, or communal for both)?	male <input type="checkbox"/> female <input type="checkbox"/> comm. <input type="checkbox"/>	Enter number or 0	<input type="checkbox"/>
20	Is there a hand-washing facility at the school?	<input type="checkbox"/>	1=Yes; 2=No	<input type="checkbox"/>
20.1*	What water source is used for hand-washing? (all applicable)	<input type="checkbox"/> <input type="checkbox"/> [ Specify: <input type="checkbox"/> <input type="checkbox"/>	1=Tubewell; 2=Pot/ Bucket; 3=Other (Specify)	<input type="checkbox"/>
20	Is the hand-washing facility near the latrines?	<input type="checkbox"/>	1=Yes; 2=No	<input type="checkbox"/> p
20	Can the youngest children get water by themselves?	<input type="checkbox"/>	1=Yes; 2=No	
21	Is there any soap for pupils for hand-washing at the hand-washing facility or nearby, and easily accessible?	<input type="checkbox"/>	1=Yes; 2=No; 3=Sometimes	<input type="checkbox"/>
21.1*	Who provide the soap generally? (all applicable)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1=School; 2=SMC; 3=Parents; 4=Other; 5=NA	
22*	What is the main source of <u>drinking</u> water at school? (all applicable)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1=Tubewell; 2=Tap from pipe; 3=Rainwater; 4=Ring well; 5=Stream/Rive /Pond; 6=Pupils bring own water; 7=Other; 8=None	
22	If "Tubewell", has it been tested for arsenic?	<input type="checkbox"/>	1=Yes; 2=No; 3=DK	
22	What colour was the mouth of the tubewell painted after the arsenic test?	<input type="checkbox"/>	1=Green; 2=Red; 3=NA	<input type="checkbox"/>
22.3*	Is school drinking water treated for students? (all applicable)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	0=None; 1=Filtered; 2=Boiled; 3=Chlorin/Alum/Purifying agent; 4=Other	
23	Do the classrooms have electricity?	<input type="checkbox"/>	1=Yes; 2=No; 3=Some	<input type="checkbox"/>
24*	Are there educational and/or health-related drawings/posters on the classroom walls? (all)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1=Educational; 2=Health related; 3=Others; 4=Some classrooms	<input type="checkbox"/> p

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25	Are drawings/posters on the classroom walls? (all applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5=none 1=Yes; 2=No	<input type="checkbox"/>
26	Is rubbish bin provided at the school?	<input type="checkbox"/>			1=Yes; 2=No	<input type="checkbox"/>
27*	Is rubbish bin provided in each class room?	<input type="checkbox"/>			1=Burn/burry at school; 2=Collected by municipality; 3=Dump in another land; 4=Dump in river/pond; 5=Do nothing; 6=Other(Specify)	<input type="checkbox"/>
28	How do you manage the rubbish after collection? (all applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1=Yes; 2=No; 3=Never filled up until now	<input type="checkbox"/>
29	Is sludge (sewage) from latrines always emptied before/when they fill up?	<input type="checkbox"/>			1=Yes; 2=No	<input type="checkbox"/>
30	Are there enough brooms for all class rooms?	<input type="checkbox"/>			Enter number of days or "9" for "irregular cleaning"	<input type="checkbox"/>
31	How many days in 1 week does a classroom get cleaned? (cleaning rota)	<input type="checkbox"/>			1=Yes; 2=No	<input type="checkbox"/>
32	Is a cleaning brush provided for student latrine?	<input type="checkbox"/>			Enter number of days or "9" for "irregular cleaning"	<input type="checkbox"/>
33*	Who is responsible for cleaning the latrine? (all applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1=Cleaner; 2=Teachers; 3=Students; 4=Other(Specify); 5=None	<input type="checkbox"/>
33	If "Students," is it boys or girls who clean the latrine?	<input type="checkbox"/>			1=Boys; 2=Girls; 3=Both	
34	Does the school have student led body/club?	<input type="checkbox"/>			1=Yes; 2=No	
<b>Observation Only</b>						<b>Verify</b>
35	Are class rooms and corridor clean?	<input type="checkbox"/>			1=Yes; 2=No; 3=Some/So so	<input type="checkbox"/>
36*	What is the floor of the school made of? (all applicable)	<input type="checkbox"/>	<input type="checkbox"/>		1=Cement; 2=Earth; 3=Other	<input type="checkbox"/>
37*	What is the roof of the school made of? (all applicable)	<input type="checkbox"/>	<input type="checkbox"/>		1=Cement; 2=Tin; 3=Thatch; 4=Other	<input type="checkbox"/>
38	Does the school have a boundary wall/ditches around?	<input type="checkbox"/>			1=Yes (all around); 2=No; 3=Some; 4=Partly broken	<input type="checkbox"/>
39	The school gate open for public to enter?	<input type="checkbox"/>			1=Yes; 2=No	<input type="checkbox"/>
40	Water quality measurement (main water source)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Source: 1=Tubewell; 2=Tap from pipe; 3=Rainwater; 4=Ring well; 5=Stream; 7=Other; RLU:Enter figure	<input type="checkbox"/>
!	<b>!Take a school photo and GPS coordinate!</b>				<b>p &amp; GPS</b>	<input type="checkbox"/>
!	<b>Editor Sign</b> _____					

No	Question or information	Data	Coding to be used
A	Date & Time of interview	<input type="text"/> DD - <input type="text"/> MM - <input type="text"/> YY Time <input type="text"/> h <input type="text"/> h <input type="text"/> m <input type="text"/> m	Enter as dd - mm - yy; Time: hhmm
B	School Code	<input type="text"/> School - <input type="text"/> Class - <input type="text"/> Sex <input type="text"/> ID	Upazila-Union-School ID
C	ID number of child	<input type="text"/> - <input type="text"/>	<b>VERIFY</b> (1:Male; 2:Female) - Child ID (enter number: 1~10)
D	Name of Child [ ]		<input type="checkbox"/>
E	Name of Father [ ]		<input type="checkbox"/> Enter full name + <b>Verify with school register</b>
F	Name of Mother [ ]		<input type="checkbox"/>
G	Home Address [ ]		<input type="checkbox"/>
H	Child Birthday and Age	DD <input type="text"/> MM <input type="text"/> - YY <input type="text"/> <input type="text"/> Age: <input type="text"/> Year <input type="text"/> Month	Village, Union, Upazila BD: Enter as dd - mm - yy Age: Enter number for Yr-Mo; Cross out if DK
<b>Health Examination and Clinical Observation</b>			
a	Age (ask the child)	<input type="text"/> Year : <input type="text"/> Month	Enter as Year:Month
b	Height	<input type="text"/> cm	
c	Weight	<input type="text"/> . <input type="text"/> kg	<input type="checkbox"/> 1=Shirt; 2=Trouser; 3=Short-pants; 4=Skirt; 5=Dress/Camize; 6=Scarf (✓)
d	MUAC	Right handed <input type="text"/> 1 1st Measurement <input type="text"/> . <input type="text"/> cm      Left handed <input type="text"/> 2 2nd Measurement <input type="text"/> . <input type="text"/> cm      Average <input type="text"/> . <input type="text"/> cm	<input type="checkbox"/> 1=Right-handed; 2=Left-handed (✓) Average: calculate latter
e	Clean hands & ATP Measurement	<input type="checkbox"/> Yes <input type="text"/> 1 <input type="checkbox"/> No <input type="text"/> 2	<input type="checkbox"/> 1=Yes; 2=No (✓)
f	ATP Measurement	<input type="text"/> BEFORE RLU <input type="text"/> AFTER RLU	<input type="checkbox"/> 1=Yes; 2=No (✓); RLU: Enter figure(brf & aft)
g	Impetigo (clinical diagnosis)	<input type="checkbox"/> Yes <input type="text"/> 1 <input type="checkbox"/> No <input type="text"/> 2	<input type="checkbox"/> 1=Yes; 2=No (✓)
g	Trimmed and clean fingernails	1. Trimmed <input type="text"/> 1 2. Clean <input type="text"/> 1      Yes <input type="text"/> 1 No <input type="text"/> 2      Some <input type="text"/> 3	<input type="checkbox"/> 1=Yes; 2=No; 3=Some (✓)
h	Wearing footwear outside the school building	<input type="checkbox"/> Yes <input type="text"/> 1 <input type="checkbox"/> No <input type="text"/> 2	<input type="checkbox"/> 1=Yes; 2=No (✓)
<b>Clinical Diagnosis and Health Questions</b>			
1*	Cold and cough related symptoms (all applicable)	None <input type="text"/> 0      Cough <input type="text"/> 1      Breath Diff <input type="text"/> 2      Sore Throat <input type="text"/> 3 Fever <input type="text"/> 4      Runny Nose <input type="text"/> 5      Conge. Nose <input type="text"/> 6      Other <input type="text"/> 7	0=None; 1=Coughs; 2=Breathing difficulty; 3=Sore throat; 4=Fever; 5=Runny nose; 6=Congest' nose; 7=Other; 9=DK (✓)
2*	Q. Any cold and cough related symptoms in preceding 2 weeks? (all applicable)	None <input type="text"/> 0      Cough <input type="text"/> 1      Breath Diff <input type="text"/> 2      Sore Throat <input type="text"/> 3 Fever <input type="text"/> 4      Runny Nose <input type="text"/> 5      Conge. Nose <input type="text"/> 6      Other <input type="text"/> 7      DK <input type="text"/> 9	
3	Q. Have you had any <b>stomach ache</b> in preceding 2 weeks?	<input type="checkbox"/> Yes <input type="text"/> 1 <input type="checkbox"/> No <input type="text"/> 2	<input type="checkbox"/> 1=Yes; 2=No (✓)
4	Q. Have you had <b>diarrhoea</b> in preceding 2 weeks?	<input type="checkbox"/> Yes <input type="text"/> 1 <input type="checkbox"/> No <input type="text"/> 2	<input type="checkbox"/> 1=Yes; 2=No (✓)
4	Q. How many days in total did you suffer from diarrhoea in preceding 2 weeks?	<input type="text"/> days	Enter number or 00
4.2*	Q. What did you do for treatment? (all applicable)	Nothing <input type="text"/> 0      Rest <input type="text"/> 1      ORS/Saline <input type="text"/> 2      Trd.Dr. <input type="text"/> 3      M.D. <input type="text"/> 4      H.C. <input type="text"/> 5 Other Fluid <input type="text"/> Medicine <input type="text"/> Other <input type="text"/>	0=Nothing; 1=Rest; 2=ORS/Saline; 3=Trad. Dr; 4=Medical Dr. 5=Health Center
			NA

### Child Information

<p>5 Q. Have you had fever in preceding 2 weeks?</p> <p>5 Q. How many days in total did you have fever in preceding 2 weeks?</p> <p>5.2* Q. What did you do for treatment? (all applicable)</p> <p>6* Q. Do you have any of the following symptoms?</p> <p>7* Q. What did you eat this morning before coming to school or before the class? (all applicable)</p> <p>8 Q. Do you normally eat in the morning before coming to school?</p> <p>9* Q. Have you eaten the following food in the last 3 days: fish, meat, egg, vegetable, salad/raw vegetable or fruit? (all applicable)</p>	<div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input type="checkbox"/> 6 Yes <input type="checkbox"/> 1         </div> <div style="text-align: center;"> <input type="checkbox"/> 7 No <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <input type="checkbox"/> 8 [ days Nothing Rest Medicn Trad.Dr. M.D. H.C. Other NA         </div> <div style="text-align: center;"> <input type="checkbox"/> 9         </div> </div> <p>Complex; 6=Other fluid; 7=Medicine; 8=Other (Specify); 9=NA (✓) 1=Yes; 2=No (✓) Enter number or 00</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <p>1. Tired/Weak</p> <input type="checkbox"/> Yes <input type="checkbox"/> 1         </div> <div style="text-align: center;"> <p>2. Dizziness</p> <input type="checkbox"/> Yes <input type="checkbox"/> 1         </div> <div style="text-align: center;"> <p>3. Appetite Loss</p> <input type="checkbox"/> Yes <input type="checkbox"/> 1         </div> </div> <p>0=Nothing; 1=Rest; 2=Medicin; 3=Traditional Doctor; 4=Medical Doctor; 5=HealthComplex; 6=Other; 9=NA (✓) 1=Yes; 2=No (✓)</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <p>Nothing Rice Ruti/Bread/Cake/Biscuit</p> <input type="checkbox"/> 0 Dhal <input type="checkbox"/> 5         </div> <div style="text-align: center;"> <p>Egg Fish Meat Dhoi/Milk</p> <input type="checkbox"/> 1 Egg <input type="checkbox"/> 6         </div> <div style="text-align: center;"> <p>Fish Meat Egg</p> <input type="checkbox"/> 2 Fish <input type="checkbox"/> 7         </div> <div style="text-align: center;"> <p>Rice Meat Egg</p> <input type="checkbox"/> 3 Rice <input type="checkbox"/> 8         </div> <div style="text-align: center;"> <p>Ruti/Bread/Cake/Biscuit Meat Dhoi/Milk</p> <input type="checkbox"/> 4 Ruti/Bread/Cake/Biscuit <input type="checkbox"/> 9         </div> <div style="text-align: center;"> <p>Fruits Vegetables</p> <input type="checkbox"/> 5 Fruits <input type="checkbox"/> 10         </div> <div style="text-align: center;"> <p>Vege</p> <input type="checkbox"/> 6 Vegetables <input type="checkbox"/> 10         </div> </div> <p>0=Nothing; 1=Rice; 2=Ruti/Bread/Cake/Biscuit; 3=Fruits; 4=Vegetables; 5=Dhal; 6=Egg; 7=Fish; 8=Meat; 9=Dhoi/Milk; 10=Other (✓) 1=Yes; 2=No; 3=Sometimes (✓) 1=Fish; 2=Meat; 3=Egg; 4=Vegetable; 5=Salad/ Raw vege; 6=Fruit (✓)</p>	<p>]</p>
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<b>Health KAPB</b>			
<p>10 Q. Do you think it is important to eat in the morning before coming to school?</p> <p>10.1 Q. If Yes, why do you think so?</p> <p>11* Q. What kind of water do you drink at school? (all applicable)</p> <p>12 Q. Do you use latrine or urinal (for boys) at school?</p> <p>12.1* If "No" for latrine, why do you not use latrine at school? (all applicable)</p> <p>13 Q. Is water and soap readily available after you use latrine/urinal at school?</p> <p>14* Q. In which occasions, do you clean your hand? <b>If you do clean, how often, which hand, and with what</b> do you clean your hands? (all applicable)</p> <p>15 Q. Do you use <u>running water</u> for rinsing your hands?</p> <p>16 Q. How do you dry your hands after washing hands?</p> <p>17 Q. Can you show us how you wash your hands?</p>	<div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> 1         </div> <div style="text-align: center;"> <input type="checkbox"/> No <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <input type="checkbox"/> DK <input type="checkbox"/> 3         </div> </div> <p>1=Yes; 2=No; 3=DK (✓)</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <p>None Sch. Water Own Bottle Other</p> <input type="checkbox"/> 0 None <input type="checkbox"/> 1         </div> <div style="text-align: center;"> <p>Yes No Yes No NA</p> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <p>1. Latrine 2. Urinal</p> <input type="checkbox"/> 1 1. Latrine <input type="checkbox"/> 2         </div> </div> <p>0=None; 1=School water; 2=Own bottle (✓); 3=Other (Specify) 1=Yes; 2=No; 9=NA (✓) 1=Locked; 2=Broken; 3=Dirty/Smelly; 4=Dark; 5=No time; 6=Go home; 7=No need (✓); 8=Other (Specify) 1=Yes; 2=No; 3=Sometimes; 4=DK (✓)</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <p>locked broken dirty/smelly dark no time go home no need</p> <input type="checkbox"/> 1 locked <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <p>other</p> <input type="checkbox"/> 3 other <input type="checkbox"/> 4         </div> <div style="text-align: center;"> <p>dark</p> <input type="checkbox"/> 4 dark <input type="checkbox"/> 5         </div> <div style="text-align: center;"> <p>no time</p> <input type="checkbox"/> 5 no time <input type="checkbox"/> 6         </div> <div style="text-align: center;"> <p>go home</p> <input type="checkbox"/> 6 go home <input type="checkbox"/> 7         </div> <div style="text-align: center;"> <p>no need</p> <input type="checkbox"/> 7 no need <input type="checkbox"/> 8         </div> </div> <p>1=Locked; 2=Broken; 3=Dirty/Smelly; 4=Dark; 5=No time; 6=Go home; 7=No need (✓); 8=Other (Specify) 1=Yes; 2=No; 3=Sometimes; 4=DK (✓)</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <p>Yes No Sometimes DK</p> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <p>Freq Hand Water Soap Ash Mud</p> <input type="checkbox"/> 1 1. before eating <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <p>1. before eating</p> <input type="checkbox"/> 1 1. before eating <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <p>2. after defecation</p> <input type="checkbox"/> 1 2. after defecation <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <p>3. after playing</p> <input type="checkbox"/> 1 3. after playing <input type="checkbox"/> 2         </div> </div> <p>Freq: 1=Not clean; 2=Sometimes; 3=Always; Hand (enter #): 1=Left hand; 2=Right hand; 3=Both hands; Use(✓): 1=Water; 2=Soap; 3=Ash; 4=Mud 1=Yes; 2=No; 3=Sometimes (✓)</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <p>Yes No Sometimes</p> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <p>Air dry Towel Cloth Paper Other</p> <input type="checkbox"/> 1 Air dry <input type="checkbox"/> 2         </div> <div style="text-align: center;"> <p>3 4 5 [</p> <input type="checkbox"/> 3 Cloth <input type="checkbox"/> 4         </div> <div style="text-align: center;"> <p>4 5 [</p> <input type="checkbox"/> 4 Paper <input type="checkbox"/> 5         </div> <div style="text-align: center;"> <p>5 [</p> <input type="checkbox"/> 5 Other <input type="checkbox"/> 6         </div> </div> <p>1=Yes; 2=No; 3=Sometimes (✓) 1=Air dry; 2=Towel; 3=Cloth; 4=Paper; 5=Other (Specify) (✓) Count the processes performed out of 7</p>	<p>]</p>	

### Child Information

<p>18 Q. Have you seen other children NOT washing hands after using latrine <b>at school</b>?</p> <p>19 Q. Do you wear footwear when you go to latrine <b>at home</b>?</p> <p>20 Q. Do you wear footwear <b>at your house compound (yard)</b>?</p> <p>21* Q. How would you feel <b>if you saw a friend</b> who did not wash hands after defecation? (all applicable)</p> <p>22 Q. How would you feel if <b>you did not</b> wash hands after defecation?</p> <p>23 Q. Is it important to clean the latrine?</p> <p>24 Q. Have you ever cleaned a latrine at school?</p> <p>24.1* Q. If "Yes," did you get paid by cleaning the latrine? (all applicable)</p> <p>25 Q. Have you seen other pupil cleaning the latrine at school?</p> <p>26* Q. Who cleans the school latrine? (all applicable)</p> <p>27 Q. Do you swim or bath in a pond, river or paddy field?</p> <p>28* Q. <u>How often</u>, <u>when</u>, and <u>with what</u> do you brush your teeth? (all applicable)</p>	<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">No</td> <td style="width: 25%;">Sometimes</td> <td style="width: 25%;">Often</td> <td style="width: 25%;">DK</td> </tr> <tr> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> </tr> </table> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Yes</td> <td style="width: 25%;">No</td> <td style="width: 25%;">Sometimes</td> <td style="width: 25%;"></td> </tr> <tr> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td></td> </tr> </table> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Nothing</td> <td style="width: 25%;">Bad</td> <td style="width: 25%;">Good</td> <td style="width: 25%;">DK</td> </tr> <tr> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> </tr> </table> <table border="0" style="width: 100%; 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### Family and House Information

<p>29* Q. Who do you live with in your house? - please count the number (all applicable)</p> <p>30* Q. How many younger brothers and sisters, and how many older brothers and sisters do you have?</p> <p>31* Q. What is the roof of your main bedroom house made from? (all applicable)</p> <p>32* Q. What is the wall of your main bedroom house made from? (all applicable)</p> <p>33 Q. How many rooms are there in your <b>family house</b>?</p> <p>34 Q. What kind of larine is there in your</p>	<table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">1=Mother</td> <td style="width: 20%;">2=Father</td> <td style="width: 20%;">3=Bro/Sis</td> <td style="width: 20%;">4=G-Mother</td> <td style="width: 20%;">5=G-Father</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>6=Aunt</td> <td>7=Uncle</td> <td>8=Cousin</td> <td>9=Other</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>1.Younger Brother</td> <td>2.Older Brother</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3.Younger Sister</td> <td>4.Older Sister</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> </table> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Cement</td> <td style="width: 20%;">Tin</td> <td style="width: 20%;">Tally</td> <td style="width: 20%;">Thatch</td> <td style="width: 20%;">Other</td> </tr> <tr> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 5</td> </tr> </table> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Brick/Cement</td> <td style="width: 20%;">Tin</td> <td style="width: 20%;">Mud</td> <td style="width: 20%;">Wood/Thatch</td> <td style="width: 20%;">Other</td> </tr> <tr> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 5</td> </tr> </table> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">rooms</td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>None(open)</td> <td>Inside house</td> <td>Pacca</td> <td>SemiPacca</td> <td>Jute/Wooden/Plastic</td> </tr> <tr> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> </tr> <tr> <td>Hanging</td> <td>Other</td> <td>specify</td> <td></td> <td></td> </tr> </table>	1=Mother	2=Father	3=Bro/Sis	4=G-Mother	5=G-Father	<input type="checkbox"/>	6=Aunt	7=Uncle	8=Cousin	9=Other		<input type="checkbox"/>	1.Younger Brother	2.Older Brother				<input type="checkbox"/>	<input type="checkbox"/>				3.Younger Sister	4.Older Sister				<input type="checkbox"/>	<input type="checkbox"/>				Cement	Tin	Tally	Thatch	Other	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	Brick/Cement	Tin	Mud	Wood/Thatch	Other	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	rooms					<input type="checkbox"/>	None(open)	Inside house	Pacca	SemiPacca	Jute/Wooden/Plastic	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	Hanging	Other	specify			<p>Enter number or 0 for:</p> <p>1=Mother; 2=Father; 3=Brother/Sister; 4=Grand mother; 5=Grand father; 6=Aunt; 7=Uncle; 8=Cousin; 9=Other</p> <p>Enter number or 00 for:</p> <p>1=Younger brother; 2=Older brother; 3=Younger sister; 4=Older sister</p> <p>1=Cement; 2=Tin; 3=Tally (local thin brick); 4=Thatch; 5=Other (✓)</p> <p>1=Brick/Cement; 2=Tin; 3=Mud; 4=Wood/Thatch; 5=Other (✓)</p> <p>Enter number</p> <p>0=None (open); 1=Inside house; 2=Pacca (all cement); 3=Semi-Pacca (no cement)</p>												
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## Child Information

<p>34. Is there a roof on the house? (super structure)</p> <p>35. Q. Is there a hand-washing facility nearby the latrine?</p> <p>36. Q. Is there soap near or inside the latrine, or at a hand-washing place?</p> <p>37*. Q. What is the source of drinking water at home? (all applicable)</p> <p>38*. Q. How often is the drinkg water at home treated, such as boiled, filtered, chlorinised? (all applicable)</p> <p>39. Q. Who can read orwrite in your family? (all applicable)</p> <p>40*. Q. What kind of electricity do you have at home? (all applicable)</p> <p>41*. Q. What kind of TV do you have at home? (all applicable)</p> <p>42. Q. How many mobile phones does your family have?</p> <p>43. Q. How many motor bikes does your family have?</p> <p>44. Q. How many bicycles does your family have?</p> <p>45. Q. Do you have refrigerator at home?</p>	<p>5 <input type="checkbox"/> 6 <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> No <input type="checkbox"/> 3 <input type="checkbox"/> Sometimes <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> DK <input type="checkbox"/></p> <p>Handpump <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Tap <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Rain <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Ringwell <input type="checkbox"/> 4 <input type="checkbox"/> Stream/River/Pond <input type="checkbox"/> 5 <input type="checkbox"/> Other <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> DK <input type="checkbox"/></p> <p>No <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Boil <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Filter <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Chlorine/Alum/Purify <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> DK <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> DK <input type="checkbox"/></p> <p>1. S/T <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> DK <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> DK <input type="checkbox"/></p> <p>2. Always <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> DK <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> DK <input type="checkbox"/></p> <p>None <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Mother <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Father <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Bro/Sis <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> G-Prt <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Other <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> DK <input type="checkbox"/></p> <p>1. 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13*	<b>diarrhoea</b> in preceding 2 weeks? (all applicable)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Nothing Rest ORS/Saline Trd.Dr. M.D. H.C. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Other Fluid Medicine Other <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 [ ] <input type="checkbox"/> 9	3=the Child; 4=Other child 5=Grandparent(s); 6=Other member (✓)
13.1*	Q. What kind of treatment did the patient(s) have? (all applicable)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 None Father Mother Child Other child G-P Other <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	0=Nothing; 1=Rest; 2=ORS/Saline; 3=Traditional Doctor; 4=Medical Dr. 5=Health Complex; 6=Other fluid; 7=Medicine; 8=Other (Specify); 9=NA (✓)
14*	Q. Has anyone in the family had any <b>cold and cough related symptoms or fever</b> in preceding 2 weeks? (all applicable)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Cough Breathing Diff Sore Throat Fever <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Runny Nose Congested Nose Other DK NA <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9	0=None; 1=Coughs; 2=Breathing difficulty; 3=Sore throat; 4=Fever; 5=Runny nose; 6=Congested nose; 7=Other; 8=DK; 9=NA (✓)
14.1*	Q. What symptoms did the patient(s) have? (all applicable)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 None Rest Medicn Trd.Dr. H.C. Other NA <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	0=Nothing; 1=Rest; 2=Medicine; 3=Traditional Doctor; 4=Health Complex; 5=Other; 9=NA (✓)
14.2*	Q. What kind of treatment did the patient(s) have? (all applicable)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 None Father Mother Child Other child G-P Other <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	0=None; 1=Father; 2=Mother; 3=the Child; 4=Other child; 5=Grandparent(s); 6=Other member (✓)
15	Q. Who in the family currently have impetigo?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Freq Hand Water Soap Ash Mud 1.before eating - - 1 2 3 4 2.after defecation - - 1 2 3 4 3.before cooking - - 1 2 3 4 4.before feeding baby - - 1 2 3 4 5. after cleaning baby's bottom - - 1 2 3 4	1=Freq. 1=Not clean; 2=Sometimes; 3=Always; Hand (enter #): 1=Left hand; 2=Right hand; 3=Both hands; Use (✓): 1=Water; 2=Soap; 3=Ash; 4=Mud
16	Q. In what occasion do you clean hands?  <b>If you do clean, how often, which hand, and with what do you clean your hands? (all applicable)</b>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Yes No Sometimes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	1=Yes; 2=No; 3=Sometimes (✓)
17	Q. Do you use <u>running water</u> for rinsing your hands after cleaning?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Air dry Towel Clothes Paper Other <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 [ ] Bushes/ground Pit Latrine Open sewer	1=Air dry; 2=Towel; 3=Clothes; 4=Paper; 5=Other (Specify) (✓)
18	Q. How do you dry your hands after washing hands?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 1 River/Pond 2 Bushes/ground 3 Pit 4 Latrine 5 Open sewer	1=Bushes/ground; 2=Pit; 3=Latrine; 4=Open sewer/drain; 5=River/Pond; 6=Other (Specify) (✓)
19*	Q. How do you dispose child feces? (all applicable)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 In latrine Under tubewell Bath in courtyard Cloth Paper Other <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Handpump Tap Rain Ringwell Stream/River/Pond <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1=Inside latrine; 2=Under tubewell; 3=Bath in courtyard; 4=Cloth; 5=Paper; 6=Other
19.1*	Q. How do you clean child bottom after defecation?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Handpump Tap Rain Ringwell Stream/River/Pond <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1=Handpump(Tubewell); 2=Tap from a pipe; 3=Rainwater; 4=Ring well; 5=Stream/river/pond; 6=Other(Specify) (✓)
20*	Q. What is the source of drinking water? (all applicable)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Other <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 None Red Green DK NA <b>VERIFY</b> No Boil Filter Chlorine/Alum/Purify	0=Not painted; 1= Red; 2=Green; 3=DK; 9=NA (✓) <b>VERIFY</b> : 1= Yes; 2=No
20.1	Q. If Q20=1(tube well), is the mouth of the tubewell painted with colour (tested for arsenic)?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 None Red Green DK NA <b>VERIFY</b> No Boil Filter Chlorine/Alum/Purify	0=Not painted; 1= Red; 2=Green; 3=DK; 9=NA (✓) <b>VERIFY</b> : 1= Yes; 2=No

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21*	Q. How often you boil, filter or chlorinate water before drinking?	<input type="checkbox"/> 0      1.S/T <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 2.Always <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 None      Mother      Father      Other      Specify <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 [ ]	0=No; 1=Sometimes; 2=Always - 1=Boil; 2=Filter; 3=Chlorin/Alum/Purifying agent
22*	Q. Is there anyone in the family who are participating in a micro-credit scheme? (all applicable)		0=None; 1=Mother; 2=Father; 3=Other (Specify) (✓)
22.1	Q. If "Yes", what is the use of the credit for?	<input type="checkbox"/> 1      Animal/Farm <input type="checkbox"/> 2      Busnss <input type="checkbox"/> 3      Consume <input type="checkbox"/> 4      Spe.Event <input type="checkbox"/> 5      Other <input type="checkbox"/> 9      NA None      MC      Health      Education      Vocational      DK <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Other (Specify) <input type="checkbox"/> 5 [ ]	1=Animal/Farm; 2=Business; 3=Consumption; 4=Special Events; 5=Other; 9=NA (✓)
23*	Q. Is there any NGO project taking place in your village? (all applicable)		0=None; 1=MC(microcredit); 2=Health; 3=Education; 4=Vocational; 5=Other (Specify); 6=DK(✓)

## Observation &amp; Interview

24*	Q. What is the wall of your bed room house made from? (all applicable)	<input type="checkbox"/> 1      Brick/Cement <input type="checkbox"/> 2      Tin <input type="checkbox"/> 3      Mud <input type="checkbox"/> 4      Wood/Thatch <input type="checkbox"/> 5      Other <input type="checkbox"/> 1      Cement <input type="checkbox"/> 2      Tin <input type="checkbox"/> 3      Tally <input type="checkbox"/> 4      Thatch <input type="checkbox"/> 5      Other	1=Brick/Cement; 2=Tin; 3=Mud; 4=Wood/Thatch; 5=Other (✓)
25*	Q. What is the roof of your bed room house made from? (all applicable)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	1=Cement; 2=Tin; 3=Tally (local thin brick); 4=Thatch; 5=Other (✓)
26	Q. How many rooms are there in your family house?	<input type="checkbox"/> <input type="checkbox"/> rooms	Enter number
27	Q. What kind of latrine is there in your house? (super structure)	<input type="checkbox"/> 0      None/Open <input type="checkbox"/> 1      Pacca <input type="checkbox"/> 2      SemiPacca <input type="checkbox"/> 3      Jute/Wooden/Plastic <input type="checkbox"/> 4      Hanging <input type="checkbox"/> 5      Other [ ]	0=None/open; 1=Pacca (all cement) ; 2=Semi-Pacca (no cement roof); 3=Jute/Wooden/ Plastic; 4=Hanging; 5=Other (Specify) (✓)
27.1	Q. Does the latrine water pan have a water seal?	<input type="checkbox"/> 1      Yes <input type="checkbox"/> 2      No <input type="checkbox"/> 3      DK <input type="checkbox"/> 1      Yes <input type="checkbox"/> 2      No	1=Yes; 2=No; 3=DK (✓) <span style="color:red">VERIFY</span> : 1= Yes; 2=No
28	Q. Is there hand-washing facility nearby the latrine?	<input type="checkbox"/> 1      Yes <input type="checkbox"/> 2      No	1=Yes; 2=No (✓) <span style="color:red">VERIFY</span> : 1= Yes; 2=No
29	Q. Is there soap at the hand-washing facility?	<input type="checkbox"/> 1      Yes <input type="checkbox"/> 2      No <input type="checkbox"/> 3      Sometimes	1=Yes; 2=No; 3=Sometimes (✓) <span style="color:red">VERIFY</span> : 1= Yes; 2=No
29.1*	Q. What kind of soap do you use for hand-washing? (all applicable)	<input type="checkbox"/> 0      None <input type="checkbox"/> 1      Powder <input type="checkbox"/> 2      Beauty soap <input type="checkbox"/> 3      Multi bar soap <input type="checkbox"/> 1      1. Powder <input type="checkbox"/> 2      2. Beauty Large <input type="checkbox"/> 3      3. Beauty Medi <input type="checkbox"/> 2      4. Beauty Small <input type="checkbox"/> 3      5. Multi bar soap	0=None; 1=Powder/Detergent; 2=Beauty/Toilet soap; 3=Multipurpose bar soap (✓)
30*	Q. How many bars or bag of soap does your family use in 1 month?	<input type="checkbox"/> g <input type="checkbox"/> bars <input type="checkbox"/> bars <input type="checkbox"/> bars	Enter number for each: 1. Powder/Detergent; 2. Beauty large; 3. Beauty Medium; 4. Beauty small; 4. Multipurpose bar soap
31*	Q. How much do you spend for each type of soap in 1 month?	<input type="checkbox"/> 1 Powder <input type="checkbox"/> 2 Beauty <input type="checkbox"/> 3 Multipurpose <input type="checkbox"/> ]tk [ <input type="checkbox"/> ]tk [ <input type="checkbox"/> ]tk [	Enter number; <u>If the answer is DK, write the size/brand of soap</u>
32*	Q. What fuel do you use for cooking? (all applicable)	<input type="checkbox"/> 1      Wood <input type="checkbox"/> 2      Dung <input type="checkbox"/> 3      Straw <input type="checkbox"/> 4      Charcoal <input type="checkbox"/> 5      Kerosene <input type="checkbox"/> 6      Gas <input type="checkbox"/> 7      Other [ ]	1=Firewood; 2=Dung; 3=Straw, Twigs, Leaves, Rice husks, Jute; 4=Charcoal; 5=Kerosene; 6=Gas; 7=Other (Specify) (✓)
33	Q. How many Bigha or Katha of land does your household own for the house and farmland?	<input type="checkbox"/> . <input type="checkbox"/> Bigha <input type="checkbox"/> . <input type="checkbox"/> Katha <input type="checkbox"/> . <input type="checkbox"/> Decimal	Enter number or 00.0
33.1	Indicate if the land is borrowed for free	<input type="checkbox"/> 1      Land borroed for free <input type="checkbox"/> 2      Yes <input type="checkbox"/> 3      No <input type="checkbox"/> 3      Partly	1=Yes; 2=No; 3=Partly

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<p>34* Q. What kind of TV do you have at home?</p> <p>35 Q. How many mobile phones does your family have?</p> <p>36 Q. How many motorbikes?</p> <p>37 Q. How many bicycles?</p> <p>38 Q. Do you have refrigerator at home?</p> <p>39* Q. Who can read or write in the family? (all applicable)</p> <p>40* Q. What is the household head occupation? (all applicable)</p> <p>41 Q. What is your family's religion?</p>	<table border="1"> <tbody> <tr> <td>None</td> <td>Colour</td> <td>B&amp;W</td> </tr> <tr> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> </tr> <tr> <td colspan="3">phones</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> motorbikes</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> bicycles</td> </tr> <tr> <td>Yes</td> <td>No</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td></td> </tr> <tr> <td>1.Read</td> <td>None</td> <td>Mother</td> <td>Father</td> <td>Child</td> <td>G-P</td> <td>Other</td> </tr> <tr> <td></td> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 5</td> </tr> <tr> <td>2.Write</td> <td>None</td> <td>Mother</td> <td>Father</td> <td>Child</td> <td>G-P</td> <td>Other</td> </tr> <tr> <td></td> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 5</td> </tr> <tr> <td>None</td> <td>Farmer</td> <td>Fisher</td> <td>Rikshaw</td> <td>Skilled</td> <td>Unskilled</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 5</td> <td></td> </tr> <tr> <td>Teacher</td> <td>Gov</td> <td>NGO</td> <td>Compa.</td> <td>S.Bus</td> <td>L.Bus</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 6</td> <td><input type="checkbox"/> 7</td> <td><input type="checkbox"/> 8</td> <td><input type="checkbox"/> 9</td> <td><input type="checkbox"/> 10</td> <td><input type="checkbox"/> 11</td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> 12</td> <td>[</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>None</td> <td>Muslim</td> <td>Hindu</td> <td>Budd</td> <td>Chirst</td> <td>Other</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 0</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 5</td> <td></td> </tr> </tbody> </table>	None	Colour	B&W	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	phones			<input type="checkbox"/> motorbikes			<input type="checkbox"/> bicycles			Yes	No		<input type="checkbox"/> 1	<input type="checkbox"/> 2		1.Read	None	Mother	Father	Child	G-P	Other		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	2.Write	None	Mother	Father	Child	G-P	Other		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	None	Farmer	Fisher	Rikshaw	Skilled	Unskilled		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5		Teacher	Gov	NGO	Compa.	S.Bus	L.Bus		<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11		Other							<input type="checkbox"/> 12	[						None	Muslim	Hindu	Budd	Chirst	Other		<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5		<p>0=None; 1=Coloured; 2=Black &amp; White (✓)</p> <p>Enter number or 00</p> <p>Enter number or 00</p> <p>Enter number or 00</p> <p>1=Yes; 2=No (✓)</p> <p>0=None; 1=Moher; 2=Father; 3=Child(ren); 4=Grandparent(s); 5=Other (✓)</p> <p>0=None; 1=Farmer; 2=Fisherman; 3=Rikshaw/Van-pooler; 4=Skilled labor; 5=Unskilled labor; 6=Teacher; 7=Govt; 8=NGO; 9=Company; 10=Small business; 11=Large business; 12=Other (Specify) (✓)</p> <p>0=None; 1=Muslim; 2=Hindu; 3=Buddhist; 4=Christian; 5=Other (✓)</p> <p><b>GPS</b></p>
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! Take the photo of the house, latrine super structure & water pan!																																																																																																											
! Take GPS coordinate of the house !																																																																																																											
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