THE GAMBIA MICS2

EA no. __ __ ____ ____ __ Household no. __ ____ __ Caretaker line no. __ __ Child line no. __ __

QUESTIONNAIRE FOR CHILDREN UNDER FIVE

This questionnaire is to be administered to all women who care for a child that lives with them and is under the age of 5 years (see Q.4 of the HH listing).
A separate form should be used for each eligible child.
Questions should be administered to the mother or caretaker of the eligible child (see Q.7 of the HH listing).
Fill in the line number of each child, the line number of the child's mother or caretaker, and the household and EA numbers in the space at the top of each page.

BIRTH REGISTRATION AND EARLY LEARNING MODULE		
1. Child's name.	Name _____	
2. Child's age (copy from Q.4 of HH listing).	Age (in completed years)..... __ __	
3. NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH OF EACH CHILD UNDER THE AGE OF 5 IN YOUR CARE, WHO LIVES WITH YOU NOW. NOW I WANT TO ASK YOU ABOUT (*name*). IN WHAT MONTH AND YEAR WAS (*name*) BORN? *Probe*: WHAT IS HIS/HER BIRTHDAY? *If the mother knows the exact birth date, also enter the day; otherwise, enter 99 for day.*	Date of birth Day/Month/Year..... __ __/__ __/__ __ __ __	
4. DOES (*name*) HAVE A BIRTH CERTIFICATE? MAY I SEE IT? *If certificate is presented, verify reported birth date. If no birth certificate is presented, try to verify date using another document (health card, etc.). Correct stated age, if necessary.*	Yes, seen ..... 1 Yes, not seen ..... 2 No..... 3 DK 9	1⇨Q.5AA
5. *If no birth certificate is shown, ask*: HAS (*name's*) BIRTH BEEN REGISTERED?	Yes ..... 1 No..... 2 DK 9	2⇨Q6 9⇨Q.7
5AA. WHERE HAS THE BIRTH BEEN REGISTERED?	Health Centre……1 Medical & Health Headquarters……..2 DK……9	⇨Skip Q.8
6. WHY IS (*name's*) BIRTH NOT REGISTERED?	Transport costs too much** ..... 1 Must travel too far ..... 2 Did not know it should be registered..... 3 Late, and did not want to pay fine..... 4 Does not know where to register ..... 5 Other (*specify*) _____ 6 DK 9	
7. DO YOU KNOW HOW TO REGISTER YOUR CHILD'S BIRTH?	Yes ..... 1 No..... 2 No answer 8	

8. *Check age. If child is 3 years old or more, ask*: DOES (*name*) ATTEND ANY ORGANIZED LEARNING OR EARLY CHILDHOOD EDUCATION PROGRAMME, SUCH AS A PRIVATE OR GOVERNMENT FACILITY, INCLUDING KINDERGARTEN OR COMMUNITY CHILD CARE?	Yes ..... 1 No..... 2 DK 9	 2⇨NEXT MODULE 9⇨NEXT MODULE
9. WITHIN THE LAST SEVEN DAYS, ABOUT HOW MANY HOURS DID (*name*) ATTEND?	Number of hours ..... __ __	

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VITAMIN A MODULE		
Further optional questions are found in Appendix Two.		
1. HAS (*name*) EVER RECEIVED A VITAMIN A CAPSULE (SUPPLEMENT) LIKE THIS ONE? *Show capsule or dispenser.*	Yes ..... 1 No..... 2 DK 9	 2⇨NEXT MODULE 9⇨NEXT MODULE
2. HOW MANY MONTHS AGO DID (*name*) TAKE THE LAST DOSE?	Months ago ..... __ __ DK 99	
3. WHERE DID (*name*) GET THIS LAST DOSE?	On routine visit to health centre ..... 1 Sick child visit to health centre..... 2 National Immunization Day campaign ..... 3 Other (*specify*) _____ 4 DK 9	
4. DOES YOUR CHILD HAVE ANY PROBLEMS SEEING IN THE DAY TIME?	Yes ..... 1 No..... 2 DK 9	
5. DOES YOUR CHILD HAVE ANY PROBLEMS SEEING IN THE NIGHT TIME?	Yes ..... 1 No..... 2 DK 9	 2⇨skip to Q7 9⇨skip to Q7
6. IS THIS PROBLEM DIFFERENT FROM OTHER CHILDREN IN YOUR COMMUNITY?	Yes ..... 1 No..... 2 DK 9	
7. DOES YOUR CHILD HAVE NIGHT BLINDNESS? *(USE LOCAL TERM FOR NIGHT BLINDNESS)*	Yes ..... 1 No..... 2 DK 9	

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BREASTFEEDING MODULE		
1. HAS (*name*) EVER BEEN BREASTFED?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.2BB 9⇨Q.4
*1AA. DID YOU GIVE (*name*) THE FIRST MILK THAT COMES OUT OF THE BREAST (COLOSTRUM)?	Yes ..... 1 No ..... 2 DK 9	
2. IS HE/SHE STILL BEING BREASTFED?	Yes ..... 1 No ..... 2 DK 9	1⇨Q.3 2⇨Q.2AA 9⇨Q.4
*2AA. FOR HOW LONG HAS *(NAME)* BREASTFED?	Number of Months ……	⇨skip to Q.4
*2BB. WHAT WERE THE REASONS FOR NOT BREASTFEEDING?	Less or no milk in mother's breast……1 Orphan……2 Preferred formula……..3 Mother ill or sick……4 Child refuse……5 Other (specify)……..6	 ⇨Q.4
3. SINCE THIS TIME YESTERDAY, DID HE/SHE RECEIVE ANY OF THE FOLLOWING: *Read each item aloud and record response before proceeding to the next item.*	Y N DK	
3A. VITAMIN, MINERAL SUPPLEMENTS OR MEDICINE?	A. Vitamin supplements 1 2 9	
3B. PLAIN WATER?	B. Plain water 1 2 9	
3C. SWEETENED, FLAVOURED WATER OR FRUIT JUICE OR TEA OR INFUSION?	C. Sweetened water or juice 1 2 9	
3D. ORAL REHYDRATION SOLUTION (ORS)?	D. ORS 1 2 9	
3E. TINNED, POWDERED OR FRESH MILK OR INFANT FORMULA?	E. Milk 1 2 9	
3F. ANY OTHER LIQUIDS?	F. Other liquids (*specify*) _____ 1 2 9	
3G. SOLID OR SEMI-SOLID (MUSHY) FOOD?	G. Mushy food 1 2 9	
4. SINCE THIS TIME YESTERDAY, HAS (*name*) BEEN GIVEN ANYTHING TO DRINK FROM A BOTTLE WITH A NIPPLE OR TEAT?	Yes ..... 1 No ..... 2 DK 9	

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EA no. __ __ __ __ __ Household no. __ __ __ Caretaker line no. __ __ Child line no. __ __

CARE OF ILLNESS MODULE		
1. HAS (*name*) HAD DIARRHOEA IN THE LAST TWO WEEKS, THAT IS, SINCE (*day of the week*) OF THE WEEK BEFORE LAST? *Diarrhoea is determined as perceived by mother or caretaker, or as three or more loose or watery stools per day, or blood in stool.*	Yes ..... 1 No ..... 2 DK 9	1⇨Q.2AA
2. IN THE LAST TWO WEEKS, HAS (*name*) HAD ANY OTHER ILLNESS, SUCH AS COUGH OR FEVER, OR ANY OTHER HEALTH PROBLEM?	Yes ..... 1 No ..... 2 DK 9	1⇨Q.4 2⇨Q.11 9⇨Q.11
*2AA. DID YOU SEEK ADVICE OR TREATMENT FOR THE DIARRHOEA OUTSIDE THE HOME?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.3 9⇨Q.3
*2BB. HOW LONG AFTER THE ONSET OF DIARRHOEA DID YOU SEEK HELP?	Same day……1 1 – 2 days……2 3 days and after……..3	
3. DURING THIS LAST EPISODE OF DIARRHOEA, DID (*name*) DRINK ANY OF THE FOLLOWING: *Read each item aloud and record response before proceeding to the next item.*	Y N DK	
3A. BREAST MILK?	A. Breast milk 1 2 9	
3B. CEREAL-BASED GRUEL OR GRUEL MADE FROM ROOTS OR SOUP?	B. Gruel 1 2 9	
3C. ***other locally-defined acceptable home fluids (e.g., SSS, yogurt drink)***?	C. Other acceptable 1 2 9	
3D. ORS PACKET SOLUTION?	D. ORS packet 1 2 9	
3E. OTHER MILK OR INFANT FORMULA?	E. Other milk 1 2 9	
3F. WATER WITH FEEDING DURING SOME PART OF THE DAY?	F. Water with feeding 1 2 9	
3G. WATER ALONE?	G. Water alone 1 2 9	
3H. ***defined "unacceptable" fluids (e.g., cola, etc. (insert local names))***	H. Unacceptable fluids 1 2 9	
3I. NOTHING	I. Nothing 1 2 9	1⇨Q.5
4. DURING (*name's*) ILLNESS, DID HE/SHE DRINK MUCH LESS, ABOUT THE SAME, OR MORE THAN USUAL?	Much less or none ..... 1 About the same (or somewhat less) ..... 2 More ..... 3 DK 9	
5. DURING (*name's*) ILLNESS, DID HE/SHE EAT LESS, ABOUT THE SAME, OR MORE FOOD THAN USUAL? *If "less", probe:* MUCH LESS OR A LITTLE LESS?	None ..... 1 Much less ..... 2 Somewhat less ..... 3 About the same ..... 4 More ..... 5 DK 9	
6. HAS (*name*) HAD AN ILLNESS WITH A COUGH AT ANY TIME IN THE LAST TWO WEEKS, THAT IS, SINCE (*day of the week*) OF THE WEEK BEFORE	Yes ..... 1 No 2	 2⇨Q.11

LAST?	DK 9	9⇨Q.11
7. WHEN (*name*) HAD AN ILLNESS WITH A COUGH, DID HE/SHE BREATHE FASTER THAN USUAL WITH SHORT, QUICK BREATHS OR HAVE DIFFICULTY BREATHING?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.11 9⇨Q.11
8. WERE THE SYMPTOMS DUE TO A PROBLEM IN THE CHEST OR A BLOCKED NOSE?	Blocked nose ..... 1 Problem in chest ..... 2 Both ..... 3 Other (*specify*) _____ 4 DK 9	1⇨Q.11 4⇨Q.11
9. DID YOU SEEK ADVICE OR TREATMENT FOR THE ILLNESS OUTSIDE THE HOME?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.11 9⇨Q.11
*9AA. HOW LONG AFTER THE ONSET OF ILLNESS DID YOU SEEK HELP?	Same day……1 1 – 2 days……2 3 days and after……..3	
10. FROM WHERE DID YOU SEEK CARE? ANYWHERE ELSE? *Circle all providers mentioned, but do NOT prompt with any suggestions.*	Hospital ..... 01 Health centre ..... 02 Dispensary ..... 03 Village health worker ..... 04 MCH clinic ..... 05 Mobile/outreach clinic ..... 06 Private physician ..... 07 Traditional healer ..... 08 Pharmacy or drug seller ..... 09 Relative or friend ..... 10 Other (*specify*) _____ 11	
Ask this question (Q.11) only once for each caretaker. 11. SOMETIMES CHILDREN HAVE SEVERE ILLNESSES AND SHOULD BE TAKEN IMMEDIATELY TO A HEALTH FACILITY. WHAT TYPES OF SYMPTOMS WOULD CAUSE YOU TO TAKE YOUR CHILD TO A HEALTH FACILITY RIGHT AWAY? *Keep asking for more signs or symptoms until the caretaker cannot recall any additional symptoms. Circle all symptoms mentioned, but do NOT prompt with any suggestions.*	Child not able to drink or breastfeed ..... 01 Child becomes sicker ..... 02 Child develops a fever ..... 03 Child has fast breathing ..... 04 Child has difficult breathing ..... 05 Child has blood in stool ..... 06 Child is drinking poorly ..... 07 Other (*specify*) _____ 08 Other (*specify*) _____ 09 Other (*specify*) _____ 10	

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MALARIA MODULE		
This module is for use in countries or regions at high risk of malaria. See manual for definition.		
1. IN THE LAST TWO WEEKS, THAT IS, SINCE (*day of the week*) OF THE WEEK BEFORE LAST, HAS (*name*) BEEN ILL WITH A FEVER?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.8 9⇨Q.8
2. WAS (*name*) SEEN AT A HEALTH FACILITY DURING THIS ILLNESS?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.6 9⇨Q.6
*2AA. WHEN (*name*) HAD MALARIA, HOW SOON DID YOU SEEK MEDICAL CARE?	Same day……..1 2 to 5 days……2 After 5 days ……3 After 2 weeks……4 Don't Know……9	
*2BB. FROM WHERE DID YOU SEEK CARE? *CIRCLE 1 FOR ALL SOURCES MENTIONED. DO NOT PROMPT, EXCEPT FOR TRADITIONAL HEALERS.*	Y N a. Hospital ……1 2 b. Health centre……1 2 c. Dispensary……1 2 d. Village health worker……1 2 e. MCH clinic……..1 2 f. Private physician……...1 2 g. Traditional healer……..1 2 h. Pharmacy or drug seller……..1 2 i. Relative or friend……..1 2 j. Other……...1 2	
3. DID (*name*) TAKE A MEDICINE FOR FEVER OR MALARIA THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.5 9⇨Q.5
4. WHAT MEDICINE DID (*name*) TAKE THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY? *Circle all medicines mentioned.*	Paracetamol ..... 1 Chloroquine ..... 2 Fansidar ..... 3 Other (*specify*) _____ 4 DK 9	
5. WAS (*name*) GIVEN MEDICINE FOR THE FEVER OR MALARIA BEFORE BEING TAKEN TO THE HEALTH FACILITY?	Yes ..... 1 No ..... 2 DK 9	1⇨Q.7 2⇨Q.8 9⇨Q.8
6. WAS (*name*) GIVEN MEDICINE FOR FEVER OR MALARIA DURING THIS ILLNESS?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.8 9⇨Q.8
7. WHAT MEDICINE WAS (*name*) GIVEN? *Circle all medicines given before visiting a health facility or if no visit was made to a health facility.*	Paracetamol ..... 1 Chloroquine ..... 2 Fansidar ..... 3 Other (*specify*) _____ 4 DK 9	
*7 DID (*name*) RECOVER FROM THAT ILLNESS?	Yes ..... 1 No ..... 2 DK 9	
8. DID (*name*) SLEEP UNDER A BEDNET LAST NIGHT?	Yes ..... 1 No 2	 2⇨NEXT

	DK 9	MODULE 9⇨NEXT MODULE
9. WAS THIS BEDNET EVER TREATED WITH A PRODUCT TO KILL MOSQUITOS?	Yes ..... 1 No..... 2 DK 9	 2⇨NEXT MODULE 9⇨NEXT MODULE
10. WHEN WAS THE BEDNET LAST TREATED?	Months ago ..... __ __ DK 99	

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IMMUNIZATION MODULE

If an immunization card is available, copy the dates in Qs.2-5 for each type of immunization recorded on the card. Qs.7-15 are for recording vaccinations that are not recorded on the card. Qs.7-15 will only be asked when a card is not available.

1. IS THERE A VACCINATION RECORD FOR (*name*)?	Yes, seen ..... 1 Yes, not seen ..... 2 No..... 3	 2⇨Q.7 3⇨Q.7

(a) Copy dates of all vaccinations from the card.
(b) Write '44' in day column if card shows that vaccination was given but no date recorded.

		Date of Immunization							
		DAY		MONTH		YEAR			
2. BCG	BCG								
2AA. HEP.B1	HEP.B								
2BB. HEP.B2	HEP.B								
2CC. HEP.B3	HEP.B								
3A. OPV0	OPV0								
3B. OPV1	OPV1								
3C. OPV2	OPV2								
3D. OPV3	OPV3								
*3AA. OPV4	OPV4								
*3BB. OPV5	OPV5								
4A. DPT1	DPT1								
4B. DPT2	DPT2								
4C. DPT3	DPT3								
4AA. DPT4 (BOOSTER)	DPT4								
5. MEASLES	MEASLES								
5AA. YELLOW FEVER	YELLOW FEVER								

6. IN ADDITION TO THE VACCINATIONS SHOWN ON THIS CARD, DID (*name*) RECEIVE ANY OTHER VACCINATIONS - INCLUDING VACCINATIONS RECEIVED IN A NATIONAL IMMUNIZATION DAY? *Record 'Yes' only if respondent mentions BCG, OPV 0-3, DPT 1-3, and/or Measles vaccine(s). Go to Q.15 after you finish.*	Yes ..... 1 *(Probe for vaccinations and write '66' in the corresponding day column on Q. 2 to Q. 5.)* No..... 2 DK 9	1⇨Q.15 2⇨Q.15 9⇨Q.15
7. HAS (*name*) EVER RECEIVED ANY VACCINATIONS TO PREVENT HIM/HER FROM GETTING DISEASES, INCLUDING VACCINATIONS RECEIVED IN A NATIONAL IMMUNIZATION DAY CAMPAIGN?	Yes ..... 1 No..... 2	 2⇨Q.15

	DK 9	9⇨Q.15
8. HAS (*name*) EVER BEEN GIVEN A BCG VACCINATION AGAINST TUBERCULOSIS – THAT IS, AN INJECTION IN THE LEFT SHOULDER THAT CAUSED A SCAR?	Yes ..... 1 No ..... 2 DK 9	
9. HAS (*name*) EVER BEEN GIVEN ANY "VACCINATION DROPS IN THE MOUTH" TO PROTECT HIM/HER FROM GETTING DISEASES – THAT IS, POLIO?	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.12 9⇨Q.12
10. HOW OLD WAS HE/SHE WHEN THE FIRST DOSE WAS GIVEN – JUST AFTER BIRTH OR LATER?	Just after birth ..... 1 Later 2	
11. HOW MANY TIMES HAS HE/SHE BEEN GIVEN THESE DROPS?	No. of times ..... __ __	
12. HAS (*name*) EVER BEEN GIVEN "VACCINATION INJECTIONS" – THAT IS, AN INJECTION IN THE THIGH OR BUTTOCKS – TO PREVENT HIM/HER FROM GETTING TETANUS, WHOOPING COUGH, DIPHTHERIA? (SOMETIMES GIVEN AT THE SAME TIME AS POLIO)	Yes ..... 1 No ..... 2 DK 9	 2⇨Q.14 9⇨Q.14
13. HOW MANY TIMES?	No. of times ..... __ __	
14. HAS (*name*) EVER BEEN GIVEN "VACCINATION INJECTIONS" – THAT IS, A SHOT IN THE ARM AT THE AGE OF 9 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING MEASLES?	Yes ..... 1 No ..... 2 DK 9	
15. PLEASE TELL ME IF (*name*) HAS PARTICIPATED IN ANY OF THE FOLLOWING NATIONAL IMMUNIZATION DAYS: POLIO DATE……../……./……. MENINGITIS DATE……../……./…… ***Insert date and type of vaccination given in the most recent NID campaigns.***	Y N DK *Polio* ..... 1 2 9 *Meningitis* 1 2 9	

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ANTHROPOMETRY MODULE		
After questionnaires for all children are complete, the measurer weighs and measures each child. Record weight and length/height below, taking care to record the measurements on the correct questionnaire for each child. Check the child's name and line number on the HH listing before recording measurements.		
1. Child's weight.	Kilograms (kg)..... ___ ___ . ___	
2. Child's length or height. *Check age of child:* ☐ *Child under 2 years old. ⇨ Measure length (lying down).* ☐ *Child age 2 or more years. ⇨ Measure height (standing up).*	Length (cm) Lying down..... 1 ___ ___ ___ . ___ Height (cm) Standing up..... 2 ___ ___ ___ . ___	
4. Result.	Measured..... 1 Not present ..... 2 Refused..... 3 Other (*specify*) _____ 4	
5. Is there another child in the household who is eligible for measurement? ☐ *Yes. ⇨ Record measurements for next child.* ☐ *No. ⇨ End the interview with this household by thanking all participants for their cooperation. Gather together all questionnaires for this household and check that identification numbers are at the top of each page. Tally on the Household Information Panel the number of interviews completed.*		