

QUESTIONNAIRE FOR CHILDREN UNDER FIVE

UNDER-FIVE CHILD INFORMATION PANEL

UF

This questionnaire is to be administered to all mothers or caretakers (see Household Listing Form, column HL9) who care for a child that lives with them and is under the age of 5 years (see Household Listing Form, column HL6).

A separate questionnaire should be used for each eligible child.

UF1. Cluster number: _____	UF2. Household number: _____
UF3. Child's name: Name _____	UF4. Child's line number: _____
UF5. Mother's / Caretaker's name: Name _____	UF6. Mother's / Caretaker's line number: _____
UF7. Interviewer name and number: Name _____	UF8. Day / Month / Year of interview: ___ / ___ / _____
Repeat greeting if not already read to this respondent: We are from (THE GAMBIA BUREAU OF STATISTICS, MOB&SE, MOH&SW, WOMEN'S BUREAU, COMMUNITY DEVELOPMENT). We are working on a project concerned with family health and education. I would like to talk to you about (NAME)'s health and well-being. The interview will take about (45) minutes. All the information we obtain will remain strictly confidential and your answers will never be shared with anyone other than our project team.	If greeting at the beginning of the household questionnaire has already been read to this woman, then read the following: Now I would like to talk to you more about (CHILD'S NAME FROM UF3)'s health and other topics. This interview will take about (45) minutes. Again, all the information we obtain will remain strictly confidential and your answers will never be shared with anyone other than our project team.
MAY I START NOW? <input type="checkbox"/> Yes, permission is given ⇒ Go to UF12 to record the time and then begin the interview. <input type="checkbox"/> No, permission is not given ⇒ Complete UF9. Discuss this result with your supervisor	
UF9. Result of interview for children under 5 Codes refer to mother/caretaker.	Completed..... 1 Not at home..... 2 Refused..... 3 Partly completed 4 Incapacitated 5 Other (specify) _____ 9
UF10. Field edited by (Name and number): Name _____	UF11. Data entry clerk (Name and number): Name _____
UF12. Record the time.	Hour and minutes : _____

AGE

AG

AG1	NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE AGE OF (name). IN WHAT MONTH AND YEAR WAS (name) BORN? Probe: WHAT IS HIS / HER BIRTHDAY? If the mother/caretaker knows the exact birth date, also enter the day; otherwise, circle 98 for day Month and year must be recorded.	Date of birth Day DK day.....98 Month Year.....
AG2	HOW OLD IS (name)? Probe: HOW OLD WAS (name) AT HIS / HER LAST BIRTHDAY? Record age in completed years. Record '0' if less than 1 year. Compare and correct AG1 and/or AG2 if inconsistent.	Age (in completed years).....

BIRTH REGISTRATION

BR

BR1	DOES (name) HAVE A BIRTH CERTIFICATE? If yes, ask: MAY I SEE IT?	Yes, seen.....1 Yes, not seen.....2 No.....3 DK.....8	1⇒Next Module 2⇒Next Module
BR2	HAS (name's) BIRTH BEEN REGISTERED WITH THE CIVIL AUTHORITIES?	Yes.....1 No.....2 DK.....8	2⇒ BR3 8⇒ BR3
BR2A	WHERE WAS (name) REGISTERED?	Health Centre1 Medical & Health Headquarters.....2 DK.....8	1⇒Next Module 2⇒Next Module 8⇒Next Module
BR3	DO YOU KNOW HOW TO REGISTER YOUR CHILD'S BIRTH?	Yes.....1 No.....2	
BR4	WHY IS (name)'S BIRTH NOT REGISTERED?	Costs too much.....1 Must travel too far2 Did not know it should be registered3 Does not know where to register.....5 Nothing will do it later7 Other (specify)6	

EARLY CHILDHOOD DEVELOPMENT

EC

EC1	HOW MANY CHILDREN'S BOOKS OR PICTURE BOOKS DO YOU HAVE FOR (name)?	None 00 Number of children's or picture books..... 0 __ Ten or more books 10	
EC2	I AM INTERESTED IN LEARNING ABOUT THE THINGS THAT (name) PLAYS WITH WHEN HE/SHE IS AT HOME. DOES HE/SHE PLAY WITH: [A] HOMEMADE TOYS (SUCH AS DOLLS, CARS, OR OTHER TOYS MADE AT HOME)? [B] TOYS FROM A SHOP OR MANUFACTURED TOYS? [C] HOUSEHOLD OBJECTS (SUCH AS BOWLS OR POTS) OR OBJECTS FOUND OUTSIDE (SUCH AS STICKS, ROCKS, ANIMAL SHELLS OR LEAVES)? If the respondent says "YES" to the categories above, then probe to learn specifically what the child plays with to ascertain the response	Y N DK Homemade toys..... 1 2 8 Toys from a shop..... 1 2 8 Household objects or outside objects 1 2 8	
EC3	SOMETIMES ADULTS TAKING CARE OF CHILDREN HAVE TO LEAVE THE HOUSE TO GO SHOPPING, WASH CLOTHES, OR FOR OTHER REASONS AND HAVE TO LEAVE YOUNG CHILDREN. ON HOW MANY DAYS IN THE PAST WEEK WAS (name): [A] LEFT ALONE FOR MORE THAN AN HOUR? [B] LEFT IN THE CARE OF ANOTHER CHILD (THAT IS, SOMEONE LESS THAN 10 YEARS OLD) FOR MORE THAN AN HOUR? If 'none' enter '0'. If 'don't know' enter '8'	Number of days left alone for more than an hour __ Number of days left with other child for more than an hour __	
EC5	DOES (name) ATTEND ANY ORGANIZED LEARNING OR EARLY CHILDHOOD EDUCATION PROGRAMME, SUCH AS A PRIVATE OR GOVERNMENT FACILITY, INCLUDING KINDERGARTEN, DAY CARE CENTRE OR COMMUNITY CHILD CARE?	Yes.....1 No.....2 DK.....8	2⇒EC6B 8⇒EC6B

EC6	WITHIN THE LAST SEVEN DAYS, ABOUT HOW MANY HOURS DID (name) ATTEND?	Number of hours..... ____																																				
EC6A	DO YOU PAY FEES/CONTRIBUTIONS FOR (NAME) ATTENDANCE TO ANY ORGANIZED LEARNING OR EARLY CHILDHOOD EDUCATION?	Yes.....1 No.....2 DK.....8	1⇒EC6C 2⇒EC6C 8⇒EC6C																																			
EC6B	WHY DOES (name) NOT ATTEND ANY ORGANIZED LEARNING OR EARLY CHILDHOOD EDUCATION PROGRAMME, SUCH AS A PRIVATE OR GOVERNMENT FACILITY, INCLUDING KINDERGARTEN, DAY CARE CENTER OR COMMUNITY CHILD CARE?	Not interested.....1 Facility too far.....2 Too young.....3 Cannot afford cost.....4 Don't know where to find one..... Nothing.....6 Other (specify).....9																																				
EC6C	Check AG2: Age of child <input type="checkbox"/> Child age 3 or 4 ⇒ Continue with EC7 <input type="checkbox"/> Child age 0, 1 or 2 ⇒ Go to Next Module																																					
EC7	IN THE PAST 3 DAYS, DID YOU OR ANY HOUSEHOLD MEMBER OVER 15 YEARS OF AGE ENGAGE IN ANY OF THE FOLLOWING ACTIVITIES WITH (name): If yes, ask: WHO ENGAGED IN THIS ACTIVITY WITH (name)? Circle all that apply. [A] READ BOOKS TO OR LOOKED AT PICTURE BOOKS WITH (name)? [B] TOLD STORIES TO (name)? [C] SANG SONGS TO (name) OR WITH (name), INCLUDING LULLABIES? [D] TOOK (name) OUTSIDE THE HOME, COMPOUND, YARD OR ENCLOSURE? [E] PLAYED WITH (name)? [F] NAMED, COUNTED, OR DREW THINGS TO OR WITH (name)?	<table border="1"> <thead> <tr> <th></th> <th>Mother</th> <th>Father</th> <th>Other</th> <th>No one</th> </tr> </thead> <tbody> <tr> <td>Read books</td> <td>A</td> <td>B</td> <td>X</td> <td>Y</td> </tr> <tr> <td>Told stories</td> <td>A</td> <td>B</td> <td>X</td> <td>Y</td> </tr> <tr> <td>Sang songs</td> <td>A</td> <td>B</td> <td>X</td> <td>Y</td> </tr> <tr> <td>Took outside</td> <td>A</td> <td>B</td> <td>X</td> <td>Y</td> </tr> <tr> <td>Played with</td> <td>A</td> <td>B</td> <td>X</td> <td>Y</td> </tr> <tr> <td>Named/counted</td> <td>A</td> <td>B</td> <td>X</td> <td>Y</td> </tr> </tbody> </table>		Mother	Father	Other	No one	Read books	A	B	X	Y	Told stories	A	B	X	Y	Sang songs	A	B	X	Y	Took outside	A	B	X	Y	Played with	A	B	X	Y	Named/counted	A	B	X	Y	
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EC8	I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH AND DEVELOPMENT OF YOUR CHILD. CHILDREN DO NOT ALL DEVELOP AND LEARN AT THE SAME RATE. FOR EXAMPLE, SOME WALK EARLIER THAN OTHERS. THESE QUESTIONS ARE RELATED TO SEVERAL ASPECTS OF YOUR CHILD'S DEVELOPMENT. CAN (name) IDENTIFY OR NAME AT LEAST TEN LETTERS OF THE ALPHABET?	Yes..... 1 No..... 2 DK..... 8																																				
EC9	CAN (name) READ AT LEAST FOUR SIMPLE, POPULAR WORDS?	Yes..... 1 No..... 2 DK..... 8																																				
EC10	DOES (name) KNOW THE NAME AND RECOGNIZE THE SYMBOL OF ALL NUMBERS FROM 1 TO 10?	Yes..... 1 No..... 2 DK..... 8																																				
EC11	CAN (name) PICK UP A SMALL OBJECT WITH TWO FINGERS, LIKE A STICK OR A ROCK FROM THE GROUND?	Yes..... 1 No..... 2 DK..... 8																																				
EC12	IS (name) SOMETIMES TOO SICK TO PLAY?	Yes..... 1 No..... 2 DK..... 8																																				
EC13	DOES (name) FOLLOW SIMPLE DIRECTIONS ON HOW TO DO SOMETHING CORRECTLY?	Yes..... 1 No..... 2 DK..... 8																																				

EC14	WHEN GIVEN SOMETHING TO DO, IS (name) ABLE TO DO IT INDEPENDENTLY?	Yes..... 1 No..... 2 DK..... 8	
EC15	DOES (name) GET ALONG WELL WITH OTHER CHILDREN?	Yes..... 1 No..... 2 DK..... 8	
EC16	DOES (name) KICK, BITE, OR HIT OTHER CHILDREN OR ADULTS?	Yes..... 1 No..... 2 DK..... 8	
EC17	DOES (name) GET DISTRACTED EASILY?	Yes..... 1 No..... 2 DK..... 8	

BREASTFEEDING

BF

BF1	HAS (name) EVER BEEN BREASTFED?	Yes..... 1 No..... 2 DK..... 8	2⇒BF3 8⇒BF3
BF1A	FOR HOW MANY MONTHS HAS (name) BEEN BREASTFEED?	Months..... DK.....98	
BF1B	WAS (name) GIVEN THE FIRST MILK THAT CAME OUT OF THE BREAST (COLOSTRUM)?	Yes..... 1 No..... 2 DK..... 8	
BF2	IS HE/SHE STILL BEING BREASTFED?	Yes..... 1 No..... 2 DK..... 8	2⇒BF3 8⇒BF3
BF2A	AT WHAT MONTH/ YEAR DO YOU THINK (name) WILL STOP TO BE BREAST-FED?	Months..... 1 ___ Years 2 ___	
BF3	I WOULD LIKE TO ASK YOU ABOUT LIQUIDS THAT (name) MAY HAVE HAD YESTERDAY DURING THE DAY OR THE NIGHT. I AM INTERESTED IN WHETHER (name) HAD THE ITEM EVEN IF IT WAS COMBINED WITH OTHER FOODS. DID (name) DRINK PLAIN WATER YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	
BF4	DID (name) DRINK INFANT FORMULA YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	2⇒BF6 8⇒BF6
BF5	HOW MANY TIMES DID (name) DRINK INFANT FORMULA?	Number of times	
BF6	DID (name) DRINK MILK, SUCH AS TINNED, POWDERED OR FRESH ANIMAL MILK YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	2⇒BF8 8⇒BF8
BF7	HOW MANY TIMES DID (name) DRINK TINNED, POWDERED OR FRESH ANIMAL MILK?	Number of times	
BF8	DID (name) DRINK JUICE OR JUICE DRINKS YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	
BF9	DID (name) DRINK ('Ogi' 'Gisuma monor') YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	
BF10	DID (name) DRINK OR EAT VITAMIN OR MINERAL SUPPLEMENTS OR ANY MEDICINES YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	

BF11	DID (name) DRINK ORS (ORAL REHYDRATION SOLUTION) YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	
BF12	DID (name) DRINK ANY OTHER LIQUIDS YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	
BF13	DID (name) DRINK OR EAT YOGURT YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	2⇒BF15 8⇒BF15
BF14	HOW MANY TIMES DID (name) DRINK OR EAT YOGURT YESTERDAY, DURING THE DAY OR NIGHT?	Number of times _ _	
BF15	DID (NAME) EAT THIN PORRIDGE YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	
BF16	DID (name) EAT SOLID OR SEMI-SOLID (SOFT, MUSHY) FOOD YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No..... 2 DK..... 8	2⇒BF18 8⇒BF18
BF17	HOW MANY TIMES DID (name) EAT SOLID OR SEMI-SOLID (SOFT, MUSHY) FOOD YESTERDAY, DURING THE DAY OR NIGHT?	Number of times _ _	
BF18	YESTERDAY, DURING THE DAY OR NIGHT, DID (name) DRINK ANYTHING FROM A BOTTLE WITH A NIPPLE?	Yes..... 1 No..... 2 DK..... 8	1⇒Next Module 8⇒Next Module
BF19	HAS NAME EVER BEEN GIVEN ANYTHING FROM A BOTTLE WITH A NIPPLE?	Yes..... 1 No..... 2 DK..... 8	

CARE OF ILLNESS

CA

CA1	IN THE LAST TWO WEEKS, HAS (name) HAD DIARRHOEA?	Yes..... 1 No..... 2 DK..... 8	2⇒CA7 8⇒CA7
CA2	I WOULD LIKE TO KNOW HOW MUCH (name) WAS GIVEN TO DRINK DURING THE DIARRHOEA (INCLUDING BREASTMILK). DURING THE TIME (name) HAD DIARRHOEA, WAS HE/SHE GIVEN LESS THAN USUAL TO DRINK, ABOUT THE SAME AMOUNT, OR MORE THAN USUAL? If less, probe: WAS HE/SHE GIVEN MUCH LESS THAN USUAL TO DRINK, OR SOMEWHAT LESS?	Much less 1 Somewhat less 2 About the same 3 More 4 Nothing to drink..... 5 DK..... 8	
CA3	DURING THE TIME (name) HAD DIARRHOEA, WAS HE/SHE GIVEN LESS THAN USUAL TO EAT, ABOUT THE SAME AMOUNT, MORE THAN USUAL, OR NOTHING TO EAT? If "less", probe: WAS HE/SHE GIVEN MUCH LESS THAN USUAL TO EAT OR SOMEWHAT LESS?	Much less 1 Somewhat less 2 About the same 3 More 4 Stopped food 5 Never gave food 6 DK..... 8	
CA4	DURING THE EPISODE OF DIARRHOEA, WAS (name) GIVEN TO DRINK ANY OF THE FOLLOWING: Read each item aloud and record response before proceeding to the next item. [A] A FLUID MADE FROM A SPECIAL PACKET CALLED (local name for ORS packet solution)? [B] SUGAR SALT SOLUTION (SSS)	Y N DK Fluid from ORS packet..... 1 2 8 SSS..... 1 2 8	

CA5	<p>WAS ANYTHING (ELSE) GIVEN TO TREAT THE DIARRHOEA?</p>	<p>Yes..... 1 No..... 2 DK..... 8</p>	<p>2⇒CA7 8⇒CA7</p>
CA6	<p>WHAT (ELSE) WAS GIVEN TO TREAT THE DIARRHOEA? Probe: ANYTHING ELSE? Record all treatments given. Write brand name(s) of all medicines mentioned.</p> <p>----- (Name)</p>	<p>Pill or Syrup Antibiotic..... A Antimotility..... B Zinc..... C Other (Not antibiotic, antimotility or zinc)...G Unknown pill or syrup.....H Injection Antibiotic.....L Non-antibiotic.....M Unknown injection.....N Intravenous.....O Home remedy / Herbal medicine.....Q Other (specify) _____ X</p>	
CA7	<p>AT ANY TIME IN THE LAST TWO WEEKS, HAS (name) HAD AN ILLNESS WITH A COUGH?</p>	<p>Yes..... 1 No..... 2 DK..... 8</p>	<p>2⇒CA14 8⇒CA14</p>
CA8	<p>WHEN (name) HAD AN ILLNESS WITH A COUGH, DID HE/SHE BREATHE FASTER THAN USUAL WITH SHORT, RAPID BREATHS OR HAVE DIFFICULTY BREATHING?</p>	<p>Yes..... 1 No..... 2 DK..... 8</p>	<p>2⇒CA14 8⇒CA14</p>
CA9	<p>WAS THE FAST OR DIFFICULT BREATHING DUE TO A PROBLEM IN THE CHEST OR A BLOCKED OR RUNNY NOSE?</p>	<p>Problem in chest 1 Blocked or runny nose..... 2 Both 3 Other (specify) _____ 6 DK..... 8</p>	<p>2⇒CA14 8⇒CA14</p>
CA10	<p>DID YOU SEEK ANY ADVICE OR TREATMENT FOR THE ILLNESS FROM ANY SOURCE?</p>	<p>Yes..... 1 No..... 2 DK..... 8</p>	<p>2⇒CA12 8⇒CA12</p>
CA11	<p>CA11. FROM WHERE DID YOU SEEK ADVICE OR TREATMENT? Probe: ANYWHERE ELSE? Circle all providers mentioned, but do NOT prompt with any suggestions. Probe to identify each type of source. If unable to determine if public or private sector, write the name of the place.</p> <p>----- (Name of place)</p>	<p>Public sector Govt. hospital..... A Govt. health centre.....B Govt. health postC Village health worker..... D Mobile / Outreach clinicE Other public (specify) _____H Private medical sector Private hospital / clinic..... I Private physicianJ Private pharmacyK Mobile clinicL Other private medical (specify) _____ O Other source Relative / Friend.....P ShopQ Traditional practitionerR Other (specify) _____ X</p>	
CA12	<p>WAS (name) GIVEN ANY MEDICINE TO TREAT THIS ILLNESS?</p>	<p>Yes..... 1 No..... 2 DK..... 8</p>	<p>2⇒CA14 8⇒CA14</p>

CA13	<p>WHAT MEDICINE WAS (name) GIVEN? Probe: ANY OTHER MEDICINE? Circle all medicines given. Write brand name(s) of all medicines mentioned.</p> <p>----- (Names of medicines)</p>	<p>Antibiotic Pill / Syrup.....A Injection.....B Anti-malarials.....M Paracetamol / Panadol / Acetaminophen.....P Aspirin.....Q Ibuprofen.....R Other (specify) _____ X DK.....Z</p>
CA14	<p>Check AG2: Child aged under 3? <input type="checkbox"/> Yes. ⇒ Continue with CA15 <input type="checkbox"/> No. ⇒ Go to Next Module</p>	
CA15	<p>THE LAST TIME (name) PASSED STOOLS, WHAT WAS DONE TO DISPOSE OF THE STOOLS?</p>	<p>Child used toilet / latrine.....01 Put / Rinsed into toilet or latrine.....02 Put / Rinsed into drain or ditch.....03 Thrown into garbage (solid waste)04 Buried.....05 Left in the open06 Other (specify) _____ 96 DK.....98</p>

MALARIA

ML

ML1	<p>IN THE LAST TWO WEEKS, HAS (name) BEEN ILL WITH A FEVER AT ANY TIME?</p>	<p>Yes.....1 No.....2 DK.....8</p>	<p>2⇒Next Module 8⇒Next Module</p>
ML2	<p>AT ANY TIME DURING THE ILLNESS, DID (name) HAVE BLOOD TAKEN FROM HIS/HER FINGER OR HEEL FOR TESTING?</p>	<p>Yes.....1 No.....2 DK.....8</p>	
ML3	<p>DID YOU SEEK ANY ADVICE OR TREATMENT FOR THE ILLNESS FROM ANY SOURCE?</p>	<p>Yes.....1 No.....2 DK.....8</p>	<p>2⇒ML8 8⇒ML8</p>
ML4	<p>WAS (NAME) TAKEN TO A HEALTH FACILITY DURING THIS ILLNESS?</p>	<p>Yes.....1 No.....2 DK.....8</p>	<p>2⇒ML8 8⇒ML8</p>
ML5	<p>WAS (name) GIVEN ANY MEDICINE FOR FEVER OR MALARIA AT THE HEALTH FACILITY?</p>	<p>Yes.....1 No.....2 DK.....8</p>	<p>2⇒ML7 8⇒ML7</p>
ML6	<p>ML6. WHAT MEDICINE WAS (name) GIVEN? Probe: ANY OTHER MEDICINE? Circle all medicines mentioned. Write brand name(s) of all medicines, if given.</p> <p>----- (Name)</p>	<p>Anti-malarials: SP / FansidarA Chloroquine.....B Amodiaquine.....C Quinine.....D Combination with Artemisinin (Coartem)E Country-specific CBD anti-malarial.....F Other anti-malarial (specify) _____ H Antibiotic drugs Pill / Syrup.....I Injection.....J Other medications: Paracetamol/ Panadol /Acetaminophen.....P AspirinQ Ibuprofen.....R Other (specify) _____ X DK.....Z</p>	

ML7	<p>WAS (name) GIVEN ANY MEDICINE FOR THE FEVER OR MALARIA BEFORE BEING TAKEN TO THE HEALTH FACILITY?</p>	<p>Yes..... 1 No.....2 DK.....8</p>	<p>1⇒ML9 2⇒ML10 8⇒ML10</p>
ML8	<p>WAS (name) GIVEN ANY MEDICINE FOR FEVER OR MALARIA DURING THIS ILLNESS?</p>	<p>Yes..... 1 No.....2 DK.....8</p>	<p>2⇒ML10 8⇒ML10</p>
ML9	<p>WHAT MEDICINE WAS (name) GIVEN? Probe: ANY OTHER MEDICINE? Circle all medicines mentioned. Write brand name(s) of all medicines, if given.</p> <p>----- (Name)</p>	<p>Anti-malarials: SP / FansidarA Chloroquine..... B Amodiaquine.....C Quinine.....D Combination with Artemisinin (Coartem)E Country-specific CBD anti-malarial.....F Other anti-malarial (specify) _____ H</p> <p>Antibiotic drugs Pill / Syrup.....I Injection.....J</p> <p>Other medications: Paracetamol/ Panadol/ Acetaminophen..... P AspirinQ Ibuprofen.....R Other (specify) _____ X DK.....Z</p>	
ML10	<p>Check ML6 and ML9: Anti-malarial mentioned (codes A - H)?</p> <p><input type="checkbox"/> Yes. ⇒ Continue with ML11</p> <p><input type="checkbox"/> No. ⇒ Go to Next Module</p>		
ML11	<p>HOW LONG AFTER THE FEVER STARTED DID (name) FIRST TAKE (name of anti-malarial from ML6 or ML9)?</p> <p>If multiple anti-malarials mentioned in ML6 or ML9, name all anti-malarial medicines mentioned.</p> <p>Record how long after the fever started the first anti-malarial was given.</p>	<p>Same day0 Next day1 2 days after the fever2 3 days after the fever3 4 or more days after the fever.....4 DK.....8</p>	

IMMUNIZATION

IM

If an immunization card is available, copy the dates in IM3 for each type of immunization recorded on the card. IM6-IM17 are for registering vaccinations that are not recorded on the card. IM6-IM17 will only be asked when a card is not available.

IM1	DO YOU HAVE A CARD WHERE (name)'S VACCINATIONS ARE WRITTEN DOWN? (If yes) MAY I SEE IT PLEASE?	Yes, seen..... 1 Yes, not seen..... 2 No card..... 3	1⇒IM3 2⇒IM6		
IM2	DID YOU EVER HAVE A VACCINATION CARD FOR (name)?	Yes..... 1 No..... 2	1⇒IM6 2⇒IM6		
IM3	(a) Copy dates for each vaccination 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	
	BCG	BCG			
	POLIO AT BIRTH	OPV0			
	POLIO 1	OPV1			
	POLIO 2	OPV2			
	POLIO 3	OPV3			
	POLIO 4	OPV4			
	POLIO BOOSTER	OPV5			
	DPT - HIB1/ PENTA 1	DPT1/P1			
	DPT - HIB2/ PENTA 2	DPT2/P2			
	DPT -HIB3/ PENTA 3	DPT3/P3			
	DPT 4(BOOSTER)	DPT4			
	PNEUMO 1	PNE 1			
	PNEUMO 2	PNE 2			
	PNEUMO 3	PNE 3			
HEPB AT BIRTH	H0				
MEASLES (OR MMR)	MEASLES				
YELLOW FEVER	YF				
IM4	Check IM3. Are all vaccines (BCG to Yellow Fever) recorded? <input type="checkbox"/> Yes⇒ Go to IM18 <input type="checkbox"/> No ⇒ Continue with IM5				
IM5	IN ADDITION TO WHAT IS RECORDED ON THIS CARD, DID (name) RECEIVE ANY OTHER VACCINATIONS – INCLUDING VACCINATIONS RECEIVED IN CAMPAIGNS OR IMMUNIZATION DAYS? Record 'Yes' only if respondent mentions vaccines shown in the table above.	Yes..... 1 (Probe for vaccinations and write '66' in the corresponding day column for each vaccine mentioned. Then skip to IM18) No..... 2 DK..... 8	2⇒IM18 8⇒IM18		
IM6	HAS (name) EVER RECEIVED ANY VACCINATIONS TO PREVENT HIM/HER FROM GETTING DISEASES, INCLUDING VACCINATIONS RECEIVED IN A CAMPAIGN OR IMMUNIZATION DAY?	Yes..... 1 No..... 2 DK..... 8	2⇒IM18 8⇒IM18		
IM7	HAS (name) EVER RECEIVED A BCG VACCINATION AGAINST TUBERCULOSIS – THAT IS, AN INJECTION IN THE ARM OR SHOULDER THAT USUALLY CAUSES A SCAR?	Yes..... 1 No..... 2 DK..... 8			
IM8	HAS (name) EVER RECEIVED ANY "VACCINATION DROPS IN THE MOUTH" TO PROTECT HIM/HER FROM GETTING DISEASES – THAT IS, POLIO?	Yes..... 1 No..... 2 DK..... 8	2⇒IM11 8⇒IM11		
IM9	WAS THE FIRST POLIO VACCINE RECEIVED IN THE FIRST TWO WEEKS AFTER BIRTH OR LATER?	First two weeks..... 1 Later..... 2			
IM10	HOW MANY TIMES WAS THE POLIO VACCINE RECEIVED?	Number of times..... __			

IM11	HAS (name) EVER RECEIVED A DPT VACCINATION – THAT IS, AN INJECTION IN THE THIGH OR BUTTOCKS – TO PREVENT HIM/HER FROM GETTING TETANUS, WHOOPING COUGH, DIPHTHERIA? Probe by indicating that DPT vaccination is sometimes given at the same time as Polio	Yes..... 1 No..... 2 DK..... 8	2⇒IM12A 8⇒IM12A																				
IM12	HOW MANY TIMES WAS A DPT VACCINE RECEIVED?	Number of times.....__																					
IM12A	HAS (name) EVER RECEIVED A PNEUMO VACCINATION – THAT IS, AN INJECTION IN THE THIGH – TO PREVENT HIM/HER FROM GETTING PNEUMONIA?	Yes..... 1 No..... 2 DK..... 8	2⇒IM13 8⇒IM13																				
IM12B	HOW MANY TIMES WAS A PNEUMO VACCINE RECEIVED?	Number of times.....__																					
IM13	HAS (name) EVER BEEN GIVEN A HEPATITIS B VACCINATION – THAT IS, AN INJECTION IN THE THIGH OR BUTTOCKS – TO PREVENT HIM/HER FROM GETTING HEPATITIS B? Probe by indicating that the Hepatitis B vaccine is sometimes given at the same time as Polio and DPT vaccines	Yes..... 1 No..... 2 DK..... 8	2⇒IM16 8⇒IM16																				
IM14	WAS THE FIRST HEPATITIS B VACCINE RECEIVED WITHIN 24 HOURS AFTER BIRTH, OR LATER?	Within 24 hours1 Later.....2																					
IM15	HOW MANY TIMES WAS A HEPATITIS B VACCINE RECEIVED?	Number of times.....__																					
IM16	HAS (name) EVER RECEIVED A MEASLES INJECTION OR AN MMR INJECTION – 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..... 8																					
IM17	HAS (name) EVER RECEIVED THE YELLOW FEVER VACCINATION – THAT IS, A SHOT IN THE ARM AT THE AGE OF 9 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING YELLOW FEVER? Probe by indicating that the yellow fever vaccine is sometimes given at the same time as the measles vaccine	Yes..... 1 No..... 2 DK..... 8																					
IM18	HAS (name) RECEIVED A VITAMIN A DOSE LIKE (THIS/ANY OF THESE) WITHIN THE LAST 6 MONTHS? Show common types of ampules / capsules / syrups	Yes..... 1 No..... 2 DK..... 8	2⇒IM20 8⇒IM20																				
IM19	Record date for most recent Vitamin A dose as seen on vaccination card Write '44' for 'day' if card shows that Vitamin A was given but no date recorded; leave month and year blank.	Day __ __ Month __ __ Year __ __ __ __ Card does not show receipt of Vitamin A 99999994 No card / Card not seen 99999995																					
IM20	Please tell me if (name) has participated in any of the following campaigns, national immunization days and/or vitamin A or child health days: [A] 27 Nov – 3 Dec 2006/ Measles [B] 9 Nov – 11 Dec 2009/Vitamin A [C] 9 Nov – 11 Dec 2009/Deworming [D] 6 – 9 March 2010/Polio	<table border="1"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>Measles.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Vitamin</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Deworming</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>Polio.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		Y	N	DK	Measles.....	1	2	8	Vitamin	1	2	8	Deworming	1	2	8	Polio.....	1	2	8	
	Y	N	DK																				
Measles.....	1	2	8																				
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Deworming	1	2	8																				
Polio.....	1	2	8																				
UF13.	Record the time.	Hour and minutes __ : __																					
UF14.	Is the respondent the mother or caretaker of another child age 0-4 living in this household? <input type="checkbox"/> Yes. ⇒ Indicate to the respondent that you will need to measure the weight and height of the child later. Go to the next QUESTIONNAIRE FOR CHILDREN UNDER FIVE to be administered to the same respondent <input type="checkbox"/> No. ⇒ End the interview with this respondent by thanking him/her for his/her cooperation and tell her/him that you will need to measure the weight and height of the child. Check to see if there are other woman's or under-5 questionnaires to be administered in this household. Move to another woman's or under-5 questionnaire, or start making arrangements for anthropometric measurements of all eligible children in the household.																						

ANTHROPOMETRY

AN

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 household listing before recording measurements.

AN1.	Measurer's name and number:	Name.....	
AN2.	Result of height / length and weight measurement	Either or both measured.....	1
		Child not present	2 2⇒AN6
		Child or caretaker refused.....	3 3⇒AN6
		Other (specify)	6 6⇒AN6
AN3.	Child's weight	Kilograms (kg)	99.9
		Weight not measured.....	99.9
AN4.	Child's length or height	Length (cm)	
	Check age of child in AG2:	Lying down.....	1
	<input type="checkbox"/> Child under 2 years old. ⇒ Measure length (lying down).	Height (cm)	
	<input type="checkbox"/> Child age 2 or more years. ⇒ Measure height (standing up).	Standing up	2
		Length / Height not measured.....	9999.9
AN5.	Oedema	Checked	
	Observe and record	Oedema present	1
		Oedema not present.....	2
		Unsure	3
		Not checked	
		(specify reason)	7
AN6.	Is there another child in the household who is eligible for measurement?		
	<input type="checkbox"/> Yes. ⇒ Record measurements for next child.		
	<input type="checkbox"/> No. ⇒ End the interview with this household by thanking all participants for their cooperation.		
	Gather together all questionnaires for this household and check that all identification numbers are inserted on each page. Tally on the Household Information Panel the number of interviews completed.		

Interviewer's Observations

Field Editor's Observations

Supervisor's Observations