MICS JAMAICA 2005

QUESTIONNAIRE FOR CHILDREN UNDER FIVE

CONTENTS

1. **Information Panel**
2. **Birth Registration and Early Learning**
3. **Child Development**
4. **Breastfeeding**
5. **Care of Illness + Source and Cost of ORS and antibiotics**
6. **Immunization**

UNDER-FIVE CHILD INFORMATION PANEL	UF
*This questionnaire is to be administered to <u>all mothers or caretakers</u> (see household listing, column HL8) who care for a child that lives with them and is under the age of 5 years (household listing, column HL5). A **separate** questionnaire should be used for each eligible child.* *Fill in the <u>cluster and household</u> number, and <u>names and line numbers of the child and the mother/caretaker in the space below</u>. Insert your own name and number, and the date.*	

UF1. Serial Number …………………._____ ___ Parish…………………………. ___ ___ Constituency……………… …....___ ___ Enumeration District……..____ ____ ____	UF2. Dwelling number: ….………..__ __ ___ Household number:……………__ __
UF3. Child's Name: _____	UF4. Child's Line Number: __ __
UF5. Mother's/Caretaker's Name: _____	UF6. Mother's/Caretaker's Line Number: __ __
UF7. Interviewer name and number: _____ ____ ____ ___ ___	UF8. Day/Month/Year of interview: ___ ___ / ___ ___ / ___ ___ ___ ___
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) _____ 6
Data Entry Operator: _____ _____	Verifier: _____ _____

If permission is given, begin the interview. If the respondent does not agree to continue, thank him/her and go to the next interview. Discuss this result with your supervisor for a future revisit.

UF10. 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/caretaker knows the exact birth date, also enter the day; otherwise, circle 98 for day.
	Date of birth:
	  Day ....__ __
	  DK day 98
	
	  Month..__ __
	  DK month..98
	
	  Year ....__ __ __ __
	  DK year..9998	

UF11. HOW OLD WAS (*name*) AT HIS/HER LAST BIRTHDAY? *Record age in completed years.*	Age in completed years ....__ DK age………………………………………98	

BIRTH REGISTRATION AND EARLY LEARNING MODULE		BR
BR1. DOES (*name*) HAVE A BIRTH CERTIFICATE? MAY I SEE IT? (*ASK FOR "PINK SLIP" IF BIRTH CERTIFICATE IS NOT AVAILABE*)	Yes, seen... 1 Yes, not seen.. 2 No .... 3 DK... 8	1⇨BR5
BR2. HAS (*name's*) BIRTH BEEN REGISTERED WITH REGISTRAR GENERAL'S DEPARTMENT (RGD)?	Yes .... 1 No .... 2 DK.. 8	1⇨BR5 8⇨BR4
BR3. WHY IS (*name's*) BIRTH NOT REGISTERED?	Costs too much... 1 Must travel too far .... 2 Did not know it should be registered .... 3 Did not want to pay fine .... 4 Does not know where to register................ 5 Owe hospital fees……………………….....7 Father refuse use of his name……………..9 Other (*specify*) _____ 6 DK.. 8	
BR4. DO YOU KNOW HOW TO REGISTER YOUR CHILD'S BIRTH?	Yes .... 1 No 2	
BR5. *Check age of child in UF11: Child is 3 or 4 years old?* ☐ *Yes.* ⇨ *Continue with BR6* ☐ *No.* ⇨ *Go to BR8*		
BR6. 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.. 8	2⇨BR8 8⇨BR8
BR7. WITHIN THE LAST SEVEN DAYS, ABOUT HOW MANY HOURS DID (*name*) ATTEND?	No. of hours ....__ __	

BR8. 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 the child?

Circle all that apply.

		Mother	Father	Other	No one	
BR8A. READ BOOKS OR LOOK AT PICTURE BOOKS WITH (*name*)?	Books	A	B	X	Y	
BR8B. TELL STORIES TO (*name*)?	Stories	A	B	X	Y	
BR8C. SING SONGS WITH (*name*)?	Songs	A	B	X	Y	
BR8D. TAKE (*name*) OUTSIDE THE HOME, COMPOUND, YARD OR ENCLOSURE?	Take outside	A	B	X	Y	
BR8E. PLAY WITH (*name*)?	Play with	A	B	X	Y	
BR8F. SPEND TIME WITH (*name*) NAMING, COUNTING, AND/OR DRAWING THINGS?	Spend time with	A	B	X	Y	

CHILD DEVELOPMENT MODULE		CE
Question CE1 is to be administered only once to each caretaker		
CE1. HOW MANY BOOKS ARE THERE IN THE HOUSEHOLD? PLEASE INCLUDE SCHOOLBOOKS, BUT NOT OTHER BOOKS MEANT FOR CHILDREN, SUCH AS PICTURE BOOKS If 'none' enter 00	Number of non-children's books 0 __ Ten or more non-children's books 10	
CE2. HOW MANY CHILDREN'S BOOKS OR PICTURE BOOKS DO YOU HAVE FOR (*name*)? If 'none' enter 00	Number of children's books 0 __ Ten or more children's books 10	
CE3. I AM INTERESTED IN LEARNING ABOUT THE THINGS THAT (*name*) PLAYS WITH WHEN HE/SHE IS AT HOME. DOES HE/SHE PLAY WITH HOUSEHOLD OBJECTS, SUCH AS CHAIRS, HASSOCKS, CUSHIONS, PLATES, CUPS OR POTS? OBJECTS AND MATERIALS FOUND OUTSIDE THE HOUSE, SUCH AS STICKS, ROCKS, ANIMALS, SHELLS, OR LEAVES? HOMEMADE TOYS, SUCH AS DOLLS, CARS AND OTHER TOYS MADE AT HOME? TOYS THAT CAME FROM A STORE? *Code Y if child does not play with any of the items mentioned.*	Household objects (chairs, hassock, plates, cups, pots) A Objects and materials found outside the house (sticks, rocks, shells) B Homemade toys (dolls, cars and other toys made at home) C Toys that came from a store D No playthings mentioned Y	
CE4. 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 WITH OTHERS. SINCE LAST (*day of the week*) HOW MANY TIMES WAS (*name*) LEFT IN THE CARE OF ANOTHER CHILD (THAT IS, SOMEONE LESS THAN 10 YEARS OLD)? If 'none' enter 00	Number of times __ __	
CE5. IN THE PAST WEEK, HOW MANY TIMES WAS (*name*) LEFT ALONE? If 'none' enter 00	Number of times __ __	

BREASTFEEDING MODULE		BF
BF1. HAS (*name*) EVER BEEN BREASTFED?	Yes .... 1 No .... 2 DK.. 8	 2⇨BF3 8⇨BF3
BF2. IS HE/SHE STILL BEING BREASTFED?	Yes .... 1 No .... 2 DK.. 8	
BF3. 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.* BF3A. VITAMIN, MINERAL SUPPLEMENTS OR MEDICINE? BF3B. PLAIN WATER? BF3C. SWEETENED, FLAVOURED WATER OR FRUIT JUICE OR TEA OR INFUSION? BF3D. ORAL REHYDRATION SOLUTION (ORS)? BF3E. INFANT FORMULA? BF3F. TINNED, POWDERED OR FRESH MILK? BF3G. ANY OTHER LIQUIDS? BF3H. SOLID OR SEMI-SOLID (MUSHY) FOOD?	 Y N DK A. Vitamin supplements ....1 2 8 B. Plain water....................................1 2 8 C. Sweetened water or juice ....1 2 8 D. ORS ....1 2 8 E. Infant formula ....1 2 8 F. Milk...1 2 8 G. Other liquids.................................1 2 8 H. Solid or semi-solid food 1 2 8	
BF4. *Check BF3H: Child received solid or semi-solid (mushy) food?* ☐ *Yes.* ⇨ *Continue with BF5* ☐ *No or DK.* ⇨ *Go to Next Module*		
BF5. SINCE THIS TIME YESTERDAY, HOW MANY TIMES DID (*name*) EAT SOLID, SEMISOLID, OR SOFT FOODS OTHER THAN LIQUIDS? *If 7 or more times, record '7'.*	No. of times...___ Don't know 8	

CARE OF ILLNESS MODULE		CA
CA1. 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/mucus in stool.*	Yes..1 No...2 DK 8	2⇨CA5 8⇨CA5
CA2. 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.* CA2A. A FLUID MADE FROM AN ORS PACKET CA2C. A PRE-PACKAGED ORS FLUID FOR DIARRHOEA? CA2D. OTHER RECOMMENDED REMEDY	<div align=right>Yes No DK</div> A. Fluid from ORS packet.................1 2 8 C. Pre-packaged ORS fluid ....1 2 8 D. Other (specify)…………………....1 2 8	
CA3. 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 8	
CA4. 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 8	
CA4A. *Check CA2A: ORS packet used?* ☐ *Yes.* ⇨ *Continue with CA4B* ☐ *No.* ⇨ *Go to CA5*		

CA4B. WHERE DID YOU GET THE (*local name for ORS packet from CA2A)?*	Public sector
	     Govt. hospital …………………11
	     Govt. health centre……………...12
	     Community health aid…………..14
	     Mobile/outreach clinic…………..15
	     Other public (*specify*)
	 _____16
	 Private medical sector
	     Private hospital/clinic …..…21
	     Private physician………………..22
	     Private pharmacy ………………23
	 Mobile clinic …………………………….24
	 Other private medical (*specify*)_____ 26
	 Other source
	     Relative or friend………………..31
	     Shop ……………………………..32
	     Traditional practitioner …………33
	 Other (*specify*)_____ 96
	 DK………………………………………….98	

CA4C. HOW MUCH DID YOU PAY FOR THE (*local name for ORS packet from CA2A)?*	Local currency _ _ _ ._ _ Free 9996 DK 9998	

CA5. 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 LAST?	Yes.. 1 No .... 2 DK... 8	2⇨CA12 8⇨CA12
CA6. 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... 8	2⇨CA12 8⇨CA12
CA7. WERE THE SYMPTOMS DUE TO A PROBLEM IN THE CHEST OR A BLOCKED NOSE?	Problem in chest .... 1 Blocked nose .... 2 Both .... 3 Other (*specify*)_____6 DK... 8	2⇨CA12 6⇨CA12
CA8. DID YOU SEEK ADVICE OR TREATMENT FOR THE ILLNESS OUTSIDE THE HOME?	Yes.. 1 No .... 2 DK... 8	2⇨CA10 8⇨CA10

CA9. FROM WHERE DID YOU SEEK CARE?
 	
ANYWHERE ELSE?
 	
Circle all providers mentioned,
but do NOT prompt with any suggestions.
 	
If source is hospital, health center, or clinic, write the name of the place below. Probe to identify the type of source and circle the appropriate code.
 	
_____
(Name of place)
	Public sector
	   Govt. hospital.................................A
	   Govt. health centre ....B
	   Community health aid ....D
	   Mobile/outreach clinic ....E
	   Other public (*specify*) _____ H
	
	Private medical sector
	   Private hospital/clinic I
	   Private physician.............................J
	   Private pharmacy ....K
	   Mobile clinic L
	   Other private
	      medical (*specify*) _____ O
	
	Other source
	   Relative or friend...........................P
	   Shop ....Q
	   Traditional practitioner ....R
	
	Other (*specify*)_____ X	

CA10. WAS (*name*) GIVEN MEDICINE TO TREAT THIS ILLNESS?	Yes.. 1 No... 2 DK 8	2⇨CA12 8⇨CA12
CA11. WHAT MEDICINE WAS (*name*) GIVEN? *Circle all medicines given.*	Antibiotics……………………………………A Amoxil ....A1 Ampicillin…..…………………………...A2 Bactrim…………………………………A3 Evithromycin…………………………...A4 Paracetamol/Panadol/Acetaminophen ....P Aspirin...Q Ibupropfen ....R Other (*specify*)_____ X DK... Z	
CA11A. *Check CA11: Antibiotic given?* ☐ *Yes.* ⇨ *Continue with CA11B*		

	☐ *No.* ⇨ *Go to CA12*	

CA11B. WHERE DID YOU GET THE ANTIBIOTIC?	Public sector
	    Govt. hospital ……………….11
	    Govt. health centre……………..12
	    Community health aid …….14
	    Mobile/outreach clinic…………15
	    Other public (*specify*)
	    _____ 16
	
	Private medical sector
	    Private hospital/clinic…………..21
	    Private physician………………22
	    Private pharmacy ………………23
	    Mobile clinic …………………..24
	Other private medical (*specify*)_____ 26
	
	Other source
	    Relative or friend………….……31
	    Shop ……………………………32
	    Traditional practitioner ………..33
	
	Other (*specify*)……………………………96
	DK………………………………………….98	

CA11C. HOW MUCH DID YOU PAY FOR THE ANTIBIOTIC?	Local currency __ __ __ .__ __ Free 9996 DK 9998	
CA12. *Check UF11: Child aged under 3?* ☐ *Yes.* ⇨ *Continue with CA13* ☐ *No.* ⇨ *Go to CA14*		
CA13. THE LAST TIME *(name)* PASSED STOOLS, WHAT WAS DONE TO DISPOSE OF THE STOOLS?	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 open ....06 Other (*specify*)_____96 DK...98	
Ask the following question (CA14) only once for each caretaker. CA14. 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 ....A Child becomes sicker ....B Child develops a fever.......................................C Child has fast breathing ....D Child has difficult breathing.............................E Child has blood in stool....................................F Child is drinking poorly ....G Other (*specify*)_____ X Other (*specify*)_____ Y Other (*specify*)_____ Z	

IMMUNIZATION MODULE					**IM**

If an immunization card is available, copy the dates in IM2-IM8 for each type of immunization recorded on the card. IM10-IM18 are for recording vaccinations that are not recorded on the card. <u>IM10-IM18 will only be asked when a card is not available.</u>

IM1. IS THERE A VACCINATION CARD FOR (*name*)?	Yes, seen 1	
	Yes, not seen 2	2⇨IM10
	No 3	3⇨IM10

(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	
IM2. BCG	BCG				
IM3B. POLIO 1	OPV1/IPV1				
IM3C. POLIO 2	OPV2/IPV2				
IM3D. POLIO 3	OPV3/IPV3				
IM4A. DPT1	DPT1				
IM4B. DPT2	DPT2				
IM4C. DPT3	DPT3				
IM5A. HEPB1 (OR DPTHEPB1)	(DPT)H1				
IM5B. HEPB2 (OR DPTHEPB2)	(DPT)H2				
IM5C. HEPB3 (OR DPTHEPB3)	(DPT)H3				
IM5D. HIB1	HIB1				
IM5E. HIB2	HIB2				
IM5F. HIB3	HIB3				
IM6. MEASLES (OR MMR)	MEASLES				

IM9. IN ADDITION TO THE VACCINATIONS SHOWN ON THIS CARD, DID (*name*) RECEIVE ANY OTHER VACCINATIONS − INCLUDING VACCINATIONS RECEIVED IN CAMPAIGNS OR IMMUNIZATION DAYS? *Record 'Yes' only if respondent mentions BCG, OPV 0-3, DPT 1-3, Hepatitis B 1-3, Measles, HiB 1-3*	Yes.. 1 *(Probe for vaccinations and write '66' in the corresponding day column on IM2 to IM6B.)*	1⇨IM19
	No 2	2⇨IM19
	DK 8	8⇨IM19

IM10. 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	2⇨IM19
	DK 8	8⇨IM19

IM11. HAS (*name*) EVER BEEN GIVEN A BCG VACCINATION AGAINST TUBERCULOSIS – THAT IS, AN INJECTION IN THE ARM OR SHOULDER THAT CAUSED A SCAR?	Yes... 1 No .... 2 DK 8	
IM12. HAS (*name*) EVER BEEN GIVEN ANY "VACCINATION DROPS IN THE MOUTH" TO PROTECT HIM/HER FROM GETTING POLIO?	Yes... 1 No .... 2 DK 8	2⇨IM15 8⇨IM15
IM14. HOW MANY TIMES HAS HE/SHE BEEN GIVEN THESE DROPS?	No. of times .... __ __	
IM15. HAS (*name*) EVER BEEN GIVEN "DPT 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) ***DPT = DIPHTHERIA, PERTOUSIS, TETANUS***	Yes... 1 No .... 2 DK 8	 2⇨IM17 8⇨IM17
IM16. HOW MANY TIMES?	No. of times .... __ __	
IM17. HAS (*name*) EVER BEEN GIVEN "MEASLES VACCINATION INJECTIONS" OR MMR – THAT IS, A SHOT IN THE ARM AT THE AGE OF 12 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING MEASLES? ***FOR CHILD ONE AND OVER***	Yes... 1 No .... 2 DK 8	
IM19. PLEASE TELL ME IF (*name*) HAS PARTICIPATED IN ANY OF THE FOLLOWING CAMPAIGNS, NATIONAL IMMUNIZATION DAYS AND/OR CHILD HEALTH DAYS: IM19A. *MMR CAMPAIGN 2001-2002* IM19B VACCINATION WEEK 2004 *IM19C. MOP-UP CAMPAIGN 2005*	Y N DK *Campaign A* .... 1 2 8 *Campaign B* .... 1 2 8 *Campaign C* 1 2 8	

IM20. *Does another eligible child reside in the household for whom this respondent is mother/caretaker? Check household listing, column HL8.*

☐ *Yes. ⇨ End the current questionnaire and then go to another QUESTIONNAIRE FOR CHILDREN UNDER FIVE to administer the questionnaire for the next eligible child.*

☐ *No. ⇨ End the interview with this respondent by thanking him/her for his/her cooperation.*

If this is the last eligible child in the household, end the interview by thanking the family.