

**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 STATE STATISTICS SERVICE.  
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 20 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 person, 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 20 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?

- *YES, PERMISSION IS GIVEN* ⇒ *Go to UF12 to record the time and then BEGIN THE INTERVIEW.*
- *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 .....01 Not at home ..... 02 Refused..... 03 Partly completed..... 04 Incapacitated.....05 Other ( <i>specify</i> ) _____ 96
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UF10. Field edited by (Name and number): Name _____	UF11. First data entry clerk (Name and number): Name _____
UF11A. Second data entry clerk (Name and number): Name _____	

UF12. <i>Record the time.</i>	Hour and minutes .....__ __ : __ __	
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AGE	AG	
<p>AG1. NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH OF (name).</p> <p>IN WHAT MONTH AND YEAR WAS (NAME) BORN?</p> <p><i>PROBE:</i> WHAT IS HIS / HER BIRTHDAY?</p> <p><i>If the mother/caretaker knows the exact birth date, also enter the day; otherwise, circle 98 for day</i></p> <p><i>Month and year must be recorded.</i></p>	<p>Date of birth Day ..... _ _</p> <p>DK day ..... 98</p> <p>Month ..... _ _</p> <p>Year ..... _ _ _ _</p>	
<p>AG2. HOW OLD IS (NAME)?</p> <p><i>PROBE:</i> HOW OLD WAS (NAME) AT HIS / HER LAST BIRTHDAY?</p> <p><i>Record age in completed years.</i></p> <p><i>Record '0' if less than 1 year.</i></p> <p><i>Compare and correct AG1 and/or AG2 if inconsistent.</i></p>	<p>Age (in completed years)..... _</p>	

<b>BIRTH REGISTRATION</b>		<b>BR</b>
<b>BR1. DOES (NAME) HAVE A BIRTH CERTIFICATE?</b>  <i>If yes, ask:</i> <b>MAY I SEE IT?</b>	Yes, seen..... 1	1⇒Next
	Yes, not seen.....2	Module
	No .....3	2⇒Next
	DK .....8	Module
<b>BR2. HAS (NAME)'S BIRTH BEEN REGISTERED WITH THE RESPECTIVE AUTHORITIES?</b>	Yes..... 1	1⇒Next
	No .....2	Module
	DK .....8	
<b>BR3. DO YOU KNOW HOW TO REGISTER YOUR CHILD'S BIRTH?</b>	Yes..... 1	
	No .....2	

**EARLY CHILDHOOD DEVELOPMENT** **EC**

<p>EC1. HOW MANY CHILDREN’S BOOKS OR PICTURE BOOKS DO YOU HAVE FOR (NAME)?</p>	<p>None .....00</p> <p>Number of children’s books .....0 __</p> <p>Ten or more books .....10</p>																	
<p>EC2. I AM INTERESTED IN LEARNING ABOUT THE THINGS THAT (NAME) PLAYS WITH WHEN HE/SHE IS AT HOME.</p> <p>DOES HE/SHE PLAY WITH:</p> <p>[A] HOMEMADE TOYS (SUCH AS DOLLS, CARS, OR OTHER TOYS MADE AT HOME)?</p> <p>[B] TOYS FROM A SHOP OR MANUFACTURED TOYS?</p> <p>[C] HOUSEHOLD OBJECTS (SUCH AS BOWLS OR POTS) OR OBJECTS FOUND OUTSIDE (SUCH AS STICKS, ROCKS, ANIMAL SHELLS OR LEAVES)?</p> <p><i>If the respondent says “YES” to the categories above, then probe to learn specifically what the child plays with to ascertain the response</i></p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Y</th> <th style="width: 10%; text-align: center;">N</th> <th style="width: 10%; text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>Homemade toys.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Toys from a shop.....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>Household objects or outside objects .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </tbody> </table>		Y	N	DK	Homemade toys.....	1	2	8	Toys from a shop.....	1	2	8	Household objects or outside objects .....	1	2	8	
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<p>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.</p> <p>ON HOW MANY DAYS IN THE PAST WEEK WAS (NAME):</p> <p>[A] LEFT ALONE FOR MORE THAN AN HOUR?</p> <p>[B] LEFT IN THE CARE OF ANOTHER CHILD, THAT IS, SOMEONE LESS THAN 10 YEARS OLD, FOR MORE THAN AN HOUR?</p> <p><i>If ‘none’ enter ‘0’. If ‘don’t know’ enter ‘8’</i></p>	<p>Number of days left alone for more than an hour.....__</p> <p>Number of days left with other child for more than an hour .....</p>																	

EC4. Check AG2: Age of child																																					
<input type="checkbox"/> Child age 3 or 4 ⇒ Continue with EC5  <input type="checkbox"/> Child age 0, 1 or 2 ⇒ Go to Next Module																																					
EC5. 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⇒EC7 8⇒EC7																																			
EC6. WITHIN THE LAST SEVEN DAYS, ABOUT HOW MANY HOURS DID (NAME) ATTEND?	Number of hours..... _ _																																				
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): <i>IF YES, ASK:</i> WHO ENGAGED IN THIS ACTIVITY WITH (NAME)? <i>CIRCLE ALL THAT APPLY.</i>  [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="0" style="width: 100%; text-align: center;"> <thead> <tr> <th></th> <th>Mot her</th> <th>Fath er</th> <th>Oth er</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/count ed</td> <td>A</td> <td>B</td> <td>X</td> <td>Y</td> </tr> </tbody> </table>		Mot her	Fath er	Oth er	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/count ed	A	B	X	Y	
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EC8. I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT THE HEALTH AND DEVELOPMENT OF (NAME). 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 ( <i>NAME</i> ) KNOW THE NAME AND RECOGNIZE THE SYMBOL OF ALL NUMBERS FROM 1 TO 10?	Yes.....1 No.....2 DK.....8	
EC11. CAN ( <i>NAME</i> ) 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 ( <i>NAME</i> ) SOMETIMES TOO SICK TO PLAY?	Yes.....1 No.....2 DK.....8	
EC13. DOES ( <i>NAME</i> ) FOLLOW SIMPLE DIRECTIONS ON HOW TO DO SOMETHING CORRECTLY?	Yes.....1 No.....2 DK.....8	
EC14. WHEN GIVEN SOMETHING TO DO, IS ( <i>NAME</i> ) ABLE TO DO IT INDEPENDENTLY?	Yes.....1 No.....2 DK.....8	
EC15. DOES ( <i>NAME</i> ) GET ALONG WELL WITH OTHER CHILDREN?	Yes.....1 No.....2 DK.....8	
EC16. DOES ( <i>NAME</i> ) KICK, BITE, OR HIT OTHER CHILDREN OR ADULTS?	Yes.....1 No.....2 DK.....8	
EC17. DOES ( <i>NAME</i> ) GET DISTRACTED EASILY?	Yes.....1 No.....2 DK.....8	

<b>BREASTFEEDING</b>		<b>BF</b>
BF1. HAS ( <i>NAME</i> ) 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. I WOULD LIKE TO ASK YOU ABOUT LIQUIDS THAT ( <i>NAME</i> ) MAY HAVE HAD YESTERDAY DURING THE DAY OR THE NIGHT. I AM INTERESTED IN WHETHER ( <i>NAME</i> ) HAD THE ITEM EVEN IF IT WAS COMBINED WITH OTHER FOODS.  PLEASE INCLUDE LIQUIDS CONSUMED OUTSIDE OF YOUR HOME.  DID ( <i>NAME</i> ) <u>DRINK PLAIN WATER</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes.....1 No.....2 DK.....8	
BF4. DID ( <i>NAME</i> ) <u>DRINK INFANT FORMULA</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes.....1 No.....2 DK.....8	2⇒BF6 8⇒BF6
BF5. HOW MANY TIMES DID ( <i>NAME</i> ) <u>DRINK INFANT FORMULA</u> ?	Number of times.....__ __	
BF6. DID ( <i>NAME</i> ) <u>DRINK MILK, SUCH AS TINNED, POWDERED OR FRESH ANIMAL MILK</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes.....1 No.....2 DK.....8	2⇒BF8 8⇒BF8
BF7. HOW MANY TIMES DID ( <i>NAME</i> ) <u>DRINK TINNED, POWDERED OR FRESH ANIMAL MILK</u> ?	Number of times.....__ __	
BF8. DID ( <i>NAME</i> ) <u>DRINK JUICE OR JUICE DRINKS</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes.....1 No.....2 DK.....8	
BF9. DID ( <i>NAME</i> ) <u>DRINK BORSHCH/LIQUID SOUP</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes.....1 No.....2 DK.....8	
BF10. DID ( <i>NAME</i> ) <u>DRINK OR EAT VITAMIN OR MINERAL SUPPLEMENTS OR ANY MEDICINES</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes.....1 No.....2 DK.....8	



BF11. DID ( <i>NAME</i> ) <u>DRINK ORS (ORAL REHYDRATION SOLUTION)</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No ..... 2 DK ..... 8	
BF12. DID ( <i>NAME</i> ) <u>DRINK ANY OTHER LIQUIDS</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No ..... 2 DK ..... 8	
BF13. DID ( <i>NAME</i> ) <u>DRINK OR EAT YOGURT</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No ..... 2 DK ..... 8	2⇒BF15 8⇒BF15
BF14. HOW MANY TIMES DID ( <i>NAME</i> ) DRINK OR EAT YOGURT YESTERDAY, DURING THE DAY OR NIGHT?	Number of times ..... __ __	
BF15. DID ( <i>NAME</i> ) <u>EAT THIN PORRIDGE</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No ..... 2 DK ..... 8	
BF16. DID ( <i>NAME</i> ) <u>EAT SOLID OR SEMI-SOLID (SOFT, MUSHY) FOOD</u> YESTERDAY, DURING THE DAY OR NIGHT?	Yes..... 1 No ..... 2 DK ..... 8	2⇒BF18 8⇒BF18
BF17. HOW MANY TIMES DID ( <i>NAME</i> ) 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 ( <i>NAME</i> ) <u>DRINK ANYTHING FROM A BOTTLE WITH A NIPPLE?</u>	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?  <i>If less, probe:</i> 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?  <i>If "less", probe:</i> 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	
CA4A. DURING THE TIME (NAME) HAD DIARRHOEA, WAS HE/SHE GIVEN THE ORAL REHYDRATATION SOLUTION (REGIDRON/GASTROLIT)?	Yes.....1 No .....2  DK .....8	
CA5. WAS ANYTHING (ELSE) GIVEN TO TREAT THE DIARRHOEA?	Yes.....1 No .....2  DK .....8	2⇒CA7 8⇒CA7
CA6. WHAT (ELSE) WAS GIVEN TO TREAT THE DIARRHOEA?  <i>Probe:</i> ANYTHING ELSE?  <i>Record all treatments given. Write brand name(s) of all medicines mentioned.</i>  _____ (Name)	Pill or Syrup Antibiotic .....A Antimotility/loperamid .....B Zinc .....C Other pill or syrup (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 ( <i>specify</i> ) .....X	

<p>CA7. AT ANY TIME IN THE LAST TWO WEEKS, HAS (<i>NAME</i>) HAD AN ILLNESS WITH A COUGH?</p>	<p>Yes..... 1  No ..... 2  DK ..... 8</p>	<p>2⇒NEXT  MODULE  8⇒ NEXT  MODULE</p>
<p>CA8. WHEN (<i>NAME</i>) 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⇒ NEXT  MODULE  8⇒ NEXT  MODULE</p>
<p>CA9. WAS THE FAST OR DIFFICULT BREATHING DUE TO A PROBLEM IN THE CHEST OR A BLOCKED OR RUNNY NOSE?</p>	<p>Problem in chest only ..... 1  Blocked or runny nose only..... 2  Both ..... 3  Other (<i>specify</i>) ..... 6  DK ..... 8</p>	<p>2⇒ NEXT  MODULE  6⇒ NEXT  MODULE</p>
<p>CA10. 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>
<p>CA11. FROM WHERE DID YOU SEEK ADVICE OR TREATMENT?</p> <p><i>Probe:</i>  ANYWHERE ELSE?</p> <p>Circle all providers mentioned, but do NOT prompt with any suggestions.</p> <p>Probe to identify each type of source.</p> <p>If unable to determine if public or private sector, write the name of the place.</p> <p>_____</p> <p>(Name of place)</p>	<p>Public sector  Govt. hospital..... A  Govt. health centre..... B  Outpatient clinic..... C  FAP ..... D  Medical emergency..... E  Other public (<i>specify</i>) ..... F</p> <p>Private medical sector  Private hospital / clinic ..... G  Private physician..... H  Private pharmacy ..... I  Other private medical (<i>specify</i>)..... J</p> <p>Other source  Relative / Friend..... K  Shop ..... L  Traditional practitioner ..... M</p> <p>Other (<i>specify</i>) ..... X</p>	
<p>CA12. WAS (<i>NAME</i>) GIVEN ANY MEDICINE TO TREAT THIS ILLNESS?</p>	<p>Yes..... 1  No ..... 2  DK ..... 8</p>	<p>2⇒ NEXT  MODULE  8⇒ NEXT  MODULE</p>

<p>CA13. WHAT MEDICINE WAS (NAME) GIVEN?</p> <p>Probe: ANY OTHER MEDICINE?</p> <p><i>Circle all medicines given. Write brand name(s) of all medicines mentioned.</i></p> <p><i>(Names of medicines)</i></p>	<p>Antibiotic Pill / Syrup ..... A Injection ..... B</p> <p>Paracetamol / Panadol / Acetaminophen ..... C Aspirin ..... D Ibuprofen/nurofen ..... E</p> <p>Other (<i>specify</i>) _____ X</p> <p>DK..... Z</p>	
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**IMMUNIZATION**

**IM**

*If a card listing immunizations is available, copy the dates in IM3 for each type of immunization recorded on the card. IM6-IM15 are for registering vaccinations that are not recorded on the card. IM6-IM15 will only be asked when a card is not available.*

*In case the card is not at home find out where it is kept and add respective comment at the end of the questionnaire (e.g. name and address of the polyclinic, FAP etc.). If the card is kept at a medical facility **ISSUE THE FORM FOR VACCINATIONS AT HEALTH FACILITY, FILL THE IDENTIFICATION INFORMATION OF its COVER PAGE AND THEN GET THE written CONSENT OF THE MOTHER/CARETAKER/RESPONDENT** (page 3 of the form).*

IM1. DO YOU HAVE A CARD WHERE (NAME)'S VACCINATIONS ARE WRITTEN DOWN?  (IF YES) MAY I SEE IT PLEASE?		Yes, at home, seen ..... 1 Yes, at home, not seen ..... 2 No card at home ..... 3								1⇒IM3 2⇒IM6
IM2. DID YOU EVER HAVE A VACCINATION CARD FOR (NAME)?		Yes ..... 1 No..... 2								1⇒IM6 2⇒IM6
IM3. 1 Copy dates for each vaccination from the card. 2 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 1	IPV1									
POLIO 2	IPV2									
POLIO 3	OPV3 /IPV3									
POLIO 4	OPV4 /IPV4									
DPT1	ADPT1									
DPT2	ADPT2									
DPT3	ADPT3									
DPT4	ADPT4									
HEPB AT BIRTH	H0									
HEPB 1	H1									

HEPB2	H2									
HIB1	HIB1									
HIB2	HIB2									
HIB3	HIB3									
MMR	MMR									
<p>IM4. Check IM3. Are all vaccines (BCG to MMR) recorded?</p> <p><input type="checkbox"/> Yes ⇒ Go to IM19A</p> <p><input type="checkbox"/> No ⇒ Continue with IM5</p>										
<p>IM5. IN ADDITION TO WHAT IS RECORDED ON THIS CARD, DID (NAME) RECEIVE ANY OTHER?</p> <p><i>Record 'Yes' only if respondent mentions vaccines shown in the table above.</i></p>		<p>Yes ..... 1 (Probe for vaccinations and write '66' in the corresponding day column for each vaccine mentioned. Then skip to IM19A)</p> <p>No..... 2</p> <p>DK..... 8</p>	<p>2⇒IM19A</p> <p>8⇒IM19A</p>							
<p>IM6. HAS (NAME) EVER RECEIVED ANY VACCINATIONS TO PREVENT HIM/HER FROM GETTING DISEASES?</p>		<p>Yes ..... 1</p> <p>No..... 2</p> <p>DK..... 8</p>	<p>2⇒IM19A</p> <p>8⇒IM19A</p>							
<p>IM7. HAS (NAME) EVER RECEIVED A BCG VACCINATION AGAINST TUBERCULOSIS – THAT IS, AN INJECTION IN THE ARM OR SHOULDER THAT USUALLY CAUSES A SCAR?</p>		<p>Yes ..... 1</p> <p>No..... 2</p> <p>DK..... 8</p>								
<p>IM8. HAS (NAME) EVER RECEIVED VACCINATION TO PROTECT HIM/HER FROM GETTING POLIO?</p>		<p>Yes ..... 1</p> <p>No..... 2</p> <p>DK..... 8</p>	<p>2⇒IM11</p> <p>8⇒IM11</p>							
<p>IM10. HOW MANY TIMES WAS THE POLIO VACCINE RECEIVED?</p>		<p>Number of times ..... _</p>								
<p>IM11. HAS (NAME) EVER RECEIVED AN ADPT VACCINATION – THAT IS, AN INJECTION IN THE THIGH – TO PREVENT HIM/HER FROM GETTING TETANUS, WHOOPING COUGH, OR DIPHTHERIA?</p> <p><i>PROBE BY INDICATING THAT DPT VACCINATION IS SOMETIMES GIVEN AT THE SAME TIME AS POLIO</i></p>		<p>Yes ..... 1</p> <p>No..... 2</p> <p>DK..... 8</p>	<p>2⇒IM13</p> <p>8⇒IM13</p>							

IM12. HOW MANY TIMES WAS ADPT VACCINE RECEIVED?	Number of times .....	___
IM13. HAS ( <i>NAME</i> ) EVER BEEN GIVEN A HEPATITIS B VACCINATION – THAT IS, AN INJECTION IN THE THIGH – TO PREVENT HIM/HER FROM GETTING HEPATITIS B?  <i>PROBE BY INDICATING THAT THE HEPATITIS B VACCINE IS SOMETIMES GIVEN AT THE SAME TIME AS POLIO AND DPT VACCINES</i>	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 hours..... Later .....	1 2
IM15. HOW MANY TIMES WAS A HEPATITIS B VACCINE RECEIVED?	Number of times .....	___
IM16. HAS ( <i>NAME</i> ) EVER RECEIVED AN MMR INJECTION – THAT IS, A SHOT IN THE ARM AT THE AGE OF 12 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING MEASLES, MUMPS AND RUBELLA?	Yes .....	1 No..... 2 DK..... 8
IM16A. HAS ( <i>NAME</i> ) EVER RECEIVED A HIB INJECTION OR AN MMR INJECTION – THAT IS, A SHOT AT THE AGE OF 3 MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING HAEMOPHILUS INFLUENZAE?	Yes .....	1 No..... 2 DK..... 8
		2⇒IM19A 8⇒IM19A
IM16B. HOW MANY TIMES WAS A HIB VACCINE RECEIVED?	Number of times .....	___
IM19A. In your opinion, can immunization protect children against certain diseases?	Yes .....	1 No..... 2 Not sure/Depends/DK..... 8
IM19B. In your opinion, is immunization a safe medical practice?	Yes .....	1 No..... 2 Not sure/Depends/DK..... 8
IM19C. Are you going to get your child fully immunized according to the national calendar of compulsory vaccination?	Yes..... No..... Not sure/Depends/DK.....	1 2 8
IM19D. Have you ever refused from vaccinating ( <i>name</i> )?	Yes .....	1 No..... 2
		2⇒IM19F

IM19E. When refusing from vaccinating ( <i>name</i> ) you did so temporarily (for example, until he is not sick any more) or you did so because you are not going to get him/her vaccinated at all?	Temporarily..... 1 Permanently ..... 2	
IM19F. Has ( <i>name</i> ) ever had any side reactions to vaccinations?	Yes ..... 1 No..... 2  Not sure/ DK..... 8	
IM19G. Have you ever had to beg or bribe a health worker to get a fake/false vaccination record for ( <i>name</i> )?	Yes ..... 1 No..... 2	

UF13. <i>Record the time.</i>	Hour and minutes .....__ __ : __ __	
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UF14. *Is the respondent the mother or caretaker of another child age 0-4 living in this household?*

*Yes ⇒ Go to the next QUESTIONNAIRE FOR CHILDREN UNDER FIVE to be administered to the same respondent*

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

*Check to see if there are other woman's, man's or under-5 questionnaires to be administered in this household.*

*Move to another woman's, man's or under-5 questionnaire.*



**QUESTIONNAIRE FORM FOR  
VACCINATIONS AT HEALTH FACILITY**

<b>UNDER-FIVE CHILD INFORMATION PANEL</b>		<b>HF</b>
<p><i>This questionnaire form is to be used at health facilities to record information on the vaccinations of children age 0-4 years. A separate questionnaire form should be used for each eligible child.</i></p> <p><i>The Questionnaire for Under Five Children must be completed for the child prior to completing this form. This panel should be completed before visiting the health facility.</i></p> <p><i>This questionnaire form must be appended to the Questionnaire for Under Five Children for each child.</i></p>		
HF1. Cluster number: _____	HF2. Household number: _____	
HF3. Child's name: Name _____	HF4. Child's line number: _____	
HF5. Mother's / Caretaker's name: Name _____	HF6. Mother's / Caretaker's line number: _____	
HF7. Interviewer name and number: Name _____	HF8. Day / Month / Year of facility visit: _____ / _____ / _____	
HF9. Day, month and year of birth (From AG1 in Under-5 Questionnaire) _____ / _____ / _____	HF10. Name of health facility: _____	

HF11. Result of health facility visit	Vaccination record seen..... 01 Vaccination record not seen..... 02  Other (specify) _____ 96
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IMMUNIZATION											HF
HF12. Record day, month and year of birth as written on vaccination record		_____ / _____ / _____									
HF13. (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 1	IPV1										
POLIO 2	IPV2										
POLIO 3	OPV3 /IPV3										
POLIO 4	OPV4 /IPV4										
DPT1	ADPT1										
DPT2	ADPT2										
DPT3	ADPT3										
DPT4	ADPT4										
HEPB AT BIRTH	H0										
HEPB1	H1										
HEPB2	H2										
HIB1	HIB1										
HIB2	HIB2										
HIB3	HIB3										
MMR	MMR										

I, \_\_\_\_\_(*name*), the mother/caretaker of the child \_\_\_\_\_ (*name*) hereby give my consent to the State Statistics Service of Ukraine to get the data on the vaccinations made to my child kept in the records of the local health facility for the purpose of conducting the Multiple Indicator Cluster Survey.

(date)

(signature)