

Cluster 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 cluster 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? <i>Probe:</i> WHAT IS HIS/HER BIRTHDAY? <i>If the mother knows the exact birth date, also enter the day; otherwise, enter 99 for day.</i>	Date of birth Day/Month/Year ____/____/____	
4. DOES (name) HAVE A BIRTH CERTIFICATE? MAY I SEE IT? <i>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.</i>	Yes, seen 1 Yes, not seen 2 No 3 DK 9	1⇒Q.8
5. <i>If no birth certificate is shown, ask:</i> HAS (name's) BIRTH BEEN REGISTERED?	Yes 1 No 2 DK 9	1⇒Q.8 9⇒Q.7
6. WHY IS (name's) BIRTH NOT REGISTERED?	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		
<i>Further optional questions are found in Appendix Two.</i>		
1. HAS (<i>name</i>) EVER RECEIVED A VITAMIN A CAPSULE (SUPPLEMENT) LIKE THIS ONE? <i>Show capsule or dispenser.</i>	Yes 1 No 2 DK 9	2⇒NEXT MODULE 9⇒NEXT MODULE
2. HOW MANY MONTHS AGO DID (<i>name</i>) TAKE THE LAST DOSE?	Months ago ____ DK 99	
3. WHERE DID (<i>name</i>) GET THIS LAST DOSE?	On routine visit to health centre 1 Sick child visit to health centre 2 National Immunization Day campaign 3 Other (<i>specify</i>) 4 DK 9	

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BREASTFEEDING MODULE		
1. HAS (<i>name</i>) EVER BEEN BREASTFED?	Yes 1 No 2 DK 9	2⇒Q.4 9⇒Q.4
2. IS HE/SHE STILL BEING BREASTFED?	Yes 1 No 2 DK 9	2⇒Q.4 9⇒Q.4
3. SINCE THIS TIME YESTERDAY, DID HE/SHE RECEIVE ANY OF THE FOLLOWING: <i>Read each item aloud and record response before proceeding to the next item.</i>	<div style="text-align: right; margin-bottom: 10px;">Y N DK</div> A. Vitamin supplements 1 2 9 B. Plain water 1 2 9 C. Sweetened water or juice 1 2 9 D. ORS 1 2 9 E. Milk 1 2 9 F. Other liquids (<i>specify</i>) 1 2 9 G. Mushy food 1 2 9	
4. SINCE THIS TIME YESTERDAY, HAS (<i>name</i>) BEEN GIVEN ANYTHING TO DRINK FROM A BOTTLE WITH A NIPPLE OR TEAT?	Yes 1 No 2 DK 9	

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

<p>7. WHEN (<i>name</i>) HAD AN ILLNESS WITH A COUGH, DID HE/SHE BREATHE FASTER THAN USUAL WITH SHORT, QUICK BREATHS OR HAVE DIFFICULTY BREATHING?</p>	<p>Yes 1 No..... 2 DK 9</p>	<p>2⇒Q.11 9⇒Q.11</p>
<p>8. WERE THE SYMPTOMS DUE TO A PROBLEM IN THE CHEST OR A BLOCKED NOSE?</p>	<p>Blocked nose 1 Problem in chest 2 Both..... 3 Other (<i>specify</i>) 4 DK 9</p>	<p>1⇒Q.11 4⇒Q.11</p>
<p>9. DID YOU SEEK ADVICE OR TREATMENT FOR THE ILLNESS OUTSIDE THE HOME?</p>	<p>Yes 1 No..... 2 DK 9</p>	<p>2⇒Q.11 9⇒Q.11</p>
<p>10. FROM WHERE DID YOU SEEK CARE?</p> <p>ANYWHERE ELSE?</p> <p><i>Circle all providers mentioned, but do NOT prompt with any suggestions.</i></p>	<p>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 (<i>specify</i>) 11</p>	
<p><i>Ask this question (Q.11) only once for each caretaker.</i></p> <p>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?</p> <p><i>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.</i></p>	<p>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 (<i>specify</i>) 08 Other (<i>specify</i>) 09 Other (<i>specify</i>) 10</p>	

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MALARIA MODULE		
<i>This module is for use in countries or regions at high risk of malaria. See manual for definition.</i>		
1. IN THE LAST TWO WEEKS, THAT IS, SINCE (<i>day of the week</i>) OF THE WEEK BEFORE LAST, HAS (<i>name</i>) BEEN ILL WITH A FEVER?	Yes 1 No 2 DK 9	2⇒Q.8 9⇒Q.8
2. WAS (<i>name</i>) SEEN AT A HEALTH FACILITY DURING THIS ILLNESS?	Yes 1 No 2 DK 9	2⇒Q.6 9⇒Q.6
3. DID (<i>name</i>) 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 (<i>name</i>) TAKE THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY? <i>Circle all medicines mentioned.</i>	Paracetamol 1 Chloroquine 2 Fansidar 3 <i>Develop categories to include locally-used drugs, then pre-test</i> Other (<i>specify</i>) 4 DK 9	
5. WAS (<i>name</i>) 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 (<i>name</i>) 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 (<i>name</i>) GIVEN? <i>Circle all medicines given before visiting a health facility or if no visit was made to a health facility.</i>	Paracetamol 1 Chloroquine 2 Fansidar 3 <i>Develop categories to include locally-used drugs, then pre-test</i> Other (<i>specify</i>) 4 DK 9	
8. DID (<i>name</i>) SLEEP UNDER A BEDNET LAST NIGHT?	Yes 1 No 2 DK 9	2⇒NEXT 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				2⇒Q.7	
				Yes, not seen 2					
				No..... 3				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							
3A. OPV0		OPV0							
3B. OPV1		OPV1							
3C. OPV2		OPV2							
3D. OPV3		OPV3							
4A. DPT1		DPT1							
4B. DPT2		DPT2							
4C. DPT3		DPT3							
5. MEASLES		MEASLES							
6. IN ADDITION TO THE VACCINATIONS SHOWN ON THIS CARD, DID (name) RECEIVE ANY OTHER VACCINATIONS - INCLUDING VACCINATIONS RECEIVED IN A NATIONAL IMMUNIZATION DAY?				Yes 1				1⇒Q.15	
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.				(Probe for vaccinations and write '66' in the corresponding day column on Q. 2 to Q. 5.)					
				No..... 2				2⇒Q.15	
				DK 9				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 (<i>name</i>) 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 (<i>name</i>) 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 (<i>name</i>) 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 (<i>name</i>) HAS PARTICIPATED IN ANY OF THE FOLLOWING NATIONAL IMMUNIZATION DAYS: <i>Date/type of campaign A</i> <i>Date/type of campaign B</i> <i>Date/type of campaign C</i> <i>Insert date and type of vaccination given in the most recent NID campaigns.</i>	<div style="text-align: right; margin-bottom: 5px;">Y N DK</div> <i>Campaign A</i> 1 2 9 <i>Campaign B</i> 1 2 9 <i>Campaign C</i> 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: <input type="checkbox"/> Child under 2 years old. ⇒ Measure length (lying down). <input type="checkbox"/> Child age 2 or more years. ⇒ Measure height (standing up).	Length (cm) Lying down 1 ____ . ____ Height (cm) Standing up 2 ____ . ____	
3. Measurer's identification code.	Measurer code ____	
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? <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 identification numbers are at the top of each page. Tally on the Household Information Panel the number of interviews completed.		