THE GAMBIA MICS3, 2005   EA NO: HOUSEHOLD NO:

MICS

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, column HL8) who care for a child that lives with them and is under the age of 5 years (see household listing, column HL5).
A separate questionnaire should be used for each eligible child.
Fill in the cluster and household number, and names and line numbers of the child and the mother/caretaker in the space below. Insert your own name and number, and the date.

UF1. Enumeration Area Number: ___ ___ ___	UF2. Household number: ___ ___
UF3. Child's Name: _____	UF4. Child's Line Number: ___ ___ ___
UF5. Mother's/Caretaker's Name: _____	UF6. Mother's/Caregiver 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

Repeat greeting if not already read to this respondent:
WE ARE FROM VARIOUS GOVERNMENT DEPARTMENTS (CENTRAL STATISTICS DEPT., DOSH, ETC.). WE ARE WORKING ON A PROJECT CONCERNED WITH FAMILY HEALTH AND EDUCATION. I WOULD LIKE TO TALK TO YOU ABOUT THIS. THE INTERVIEW WILL TAKE ABOUT 45 MINUTES. ALL THE INFORMATION WE OBTAIN WILL REMAIN STRICTLY CONFIDENTIAL AND YOUR ANSWERS WILL NEVER BE IDENTIFIED. ALSO, YOU ARE NOT OBLIGED TO ANSWER ANY QUESTION YOU DON'T WANT TO, AND YOU MAY WITHDRAW FROM THE INTERVIEW AT ANY TIME. MAY I START NOW?

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 ....___	

BIRTH REGISTRATION AND EARLY LEARNING MODULE		BR
BR1. DOES (*name*) HAVE A BIRTH CERTIFICATE? MAY I SEE IT?	Yes, seen .... 1 Yes, not seen .... 2 No .... 3 DK 8	1⇨BR5
BR2. HAS (*name's*) BIRTH BEEN REGISTERED WITH THE CIVIL AUTHORITIES?	Yes.. 1 No .... 2 DK 8	1⇨BR4AA 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 Other (*specify*) _____ 6 DK 8	
BR4. DO YOU KNOW HOW TO REGISTER YOUR CHILD'S BIRTH?	Yes.. 1 No 2	
BR4AA. DO YOU KNOW WHERE TO REGISTER YOUR CHILD?	Yes.. 1 No .... 2 DK 8	2 ⇨BR5 8 ⇨BR5
BR4BB. WHERE WAS (*name*) REGISTERED?	Health Center…………………………….1 Medical & Health Headquarters……………..2 DK……………………………………………8	
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 - THE MOTHER, THE CHILD'S FATHER OR ANOTHER ADULT MEMBER OF THE HOUSEHOLD (INCLUDING THE CARETAKER/RESPONDENT)?		

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		CE

CE3. I AM INTERESTED IN LEARNING ABOUT THE THINGS THAT (*name*) PLAYS WITH WHEN HE/SHE IS AT HOME.
 	
WHAT DOES (*name*) PLAY WITH?
 	
DOES HE/SHE PLAY WITH
 	
    HOUSEHOLD OBJECTS, SUCH AS BOWLS, PLATES, CUPS OR POTS?
 	
    OBJECTS AND MATERIALS FOUND OUTSIDE THE LIVING QUARTERS, 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?
 	
If the respondent says "YES" to any of the prompted categories, then probe to learn specifically what the child plays with to ascertain the response
 	
Code Y if child does not play with any of the items mentioned.
	Household objects
	(bowls, plates, cups, pots)…………………….. A
	
	Objects and materials found
	outside the living quarters
	(sticks, rocks, animals, shells, leaves) ……… 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 ____ ____	
CE4AA. SINCE LAST (*day of the week*) HOW MANY TIMES WAS (*name*) LEFT IN THE CARE OF ANOTHER PERSON MORE THAN 10 YRS OLD, GRAND PARENT, OR MAID? *(If response is 00, skip to CE5)*	Number of times for > 10yrs ___ ___ Number of times for grandparent___ ___ Number of times for maid ___ ___	
CE4BB 1. WHAT DO THEY DO WITH THEM? Story telling Feeding Riddles OTHER (SPECIFY)	Story telling………………………..A Feeding…………………………….B Riddles…………………………….C Other (Specify)……………………X	
CE5. IN THE PAST WEEK, HOW MANY TIMES WAS (*name*) LEFT ALONE? ***If 'none' enter 00***	Number of times ____ ____	

VITAMIN A MODULE		VA
VA1. HAS (*name*) EVER RECEIVED A VITAMIN A CAPSULE (SUPPLEMENT) LIKE THIS ONE? *Show capsule or dispenser for different doses – 100,000 IU for those 6-11 months old, 200,000 IU for those 12-59 months old.*	Yes .... 1 No .... 2 DK... 8	2⇨VA4AA 8⇨VA4AA
VA2. HOW MANY MONTHS AGO DID (*name*) TAKE THE LAST DOSE? (**please verify from infant welfare card**)	Months ago ....__ __ DK...98	
VA3. WHERE DID (*name*) GET THIS LAST DOSE?	On routine visit to health facility .... 1 Sick child visit to health facility .... 2 National Immunization Day campaign........ 3 Nutrition Surveillance Program .... 4 Other (*specify*) _____ 6 DK... 8	
VA4AA. DOES YOUR CHILD HAVE ANY PROBLEMS SEEING IN THE DAY TIME?	Yes .... 1 No .... 2 DK... 8	
VA5AA. DOES YOUR CHILD HAVE ANY PROBLEMS SEEING IN THE NIGHT TIME?	Yes .... 1 No .... 2 DK... 8	2⇨NEXT MODULE ⇨NEXT MODULE
VA6AA. IS THIS PROBLEM DIFFERENT FROM OTHER CHILDREN IN YOUR COMMUNITY?	Yes .... 1 No .... 2 DK... 8	
VA7AA. DOES YOUR CHILD HAVE NIGHT BLINDNESS? (*USE LOCAL TERM FOR NIGHT BLINDNESS*)	Yes .... 1 No .... 2 DK... 8	

GO TO NEXT MODULE ⇨

4

BREASTFEEDING MODULE		BF
BF1. HAS (*name*) EVER BEEN BREASTFED?	Yes 1	
	No 2	2⇨BF3
	DK 8	8⇨BF3
BF1AA. FOR HOW LONG HAS (*name*) BEEN BREASTFED?	Months …….	
BF1BB. DID YOU GIVE (*name*) THE FIRST MILK THAT COMES OUT OF THE BREAST (COLOSTRUM)?	Yes .... 1 No 2	
BF1CC. IS THE BREAST MILK THE ONLY SOURCE OF FOOD?	Yes .... 1 No 2	1 ⇨BF2
BF1DD. IF NO, WHEN DID (*name*) START OTHER FOODS?	Age in months ……. ………	
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	
BF3JJ. WHAT WERE THE REASONS FOR NOT BREASTFEEDING? *(Skip this question if answer to BF1 is yes = 1)*	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	
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 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 A SPECIAL PACKET CALLED (*local name for ORS packet solution*)? CA2B. GOVERNMENT-RECOMMENDED HOMEMADE FLUID? CA2C. A PRE-PACKAGED ORS FLUID FOR DIARRHOEA?	Yes No DK A. Fluid from ORS packet ....1 2 8 B. Recommended homemade fluid ....1 2 8 C. Pre-packaged ORS fluid 1 2 8	
CA2AA. DID YOU SEEK ADVICE OR TREATMENT FOR THE DIARRHOEA OUTSIDE THE HOME?	Yes .... 1 No .... 2 DK 8	 2⇨CA3 8⇨CA3
CA2BB. HOW LONG AFTER THE ONSET OF DIARRHOEA DID YOU SEEK HELP?	Same day…………………………………1 1 – 2 days…………………………………2 3 days and after…………………………3	
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 center 12
	     Govt. health post 13
	     Village health worker 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	2⇨CA12
	DK 8	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	2⇨CA12
	DK 8	8⇨CA12
CA7. WERE THE SYMPTOMS DUE TO A PROBLEM IN THE CHEST OR A BLOCKED NOSE?	Problem in chest ....1 Blocked nose 2	2⇨CA12
	Both...3	
	Other (*specify*) _____ 6 DK 8	6⇨CA12
CA8. DID YOU SEEK ADVICE OR TREATMENT FOR THE ILLNESS OUTSIDE THE HOME?	Yes..1 No...2	2⇨CA10
	DK 8	8⇨CA10
CAA8. HOW LONG AFTER THE ONSET OF ILLNESS DID YOU SEEK HELP?	Same day……………………………………1 1 – 2 days……………………………………2 3 days and after…………………………….3	

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
	   Govt. health post C
	   Village health worker...................................... 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	2⇨CA12
	DK 8	8⇨CA12
CA11. WHAT MEDICINE WAS (*name*) GIVEN? *Circle all medicines given.* *(Check clinic card for details of prescription)*	Antibiotic .... A 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 center 12		
	Govt. health post 13		
	Village health worker 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		
	Not able to eat .... H		
	Vomits everything eaten I		
	Unconscious .... J		
	Convulsion .... K		
	Other (*specify*) _____ X		
	Other (*specify*) _____ Y		
	Other (*specify*) _____ Z		

MALARIA MODULE FOR UNDER-FIVES		ML
ML1. 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 8	 2⇨ML10 8⇨ML10
ML2. WAS (*name*) SEEN AT A HEALTH FACILITY DURING THIS ILLNESS?	Yes .... 1 No.. 2 DK 8	 2⇨ML6 8⇨ML6
ML3. DID (*name*) TAKE A MEDICINE FOR FEVER OR MALARIA THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY?	Yes .... 1 No.. 2 DK 8	 2⇨ML5 8⇨ML5

ML4. WHAT MEDICINE DID (*name*) TAKE THAT WAS PROVIDED OR PRESCRIBED AT THE HEALTH FACILITY?
 	
 Circle all medicines mentioned.
	Anti-malarials:
	    SP/Fansidar.. A
	    Chloroquine .... B
	    Amodiaquine C
	    Quinine .... D
	    Artemisinin-based combinations .... E
	    Other anti-malarial
	       (*specify*)_____H
	
	 Other medications:
	    Paracetamol/Panadol/Acetaminophen .... P
	    Aspirin.. Q
	    Ibuprofen .... R
	
	 Other (*specify*) _____ X
	 DK .... Z	

ML5. WAS (*name*) GIVEN MEDICINE FOR THE FEVER OR MALARIA BEFORE BEING TAKEN TO THE HEALTH FACILITY?	Yes .... 1 No.. 2 DK 8	1⇨ML7 2⇨ML8 8⇨ML8
ML6. WAS (*name*) GIVEN MEDICINE FOR FEVER OR MALARIA DURING THIS ILLNESS?	Yes .... 1 No.. 2 DK 8	 2⇨ML8 8⇨ML8

ML7. WHAT MEDICINE WAS (*name*) GIVEN?
 	
 Circle all medicines given. Ask to see the medication if type is not known. If type of medication is still not determined, show typical anti-malarials to respondent.
	Anti-malarials:
	    SP/Fansidar.. A
	    Chloroquine .... B
	    Amodiaquine C
	    Quinine .... D
	    Artemisinin-based combinations .... E
	    Other anti-malarial
	       (*specify*) _____H
	
	 Other medications:
	    Paracetamol/Panadol/Acetaminophen .... P
	    Aspirin.. Q
	    Ibuprofen .... R
	
	 Other (*specify*) _____ X
	 DK .... Z	

ML8. *Check ML4 and ML7: Anti-malarial mentioned (codes A - H)?* ☐ *Yes.* ⇨ *Continue with ML9* ☐*No.* ⇨*Go to ML10*		
ML9. HOW LONG AFTER THE FEVER STARTED DID (*name*) FIRST TAKE (*name of anti-malarial from ML4 or ML7*)? *If multiple anti-malarials mentioned in ML4 or ML7, name all anti-malarial medicines mentioned.* *Record the code for the day on which the first anti-malarial was given.*	Same day ....0 Next day ....1 2 days after the fever...2 3 days after the fever...3 4 or more days after the fever ....4 DK 8	

ML9A. WHERE DID YOU GET THE (*name of anti-malarial from ML4 or ML7*)? *If more than one anti-malarial is mentioned in ML4 or ML7, refer to the first anti-malarial given for the fever (the anti-malarial given on the day recorded in ML9).*	Public sector Govt. hospital 11 Govt. health center 12 Govt. health post 13 Village health worker 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	
ML9B. HOW MUCH DID YOU PAY FOR THE (*name of anti-malarial from ML4 or ML7*)? *Refer to the same anti-malarial as in ML9A above*	Local currency ____ ____ ____ ____ Free 9996 DK 9998	
ML10. DID (*name*) SLEEP UNDER A MOSQUITO NET LAST NIGHT?	Yes..1 No...2 DK 8	2⇨NEXT MODULE 8⇨NEXT MODULE
ML11. HOW LONG AGO DID YOUR HOUSEHOLD OBTAIN THE MOSQUITO NET? *If less than 1 month, record '00'.* *If answer is "12 months" or "1 year", probe to determine if net was treated exactly 12 months ago or earlier or later.*	Months ago ....__ __ More than 24 months ago.................................95 Not sure 98	
ML12. WAS THE NET ONE OF THE FOLLOWING TYPES? *If the respondent does not know the type of the net, explain to him/her the type of nets available.*	Long Lasting Net (LLN) ....1 Pre-Treated with Insecticides ....2 Not Treated with Insecticide ....3 Don't Know...8	⇨NEXT MODULE ⇨NEXT MODULE ⇨ML14
ML13. WHEN YOU GOT THAT NET, WAS IT ALREADY TREATED WITH AN INSECTICIDE TO KILL OR REPEL MOSQUITOES?	Yes..1 No...2 DK/not sure 8	
ML14. SINCE YOU GOT THE MOSQUITO NET, WAS IT EVER SOAKED OR DIPPED IN A LIQUID TO KILL/REPEL MOSQUITOES OR BUGS?	Yes..1 No...2 DK 8	2⇨ NEXT MODULE 8⇨ NEXT MODULE
ML15. HOW LONG AGO WAS THE NET LAST SOAKED OR DIPPED? *If less than 1 month, record '00'.* *If answer is "12 months" or "1 year", probe to determine if net was treated exactly 12 months ago or earlier or later.*	Months ago ....__ __ More than 24 months ago.................................95 DK 98	

IMMUNIZATION MODULE								IM
If an immunization card is available, copy the dates in IM2-IM8 for each type of immunization or vitamin A dose recorded on the card. IM10-IM18 are for recording vaccinations that are not recorded on the card. IM10-IM18 will only be asked when a card is not available.								
IM1. IS THERE A VACCINATION CARD FOR (*name*)?		Yes, seen.. 1 Yes, not seen.. 2 No.. 3						2⇨IM10 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							
IM3A. POLIO AT BIRTH	OPV0							
IM3B. POLIO 1	OPV1							
IM3C. POLIO 2	OPV2							
IM3D. POLIO 3	OPV3							
IM3EE. POLIO 4	OPV4							
IM3FF. POLIO 5	OPV5							
IM4A. DPT1/HIB1	DPT1							
IM4B. DPT2/HIB2	DPT2							
IM4C. DPT3/HIB3	DPT3							
IM4EE. DPT4 (BOOSTER)	DPT4							
IM5A. HEPB1	H1							
IM5B. HEPB2	H2							
IM5C. HEPB3	H3							
IM6. MEASLES	MEASLES							
IM7. YELLOW FEVER	YF							
IM8A. VITAMIN A (1)	VITA1							
IM8B. VITAMIN A (2)	VITA2							

IM9. IN ADDITION TO THE VACCINATIONS AND VITAMIN A CAPSULES 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, Yellow Fever vaccine(s), or Vitamin A supplements.*	Yes .... 1 *(Probe for vaccinations and write '66' in the corresponding day column on IM2 to IM8B.)* No .... 2 DK... 8	1⇨IM19 2⇨IM19 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 DK... 8	2⇨IM19 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 DISEASES – THAT IS, POLIO?	Yes .... 1 No .... 2 DK... 8	 2⇨IM15 8⇨IM15
IM13. HOW OLD WAS HE/SHE WHEN THE FIRST DOSE WAS GIVEN – JUST AFTER BIRTH (WITHIN TWO WEEKS) OR LATER?	Just after birth (within two weeks) .... 1 Later 2	
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)	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 **9** MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING MEASLES?	Yes .... 1 No .... 2 DK... 8	
IM18. HAS (*name*) EVER BEEN GIVEN "YELLOW FEVER VACCINATION INJECTIONS" – THAT IS, A SHOT IN THE ARM AT THE AGE OF **9** MONTHS OR OLDER - TO PREVENT HIM/HER FROM GETTING YELLOW FEVER? (SOMETIMES GIVEN AT THE SAME TIME AS MEASLES)	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 VITAMIN A OR CHILD HEALTH DAYS: IM19A. *NOVEMBER AND DECEMBER/POLIO 2005* IM19B. *DECEMBER 2000 MEASLES* IM19C. *2001 MENNIGITIS*	 Y N DK *NOV.& DEC./POLIO 2005* ....1 2 8 *DECEMBER 2000 MEASLES*...........1 2 8 *2001 MENINGITIS*...........................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 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, go on to ANTHROPOMETRY MODULE.

ANTHROPOMETRY MODULE		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. Child's weight.	Kilograms (kg)................................__ __ . __	
AN2. Child's length or height. *Check age of child in UF11:* ☐ *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 __ __ __ . __	
AN3. Measurer's identification code.	Measurer code.....................................__ __	
AN4. Result of measurement.	Measured... 1 Not present .... 2 Refused .... 3 Other (*specify*) _____ 6	
AN5. *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 all identification numbers are inserted on each page. Tally on the Household Information Panel the number of interviews completed.*		