

VITAMIN A & IMMUNIZATION COVERAGE STUDY HOUSEHOLD QUESTIONNAIRE

Study no. Cluster Household Family Telephone no.

Address

Date of first visit: d d / m m / y y Time: h h : m m

Comment:

Date of second visit: d d / m m / y y Time: h h : m m

Comment:

Are there any children younger than 6 years that live in this household? Yes No

If yes, list their names here:

Name & Surname	Age yrs.	Age mnth	No.

If any of these children are younger than 6 months mark the block at the end of the table. These are not included in the study!

If there are no children in this home in the age group 6 months to 6 years, no further information is required.

Who is the respondent? (older than 16 yrs.) Parent Relative Other Caretaker Name of respondent

How many people sleep in this home most of the week?

Type of home: Formal Traditional home Informal

How many rooms are in this house? (Excl. toilets & bathrooms)

Is there an electricity supply to the home? Yes No Don't know

Where do you get your water from? River/Dam Borehole Tap Other

Where does the water come to? Communal To the plot In the house

Is there a working fridge in the home? Yes No Don't know

Is there a working television set in the home? Yes No Don't know

What is the highest education attained by the mother of the children? Less than Std. 5 Std. 5 Std. 8 Std. 10 Tertiary education

Is she currently employed? Yes No Don't know

What is her occupation?

Does the father of the children live here most of the week? Yes No Don't know

VITAMIN A & IMMUNIZATION COVERAGE STUDY

INDIVIDUAL CHILD QUESTIONNAIRE

Cluster Household Family Child

Study no.

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DD / MM / YY

Date of interview

Name of interviewer

Team No.

Checked by:

Field worker signature

Supervisor signature

Child's surname: _____

Child's name: _____

Does the child have an immunization card or Road-to-Health chart?

Yes No

If yes, can I see it?

Yes No

If no, can I see a birth certificate for this child?

Yes No

If the immunization card or Road-to-Health chart is not here, is it kept at another place?

Yes No

If yes, where is it kept?

When was this child born?

DD / MM / YY

OR

Age:

_____ yrs. _____ mnth

Is the birth date or age documented?

Yes No

Sex:

M F

VACCINATION STATUS	VACCINE	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5		
		Date	RR	S	Date	RR	S	Date	RR	S	Date	RR	S	Date	RR	S
	MONOV. POLIO															
	BCG															
	DTP															
	TRIVALENT POLIO															
	MEASLES															

KEY: Date - enter the date on the immunization card, if available
 RR (Respondent recall) - enter a ✓ if the respondent recalls immunization was given
 S (Source) - enter M for mobile, H for hospital, C for clinic, P for private institution and x for not

Do all the shaded areas above have either a date or a ✓?

Yes No

If not, ask the following question and record the answer below: "What is the most important reason your child did not get all the immunizations?" (DO NOT ASK THIS QUESTION IF THE CHILD IS YOUNGER THAN 1 YEAR)

Was this child breastfed?

Yes No

If yes, for how long?

_____ yrs. _____ months

Does the child have difficulty in seeing / finding things in the dark?

Yes No Don't know

Eye examination:

Normal¹ Corneal xerosis² Bitot's spots³ Corneal scar⁴ Keratomalacia⁵ Blindness⁶

Does the child have a visible goitre?

Yes No Unsure

Is a BCG scar visible?

Yes No Unsure

Weight:

_____ kg.

_____ kg.

Height:

_____ cm.

_____ cm.

Was blood taken from this child?

None¹ Vit A² A₂³

ON ALL CHILDREN WHERE BLOOD IS TO BE TAKEN, ASK THE FOLLOWING QUESTIONS

Ask the parent or legal guardian: May I take blood from this child?

Yes

No

Is the child's forehead hot to touch?

Yes

No

If yes, what is the child's temperature?

°C

Has this child received high dose Vitamin A supplementation?

Yes

No

If yes, give the date of last dose.

d d / m m / y y

If the child's temperature is ≥ 38 °C, or if the parent or legal guardian does not give consent to the taking of blood or if this child has received high dosage Vitamin A supplementation in the last six months, no blood should be taken from this child!

Would you consider this child to be a healthy child?

Yes

No

Don't know

Has the child been ill in the last 48 hours?

Yes

No

Don't know

If yes,

Did he/she have diarrhoea?

Yes

No

Don't know

Did he/she have a cough?

Yes

No

Don't know

Did he/she have a fever?

Yes

No

Don't know

Has the child been taken to a doctor / clinic / traditional healer in the last month for any illness?

Yes

No

Don't know

Has the child been hospitalized in the last month?

Yes

No

Don't know

If yes,

Reason for hospitalization:

Name of hospital: