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 [1] | Relative [2] | Other Caretaker [3]

Name of respondent

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

Type of home: Formal [1] | Traditional home [2] | Informal [3]

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 [1] | Borehole [2] | Tap [3] | Other [4]

Where does the water come to? Communal [1] | To the plot [2] | In the house [3]

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 [1] | Std. 5 [2] | Std. 8 [3] | Std. 10 [4] | Tertiary education [5]

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

Study no. Cluster | Household | Family | Child

Date of interview (dd / mm / yy)

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: Normal[1] / Corneal xerosis[2] / Bitot's spots[3] / Corneal scar[4] / Keratomalacia[5] / Blindness[6]

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? None[1] / Vit A[2] / A_2[3]

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: _____