CGPP Household Questionnaire for Year 4 Assessment Interview Number:

Women or care takers with at least one child between 12 and 23 months old (children who have turned one year old, but not yet turned two years old)

|  |  |
| --- | --- |
| **IDENTIFICATION OF INTERVIEW** | |
| PVO/NGO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ZONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| WOREDA:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | KEBELE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| VILLAGE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | SUPERVISOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| INTERVIEWER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DATE: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Hello. My name is \_\_\_\_\_\_\_\_\_\_\_\_\_, and I work with CORE Group Ethiopia and the Ministry of Health. We are conducting a survey and we would like your participation in order to learn more about the vaccination status of your children. This interview should last no more than 10 minutes. The information that you volunteer will help CORE and the Ministry of Health to improve vaccination services. It will be completely confidential and your information will not be shared with anyone else. | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Would you like to ask any questions about this interview? | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Do you agree to be interviewed? |  |  |  |  |  |  |  | Sex of Interviewee |  |  |  |  |  |  |
| YES | | | NO | | | MALE | | | FEMALE | | |

|  |
| --- |
|  |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **IMMUNIZATION** | | | |
| **No.** | **Question** | **Coding** | **Go to…** |
| 1 | Do you believe that there are some children who should not be vaccinated or might be hurt by polio vaccination? | No……………………………………1 | **🡪 GO TO 1.2** |
| Yes/Don’t know….………………..00 | **🡪 GO TO 2** |
| 2 | At what age does a baby need to receive the polio vaccine, that is, drops in the mouth, for the first time? | First two weeks……………..………1 |  |
| Later/Don’t know...…….……..…..00 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IMMUNIZATION HISTORY** | | | | | | | | | | | | |
|  | **You will record immunization information for the youngest child in the house who is over 12 months of age and under 24 months of age (children who have turned one year old, but not yet two years old). Ask the mother or caretaker how many children, who are at least 12 months of age and under 24 months of age, live in the house even if they are not siblings, but live in the same house. Ask the mother which of these is the youngest of those at least 12 months of age. You will record vaccination information in questions 8.1 to 8.3 for the youngest child who is at least 12 months of age but under 24 months of age (children who have turned one, but not yet two years old).** | | | | | | | | | | | |
| 3.1 | What is the name of this child? | NAME: | | | | | |  | | | | |
| 3.2 | Date of Birth | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  DD MM YYYY | | | | | |  | | | | |
|  | | | | | | | | | | | | |
| 4 | Do you have a vaccination card for (*NAME)*?  May I see it? | Yes, seen……………………………1 | | | | | | | **🡪 GO TO 5** | | | |
| Yes, not seen/No card...……………...00 | | | | | | | **🡪 GO TO 6** | | | |
|  | | | | | | | | | | | | |
| **5** | 1. **COPY THE VACCINATION DATE FROM THE CARD FOR EACH VACCINATION IN THE GRID. (NOT ALL VACCINATIONS IN THE CARD ARE LISTED IN THE GRID BELOW.)** 2. **WRITE 44 IN THE DAY COLUMN IF THE CARD INDICATES THAT A VACCINATION WAS GIVEN BUT DOES NOT INDICATE A DATE** | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  |  | **Day** | | **Month** | | **Year** | | | | | |  |
| 5.1 | OPV0……………………...................................... |  |  |  |  |  |  | | |  |  |
| 5.2 | OPV3……………………...................................... |  |  |  |  |  |  | | |  |  |
| 5.3 | Measles…………………...................................... |  |  |  |  |  |  | | |  |  |
|  | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ACUTE FLACCID PARALYSIS** | | | | |
| 6 | Have you heard of acute flaccid paralysis, that is, sudden paralysis in children? | Yes…………………………………..1 | | **🡪 GO TO 6.1** |
| No/Don’t know...…………………..00 | | **🡪 GO TO 7** |
| 6.1 | Please explain what happens to a child with paralysis. | Child stops walking/crawling ……..1 | |  |
| Limp limbs…………………………..2 | |
| Don’t know/Other…………………00 | |
| 6.2 | Who would you contact besides your family if *(NAME)* had paralysis, that is, stopped being able to move his/her arm or leg? | Clinic/Municipal Authority/Hospital…….1 | |  |
| CORE/Surveillance Volunteer…….2 | |
| Don’t know/Other………… ..........00 | |
| 7 | Do you remember being visited at your home by a surveillance volunteer at times other than the days of a vaccination campaign? | Yes…………………………………..1 | |  |
| No/Don’t know...…………………..00 | |
| 8 | Have you ever attended a group health education session given by a surveillance volunteer? | Yes…………………………………..1 | |  |
| No/Don’t know...…………………..00 | |
|  | ***Thank the mother for her participation.*** | | | |
| SUPERVISOR’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | DATE REVIEWED \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ | |