



Health Results Based Financing Impact Evaluation  
Lesotho  
2015

IDENTIFIER	
CENSUS AREA NUMBER	HOUSEHOLD NUMBER

## HOUSEHOLD QUESTIONNAIRE: SELECTED WOMAN 2

GEOGRAPHICAL LOCATION		
District	<input style="width: 100px;" type="text"/>	Health Center <input style="width: 100px;" type="text"/>
Village	<input style="width: 100%; height: 20px;" type="text"/>	
GPS COORDINATES OF DWELLING		
LATITUDE (NORTH):	<input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> . <input style="width: 30px;" type="text"/>	ALTITUDE (METERS): <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/>
LONGITUDE (EAST):	<input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> <input style="width: 30px;" type="text"/> . <input style="width: 30px;" type="text"/>	

INTERVIEWER AND VISITS	LANGUAGE USED																												
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SUPERVISOR	CONTROL INFORMATION						
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DAY	MONTH	YEAR					
<input style="width: 20px;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 20px;" type="text"/>					
DATA ENTRY OPERATOR	WOMAN'S ID CODE FROM ROSTER <input style="width: 60px;" type="text"/>						
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## 6 Health Status and Utilization

SUBJECT: SELECTED WOMAN 2

RESPONDENT: SELF

Nr.	Question	CODE	SKIP	RESPONSE
(6.01)	Are you currently covered under a health care insurance scheme such as Mammoth or Bophelo Medical Scheme? (NOT INCLUDING FUNERAL INSURANCE)	YES	1	
		NO	2	
<b>ACTIVITIES OF DAILY LIVING</b>				
(6.02)	Currently, how is your health in a normal day; would you say it is excellent, good, fair or poor?	EXCELLENT	01	
		GOOD	02	
		FAIR	03	
		POOR	04	
(6.03)	If you had to carry a heavy load, such as a bucket of water, for 20 meters, could you do it easily, with some difficulty, with much difficulty or not at all?	EASILY	01	▶ (6.06)
		WITH SOME DIFFICULTY	02	
		WITH MUCH DIFFICULTY	03	
		UNABLE TO DO	04	
(6.04)	How long have you had difficulty/been unable to carry a heavy load?	LESS THAN ONE WEEK	01	
		1 TO 4 WEEKS	02	
		1 TO 6 MONTHS	03	
		MORE THAN 6 MONTHS	04	
(6.05)	Why are you unable to carry a heavy load?	DISABLED	01	
		PREGNANT	02	
		TOO WEAK	03	
		TOO SICK	04	
		TOO INJURED	05	
		OTHER (SPECIFY)	96	
(6.06)	If you had to walk 5 km, could you do it easily, with some difficulty, with much difficulty or not at all?	EASILY	01	▶ (6.09)
		WITH SOME DIFFICULTY	02	
		WITH MUCH DIFFICULTY	03	
		UNABLE TO DO	04	
(6.07)	How long have you had difficulty to walk 5 km?	LESS THAN ONE WEEK	01	
		1 TO 4 WEEKS	02	
		1 TO 6 MONTHS	03	
		MORE THAN 6 MONTHS	04	
(6.08)	Why are you unable to walk 5 km?	DISABLED	01	
		PREGNANT	02	
		TOO WEAK	03	
		TOO SICK	04	
		TOO INJURED	05	
		OTHER (SPECIFY)	96	
<b>DISABILITY AND CHRONIC ILLNESSES</b>				
(6.09)	Do you suffer from any disabilities or chronic illnesses?	YES	1	
		NO	2	
(6.10)	What disabilities or chronic illnesses do you suffer from?  (RECORD UP TO 3 ANSWERS)	<b>DISABILITIES</b>		
		PHYSICAL DISABILITY	01	
		MENTAL DISABILITY	02	
		BLINDNESS	03	
		DEAFNESS/MUTENESS	04	
		OTHER DISABILITY, SPECIFY:	96A	
		<b>CHRONIC ILLNESS</b>		
		HEART CONDITION	05	
		DIABETES	06	
		EPILEPSY	07	
		ASTHMA	08	
		CANCER	09	
		HIV/AIDS	10	
		TUBERCULOSIS	11	
OTHER CHRONIC ILLNESS, SPECIFY:	96B			
(6.11)	Given your health, how are you currently able to do daily activities such as work, housekeeping, etc?	EASILY	01	
		WITH SOME DIFFICULTY	02	
		WITH MUCH DIFFICULTY	03	
		UNABLE TO DO	04	

**ACUTE ILLNESS**

(6.12)	In the last month, have you been sick or suffering from any illness or injury, excluding disabilities or chronic illnesses?	YES	1	
		NO	2 ▶ (7.01)	
(6.13)	What were you mainly suffering from?  (RECORD UP TO 3 ANSWERS)	<b><u>DISEASES</u></b>		
		HIV/AIDS	01	
		MEASLES	02	
		CANCER	03	
		ANEMIA	04	
		DIABETES	05	
		MALNUTRITION	06	
		MENTAL DISORDER	07	
		NERVOUS / PARALYSIS	08	
		EYE PROBLEM	09	
		EAR PROBLEM	10	
		HEART DISEASE	11	
		CHEST INFECTION	12	
		TUBERCULOSIS	13	
		PNEUMONIA	14	
		OTHER RESPIRATORY	15	
		DIGESTIVE	16	
		MUSCLE / BONE	17	
		SKIN	18	
		GENITO-URINARY	19	
		PREGNANCY / CHILDBIRTH RELATED	20	
		PERINATAL	21	
		CONGENITAL	22	
		INJURY OR POISONING	23	
		<b><u>SYMPTOMS</u></b>		
		FEVER	41	
		ABDOMINAL PAIN	42	
COUGH ONLY	43			
COUGH WITH DIFFICULT, FAST BREATHING	44			
DIARRHEA WITHOUT BLOOD	45			
DIARRHEA WITH BLOOD	46			
DIARRHEA AND VOMITING	47			
VOMITING	48			
HEADACHE	49			
OTHER, SPECIFY:	96			
(6.14)	How long ago did the illness start?	NUMBER OF DAYS		
(6.15)	How long ago did the illness stop? INTERVIEWER: CANNOT BE MORE THAN THE NUMBER OF DAYS REPORTED IN (6.14). IF STILL ILL RECORD "00"	NUMBER OF DAYS		
(6.16)	In the last month, how many days of work, or other main activities did you miss due to poor health?	NUMBER OF DAYS		
(6.17)	In the last month, how many days was you confined to bed due to poor health?	NUMBER OF DAYS		
<b>SEEKING CARE</b>				
(6.18)	Did you go to any health facility or health personnel to seek care for this illness?  (INTERVIEWER: PROBE IF PATIENT WENT TO CENTER BUT CENTER WAS CLOSED/NOT STAFFED - COUNT THIS AS A "YES")	YES	1 ▶ (6.21)	
		NO	2	
(6.19)	Did you go to any traditional healer to seek care for this illness?	YES	1	
		NO	2	

(6.20)	Why didn't you go to a health facility or health personnel for care?  DO NOT READ OUT THE OPTIONS (RECORD UP TO 3 ANSWERS)	TOO EXPENSIVE	01 ▶ (6.36)	
		TOO FAR	02 ▶ (6.36)	
		TOO BUSY (WORK, CHILDREN)	03 ▶ (6.36)	
		WASN'T SICK ENOUGH	04 ▶ (6.36)	
		FACILITY HAS POOR STRUCTURE	05 ▶ (6.36)	
		FACILITY POORLY STOCKED	06 ▶ (6.36)	
		POOR STAFF ATTITUDE	07 ▶ (6.36)	
		POOR STAFF KNOWLEDGE	08 ▶ (6.36)	
		DON'T TRUST THE STAFF	09 ▶ (6.36)	
		STAFF USUALLY ABSENT	10 ▶ (6.36)	
		HEALTH FACILITY CLOSED	11 ▶ (6.36)	
		NO TRANSPORTATION	12 ▶ (6.36)	
		POOR QUALITY OF CARE	13 ▶ (6.36)	
		INCONVENIENT HOURS	14 ▶ (6.36)	
		LONG WAITING TIMES	15 ▶ (6.36)	
PREFER HOME CARE	16 ▶ (6.36)			
OTHER, SPECIFY:	96 ▶ (6.36)			
(6.21)	How long after the illness started did you seek care?	WITHIN 24 HOURS	01	
		BETWEEN 24 AND 48 HOURS	02	
		SAME WEEK	03	
		WITHIN 2 WEEKS	04	
		WITHIN 3 WEEKS	05	
<b>SEEK OF CARE, PLACE</b>				
(6.22)	Where did you seek care?	GOVERNMENT HOSPITAL	01	
		GOVERNMENT HEALTH CENTER	02	
		GOVERNMENT HEALTH POST	03	
		CHAL HEALTH CENTER	04	
		PRIVATE HOSPITAL	05	
		PRIVATE CLINIC	06	
		PRIVATE HEALTH POST	07	
		PRIVATE PRACTITIONER	08	
		PHARMACY	09	
		MOBILE CLINIC	10	
		VILLAGE HEALTH WORKER	11	
OTHER, SPECIFY:	96			
(6.23)	IF HOSPITAL, CLINIC OR HEALTH CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE	A) NAME		
		B) CODE		
<b>SEEK OF CARE, LAST VISIT</b>				
(6.24)	For the last visit, how much time did it take to travel to the health care provider? (ONE WAY ONLY)		MINUTES	
(6.25)	For the last visit, did you have a direct interaction with a health worker?	YES	1 ▶ (6.27)	
		NO	2	
(6.26)	Why did you not have a direct interaction with a health worker?	NO HEALTH WORKER PRESENT	01 ▶ (6.36)	
		HEALTH WORKER TOO BUSY	02 ▶ (6.36)	
		HEALTH WORKER NOT SEEING PATIENTS	03 ▶ (6.36)	
		HEALTH WORKER REFUSED	04 ▶ (6.36)	
		NO FEMALE HEALTH WORKER	05 ▶ (6.36)	
		HEALTH WORKER NOT QUALIFIED	06 ▶ (6.36)	
		WAITING TIME TOO LONG	07 ▶ (6.36)	
		PATIENT ARRIVED LATE	08 ▶ (6.36)	
		COULD NOT AFFORD FEE	09 ▶ (6.36)	
OTHER, SPECIFY:	96 ▶ (6.36)			
(6.27)	For the last visit, how much time did you wait to be seen by a health worker?		MINUTES	

(6.28)	For the last visit, who attended you?	MEDICAL DOCTOR	01	
		NURSE/MIDWIFE	02	
		NURSE ASSISTANT	03	
		VILLAGE HEALTH WORKER	04	
		LAB TECHNICIAN	05	
		PHARMACIST	06	
		OTHER, SPECIFY:	96	
(6.29)	Did this health care provider ask questions about how you was feeling or the symptoms that you had?	YES	1	
		NO	2	
(6.30)	Did this health care provider do any physical exams on you such as taking blood pressure, listening to the heart, etc?	YES	1	
		NO	2	
(6.31)	Did this health care provider administer any rapid test (such as a fingerprick)?	YES	1	
		NO	2	
(6.32)	Did this health care provider order any X-rays or laboratory examinations such as urine or blood tests?	YES	1	
		NO	2 ► (6.35)	
(6.33)	Did you have these tests done?	YES	1	
		NO	2	
(6.34)	Did you receive results?	YES	1	
		NO	2	
(6.35)	Did this health care provider prescribe any medicines?	YES	1	
		NO	2	
<b>EXPENDITURES</b>				
(6.36)	In the last month, how much did your household spend out of its own pocket for the treatment of your illness? Specifically, how much did your household pay out of pocket for .....  READ EACH CATEGORY ALOUD AND RECORD AMOUNT OF MONEY	A) Provider fees (Maloti)		
		B) Laboratory fees (Maloti)		
		C) Any other payment to the provider (Maloti)		
		D) Medicine (Maloti)		
		E) Transportation (Maloti)		
(6.37)	Did an employer or insurance pay for any of the provider fees, laboratory and X ray fees or transportation?	YES, EMPLOYER	01	
		YES, INSURANCE	02	
		NO	03	
		OTHER, SPECIFY:	96	
<b>HOSPITALIZATION</b>				
(6.38)	In the last month, did you have to spend the night in a health facility or hospital to treat this illness?	YES	1	
		NO	2 ► (7.01)	
(6.39)	Over the last month, how many nights did you spend in the health facility or hospital?	NIGHTS		
(6.40)	In the last month, how much did your household spend out of its own pocket on your stay on the health facility or hospital to treat this illness?	Maloti		

## 7 Pregnancy History

SUBJECT: SELECTED WOMAN 2

RESPONDENT: SELF

Nr.	Question	CODE	SKIP	RESPONSE
<b>PREGNANCY</b>				
(7.01)	What age do you think is a good age for a woman to have her first child?	YEARS (XX)		
(7.02)	What age do you think is a good age for a man to have his first child?	YEARS (XX)		
(7.03)	What is the ideal number of children that you would like to have at the time you are 50?	NUMBER (XX)		
(7.04)	According to you, in a couple, how should the number of children be decided?	PRIMARILY THE WOMAN	01	
		PRIMARILY THE MAN	02	
		BOTH	03	
		DON'T KNOW	99	
(7.05)	Are you pregnant now?	YES	1	
		NO	2 ► (7.07)	
		NOT SURE	3 ► (7.07)	
(7.06)	How many months pregnant are you? ► (7.08)	MONTHS (XX)		
(7.07)	Have you ever been pregnant, including pregnancies that may have ended in miscarriage, abortion or stillbirth (born dead)?	YES	1	
		NO	2 ► (11.01)	
(7.08)	How many times have you been pregnant?	NUMBER (XX)		
(7.09)	How old were you when you got pregnant for the first time?	YEARS (XX)		
<b>NUMBER OF CHILDREN</b>				
(7.10)	Do you have any children to whom you have given birth who are now living with you?	YES	1	
		NO	2 ► (7.12)	
(7.11)	A) How many sons live with you?	SONS (XX)		
	B) How many daughters live with you?	DAUGHTERS (XX)		
(7.12)	Do you have any children to whom you have given birth who are still alive but do not live with you?	YES	1	
		NO	2 ► (7.14)	
(7.13)	A) How many sons live elsewhere?	SONS (XX)		
	B) How many daughters live elsewhere?	DAUGHTERS (XX)		
(7.14)	Have you ever given birth to a child who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?	YES	1	
		NO	2 ► (7.16)	
(7.15)	A) How many sons died?	SONS (XX)		
	B) How many daughters died?	DAUGHTERS (XX)		
(7.16)	SUM ANSWERS TO (7.11), (7.13), AND (7.15)	TOTAL (XX)		
(7.17)	Please confirm the total number of children you have given birth to is... NUMBER IN QUESTION: (7.16)	YES	1	
		NO	2 ► PROBE AND CORRECT	

<b>LIVE BIRTHS</b>			
(7.18)	ENUMERATOR: IS THE NUMBER OF LIVE BIRTHS IN (7.16) AT LEAST ONE?	YES	1
		NO	2 ► (7.20)
(7.19)	When was the last time that you gave birth to a child that was born alive?	MONTH (MM)	
		YEAR (YYYY)	
<b>STILLBIRTH AND MISCARRIAGE OR ABORTION</b>			
(7.20)	Have you ever had a pregnancy that ended in stillbirth, that is when pregnancy has lasted at least 28 weeks but the baby dies before it is born?	YES	1
		NO	2 ► (7.23)
(7.21)	How many pregnancies have ended in a stillbirth?	NUMBER (XX)	
(7.22)	When was the last time you had a stillbirth?	MONTH (MM)	
		YEAR (YYYY)	
(7.23)	Have you ever had a pregnancy that ended in a miscarriage or abortion, that is when the pregnancy lasts less than 28 weeks?	YES	1
		NO	2 ► (8.01)
(7.24)	How many pregnancies have ended in a miscarriage or abortion?	NUMBER (XX)	
(7.25)	When was the last time you had a miscarriage or abortion?	MONTH (MM)	
		YEAR (YYYY)	

## 8 Antenatal and Postnatal Care

SUBJECT: SELECTED WOMAN 2

INTERVIEWER: LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

RESPONDENT: SELF

ANTENATAL CARE						
(8.01)	PREGNANCY NUMBER	(8.02)	(8.03)	(8.04)		
Now I am going to ask you some questions about your pregnancies (including any current pregnancy) that ended in live birth, still birth, miscarriage or abortion. How many pregnancies did you have in the last 24 months?		Did you consult any health care provider for antenatal care for this pregnancy?  FOR WOMEN WHOSE LAST PREGNANCY WAS A STILLBIRTH, MISCARRIAGE OR ABORTION, THE LAST PREGNANCY IS THE PREGNANCY THAT ENDED IN STILLBIRTH, MISCARRIAGE OR ABORTION	Why didn't you consult any health care provider for antenatal care for this pregnancy? RECORD UP TO 3 REASONS. DON'T READ OUT THE ANSWERS.	Did you ever try to go for antenatal care but the facility staff told you to go away and come back another day?  ▶ (8.12)		
			TOO EXPENSIVE 01		YES 1	
			TOO FAR 02		NO 2	
			TOO BUSY (WORK, CHILDREN) 03			
			SELF-TREATED 04			
			WAS TOO EARLY IN PREGNANCY 05			
			FACILITY HAS POOR STRUCTURE 06			
			FACILITY POORLY STOCKED 07			
			POOR STAFF ATTITUDE 08			
			POOR STAFF KNOWLEDGE 09			
			POOR QUALITY OF CARE 10			
			SERVICE NOT AVAILABLE 11			
			NO TRANSPORTATION 12			
			WENT TO A TRADITIONAL HEALER 13			
			DID NOT NEED 14			
			INCONVENIENT HOURS 15			
			LONG WAITING TIMES 16			
			PREFER HOME CARE 17			
			FAMILY DIDN'T WANT ME TO GO 18			
			OTHER (SPECIFY) 96			
		FIRST	SECOND	THIRD		
1						
2						
3						

## 8 Antenatal and Postnatal Care

**SUBJECT:** SELECTED WOMAN 2

**INTERVIEWER:** LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

**RESPONDENT:** SELF

ANTENATAL CARE						
PREGNANCY NUMBER	(8.05)	(8.06)	(8.07)	(8.08)		
	What kind of provider did you see for antenatal care for this pregnancy?	In what kind of facility or location did you see this health care provider?	IF HOSPITAL, CLINIC OR HEALTH CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.	How many months pregnant were you when you <b>first</b> received antenatal care for this pregnancy?		
	IF MORE THAN ONE PROVIDER, WRITE THE PROVIDER THAT IS HIGHEST ON THE LIST.	IF MORE THAN ONE, WRITE FACILITY CORRESPONDING TO PROVIDER IN CELL (8.05)	INTERVIEWER: BELOW INSTRUCTIONS ARE FOR DATA ENTRY ONLY. DO NOT RECORD CODES 33333, 66666 OR 99999. RECORD HEALTH FACILITY CODE.			
	MEDICAL DOCTOR	01	GOVERNMENT HOSPITAL	01	NOT A REAL HEALTH CENTER (EG RED CROSS)	33333
	NURSE/MIDWIFE	02	GOVERNMENT HEALTH CENTER	02	HEALTH CENTER COULD NOT BE IDENTIFIED BY INTERVIEWER	66666
	NURSE ASSISTANT	03	GOVERNMENT HEALTH POST	03	HEALTH CENTER IS OUTSIDE THE STUDY AREA	99999
	VILLAGE HEALTH WORKER	04	CHAL HEALTH CENTER	04		
	TRADITIONAL BIRTH ATTENDANT	05	PRIVATE HOSPITAL	05		
	TRADITIONAL HEALER	06	PRIVATE CLINIC	06		
	SPIRITUAL HEALER	07	PRIVATE HEALTH POST	07		
OTHER (SPECIFY)	96	PHARMACY	08 ► (8.08)			
		MOBILE CLINIC	09 ► (8.08)			
		PROVIDER'S HOME	10 ► (8.08)			
		OWN HOME	11 ► (8.08)			
		OTHER HOME	12 ► (8.08)			
		OUTDOOR LOCATION	13 ► (8.08)			
		OTHER (SPECIFY)	96 ► (8.08)			
			NAME	CODE	NUMBER OF MONTHS	
1						
2						
3						

## 8 Antenatal and Postnatal Care

SUBJECT: SELECTED WOMAN 2

INTERVIEWER: LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

RESPONDENT: SELF

ANTENATAL CARE																							
PREGNANCY NUMBER	(8.09)	(8.10)	(8.11)																				
	How many times did you receive antenatal care for this pregnancy?	How many months pregnant were you when you <u>last</u> received antenatal care for this pregnancy?	Now I would like to ask you about things that may have been done during the antenatal care visits for your last pregnancy. During those visits, was the following done during at least one visit?																				
	IF ONCE, RECORD 1 AND ► (8.11)	INTERVIEWER ROUND MONTHS	<table border="1"> <tr> <td>YES</td> <td>1</td> <td>DONT KNOW</td> <td>96</td> </tr> <tr> <td>NO</td> <td>2</td> <td></td> <td></td> </tr> </table>		YES	1	DONT KNOW	96	NO	2			A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.
YES	1	DONT KNOW	96																				
NO	2																						
NUMBER OF TIMES	NUMBER OF MONTHS	Were you weighed?	Was your height measured?	Was your blood pressure measured?	Did you give a urine sample?	Did you give a blood sample?	Did you schedule your delivery in the facility?	Did the provider palpate your tummy?	Did the health worker estimate your due date?	Was your uterine height measured (this is when the provider measures your tummy using a measurement tape)?	Did the health worker ask for your blood type and Rhesus?	Did you receive advice on the diet during your pregnancy?	Did you receive advice on what to do in case of an emergency?										
1																							
2																							
3																							

## 8 Antenatal and Postnatal Care

SUBJECT: SELECTED WOMAN 2

INTERVIEWER: LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

RESPONDENT: SELF

PREGNANCY NUMBER	AIDS & TETANUS				MOTHER-BABY PACK & IRON				
	(8.12)	(8.13)	(8.14)	(8.15)	(8.16)	(8.17)	(8.18)	(8.19)	(8.20)
	During this pregnancy, were you offered counseling and testing for the virus that causes AIDS?	I will not ask you the result, but were you tested?	I will not ask you the result, but did you receive the result?	During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?	How many times did you receive this shot during the pregnancy?	During this pregnancy, were you given the mother-baby pack?	Who provided you with the mother-baby pack?  ▶ (8.20)	During this pregnancy, were you given or did you buy any iron tablets or iron syrup?	During the pregnancy, for how many days did you take the iron tablets/syrup (from your mother-baby pack or the ones you were given/bought)?
	YES 1 NO 2 ▶ (8.15)	YES 1 NO 2 ▶ (8.15)	YES 1 NO 2	YES 1 NO 2 ▶ (8.17)	NUMBER OF SHOTS	YES 1 NO 2 ▶ (8.19)	MEDICAL DOCTOR 01 NURSE/MIDWIFE 02 NURSE ASSISTANT 03 VILLAGE HEALTH WORKER 04 LAB TECHNICIAN 05 PHARMACIST 06  TRADITIONAL HEALER 07 TRADITIONAL BIRTH ATTENDANT 08 SPIRITUAL HEALER 09  FAMILY MEMBER 10 FRIEND/NEIGHBOR 11  OTHER, SPECIFY 96	YES 1 NO 2 ▶ (8.21)	NUMBER OF DAYS
1									
2									
3									

# 8

# Antenatal ar Antenatal and Postnatal Care

SUBJECT: SELECTED WOMAN 2

INTERVIEWER: LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

RESPONDENT: SELF

PREGNANCY NUMBER	PREGNANCY RESULT			DELIVERY								
	(8.21)	(8.22)	(8.23)	(8.24)		(8.25)						
	When did this pregnancy end?  INTERVIEWER: RECORD END DATE OF PREGNANCY REGARDLESS OF RESULT (LIVE BIRTH, STILLBIRTH, MISCARRIAGE OR ABORTION). RECORD ANY MISSING ELEMENT OF THE DATE AS "DK".  IF STILL PREGNANT WRITE 97 AND ► NEXT PREGNANCY	What was the result of this pregnancy?  BORN ALIVE, SINGLE BIRTH 1  BORN ALIVE, MULTIPLE BIRTH 2  STILL BIRTH 3  MISCARRIAGE ► (8.38) 4  ABORTION ► (8.38) 5	Who assisted with the delivery for this pregnancy?  IF MORE THAN ONE, WRITE THE HEALTH PERSONNEL THAT IS HIGHEST ON THE LIST.  MEDICAL DOCTOR 01 NURSE/MIDWIFE 02 NURSE ASSISTANT 03 VILLAGE HEALTH WORKER 04 TRADITIONAL BIRTH ATTENDANT 05 TRADITIONAL HEALER 06 SPIRITUAL HEALER 07 FAMILY MEMBER 08 FRIEND/NEIGHBOR 09 NO ONE 10 OTHER, SPECIFY: 96	Where did you deliver?  GOVERNMENT HOSPITAL 01 GOVERNMENT HEALTH CENTER 02 GOVERNMENT HEALTH POST 03 CHAL HEALTH CENTER 04 PRIVATE HOSPITAL 05 PRIVATE CLINIC 06 PRIVATE HEALTH POST 07  MOBILE CLINIC 08 ► (8.26) OWN HOME 09 ► (8.26) ANOTHER HOME 10 ► (8.26) A PUBLIC PLACE 11 ► (8.26) OTHER (SPECIFY) 96 ► (8.26)		IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.  INTERVIEWER: BELOW INSTRUCTIONS ARE FOR DATA ENTRY ONLY. DO NOT RECORD CODES 33333, 66666 OR 99999. RECORD HEALTH FACILITY CODE.  NOT A REAL HEALTH CENTER (EG. RED CROSS) 33333 HEALTH CENTER COULD NOT BE IDENTIFIED BY INTERVIEWER 66666 HEALTH CENTER IS OUTSIDE THE STUDY AREA 99999  ► (8.27)						
								DD	MM	YYYY	NAME	CODE
								1				
								2				
								3				

## 8 Antenatal and Postnatal Care

SUBJECT: SELECTED WOMAN 2

INTERVIEWER: LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

RESPONDENT: SELF

		DELIVERY					INFANT CHARACTERISTICS						
PREGNANCY NUMBER	(8.26)				(8.27)	INTERVIEWER: CHECK QUESTION  (8.22)  IF LIVE BIRTH: ASK FOLLOWING QUESTIONS FOR AT LEAST FIRST CHILD, AND IF MULTIPLE BIRTHS, PROCEED TO SAME QUESTIONS FOR SECOND/THIRD CHILD IF APPLICABLE.  IF STILLBIRTH: ► (8.38)	(8.28)			(8.29)			
	Why didn't you deliver in a formal health facility for this pregnancy? RECORD UP TO 3 REASONS.				Was the birth delivered by caesarean section, that is did they cut your belly open to take the baby out?		Was the infant(s) a boy or a girl?				Was the infant(s) weighed at birth?		
	TOO EXPENSIVE		01				BOY	01	YES	1			
	TOO FAR		02				GIRL	02	NO	2			
	WAS TOO LATE IN DELIVERY		03				► (8.32)						
	FACILITY HAS POOR STRUCTURE		04				A.	B.	C.	A.	B.	C.	
	FACILITY POORLY STOCKED		05				FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	
	POOR STAFF ATTITUDE		06										
	POOR STAFF KNOWLEDGE		07										
	POOR QUALITY OF CARE		08										
	SERVICE NOT AVAILABLE		09										
	NO TRANSPORTATION		10										
	WENT TO A TRADITIONAL HEALER		11										
	DID NOT NEED		12										
	INCONVENIENT HOURS		13										
	LONG WAITING TIME		14										
	PREFER HOME DELIVERY		15										
	FAMILY DIDN'T WANT ME TO GO		16										
	OTHER, SPECIFY:		96	YES	1								
	FIRST	SECOND	THIRD	NO	2								
1													
2													
3													

# 8 Antenatal and Postnatal Care

SUBJECT: SELECTED WOMAN 2

INTERVIEWER: LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

RESPONDENT: SELF

PREGNANCY NUMBER	INFANT CHARACTERISTICS									FEEDING											
	(8.30)			(8.31)			(8.32)			(8.33)			(8.34)			(8.35)					
	How much did the infant(s) weigh?			CONFIRM: IS THE SOURCE FOR WEIGHT RECALL OR FROM BUKANA?			When the infant(s) was born for this pregnancy, was he/she very large, larger than average, average, smaller than average or very small?			Did you ever breastfeed the infant(s)?			After the infant(s) was born, how much time did it take before you started breastfeeding him/her?			In the first 6 months after delivery, was the infant(s) given anything to drink other than breast milk?					
	RECORD WEIGHT IN KILOGRAMS			RECALL BUKANA			VERY LARGE LARGER THAN AVERAGE AVERAGE SMALLER THAN AVERAGE VERY SMALL			YES NO			WRITE THE ANSWER IN HOURS IF LESS THAN ONE HOURS, RECORD 00			YES NO					
A.	B.	C.	A.	B.	C.	A.	B.	C.	A.	B.	C.	A.	B.	C.	A.	B.	C.	A.	B.	C.	
FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	
KGS	KGS	KGS										HOURS	HOURS	HOURS							
1	.	.	.																		
2	.	.	.																		
3	.	.	.																		

## 8 Antenatal and Postnatal Care

**SUBJECT:** SELECTED WOMAN 2

**INTERVIEWER:** LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

**RESPONDENT:** SELF

PREGNANCY NUMBER	FEEDING									POSTNATAL CARE										
	(8.36)									(8.37)			(8.38)		(8.39)	(8.40)				
	What was the infant given to drink other than breastmilk? INTERVIEWER: RECORD UP TO 3 RESPONSES.									For how many months did you breastfeed?			After the birth/miscarriage, did a health professional check on your health?		How many post-natal check ups did you attend/receive in the first 2 months after the birth / miscarriage?	How long after the birth/miscarriage did you receive the first post-natal check?				
	MILK (OTHER THAN BREASTMILK) 01			INFANT FORMULA 06			RECORD IN MONTHS			IF LESS THAN ONE MONTH, RECORD 00  IF STILL BREASTFEEDING RECORD 98	YES 1 NO 2 ► (8.44)	WRITE THE ANSWER IN DAYS. IF LESS THAN A DAY, WRITE 00								
PLAIN WATER 02			GRIPE WATER 07			FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD				SECOND CHILD	THIRD CHILD						
SUGAR/GLUCOSE WATER 03			TEA/INFUSIONS 08												FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD
SUGAR-SALT-WATER SOLUTION 04			HONEY 09																	
FRUIT JUICE 05			COFFEE 10			FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD				SECOND CHILD	THIRD CHILD						
			OTHER (SPECIFY) 96							FIRST CHILD	SECOND CHILD	THIRD CHILD			FIRST CHILD	SECOND CHILD	THIRD CHILD			
A.			B.			C.			MONTHS				MONTHS	MONTHS				NUMBER	DAYS	
FIRST CHILD			SECOND CHILD			THIRD CHILD				MONTHS	MONTHS	MONTHS			NUMBER	DAYS				
1	2	3	1	2	3	1	2	3	MONTHS				MONTHS	MONTHS			NUMBER	DAYS		
1																				
2																				
3																				

## 8 Antenatal and Postnatal Care

**SUBJECT:** SELECTED WOMAN 2

**INTERVIEWER:** LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

**RESPONDENT:** SELF

		POSTNATAL CARE					
PREGNANCY NUMBER	(8.41)	(8.42)	(8.43)		(8.44)		
	Who checked on your health the first time?  IF MORE THAN ONE, WRITE THE HEALTH PERSONNEL THAT IS HIGHEST ON THE LIST.	Where did this check take place?	IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.  ▶ (8.45)		Why didn't you have a postnatal check up with a health professional in a formal health facility for this pregnancy? RECORD UP TO 3 RESPONSES		
	MEDICAL DOCTOR 01	GOVERNMENT HOSPITAL 01	INTERVIEWER: BELOW INSTRUCTIONS ARE FOR DATA ENTRY ONLY. DO NOT RECORD CODES 33333, 66666 OR 99999. RECORD HEALTH FACILITY CODE.  NOT A REAL HEALTH CENTER (EG. RED CROSS) 33333 HEALTH CENTER COULD NOT BE IDENTIFIED 66666 HEALTH CENTER IS OUTSIDE THE STUDY AREA 99999		TOO EXPENSIVE	01	
	NURSE/MIDWIFE 02	GOVERNMENT HEALTH CENTER 02			TOO FAR	02	
	NURSE ASSISTANT 03	GOVERNMENT HEALTH POST 03			TOO BUSY (WORK, CHILDREN)	03	
	VILLAGE HEALTH WORKER 04	CHAL HEALTH CENTER 04			SELF-TREATED	04	
	TRADITIONAL BIRTH ATTENDANT 05	PRIVATE HOSPITAL 05			DID NOT NEED	05	
	TRADITIONAL HEALER 06	PRIVATE CLINIC 06			FACILITY HAS POOR STRUCTURE	06	
	SPIRITUAL HEALER 07	PRIVATE HEALTH POST 07			FACILITY POORLY STOCKED	07	
	OTHER, SPECIFY: 96	PRIVATE HEALTH POST 07			POOR STAFF ATTITUDE	08	
		MOBILE CLINIC 08 ▶ (8.44)			POOR STAFF KNOWLEDGE	09	
		PROVIDER'S HOME 09 ▶ (8.44)			POOR QUALITY OF CARE	10	
		OWN HOME 10 ▶ (8.44)	SERVICE NOT AVAILABLE	11			
		OTHER HOME 11 ▶ (8.44)	WENT TO A TRADITIONAL HEALER	12			
		OUTDOOR LOCATION 12 ▶ (8.44)	NO TRANSPORTATION	13			
		OTHER (SPECIFY) 96 ▶ (8.44)	INCONVENIENT HOURS	14			
			LONG WAITING TIMES	15			
			PREFER HOME CARE	16			
			FAMILY DIDN'T WANT ME TO GO	17			
			OTHER (SPECIFY)	96			
			NAME	CODE	FIRST	SECOND	THIRD
1							
2							
3							

## 8 Antenatal and Postnatal Care

SUBJECT: SELECTED WOMAN 2

INTERVIEWER: LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

RESPONDENT: SELF

PREGNANCY NUMBER	IRON TABLETS/SYRUP			VITAMIN A				DEATH					
	(8.45)	(8.46)	(8.47)	(8.48)	(8.49)			(8.50)			(8.51)		
	After the birth/miscarriage, did you continue to take any iron tablets or iron syrup or folic acid (from the mother-baby pack or from other source)?	How long after the birth/miscarriage did you take the first iron dose?	For how many days after the birth/miscarriage did you take the iron tablets or iron syrup?	In the first two months after the birth/miscarriage, did you receive a vitamin A dose? This might have been provided to you with your mother-baby-pack.	Who provided you with the vitamin A dose?			Is the child still alive?			How old was the child when he/she died?		
	YES 1 NO 2 ► (8.48)	WRITE THE ANSWER IN DAYS	NUMBER OF DAYS	YES 1 NO 2 ► (8.50)	MEDICAL DOCTOR 01	YES 1 ► (8.52) NO 2	IF LESS THAN ONE MONTH, WRITE ZERO  ► NEXT PREGNANCY						
								A.	B.	C.	A.	B.	C.
								FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD
1													
2													
3													

## 8 Antenatal and Postnatal Care

**SUBJECT:** SELECTED WOMAN 2

**INTERVIEWER:** LIST ALL PREGNANCIES WITHIN THE PAST 24 MONTHS. START WITH THE MOST RECENT PREGNANCY.

**RESPONDENT:** SELF

PREGNANCY NUMBER	PRESENCE IN HOUSEHOLD						FEEDING IN LAST 24 HOURS									
	(8.52)			(8.53)			(8.54)									
	Is the child still living with you?			INTERVIEWER: RECORD THE INDIVIDUAL ID CODE OF THE CHILD FROM ROSTER			INTERVIEWER: IF MULTIPLE BIRTH RECORD ONLY FOR FIRST CHILD. In the last 24 hours, have you given the child any of the following?									
	YES 1 NO 2 ► NEXT PREGNANCY						<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>YES</td> <td>1</td> </tr> <tr> <td>NO</td> <td>2</td> </tr> </table> <p style="text-align: center;">► NEXT PREGNANCY</p>									
YES	1															
NO	2															
						A	B	C	D	E	F	G	H	I	J	
A. B. C.			A. B. C.			Vitamin supplements	Plain water	Sweet water/ Fruit juice	Oral rehydration solution (ORS)	Infant formula	Breastmilk	Milk other than breastmilk	Other liquids	Solid food	Musty food	
FIRST CHILD SECOND CHILD THIRD CHILD			FIRST CHILD SECOND CHILD THIRD CHILD													
ID CODE ID CODE ID CODE			ID CODE ID CODE ID CODE													
1																
2																
3																

# 9 Vaccination

SUBJECT: CHILDREN < 5 YEARS OLD OF SELECTED WOMAN 2

RESPONDENT: SELECTED WOMAN 2

(9.00) CONFIRM USING THE FLAP THE TOTAL NUMBER OF LIVING CHILDREN < 5 YEARS OLD OF SELECTED WOMAN 2:

ID CODE	(9.01)	(9.02)																																				
	Do you have a bukana where [NAME]'S vaccinations are written down?  IF YES, RECORD IF YOU SEE THE CARD OR NOT.	INTERVIEWER: COPY VACCINATION DATE FOR EACH VACCINE FROM CARD * IF VACCINE WAS RECEIVED AND DATE WAS RECORDED, RECORD AS FOLLOWING: RECORD DAY USING 2 DIGITS DD (RANGE 01-31) RECORD MONTH USING 2 DIGITS MM (RANGE 01-12) RECORD YEAR USING 2 DIGITS YY (RANGE 10-15) RECORD ANY MISSING ELEMENT OF THE DATE AS "DK" IF DATE DOES NOT INCLUDE DD OR MM OR YY. * IF VACCINE WAS RECEIVED BUT NO DATE WAS RECORDED, RECORD "44" IN DAY COLUMN. * IF VACCINE WAS NOT RECEIVED AT ALL, RECORD "00" IN DAY COLUMN.  ALL VACCINE COLUMNS SHOULD BE FILLED OUT.																																				
	YES, SEEN 1																																					
	YES, NOT SEEN 2																																					
		A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	(9.05)			(9.04)																						
	NO 3	BCG			OPV0			OPV1			OPV2			OPV3			PENTV1			PENTV2			PENTV3			MEASLES1			MEASLES2			DT booster						
		DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	
01																																						
02																																						
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15																																						

# 9 Vaccination

**SUBJECT:** CHILDREN < 5 YEARS OLD OF THE SELECTED WOMAN 2

**RESPONDENT:** SELECTED WOMAN 2

<b>ID CODE</b>	(9.02) continued																								(9.03)																
	INTERVIEWER: COPY VACCINATION DATE FOR EACH VACCINE FROM CARD												FOR VITAMIN A AND ALBENDAZOLE ALSO RECORD UNDER TOTAL THE										Has [NAME] received																		
	* IF VACCINE WAS RECEIVED AND DATE WAS RECORDED, RECORD AS FOLLOWING:												NUMBER OF TIMES RECEIVED										any vaccinations or																		
	RECORD DAY USING 2 DIGITS DD (RANGE 01-31)																						vitamin A, not																		
	RECORD MONTH USING 2 DIGITS MM (RANGE 01-12)																						recorded on this card,																		
	RECORD YEAR USING 2 DIGITS YY (RANGE 10-15)																						including vaccinations																		
	RECORD ANY MISSING ELEMENT OF THE DATE AS "DK".																						given on a national																		
	* IF VACCINE WAS RECEIVED BUT NO DATE WAS RECORDED, RECORD "44" IN DAY COLUMN.																						immunization day or																		
	* IF VACCINE WAS NOT RECEIVED AT ALL, RECORD "00" IN DAY COLUMN.																						child health week?																		
	ALL VACCINE COLUMNS SHOULD BE FILLED OUT.																																								
	L.			M.			N.			O.			P.			Q.			R.			S.			T.			U.													
	PCV1			PCV2			PCV3			ROTA VIRUS1			ROTA VIRUS2			ROTA VIRUS3			VITAMIN A (first)			VITAMIN A (last)			ALBENDAZOLE (first)			ALBENDAZOLE (last)			CORRESPONDING										
	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	TOTAL	NO
																																								2	
	01																																								
02																																									
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14																																									
15																																									

## 9 Vaccination

SUBJECT: CHILDREN < 5 YEARS OLD OF SELECTED WOMAN 2

RESPONDENT: SELECTED WOMAN 2

ID CODE	(9.04)	(9.05)	(9.06)	(9.07)	(9.08)	(9.09)	(9.10)	(9.11)	(9.12)	(9.13)
	Did you ever have a bukana where [NAME]'s vaccinations are written down?	Did [NAME] ever receive any vaccinations to prevent him/her from getting diseases, including vaccines received on national immunization day or child health week?	Did [NAME] receive a BCG vaccination against tuberculosis, that is an injection in the forearm that usually causes a scar?	Did [NAME] receive a polio vaccine, that is drops in the mouth?	When did [NAME] receive the polio vaccine the first time?	How many times was the polio vaccine given?	Did [NAME] receive a Pentavalent vaccine, that is an injection in the thigh?	How many times was the Pentavalent vaccine given?	Did [NAME] receive a measles injection or an MMR injection - that is, an injection in the arm at the age of 9 months or older - to prevent [HIM/HER] from getting measles?	Did [NAME] receive this measles vaccine before [HE/SHE] turned one year old, or after?
	YES 1 NO 2	YES 1 NO 2 ▶ (9.14)	YES 1 NO 2	YES 1 NO 2 ▶ (9.10)	JUST AFTER BIRTH 01 LATER 02	# OF TIMES	YES 1 NO 2 ▶ (9.12)	# OF TIMES	YES 1 NO 2 ▶ (9.14)	BEFORE 01 AFTER 02
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										
15										

## 9 Vaccination

SUBJECT: CHILDREN < 5 YEARS OLD OF SELECTED WOMAN 2

RESPONDENT: SELECTED WOMAN 2

ID CODE	(9.14)	(9.15)	(9.16)	(9.17)
	Did [NAME] ever receive a vitamin A supplement?	When was the last vitamin A supplement provided?	Did [NAME] ever received Albendazole, that is an anti-worm medication?	When was the last time [NAME] received Albendazole?
		6 MONTHS AGO 01 OR LESS		6 MONTHS AGO 01 OR LESS
		MORE THAN 6 MONTHS AGO 02		MORE THAN 6 MONTHS AGO 02
YES 1 NO 2 ▶ (9.16)		YES 1 NO 2 ▶ NEXT CHILD		
01				
02				
03				
04				
05				
06				
07				
08				
09				
10				
11				
12				
13				
14				
15				

# 10 Height and Weight

SUBJECTS: CHILDREN <5 YEARS OLD OF SELECTED WOMAN 2

RESPONDENT: SELECTED WOMAN 2

ID CODE	(10.01)		(10.02)	(10.03)	(10.04)	(10.05)	(10.06)		(10.07)	(10.08)	(10.09)
	RECORD INDIVIDUAL'S AGE FROM ROSTER (QUESTION 1.11)		Did [NAME] sleep in the house last night?	In the last 6 months, was [NAME] measured to determine [NAME]'s nutritional status?	What was the date of the last measurement?	For the last measurement, which method was used to determine [NAME]'S nutritional status?	For the last measurement, where was [NAME] measured?		What was the result of the last measurement?	Did you obtain any specialized care for [NAME]'s malnutrition after the last measurement?	Where was the care for [NAME]'s malnutrition obtained from?
	A.	B.			MM	YYYY					
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											
15											



# 11 Reproductive Decisions

SUBJECT: SELECTED WOMAN 2

RESPONDENT: SELF

Nr.	Question	CODE	SKIP	RESPONSE
<b>PREGNANCY</b>				
(11.01)	INTERVIEWER: CHECK QUESTION (7.05) IS THE WOMAN CURRENTLY PREGNANT?	YES	1	
		NO	2 ► (11.03)	
(11.02)	At the time you became pregnant, did you want to become pregnant then, did you want to be pregnant later, or did you not want to have any (more) children at all?	THEN	01 ► (11.17)	
		LATER	02 ► (11.17)	
		NOT AT ALL	03 ► (11.17)	
(11.03)	If you could choose for yourself, how long would you wait from now until the birth of your first/next child?	WOULD NOT WAIT	01	
		LESS THAN 2 YEARS	02	
		MORE THAN 2 YEARS	03	
		DOESN'T WANT ANY (MORE)	04	
		HAVE NOT DECIDED YET	05	
		CAN'T GET PREGNANT	06	
(11.04)	In the next few weeks, if you discovered you were pregnant, would that be a big problem, a small problem, or not a problem for you?	BIG PROBLEM	01	
		SMALL PROBLEM	02	
		NO PROBLEM	03	
		CAN'T GET PREGNANT	04	
(11.05)	Do you approve or disapprove of couples using contraceptive methods to avoid getting pregnant?	APPROVE	01	
		DISAPPROVE	02	
(11.06)	Do you currently have a sexual partner?	YES	1	
		NO	2 ► (11.18)	
(11.07)	Do you think that your partner approves or disapproves of couples using contraceptive methods to avoid pregnancy?	APPROVE	01	
		DISAPPROVE	02	
(11.08)	In the last 6 months, how often did you talk to your partner about family planning/contraceptive use?	NEVER	01	
		ONCE OR TWICE	02	
		MORE THAN TWICE	03	
(11.09)	Comparing with you, do you think your partner wants more children, fewer children or the same number of children?	SAME	01	
		MORE	02	
		FEWER	03	
		DON'T KNOW (HAVE NOT DISCUSSED)	04	
<b>FAMILY PLANNING</b>				
(11.10)	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES	1 ► (11.12)	
		NO	2	
(11.11)	Why are you currently not using any method to delay or avoid getting pregnant?  ► (11.18)	WOULD LIKE TO GET PREGNANT	01	
		DOES NOT APPROVE	02	
		PARTNER DOES NOT APPROVE	03	
		FAMILY DOES NOT APPROVE	04	
		NOT AVAILABLE	05	
		TOO EXPENSIVE	06	
		SCARED OF SIDE-EFFECTS	07	
		DON'T KNOW OF ANY METHOD	08	
		LACTATIONAL AMENORRHEA	09	
		HAD HYSTERECTOMY	10	
		IS MENOPAUSAL	11	
		IS INFECUND	12	
		OTHER (SPECIFY)	96	

(11.12)	Which method are you currently using?  (IF MORE THAN ONE METHOD, INDICATE THE HIGHEST METHOD IN THE LIST)	FEMALE STERILIZATION	01	▶ (11.19)
		MALE STERILIZATION	02	▶ (11.19)
		IUD / SPIRAL	03	
		INJECTABLES	04	
		IMPLANTS / NORPLANT	05	
		PILL	06	
		MALE CONDOM	07	
		FEMALE CONDOM	08	
		DIAPHRAGM	09	
		FOAM/JELLY	10	
		LACTATIONAL AMENORRHEA METHOD	11	▶ (11.19)
		RHYTHM / NATURAL METHOD	12	▶ (11.19)
		WITHDRAWAL	13	▶ (11.19)
		OTHER MODERN METHOD, SPECIFY	14	
OTHER TRADITIONAL METHOD, SPECIFY	15			
(11.13)	Where did you obtain the current method when you started using it (first time)?	MEDICAL DOCTOR	01	
		NURSE/MIDWIFE	02	
		NURSE ASSISTANT	03	
		VILLAGE HEALTH WORKER	04	
		PHARMACIST	05	
		LESOTHO PLANNED PARENTHOOD ASSOCIATION	06	
		TRADITIONAL HEALER	07	
		TRADITIONAL BIRTH ATTENDANT	08	
		OTHER SHOP	09	
		FAMILY MEMBER	10	
		FRIEND/NEIGHBOR	11	
		OTHER (SPECIFY)	96	
(11.14)	Where did you obtain the current method at your last refill?	MEDICAL DOCTOR	01	
		NURSE/MIDWIFE	02	
		NURSE ASSISTANT	03	
		VILLAGE HEALTH WORKER	04	
		PHARMACIST	05	
		LESOTHO PLANNED PARENTHOOD ASSOCIATION	06	
		TRADITIONAL HEALER	07	
		TRADITIONAL BIRTH ATTENDANT	08	
		OTHER SHOP	09	
		FAMILY MEMBER	10	
		FRIEND/NEIGHBOR	11	
		OTHER (SPECIFY)	96	
(11.15)	How long have you been using the current method?	YEARS		
		MONTHS		
(11.16)	How much did you pay for your last refill? ▶ (11.19)	MALOTI		
(11.17)	Do you approve or disapprove of couples using contraceptive methods to avoid getting pregnant?	APPROVE	01	
		DISAPPROVE	02	▶ (11.19)
(11.18)	Have you ever used any method to delay or avoid getting pregnant?	YES	1	
		NO	2	
(11.19)	Have any of the following ever talked to you about family planning methods?  READ EACH CATEGORY ALOUD AND RECORD YES OR NO	A) Health worker at health facility		
		B) Lesotho Planned Parenthood Association (LPPA)		
		C) Village Health Worker		
		D) Friends/Family		
		E) Other, Specify:		
	YES 1			
	NO 2			

## 12 Village Health Worker Service Usage and Satisfaction

SUBJECT: SELECTED WOMAN 2

RESPONDENT: SELF

Nr.	Question	CODE	SKIP	RESPONSE
<b>SERVICES</b>				
(12.01)	Is there a Village Health Worker (VHW) in your community?	YES	1	
		NO	2 ▶ (14.01)	
(12.02)	In the last 3 months, have you met with a VHW either in your home or in the community?	YES, AT HOME	1	
		YES, IN THE COMMUNITY	2	
		YES, IN BOTH HOME AND COMMUNITY	3	
		NO	4 ▶ (14.01)	
(12.03)	Did the VHW provide any of the following services?  YES 1 NO 2	A) Referral to prenatal care		
		B) Referral to institutional delivery		
		C) Referral to postnatal care		
		D) Referral to Voluntary Counseling and Testing (VCT) / Prevention of Mother-To-Child Transmission (PMTCT)		
		E) Referral to child vaccination		
		F) Advice on HIV and AIDS		
		G) Advice on family planning		
		H) Child growth monitoring / advice on child nutrition		
		I) Advice on water and sanitation		
		J) Distribution of condoms		
		K) Information, Education and Communication sessions on other health topics		
<b>PAYMENT</b>				
(12.04)	The last time that you met with a VHW, did you pay for the services or advice?	YES	1	
		NO	2 ▶ (12.06)	
(12.05)	How much?	MALOTI		
<b>SATISFACTION</b>				
(12.06)	How satisfied are you with the following?  READ EACH CATEGORIES ALOUD AND RECORD VERY UNSATISFIED, UNSATISFIED, SATISFIED, VERY SATISFIED  VERY UNSATISFIED 01 UNSATISFIED 02 SATISFIED 03 VERY SATISFIED 04	A) Village Health Workers being knowledgeable?		
		B) Village Health Workers being responsive to your needs?		
		C) Enough Village Health Workers?		
		D) Village Health Worker's time availability to attend to you?		
		E) Information provided by Village Health Worker?		
		F) Village Health Workers respectful and friendly?		
		G) Village Health Worker being good role models?		
(12.07)	Would you recommend VHW to other women?	YES	1 ▶ (14.01)	
		NO	2	
(12.08)	Why wouldn't you recommend them? DO NOT READ OPTIONS ALOUD RECORD UP TO 3 REASONS	POOR QUALITY OF CARE	01	
		NOT HELPFUL	02	
		NOT RESPECTFUL / FRIENDLY	03	
		TREATMENT TOO EXPENSIVE	04	
		DIFFICULT TO ACCESS	05	
		LACK OF SUPPLIES / DRUGS	06	
OTHER, SPECIFY	96			

# 14 Experience with Health Center

SUBJECT: SELECTED WOMAN 2

RESPONDENT: SELF

Nr.	Question	CODE	SKIP	RESPONSE
<b>EXPERIENCE WITH THE HEALTH CENTER</b>				
(14.01)	Do you know which health center serves your community?	YES	01	
		NO	02 ▶ (15.01)	
(14.02)	What is the name of the health center that serves your community? INTERVIEWER: RECORD THE NAME AND CODE OF THE HEALTH CENTER.	NAME		
		CODE		
(14.03)	Can you tell me which services are provided at the health center?  INTERVIEWER: DO NOT READ THE OPTIONS ALOUD. RECORD 1 IF MENTIONED AND 2 IF NOT MENTIONED	A. FAMILY PLANNING		
		B. PRENATAL CARE		
		C. FACILITY BASED DELIVERY		
		D. IMMUNIZATION		
		E. CURATIVE AND PREVENTIVE CARE		
		F. HIV/AIDS SERVICES		
		G. STI SERVICES		
		H. 24-HOUR EMERGENCY CARE		
		I. OTHER, SPECIFY:		
		J. OTHER, SPECIFY:		
(14.04)	Have you ever visited the health center?	YES	01	
		NO	02 ▶ (15.01)	
(14.05)	When was the last time you visited the health center?	LESS THAN ONE MONTH AGO	01	
		LESS THAN SIX MONTHS AGO	02	
		LESS THAN ONE YEAR AGO	03	
		MORE THAN ONE YEAR AGO	04	
(14.06)	You can choose not to answer this question but we would like to ask <i>the reason you visited the health center last time</i> in order to measure the demand for the health center?  INTERVIEWER: DO NOT READ THE OPTIONS ALOUD. USE 98 IF ADOLESCENT REFUSE TO ANSWER THE QUESTION	FAMILY PLANNING	01	
		PRENATAL CARE	02	
		FACILITY BASED DELIVERY	03	
		IMMUNIZATION	04	
		CURATIVE AND PREVENTIVE CARE	05	
		HIV/AIDS SERVICES	06	
		STI SERVICES	07	
		24-HOUR EMERGENCY CARE	08	
OTHER, SPECIFY	96			
(14.07)	How satisfied are you with the following?  READ ALOUD THE CATEGORIES AND RECORD VERY UNSATISFIED, UNSATISFIED, SATISFIED, OR VERY SATISFIED	A) Health center staff being knowledgeable?		
		B) Health center staff being responsive to your needs?		
		C) Enough health center staff?		
		D) Health center staff's time availability to attend to you?		
		VERY UNSATISFIED 01		
		UNSATISFIED 02		
		SATISFIED 03		
VERY SATISFIED 04				
		E) Information provided by health center staff?		
		F) Health center staff respectful and friendly?		

## 15 Health Knowledge: Adolescents

RESPONDENT: SELECTED WOMAN 2

I would like to ask you some questions about your knowledge about health. For each question you should answer yes or no depending on what you think is right.

READ QUESTIONS AND ALL OPTIONS ALOUD AND CIRCLE YES OR NO. IF SHE DOES NOT KNOW ASK HER WHAT SHE THINKS IS MOST LIKELY

Number	Question	RESPONSE
<b>Why is it important that people wash their hands after using the latrine?</b>		
(15.01)	A) It removes dirt from the hands	YES 1 NO 2
	B) Prevents HIV	YES 1 NO 2
	C) It avoids spread of dangerous diseases, such as diarrhea, cholera, and intestinal parasites	YES 1 NO 2
	D) It prevents skin infections	YES 1 NO 2
<b>What kind of water is safe to drink?</b>		
(15.02)	A) Treated water near animals	YES 1 NO 2
	B) Treated stagnant water	YES 1 NO 2
	C) Treated water from a spring or deep well	YES 1 NO 2
	D) Treated water in streams and rivers	YES 1 NO 2
<b>What will you give to a 1 and a half year old with watery diarrhea without dehydration?</b>		
(15.03)	A) Give 1 liter a day of oral rehydration therapy (ORT)	YES 1 NO 2
	B) 1/4th - 1/2 cup of oral rehydration therapy (ORT) for every watery stool	YES 1 NO 2
	C) Give 1 liter of water per day ONLY	YES 1 NO 2
<b>Which of the following are danger signs for pregnant women?</b>		
(15.04)	A) Fever	YES 1 NO 2
	B) Vaginal Bleeding	YES 1 NO 2
	C) Swelling of hands, face, AND feet	YES 1 NO 2
	D) Loss of appetite	YES 1 NO 2
<b>Which of the following signs are dangerous signs for a baby?</b>		
(15.05)	A) The baby is convulsing	YES 1 NO 2
	B) The baby has fever	YES 1 NO 2
	C) The baby is not breastfeeding	YES 1 NO 2
	D) The baby is breathing too quickly	YES 1 NO 2
<b>Which of the following diseases can be prevented with a vaccine?</b>		
(15.06)	A) Poliomyelitis (polio)	YES 1 NO 2
	B) Measles	YES 1 NO 2
	C) Tetanus (that is convulsions after birth)	YES 1 NO 2
	D) Tuberculosis	YES 1 NO 2
	E) AIDS	YES 1 NO 2
<b>Which are effective methods of contraception?</b>		
(15.07)	A) Oral contraceptives (pills)	YES 1 NO 2
	B) Depo-provera injections (DMPA)	YES 1 NO 2
	C) Intrauterine device (IUD)	YES 1 NO 2
	D) Condoms	YES 1 NO 2
	E) Breastfeeding	YES 1 NO 2
	F) Withdrawal	YES 1 NO 2
<b>Why is it important for pregnant women to attend check-ups?</b>		
(15.08)	A) To have advice on good nutrition	YES 1 NO 2
	B) To be tested for HIV/AIDS	YES 1 NO 2
	C) To prepare for breastfeeding	YES 1 NO 2
	D) To get prenatal vitamins	YES 1 NO 2
	E) To make a schedule for delivery	YES 1 NO 2
<b>Why is it important to deliver in a health center?</b>		
(15.09)	A) To have advice on good nutrition	YES 1 NO 2
	B) To have the baby immunized	YES 1 NO 2
	C) To receive a mother-baby pack	YES 1 NO 2
	D) To prevent maternal death	YES 1 NO 2
<b>How can a woman infected with HIV give HIV to her child?</b>		
(15.10)	A) During pregnancy	YES 1 NO 2
	B) During childbirth	YES 1 NO 2
	C) During breastfeeding	YES 1 NO 2
	D) By sharing plates or glasses with her child	YES 1 NO 2
<b>What are the risks of unsafe abortion?</b>		
(15.11)	A) Maternal death	YES 1 NO 2
	B) HIV/AIDS	YES 1 NO 2
	C) Infertility	YES 1 NO 2