

IDENTIFICATION											
PROVINCE/REGION (PUNJAB=1; SINDH=2; KP=3; BALOCHISTAN=4; GB=5; AJK=6)						<div><div></div><div></div><div></div></div>					
DISTRICT						<div><div></div><div></div><div></div></div>					
TEHSIL											
NAME OF HOUSEHOLD HEAD											
CLUSTER NUMBER						<div><div></div><div></div><div></div><div></div></div>					
HOUSEHOLD NUMBER						<div><div></div><div></div><div></div><div></div></div>					
IS HOUSEHOLD SELECTED FOR (SHORT=1; LONG=2)						<div><div></div></div>					
INTERVIEWER VISITS											
	1	2	3	FINAL VISIT							
DATE				DAY	<div><div></div><div></div></div>						
				MONTH	<div><div></div><div></div></div>						
				YEAR	<div><div></div><div></div></div>	<div><div></div><div></div></div>	<div><div></div><div></div></div>	<div><div></div><div></div></div>			
INTERVIEWER'S NAME				INT. NO.	<div><div></div><div></div></div>	<div><div></div><div></div></div>	<div><div></div><div></div></div>	<div><div></div><div></div></div>			
RESULT*				RESULT*	<div><div></div></div>						
NEXT VISIT: DATE				TOTAL NUMBER OF VISITS							
TIME											
*RESULT CODES:				TOTAL PERSONS IN HOUSEHOLD							
1 COMPLETED				<div><div></div><div></div></div>							
2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT				NO. OF FEMALE DEATHS AGE 15-49 FROM Q.38							
3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME				<div><div></div></div>							
4 POSTPONED				LINE NO. OF RESPONDENT TO HOUSEHOLD SCHEDULE							
5 REFUSED											
6 DWELLING VACANT OR ADDRESS NOT A DWELLING											
7 DWELLING DESTROYED											
8 DWELLING NOT FOUND											
9 OTHER				<div><div></div><div></div></div>							
(SPECIFY)											
LANGUAGE OF QUESTIONNAIRE**		<div><div>0</div><div>1</div></div>	LANGUAGE OF INTERVIEW**		<div><div></div><div></div></div>	NATIVE LANGUAGE OF RESPONDENT**		<div><div></div><div></div></div>	TRANSLATOR USED (YES = 1, NO = 2)		<div><div></div></div>
LANGUAGE OF QUESTIONNAIRE**		ENGLISH		**LANGUAGE CODES:		01 ENGLISH		03 SINDHI		05 SARAIKI	
						02 URDU		04 PUNJABI		06 BALUCHI	
										07 PUSHTO	
										08 OTHER	
SUPERVISOR			FIELD EDITOR				KEYED BY				
<div><div></div><div></div><div></div><div></div></div>			<div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div></div>				
NAME			NAME			NUMBER					

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## INTRODUCTION AND CONSENT

Asalum-o-Alaikum. My name is \_\_\_\_\_. I am working with National Institute of Population Studies. We are conducting a survey about health and other topics all over Pakistan. The information we collect will help the government to plan health services. Your household was selected for the survey. I would like to ask you some questions about your household. The questions usually take about 25 to 30 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time. In case you need more information about the survey, you may contact the person listed on this card.

### GIVE CARD WITH CONTACT INFORMATION

Do you have any questions?  
May I begin the interview now?

SIGNATURE OF INTERVIEWER \_\_\_\_\_ DATE \_\_\_\_\_

RESPONDENT AGREES  
TO BE INTERVIEWED .. 1



RESPONDENT DOES NOT AGREE  
TO BE INTERVIEWED .. 2 → END

100	RECORD THE TIME.	HOURS .....	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				
		MINUTES .....	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				

## HOUSEHOLD SCHEDULE

							IF AGE 15 OR OLDER	IF AGE 5 YEARS OR OLDER	
LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	MARITAL STATUS	EVER ATTENDED SCHOOL	
1	2	3	4	5	6	7	8	16	17
	Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.  AFTER LISTING THE NAMES AND RECORDING THE RELATIONSHIP AND SEX FOR EACH PERSON, ASK QUESTIONS 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE.  THEN ASK APPROPRIATE QUESTIONS IN COLUMNS 5-17 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household?  SEE CODES BELOW.	Is (NAME) male or female?	Does (NAME) usually live here?	Did (NAME) stay here last night?	How old is (NAME)?  IF AGE LESS THAN 1-YEAR RECORD '00'  IF 95 OR MORE, RECORD '95'.	What is (NAME)'s current marital status?  1 = CURRENTLY MARRIED 2 = DIVORCED/ SEPARATED 3 = WIDOWED 4 = NEVER-MARRIED	Has (NAME) ever attended school?	What is the highest class (NAME) has completed?  SEE CODES BELOW.
01		<input type="text"/>	M F 1 2	Y N 1 2	Y N 1 2	IN YEARS <input type="text"/>	<input type="text"/>	Y N 1 2 ↓ NEXT LINE	CLASS <input type="text"/>
02		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>
03		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>
04		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>
05		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>
06		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>
07		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>
08		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>
09		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>
10		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 ↓ NEXT LINE	<input type="text"/>

2A) Just to make sure that I have a complete listing: are there any other people such as small children or infants that we have not listed? YES ☐ → ADD TC NO ☐ TABLE

2B) Are there any other people who may not be members of your family, such as domestic servants, lodgers, or friends who usually live here? YES ☐ → ADD TC NO ☐ TABLE

2C) Are there any guests or temporary visitors staying here, or anyone else who stayed here last night, who have not been listed? YES ☐ → ADD TC NO ☐ TABLE

**CODES FOR Q. 3: RELATIONSHIP TO HEAD OF HH**  
01 = HEAD  
02 = WIFE OR HUSBAND  
03 = SON OR DAUGHTER  
04 = SON-IN-LAW OR DAUGHTER-IN-LAW  
05 = GRANDCHILD  
06 = PARENT  
07 = PARENT-IN-LAW  
08 = BROTHER OR SISTER  
09 = BROTHER/SISTER-IN-LAW  
10 = NEICE/NEPHEW  
11 = GRAND PARENTS  
12 = AUNTS/UNCLE  
13 = OTHER RELATIVE  
14 = ADOPTED/STEPCHILD  
15 = NOT RELATED  
16 = DOMESTIC SERVANT  
98 = DON'T KNOW

**CODES FOR Q. 17: EDUCATION CLASS COMPLETED**  
00 = LESS THAN CLASS 1  
01 - 10 = CLASS 1 - CLASS 10 (MATRIC)  
11 - 12 = CLASS 11 - 12  
13 - 15 = BACHELORS DEGREE  
16 = MASTER'S DEGREE OR MBBS, PhD, MPHIL, BSc (4 YEARS)  
98 = DON'T KNOW

**HOUSEHOLD SCHEDULE**

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	IF AGE 15 OR OLDER	IF AGE 5 YEARS OR OLDER	
				5	6		MARITAL STATUS	16	17
1	2	3	4	5	6	7	8	16	17
	<p>Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.</p> <p>AFTER LISTING THE NAMES AND RECORDING THE RELATIONSHIP AND SEX FOR EACH PERSON, ASK QUESTIONS 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE.</p> <p>THEN ASK APPROPRIATE QUESTIONS IN COLUMNS 5-17 FOR EACH PERSON.</p>	<p>What is the relationship of (NAME) to the head of the household?</p> <p>SEE CODES BELOW.</p>	<p>Is (NAME) male or female?</p>	<p>Does (NAME) usually live here?</p>	<p>Did (NAME) stay here last night?</p>	<p>How old is (NAME)?</p> <p>IF AGE LESS THAN 1-YEAR RECORD '00'</p> <p>IF 95 OR MORE, RECORD '95'.</p>	<p>What is (NAME)'s current marital status?</p> <p>1 = CURRENTLY MARRIED 2 = DIVORCED/ SEPARATED 3 = WIDOWED 4 = NEVER-MARRIED</p>	<p>Has (NAME) ever attended school?</p>	<p>What is the highest class (NAME) has completed?</p> <p>SEE CODES BELOW.</p>
11		<input type="text"/>	M F 1 2	Y N 1 2	Y N 1 2	IN YEARS <input type="text"/>	<input type="text"/>	Y N 1 2 NEXT LINE	CLASS <input type="text"/>
12		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>
13		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>
14		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>
15		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>
16		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>
17		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>
18		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>
19		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>
20		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	1 2 NEXT LINE	<input type="text"/>

TICK HERE IF CONTINUATION SHEET ☐

**CODES FOR Q. 3: RELATIONSHIP TO HEAD OF HH**

01 = HEAD  
02 = WIFE OR HUSBAND  
03 = SON OR DAUGHTER  
04 = SON-IN-LAW OR DAUGHTER-IN-LAW  
05 = GRANDCHILD  
06 = PARENT  
07 = PARENT-IN-LAW  
08 = BROTHER OR SISTER

09 = BROTHER/SISTER-IN-LAW  
10 = NEICE/NEPHEW  
11 = GRAND PARENTS  
12 = AUNTS/UNCLE  
13 = OTHER RELATIVE  
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16 = MASTER'S DEGREE OR MBBS, PhD, MPHIL, BSc (4 YEARS)  
98 = DON'T KNOW

**INFORMATION ABOUT BIRTHS AND DEATHS IN THE HOUSEHOLD IN THE PREVIOUS 3 YEARS**

18	Now I would like to ask you about all the <u>births</u> that occurred in this household <u>in the last 3 years</u> , whether they were born alive or dead. Since 1st January 2016, did any woman who was a usual resident of this household at the time give birth? I am interested in any birth, even stillbirth & children who didn't survive.					YES ..... 1 NO ..... 2 → 27
19 How many births occurred in this household <u>in the last 3 years</u> ? <span style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; vertical-align: middle;"></span> <span style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; vertical-align: middle;"></span>						
NO	What are the names of the babies born in the last 3 years? IF STILL BORN WRITE 'BABY'.	Is (NAME) a boy or a girl?	In what month and year was (NAME) born?  <b>IF MONTH DON'T KNOW RECORD '98'</b>	Was (NAME) born alive?	Is (NAME) still alive?	LINE NUMBER FROM HOUSEHOLD ROSTER (RECORD '00' IF CHILD NOT LISTED IN HH ROSTER)
20	21	22	23	24	25	26
01	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	BOY 1 GIRL 2	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div>	YES ..... 1 NO ..... 2 NEXT ←	YES ..... 1 NO ..... 2 NEXT ←	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NEXT ←
02	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	BOY 1 GIRL 2	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div>	YES ..... 1 NO ..... 2 NEXT ←	YES ..... 1 NO ..... 2 NEXT ←	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NEXT ←
03	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	BOY 1 GIRL 2	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div>	YES ..... 1 NO ..... 2 NEXT ←	YES ..... 1 NO ..... 2 NEXT ←	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NEXT ←
04	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	BOY 1 GIRL 2	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div>	YES ..... 1 NO ..... 2 NEXT ←	YES ..... 1 NO ..... 2 NEXT ←	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NEXT ←
05	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	BOY 1 GIRL 2	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div>	YES ..... 1 NO ..... 2 NEXT ←	YES ..... 1 NO ..... 2 NEXT ←	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NEXT ←
06	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	BOY 1 GIRL 2	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div>	YES ..... 1 NO ..... 2 NEXT ←	YES ..... 1 NO ..... 2 NEXT ←	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NEXT ←
07	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	BOY 1 GIRL 2	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div>	YES ..... 1 NO ..... 2 NEXT ←	YES ..... 1 NO ..... 2 NEXT ←	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NEXT ←
08	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	BOY 1 GIRL 2	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; vertical-align: middle;"></div>	YES ..... 1 NO ..... 2 NEXT ←	YES ..... 1 NO ..... 2 NEXT ←	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NEXT ←

**INFORMATION ABOUT BIRTHS AND DEATHS IN THE HOUSEHOLD IN THE PREVIOUS 3 YEARS**

27	Now I would like to ask you about any <u>deaths</u> that occurred in this household <u>in the last 3 years</u> Since 1st January 2016, God forbid, has any usual member of this household died?					YES ..... 1 NO ..... 2 → 38		
28	How many deaths occurred to usual residents in this household in the last 3 years?      <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>							
NO	What were the names of the people who died in the last 3 years?	Was (NAME) Male or Female?	In what month and year did (NAME) die?  <b>IF MONTH DON'T KNOW RECORD '98'</b>	How old was (NAME) when He/She died? RECORD DAYS IF LESS THAN 1 MONTHS' MONTHS IF LESS THAN 2 YEARS' OR YEARS	<b>CHECK 31 AND 33 WAS THIS A WOMAN AGE 15-49 WHEN SHE DIED?</b>	<b>Female, 15 - 49 years old</b>		
29	30	31	32	33	34	35	36	37
01		MALE .... 1 FEMALE... 2	MONTH <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table> YR <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table>	DAYS 1 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> MONTH 2 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> YRS 3 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>	YES ... 1 NO ... 2 NEXT ←	YES ... 1 NEXT ← NO ... 2	YES ... 1 NEXT ← NO ... 2	YES ... 1 NEXT ← NO ... 2
02		MALE .... 1 FEMALE... 2	MONTH <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table> YR <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table>	DAYS 1 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> MONTH 2 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> YRS 3 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>	YES ... 1 NO ... 2 NEXT ←	YES ... 1 NEXT ← NO ... 2	YES ... 1 NEXT ← NO ... 2	YES ... 1 NEXT ← NO ... 2
03		MALE .... 1 FEMALE... 2	MONTH <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table> YR <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table>	DAYS 1 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> MONTH 2 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> YRS 3 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>	YES ... 1 NO ... 2 NEXT ←	YES ... 1 NEXT ← NO ... 2	YES ... 1 NEXT ← NO ... 2	YES ... 1 NEXT ← NO ... 2
04		MALE .... 1 FEMALE... 2	MONTH <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table> YR <table border="1" style="display: inline-table; width: 60px; height: 20px; vertical-align: middle;"></table>	DAYS 1 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> MONTH 2 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> YRS 3 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>	YES ... 1 NO ... 2 NEXT ←	YES ... 1 NEXT ← NO ... 2	YES ... 1 NEXT ← NO ... 2	YES ... 1 NEXT ← NO ... 2
38	CHECK COLUMN 32 AND 34: NUMBER OF DEATHS TO WOMEN AGE 15-49 YEARS OLD IN JANUARY 2016 OR AFTER					<table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>		
39	RECORD THE TIME.			HOURS ..... MINUTES .....		<table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table>		

(A) INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT INTERVIEW:

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COMMENTS ON SPECIFIC QUESTIONS:

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ANY OTHER COMMENTS:

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(B) SUPERVISOR'S OBSERVATIONS

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(C) EDITOR'S OBSERVATIONS

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**PAKISTAN MATERNAL MORTALITY SURVEY 2019**  
**LONG HOUSEHOLD QUESTIONNAIRE**  
 PAKISTAN  
 NATIONAL INSTITUTE OF POPULATION STUDIES

IDENTIFICATION					
PROVINCE/REGION (PUNJAB=1; SINDH=2; KPK=3; BALOCHISTAN=4; GB=5; AJK=6) .....					<input style="width: 20px; height: 20px;" type="text"/>
DISTRICT .....					<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
TEHSIL .....					
NAME OF HOUSEHOLD HEAD .....					
CLUSTER NUMBER .....					<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
HOUSEHOLD NUMBER .....					<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
IS HOUSEHOLD SELECTED FOR (SHORT=1; LONG=2) .....					<input style="width: 20px; height: 20px;" type="text"/>
INTERVIEWER VISITS					
	1	2	3	FINAL VISIT	
DATE	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	DAY	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
INTERVIEWER'S NAME	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	MONTH	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
				YEAR	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
				INT. NO.	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
RESULT*	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	RESULT*	<input style="width: 20px; height: 20px;" type="text"/>
NEXT VISIT: DATE	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>		TOTAL NUMBER OF VISITS <input style="width: 20px; height: 20px;" type="text"/>	
TIME	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>			
<b>*RESULT CODES:</b> 1 COMPLETED 2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT 3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME 4 POSTPONED 5 REFUSED 6 DWELLING VACANT OR ADDRESS NOT A DWELLING 7 DWELLING DESTROYED 8 DWELLING NOT FOUND 9 OTHER _____ <div style="text-align: right;">(SPECIFY)</div>				TOTAL PERSONS IN HOUSEHOLD <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
				TOTAL ELIGIBLE WOMEN <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
				NO. OF FEMALE DEATHS AGE 15-49 FROM Q.38 <input style="width: 20px; height: 20px;" type="text"/>	
				LINE NO. OF RESPONDENT TO HOUSEHOLD SCHEDULE <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
LANGUAGE OF QUESTIONNAIRE** <b>0 1</b>		LANGUAGE OF INTERVIEW** <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>		NATIVE LANGUAGE OF RESPONDENT** <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	
LANGUAGE OF QUESTIONNAIRE** <b>ENGLISH</b>		**LANGUAGE CODES: 01 ENGLISH      03 SINDHI      05 SARAIKI 02 URDU      04 PUNJABI      06 BALUCHI 07 PUSHTO 08 OTHER			
SUPERVISOR NAME <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> NUMBER		FIELD EDITOR NAME <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> NUMBER		KEYED BY <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> NUMBER	

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## INTRODUCTION AND CONSENT

Asalum-o-Alaikum. My name is \_\_\_\_\_. I am working with National Institute of Population Studies. We are conducting a survey about health and other topics all over Pakistan. The information we collect will help the government to plan health services. Your household was selected for the survey. I would like to ask you some questions about your household. The questions usually take about 25 to 30 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time. In case you need more information about the survey, you may contact the person listed on this card.

GIVE CARD WITH CONTACT INFORMATION

Do you have any questions?  
May I begin the interview now?

SIGNATURE OF INTERVIEWER \_\_\_\_\_ DATE \_\_\_\_\_

RESPONDENT AGREES  
TO BE INTERVIEWED . . . 1



RESPONDENT DOES NOT AGREE  
TO BE INTERVIEWED . . . 2 → END

100	RECORD THE TIME.	HOURS . . . . .	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				
		MINUTES . . . . .	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>				

**HOUSEHOLD SCHEDULE**

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	IF AGE 15 OR OLDER	ELIGIBILITY	IF AGE 5 YEARS OR OLDER	
							MARITAL STATUS		EVER ATTENDED SCHOOL	
1	2	3	4	5	6	7	8	9	16	17
	<p>Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.</p> <p>AFTER LISTING THE NAMES AND RECORDING THE RELATIONSHIP AND SEX FOR EACH PERSON, ASK QUESTIONS 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE.</p> <p>THEN ASK APPROPRIATE QUESTIONS IN COLUMNS 5-17 FOR EACH PERSON.</p>	<p>What is the relationship of (NAME) to the head of the household?</p> <p>SEE CODES BELOW.</p>	<p>Is (NAME) male or female?</p>	<p>Does (NAME) usually live here?</p>	<p>Did (NAME) stay here last night?</p>	<p>How old is (NAME)?</p> <p>IF AGE LESS THAN 1-YEAR RECORD '00'</p> <p>IF 95 OR MORE, RECORD '95'.</p>	<p>What is (NAME)'s current marital status?</p> <p>1 = CURRENTLY MARRIED 2 = DIVORCED/ SEPARATED 3 = WIDOWED 4 = NEVER- MARRIED</p>	<p>CIRCLE LINE NUMBER OF ALL WOMEN AGE 15 to 49 YEARS WHO ARE MARRIED DIVORCED OR SEPARATED OR WIDOWED</p>	<p>Has (NAME) ever attended school?</p>	<p>What is the highest class (NAME) has completed?</p> <p>SEE CODES BELOW.</p>
01		<input type="text"/>	M F 1 2	Y N 1 2	Y N 1 2	IN YEARS <input type="text"/>	<input type="text"/>	01	Y N 1 2 NEXT LINE	CLASS <input type="text"/>
02		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	02	1 2 NEXT LINE	<input type="text"/>
03		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	03	1 2 NEXT LINE	<input type="text"/>
04		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	04	1 2 NEXT LINE	<input type="text"/>
05		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	05	1 2 NEXT LINE	<input type="text"/>
06		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	06	1 2 NEXT LINE	<input type="text"/>
07		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	07	1 2 NEXT LINE	<input type="text"/>
08		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	08	1 2 NEXT LINE	<input type="text"/>
09		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	09	1 2 NEXT LINE	<input type="text"/>
10		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	10	1 2 NEXT LINE	<input type="text"/>

2A) Just to make sure that I have a complete listing: are there any other people such as small children or infants that we have not listed?

YES ☐ → ADD TO TABLE NO ☐

2B) Are there any other people who may not be members of your family, such as domestic servants, lodgers, or friends who usually live here?

YES ☐ → ADD TO TABLE NO ☐

2C) Are there any guests or temporary visitors staying here, or anyone else who stayed here last night, who have not been listed?

YES ☐ → ADD TO TABLE NO ☐

**CODES FOR Q. 3: RELATIONSHIP**

**TO HEAD OF HH**

01 = HEAD  
02 = WIFE OR HUSBAND  
03 = SON OR DAUGHTER  
04 = SON-IN-LAW OR DAUGHTER-IN-LAW  
05 = GRANDCHILD  
06 = PARENT  
07 = PARENT-IN-LAW  
08 = BROTHER OR SISTER

09 = BROTHER/SISTER-IN-LAW  
10 = NEICE/NEPHEW  
11 = GRAND PARENTS  
12 = AUNTS/UNCLE  
13 = OTHER RELATIVE  
14 = ADOPTED/STEPCHILD  
15 = NOT RELATED  
16 = DOMESTIC SERVANT  
98 = DON'T KNOW

**CODES FOR Q. 17: EDUCATION CLASS**

00 = LESS THAN CLASS 1 COMPLETED  
01 - 10 = CLASS 1 - CLASS 10 (MATRIC)  
11 - 12 = CLASS 11 - 12  
13 - 15 = BACHELORS DEGREE  
16 = MASTER'S DEGREE OR MBBS, PhD, MPhil, BSc (4 YEARS)  
98 = DON'T KNOW

**HOUSEHOLD SCHEDULE**

							IF AGE 15 OR OLDER		IF AGE 5 YEARS OR OLDER	
LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	MARITAL STATUS	ELIGIBILITY	EVER ATTENDED SCHOOL	
1	2	3	4	5	6	7	8	9	16	17
	<p>Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.</p> <p>AFTER LISTING THE NAMES AND RECORDING THE RELATIONSHIP AND SEX FOR EACH PERSON, ASK QUESTIONS 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE.</p> <p>THEN ASK APPROPRIATE QUESTIONS IN COLUMNS 5-17 FOR EACH PERSON.</p>	<p>What is the relationship of (NAME) to the head of the household?</p> <p>SEE CODES BELOW.</p>	<p>Is (NAME) male or female?</p>	<p>Does (NAME) usually live here?</p>	<p>Did (NAME) stay here last night?</p>	<p>How old is (NAME)?</p> <p>IF AGE LESS THAN 1-YEAR RECORD '00'</p> <p>IF 95 OR MORE, RECORD '95'.</p>	<p>What is (NAME)'s current marital status?</p> <p>1 = CURRENTLY MARRIED 2 = DIVORCED/SEPARATED 3 = WIDOWED 4 = NEVER-MARRIED</p>	<p>CIRCLE LINE NUMBER OF ALL WOMEN AGE 15 to 49 YEARS WHO ARE MARRIED DIVORCED OR SEPARATED OR WIDOWED</p>	<p>Has (NAME) ever attended school?</p>	<p>What is the highest class (NAME) has completed?</p> <p>SEE CODES BELOW.</p>
#		<input type="text"/>	M F 1 2	Y N 1 2	Y N 1 2	IN YEARS <input type="text"/>	<input type="text"/>	11	Y N 1 2 ↓ NEXT LINE	CLASS <input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	12	1 2 ↓ NEXT LINE	<input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	13	1 2 ↓ NEXT LINE	<input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	14	1 2 ↓ NEXT LINE	<input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	15	1 2 ↓ NEXT LINE	<input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	16	1 2 ↓ NEXT LINE	<input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	17	1 2 ↓ NEXT LINE	<input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	18	1 2 ↓ NEXT LINE	<input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	19	1 2 ↓ NEXT LINE	<input type="text"/>
#		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	<input type="text"/>	20	1 2 ↓ NEXT LINE	<input type="text"/>

TICK HERE IF CONTINUATION SHEET ☐

**CODES FOR Q. 3: RELATIONSHIP TO HEAD OF HH**

01 = HEAD                      09 = BROTHER/SISTER-IN-LAW  
02 = WIFE OR HUSBAND    10 = NEICE/NEPHEW  
03 = SON OR DAUGHTER    11 = GRAND PARENTS  
04 = SON-IN-LAW OR      12 = AUNTS/UNCLE  
DAUGHTER-IN-LAW       13 = OTHER RELATIVE  
05 = GRANDCHILD        14 = ADOPTED/STEPCHILD  
06 = PARENT               15 = NOT RELATED  
07 = PARENT-IN-LAW      16 = DOMESTIC SERVANT  
08 = BROTHER OR SISTER 98 = DON'T KNOW

**CODES FOR Q. 17: EDUCATION CLASS**

00 = LESS THAN CLASS 1 COMPLETED  
01 - 10 = CLASS 1 - CLASS 10 (MATRIC)  
11 - 12 = CLASS 11 - 12  
13 -15 = BACHELORS DEGREE  
16 = MASTER'S DEGREE OR MBBS, PhD, MPHIL, BSc (4 YEARS)  
98 = DON'T KNOW

**INFORMATION ABOUT BIRTHS AND DEATHS IN THE HOUSEHOLD IN THE PREVIOUS 3 YEARS**

18 Now I would like to ask you about all <u>the births</u> that occurred in this household <u>in the last 3 years</u> , whether they were born alive or dead. Since 1st January 2016, did any woman who was a usual resident of this household at the time give birth? I am interested in any birth, even stillbirth & children who didn't survive.						YES ..... 1 NO ..... 2 → 27
19 How many births occurred in this household <u>in the last 3 years</u> ? <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div>						
NO	What are the names of the babies born in the last 3 years?  IF STILL BORN WRITE 'BABY'.	Is (NAME) a boy or a girl?	In what month and year was (NAME) born?  IF MONTH DON'T KNOW RECORD '98'	Was (NAME) born alive?	Is (NAME) still alive?	LINE NUMBER FROM HOUSEHOLD ROSTER (RECORD '00' IF CHILD NOT LISTED IN HH ROSTER)
20	21	22	23	24	25	26
01		BOY GIRL	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	YES ..... NO ..... NEXT ←	YES ..... NO ..... NEXT ←	<div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> NEXT ←
02		BOY GIRL	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	YES ..... NO ..... NEXT ←	YES ..... NO ..... NEXT ←	<div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> NEXT ←
03		BOY GIRL	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	YES ..... NO ..... NEXT ←	YES ..... NO ..... NEXT ←	<div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> NEXT ←
04		BOY GIRL	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	YES ..... NO ..... NEXT ←	YES ..... NO ..... NEXT ←	<div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> NEXT ←
05		BOY GIRL	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	YES ..... NO ..... NEXT ←	YES ..... NO ..... NEXT ←	<div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> NEXT ←
06		BOY GIRL	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	YES ..... NO ..... NEXT ←	YES ..... NO ..... NEXT ←	<div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> NEXT ←
07		BOY GIRL	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	YES ..... NO ..... NEXT ←	YES ..... NO ..... NEXT ←	<div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> NEXT ←
08		BOY GIRL	MONTH <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div> YR <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">2</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">0</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px; text-align: center;">1</div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px; margin: 0 5px;"></div>	YES ..... NO ..... NEXT ←	YES ..... NO ..... NEXT ←	<div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> NEXT ←

**INFORMATION ABOUT BIRTHS AND DEATHS IN THE HOUSEHOLD IN THE PREVIOUS 3 YEARS**

27	Now I would like to ask you about <u>any deaths</u> that occurred in this household <u>in the last 3 years</u> Since 1st January 2016, God forbid, has any usual member of this household died?					YES ..... 1 NO ..... 2 → 38		
28	How many deaths occurred to usual residents in this household in the last 3 years?   <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block; vertical-align: middle;"></div>							
NO	What were the names of the people who died in the last 3 years?	Was (NAME) Male or Female?	In what month and year did (NAME) die?  IF MONTH DON'T KNOW RECORD '98'	How old was (NAME) when He/She died? RECORD DAYS IF LESS THAN 1 MONTHS' MONTHS IF LESS THAN 2 YEARS' OR YEARS	CHECK 31 AND 33 WAS THIS A WOMAN AGE 15-49 WHEN SHE DIED?	<b>Female, 15 - 49 years old</b>		
29	30	31	32	33	34	35	36	37
01		MALE.... 1 FEMALE... 2	MONTH <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> YR <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>	DAYS 1 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> MONTH-2 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> YRS 3 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>	YES .. 1 NO .. 2 NEXT ←	YES .. 1 NEXT ← NO .. 2	YES .. 1 NEXT ← NO .. 2	YES .. 1 NEXT ← NO .. 2
02		MALE.... 1 FEMALE... 2	MONTH <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> YR <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>	DAYS 1 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> MONTH-2 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> YRS 3 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>	YES .. 1 NO .. 2 NEXT ←	YES .. 1 NEXT ← NO .. 2	YES .. 1 NEXT ← NO .. 2	YES .. 1 NEXT ← NO .. 2
03		MALE.... 1 FEMALE... 2	MONTH <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> YR <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>	DAYS 1 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> MONTH-2 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> YRS 3 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>	YES .. 1 NO .. 2 NEXT ←	YES .. 1 NEXT ← NO .. 2	YES .. 1 NEXT ← NO .. 2	YES .. 1 NEXT ← NO .. 2
04		MALE.... 1 FEMALE... 2	MONTH <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> YR <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>	DAYS 1 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> MONTH-2 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div> YRS 3 <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; vertical-align: middle;"></div>	YES .. 1 NO .. 2 NEXT ←	YES .. 1 NEXT ← NO .. 2	YES .. 1 NEXT ← NO .. 2	YES .. 1 NEXT ← NO .. 2
38	CHECK COLUMN 32 AND 34: NUMBER OF DEATHS TO WOMEN AGE 15-49 YEARS OLD IN JANUARY 2016 OR AFTER					<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block; vertical-align: middle;"></div>		

# HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	What is the main source of drinking water for members of your household?	<b>PIPED WATER</b> PIPED INTO DWELLING ..... 11 PIPED TO YARD/PLO ..... 12 PIPED TO NEIGHBOUR ..... 13 PUBLIC TAP/STANDPIPE ..... 14  TUBE WELL OR BOREHOLE ..... 21 <b>DUG WELL</b> PROTECTED WEL ..... 31 UNPROTECTED WEL ..... 32 <b>WATER FROM SPRING</b> PROTECTED SPRING ..... 41 UNPROTECTED SPRING ..... 42  RAINWATER ..... 51 TANKER TRUCK ..... 61 CART WITH SMALL TAN ..... 71 SURFACE WATER (RIVER/DAM/ LAKE/POND/STREAM/CANAL/ IRRIGATION CHANNEL) ..... 81 BOTTLED WATER ..... 91  OTHER ..... 96 (SPECIFY)	→ 106   → 103  → 103
102	What is the main source of water used by your household for other purposes such as cooking and handwashing?	<b>PIPED WATER</b> PIPED INTO DWELLING ..... 11 PIPED TO YARD/PLO ..... 12 PIPED TO NEIGHBOUR ..... 13 PUBLIC TAP/STANDPIPE ..... 14  TUBE WELL OR BOREHOLE ..... 21 <b>DUG WELL</b> PROTECTED WEL ..... 31 UNPROTECTED WEL ..... 32 <b>WATER FROM SPRING</b> PROTECTED SPRING ..... 41 UNPROTECTED SPRING ..... 42  RAINWATER ..... 51 TANKER TRUCK ..... 61 CART WITH SMALL TAN ..... 71 SURFACE WATER (RIVER/DAM/ LAKE/POND/STREAM/CANAL/ IRRIGATION CHANNEL) ..... 81  OTHER ..... 96 (SPECIFY)	→ 106
103	Where is that water source located?	IN OWN DWELLING ..... 1 IN OWN YARD/PLOT ..... 2 ELSEWHERE ..... 3	→ 105
104	How long does it take to go there, get water, and come back?  IF WATER IS DELIVERED AT HOME, RECORD	MINUTES ..... <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW ..... 998	
105	CHECK 101 AND 102: CODE '14' OR '21'  YES <input type="checkbox"/> NO <input type="checkbox"/>		→ 107



# HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP		
106	In the past two weeks, was the water from this source not available for at least one full day?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
107	Do you do anything to the water to make it safer to drink?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 109		
108	What do you usually do to make the water safer to drink? Anything else?  RECORD ALL MENTIONED.	BOIL ..... A ADD BLEACH/CHLORINE ..... B STRAIN THROUGH A CLOT ..... C USE WATER FILTER (CERAMIC/ SAND/COMPOSITE/ETC ..... D SOLAR DISINFECTION ..... E LET IT STAND AND SETTLE ..... F  OTHER ..... X (SPECIFY) DON'T KNOW ..... Z			
109	What kind of toilet facility do members of your household usually use?  IF NOT POSSIBLE TO DETERMINE, ASK PERMISSION TO OBSERVE THE FACILITY.	<b>FLUSH OR POUR FLUSH TOILET</b> FLUSH TO PIPED SEWER SYSTEM ..... 11 FLUSH TO SEPTIC TANK ..... 12 FLUSH TO PIT LATRINE ..... 13 FLUSH TO SOMEWHERE ELSE ..... 14 FLUSH, DON'T KNOW WHERE ..... 15 <b>PIT LATRINE</b> VENTILATED IMPROVED PIT LATRINE ..... 21 PIT LATRINE WITH SLAB ..... 22 PIT LATRINE WITHOUT SLAB/OPEN PIT ..... 23  COMPOSTING TOILET ..... 31 BUCKET TOILET ..... 41 HANGING TOILET/HANGING LATRINE ..... 51 NO FACILITY/BUSH/FIELD ..... 61  OTHER ..... 96 (SPECIFY)	→ 113		
110	Do you share this toilet facility with other households?	YES ..... 1 NO ..... 2	→ 112		
111	Including your own household, how many households use this toilet facility?	NO. OF HOUSEHOLDS IF LESS THAN 10 ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; text-align: center;">0</td><td style="width: 30px;"></td></tr></table>  10 OR MORE HOUSEHOLDS ..... 95 DON'T KNOW ..... 98	0		
0					
112	Where is this toilet facility located?	IN OWN DWELLING ..... 1 IN OWN YARD/PLOT ..... 2 ELSEWHERE ..... 3			

# HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP														
113	What type of fuel does your household mainly use for cooking?	ELECTRICITY ..... 01 LPG ..... 02 NATURAL GAS ..... 03 BIOGAS ..... 04 KEROSENE ..... 05 COAL, LIGNITE ..... 06 CHARCOAL ..... 07 WOOD ..... 08 STRAW/SHRUBS/GRASS ..... 09 AGRICULTURAL CROP ..... 10 ANIMAL DUNG ..... 11  NO FOOD COOKED IN HOUSEHOLD ..... 95 OTHER ..... 96 (SPECIFY)	           → 116														
114	Is the cooking usually done in the house, in a separate building, or outdoors?	IN THE HOUSE ..... 1 IN A SEPARATE BUILDING ..... 2 OUTDOORS ..... 3  OTHER ..... 6 (SPECIFY)	   → 116														
115	Do you have a separate room which is used as a kitchen?	YES ..... 1 NO ..... 2															
116	How many rooms in this household are used for sleeping?	ROOMS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>															
117	Does this household own any livestock, herds, other farm animals, or poultry?	YES ..... 1 NO ..... 2	 → 121														
118	How many of the following animals does this household own? IF NONE, RECORD '00'. IF 95 OR MORE, RECORD '95'. IF UNKNOWN, RECORD '98'.  a) Milk cows or bulls? b) Other cattle (buffalo)? c) Horses, donkeys, or mules? d) Goats? e) Sheep? f) Camels? g) Chickens or other poultry?	           a) COWS/BULLS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> b) OTHER CATTLE (BUFFALO) ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> c) HORSES/DONKEYS/MULES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> d) GOATS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> e) SHEEP ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> f) CAMELS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> g) CHICKENS/POULTRY ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>															

# HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
121	Does your household have:	YES	NO	
	a) Electricity?	a) ELECTRICITY ..... 1	2	
	b) A radio?	b) RADIO ..... 1	2	
	c) A television?	c) TELEVISION ..... 1	2	
	d) A non-mobile telephone?	d) NON-MOBILE TELEPHONE .. 1	2	
	e) A refrigerator?	e) REFRIGERATOR ..... 1	2	
	f) Almirah/cabinet?	f) ALMIRAH/CABINE ..... 1	2	
	g) Chair?	g) CHAIR ..... 1	2	
	h) Room cooler?	h) ROOM COOLER ..... 1	2	
	i) Air conditioner?	i) AIR CONDITIONER ..... 1	2	
	j) Washing machine?	j) WASHING MACHIN ..... 1	2	
	k) Water pump?	k) WATER PUMP ..... 1	2	
	l) Bed?	l) BED ..... 1	2	
	m) Clock?	m) CLOCK ..... 1	2	
	n) Sofa?	n) SOFA ..... 1	2	
	o) Camera?	o) CAMERA ..... 1	2	
	p) Sewing machine?	p) SEWING MACHINE ..... 1	2	
	q) Computer?	q) COMPUTER ..... 1	2	
	r) Internet connection?	r) INTERNET CONNECTIOI.... 1	2	
122	Does any member of this household own:	YES	NO	
	a) A watch?	a) WATCH ..... 1	2	
	b) A mobile phone?	b) MOBILE PHONI ..... 1	2	
	c) A bicycle?	c) BICYCLE ..... 1	2	
	d) A motorcycle or motor scooter?	d) MOTORCYCLE/SCOOTER .. 1	2	
	e) An animal-drawn cart?	e) ANIMAL-DRAWN CART .... 1	2	
	f) A car or truck or bus?	f) CAR/TRUCK/BUS ..... 1	2	
	g) A tractor?	g) TRACTOR ..... 1	2	
	h) A boat with a motor?	h) BOAT WITH MOTOR ..... 1	2	
	i) A boat without a motor?	i) BOAT WITHOUT MOTOF.... 1	2	
	j) A Rickshaw/chingchi ?	j) RICKSHAW/CHINGCHI .... 1	2	

**ADDITIONAL HOUSEHOLD CHARACTERISTICS**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP				
142	<p>OBSERVE MAIN MATERIAL OF THE FLOOR OF THE DWELLING.</p> <p>RECORD OBSERVATION.</p>	<p><b>NATURAL FLOOR</b></p> <p>EARTH/SAND ..... 11</p> <p>DUNG ..... 12</p> <p><b>RUDIMENTARY FLOOR</b></p> <p>WOOD PLANKS ..... 21</p> <p>PALM/BAMBOC ..... 22</p> <p><b>FINISHED FLOOR</b></p> <p>PARQUET OR POLISHED WOOD ..... 31</p> <p>VINYL OR ASPHALT STRIP ..... 32</p> <p>CERAMIC TILES ..... 33</p> <p>CEMENT ..... 34</p> <p>CARPET ..... 35</p> <p>CHIPS/TERRAZZO ..... 36</p> <p>BRICKS ..... 37</p> <p>MATS ..... 38</p> <p>MARBLE ..... 39</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>					
143	<p>OBSERVE MAIN MATERIAL OF THE ROOF OF THE DWELLING.</p> <p>RECORD OBSERVATION.</p>	<p><b>NATURAL ROOFING</b></p> <p>NO ROOF ..... 11</p> <p>THATCH/PALM LEAF ..... 12</p> <p>SOD/GRASS ..... 13</p> <p><b>RUDIMENTARY ROOFING</b></p> <p>RUSTIC MAT ..... 21</p> <p>PALM/BAMBOC ..... 22</p> <p>WOOD PLANKS ..... 23</p> <p>CARDBOARD ..... 24</p> <p><b>FINISHED ROOFING</b></p> <p>ASBESTOS ..... 31</p> <p>REINFORCED BRICK CEMENT/RC ..... 32</p> <p>METAL ..... 33</p> <p>WOOD ..... 34</p> <p>CALAMINE/CEMENT FIBER ..... 35</p> <p>CERAMIC TILES ..... 36</p> <p>CEMENT/RCC ..... 37</p> <p>ROOFING SHINGLES ..... 38</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>					
144	<p>OBSERVE MAIN MATERIAL OF THE EXTERIOR WALLS OF THE DWELLING.</p> <p>RECORD OBSERVATION.</p>	<p><b>NATURAL WALLS</b></p> <p>NO WALLS ..... 11</p> <p>CANE/PALM/TRUNKS ..... 12</p> <p>DIRT ..... 13</p> <p>MUD/STONES ..... 14</p> <p>BAMBOO/STICKS/MUD ..... 15</p> <p><b>RUDIMENTARY WALLS</b></p> <p>UNBAKED BRICKS/MUD ..... 21</p> <p>BAMBOO WITH MUD ..... 22</p> <p>STONE WITH MUD ..... 23</p> <p>UNCOVERED ADOBE ..... 24</p> <p>PLYWOOD ..... 25</p> <p>REUSED WOOD ..... 26</p> <p><b>FINISHED WALLS</b></p> <p>CEMENT ..... 31</p> <p>STONE WITH LIME/CEMENT ..... 32</p> <p>BRICKS ..... 33</p> <p>CEMENT BLOCKS ..... 34</p> <p>COVERED ADOBE ..... 35</p> <p>WOOD PLANKS/SHINGLES ..... 36</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>					
146	<p>RECORD THE TIME.</p>	<p>HOURS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table></p> <p>MINUTES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table></p>					

(A) INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT INTERVIEW:

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COMMENTS ON SPECIFIC QUESTIONS:

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ANY OTHER COMMENTS:

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(B) SUPERVISOR'S OBSERVATIONS

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(C) EDITOR'S OBSERVATIONS

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PAKISTAN MATERNAL MORTALITY SURVEY 2019  
EVER-MARRIED WOMAN'S QUESTIONNAIRE  
PAKISTAN  
NATIONAL INSTITUTE OF POPULATION STUDIES

IDENTIFICATION									
PROVINCE/REGION (PUNJAB=1; SINDH=2; KP=3; BALOCHISTAN=4; GB=5; AJK=6)								<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>	
DISTRICT _____								<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>	
TEHSIL _____									
NAME OF HOUSEHOLD HEAD _____									
CLUSTER NUMBER .....								<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>	
HOUSEHOLD NUMBER .....								<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>	
NAME AND LINE NUMBER OF WOMAN _____								<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>	
INTERVIEWER VISITS									
	1	2	3	FINAL VISIT					
DATE	_____	_____	_____	DAY	<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>				
				MONTH	<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>				
INTERVIEWER'S NAME	_____	_____	_____	YEAR	<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>				
RESULT*	_____	_____	_____	INT. NO.	<div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>				
NEXT VISIT: DATE	_____	_____		TOTAL NUMBER OF VISITS	<div style="width: 20px; height: 20px; border: 1px solid black;"></div>				
TIME _____									
*RESULT CODES: 1 COMPLETED 4 REFUSED 2 NOT AT HOME 5 PARTLY COMPLETED 7 OTHER _____ 3 POSTPONED 6 INCAPACITATED SPECIFY _____									
LANGUAGE OF QUESTIONNAIRE** <b>0 1</b>		LANGUAGE OF INTERVIEW** <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>		NATIVE LANGUAGE OF RESPONDENT** <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>		TRANSLATOR USED (YES = 1, NO = 2) <div style="width: 20px; height: 20px; border: 1px solid black;"></div>			
LANGUAGE OF QUESTIONNAIRE** <b>ENGLISH</b>		**LANGUAGE CODES: 01 ENGLISH 03 SINDHI 05 SARAIKI 02 URDU 04 PUNJABI 06 BALUCHI 07 PUSHTO 08 OTHER							
SUPERVISOR <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>				FIELD EDITOR <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>				KEYED BY <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div style="width: 20px; height: 20px; border: 1px solid black;"></div> </div>	
NAME _____				NAME _____				NAME _____	
NUMBER _____				NUMBER _____				NUMBER _____	

## INTRODUCTION AND CONSENT

Asalam-o-Alaikum. My name is \_\_\_\_\_. I am working with National Institute of Population Studies. We are conducting a survey about women's health and health care utilization all over the Pakistan. The information we collect will help the government to plan health services. Your household was selected for the survey. The questions usually take about 60 to 90 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your household.

Do you have any questions?  
May I begin the interview now?

SIGNATURE OF INTERVIEWER \_\_\_\_\_ DATE \_\_\_\_\_

RESPONDENT AGREES  
TO BE INTERVIEWED . . . 1

RESPONDENT DOES NOT AGREE  
TO BE INTERVIEWED .. 2 → END

## **SECTION 1. RESPONDENT'S BACKGROUND**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME.	HOURS ..... MINUTES .....	
102	In what month and year were you born?	MONTH ..... DON'T KNOW MONTH ..... 98 YEAR ..... DON'T KNOW YEAR ..... 9998	
103	How old were you at your last birthday?  <b>COMPARE AND CORRECT 102 AND 103 IF INCONSISTENT.</b>	AGE IN COMPLETED YEARS ..... .....	
104	Have you ever attended school?	YES ..... 1 NO ..... 2	→ 107
105	What is the highest class you completed?  <b>IF COMPLETED LESS THAN CLASS ONE, RECORD '00'. IF MA, MPHIL, PHD, MBBS, OR BSC/4 YEARS, WRITE `16'.</b>	CLASS ..... .....	
106	CHECK 105:  CLASS 00-09 <input type="checkbox"/> ↓ CLASS 10 <input type="checkbox"/> OR HIGHER		→ 108
107	Now I would like you to read this sentence to me.  <b>SHOW CARD TO RESPONDENT.</b>  <b>IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me?</b>	CANNOT READ AT ALL ..... 1 ABLE TO READ ONLY PART OF THE SENTENCE ..... 2 ABLE TO READ WHOLE SENTENCE ..... 3 NO CARD WITH REQUIRED LANGUAGE ..... 4 (SPECIFY LANGUAGE) BLIND/VISUALLY IMPAIRED ..... 5	



**SECTION 1. RESPONDENT'S BACKGROUND**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
108	What is your mother tongue?	URDU ..... 01 PUNJABI ..... 02 SINDHI ..... 03 PUSHTO ..... 04 BALOCHI ..... 05 ENGLISH ..... 06 BARAUHI ..... 07 SIRAIKI ..... 08 HINDKO ..... 09 KASHMIRI ..... 10 SHINA ..... 11 BRUSHASKI ..... 12 WAKHI ..... 13 CHITRALI/ KHWAR ..... 14 BALTI ..... 15 PAHARI ..... 16 POTOWARI ..... 17 MARWARI ..... 18 FARSI ..... 19 OTHER ..... 96	
109	Are you currently married?	YES ..... 1 NO ..... 2	→ 111
110	What is your current marital status?	WIDOWED ..... 1 DIVORCED ..... 2 SEPARATED LEGALLY FROM HUSBAND ..... 3	→ 200
111	Is your husband living with you now or is he staying elsewhere?	LIVING WITH HER ..... 1 STAYING ELSEWHERE ..... 2	

# SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP				
200	Now I would like to ask you about all the pregnancies that you have had during your life. By this I mean all the children born to you whether they were born alive or dead, whether they are still living or not, whether they live with you or somewhere else, and all the pregnancies that you have had that did not result in a live birth. I understand that it is not easy to talk about children who have died, or pregnancies that ended before full term, but it is important that you tell us about all of them, so that the government can develop programs to improve children's health.						
201	First I would like to ask about all the births you have had during your life. Have you ever given birth?	YES ..... 1 NO ..... 2	→ 206				
202	Do you have any sons or daughters to whom you have given birth who are now living with you?	YES ..... 1 NO ..... 2	→ 204				
203	a) How many sons live with you? b) And how many daughters live with you? <b>IF NONE, RECORD '00'.</b>	a) SONS AT HOME ..... b) DAUGHTERS AT HOME ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>					
204	Do you have any sons or daughters to whom you have given birth who are alive but do not live with you?	YES ..... 1 NO ..... 2	→ 206				
205	a) How many sons are alive but do not live with you? b) And how many daughters are alive but do not live with you? <b>IF NONE, RECORD '00'.</b>	a) SONS ELSEWHERE ..... b) DAUGHTERS ELSEWHERE ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>					
206	Have you ever given birth to a boy or girl who was born alive but later died? <b>IF NO, PROBE: Any baby who cried, who made any movement, sound, or effort to breathe, or who showed any other signs of life even if for a very short time?</b>	YES ..... 1 NO ..... 2	→ 207AA				
207	a) How many boys have died? b) And how many girls have died? <b>IF NONE, RECORD '00'.</b>	a) BOYS DEAD ..... b) GIRLS DEAD ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>					
207AA	Women sometimes have pregnancies that do not result in a live born child. That is, a pregnancy can end in a miscarriage, or the child can be born dead. Have you ever had a pregnancy that did not end in a live birth?	YES ..... 1 NO ..... 2	→ 208				
207BB	How many pregnancies have you had that did not end in a live birth?	PREGNANCY LOSSES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr></table>					
208	<b>SUM ANSWERS TO 203, 205, 207, AND 207BB, AND ENTER TOTAL. IF NONE, RECORD '00'.</b>	TOTAL PREGNANCIES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr></table>					
209	CHECK 208: Just to make sure that I have this right: you have had in TOTAL ____ pregnancies during your life. Is that correct? <div style="display: flex; justify-content: space-around; align-items: center;"><div>YES <input type="checkbox"/></div><div>NO <input type="checkbox"/> ↓ PROBE AND CORRECT 201-208 AS NECESSARY</div></div>						
210	CHECK 208: <div style="display: flex; justify-content: space-around; align-items: center;"><div>ONE OR MORE PREGNANCIES <input type="checkbox"/></div><div>NO PREGNANCIES <input type="checkbox"/></div></div>		→ 225				

## SECTION 2. REPRODUCTION

211 Now I would like to record all your pregnancies, whether born alive, born dead, or lost before full term, starting with the first one you had.  
RECORD ALL THE PREGNANCIES IN 212. RECORD TWINS AND TRIPLETS ON SEPARATE ROWS. IF THERE ARE MORE THAN 10 BIRTHS, USE AN ADDITIONAL QUESTIONNAIRE, STARTING WITH THE SECOND ROW.

212	212A	212B	212C	212D	213	215	216
PREG-NANCY HISTORY NUMBER	Think back to your first pregnancy.  Was that a single or multiple pregnancy?	Was the baby born alive, born dead, or lost before birth?	Did that baby cry, move, or breathe when it was born?	What name was given to the child?  <b>RECORD NAME</b>	Is (NAME) a boy or a girl?	On what day, month, and year was (NAME) born?  PROBE: When is his/her birthday?	Is (NAME) still alive?
01	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES ... 1  NO ... 2 ↓ (SKIP TO 220AB)	NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES ... 1  NO ... 2 ↓ (SKIP TO 220)
02	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES ... 1  NO ... 2 ↓ (SKIP TO 220AB)	NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES ... 1  NO ... 2 ↓ (SKIP TO 220)
03	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES ... 1  NO ... 2 ↓ (SKIP TO 220AB)	NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES ... 1  NO ... 2 ↓ (SKIP TO 220)
04	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES ... 1  NO ... 2 ↓ (SKIP TO 220AB)	NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES ... 1  NO ... 2 ↓ (SKIP TO 220)
05	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES ... 1  NO ... 2 ↓ (SKIP TO 220AB)	NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES ... 1  NO ... 2 ↓ (SKIP TO 220)

212	212A	212B	212C	212D	213	215	216
PREG- NANCY HISTORY NUMBER	Think back to your first pregnan- cy.  Was that a single or multiple pregnan- cy?	Was the baby born alive, born dead, or lost before birth?	Did that baby cry, move, or breathe when it was born?	What name was given to the child?  <b>RECORD NAME</b>	Is (NAME) a boy or a girl?	On what day, month, and year was (NAME) born?  PROBE: When is his/her birthday?	Is (NAME) still alive?
06	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES .. 1  NO ... 2 ↓ (SKIP TO 220AB)	_____ NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES .. 1  NO ... 2 ↓ (SKIP TO 220)
07	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES .. 1  NO ... 2 ↓ (SKIP TO 220AB)	_____ NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES .. 1  NO ... 2 ↓ (SKIP TO 220)
08	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES .. 1  NO ... 2 ↓ (SKIP TO 220AB)	_____ NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES .. 1  NO ... 2 ↓ (SKIP TO 220)
09	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES .. 1  NO ... 2 ↓ (SKIP TO 220AB)	_____ NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES .. 1  NO ... 2 ↓ (SKIP TO 220)
10	SING 1  MULT 2	BORN ALIVE 1 (SKIP TO 212D) ↙  BORN DEAD 2  LOST BEFORE FULL TERM 3 (SKIP TO 220AB) ↙	YES .. 1  NO ... 2 ↓ (SKIP TO 220AB)	_____ NAME	BOY ... 1  GIRL ... 2	DAY <input type="text"/> <input type="text"/>  MONTH <input type="text"/> <input type="text"/>  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	YES .. 1  NO ... 2 ↓ (SKIP TO 220)

## SECTION 2. REPRODUCTION

217 IF ALIVE:  How old was (NAME) at (NAME)'s last birthday?  <b>RECORD AGE IN COMPLETED YEARS.</b>	218 IF ALIVE:  Is (NAME) living with you?	219 IF ALIVE:  RECORD HOUSEHOLD LINE NUMBER OF CHILD. RECORD '00' IF CHILD NOT LISTED IN HOUSEHOLD.	220 IF DEAD:  How old was (NAME) when (he/she) died?  <b>IF '12 MONTHS' OR '1 YR', ASK: Did (NAME) have (his/her) first birthday? THEN ASK: Exactly how many months old was (NAME) when (he/she) died</b>  <b>RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.</b>	220AB IF BORN DEAD OR LOST BEFORE BIRTH  On what day, month, and year did this pregnancy end?	220AC  How many months did this pregnancy last?	220AD  Did you or someone else do something to end this pregnancy?	221  Were there any other pregnancies between the previous pregnancy and this pregnancy?
AGE IN YEARS <input type="text"/> <input type="text"/>	YES .. 1  NO ... 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/> ↓ (NEXT PREGNANCY)	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> (NEXT PREGNANCY)	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	MONTHS <input type="text"/> <input type="text"/>	YES ... 1  NO .... 2	
AGE IN YEARS <input type="text"/> <input type="text"/>	YES .. 1  NO ... 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/> ↓ (SKIP TO 221)	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> (SKIP TO 221)	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	MONTHS <input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES ..... 1 (ADD PREGNANCY) ←  NO ..... 2 (NEXT PREGNANCY) ←
AGE IN YEARS <input type="text"/> <input type="text"/>	YES .. 1  NO ... 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/> ↓ (SKIP TO 221)	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> (SKIP TO 221)	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	MONTHS <input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES ..... 1 (ADD PREGNANCY) ←  NO ..... 2 (NEXT PREGNANCY) ←
AGE IN YEARS <input type="text"/> <input type="text"/>	YES .. 1  NO ... 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/> ↓ (SKIP TO 221)	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> (SKIP TO 221)	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	MONTHS <input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES ..... 1 (ADD PREGNANCY) ←  NO ..... 2 (NEXT PREGNANCY) ←
AGE IN YEARS <input type="text"/> <input type="text"/>	YES .. 1  NO ... 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/> ↓ (SKIP TO 221)	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> (SKIP TO 221)	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR	MONTHS <input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES ..... 1 (ADD PREGNANCY) ←  NO ..... 2 (NEXT PREGNANCY) ←

217 IF ALIVE:	218 IF ALIVE:	219 IF ALIVE:	220 IF DEAD:	220AB IF BORN DEAD OR LOST BEFORE BIRTH	220AC	220AD	221
How old was (NAME) at (NAME)'s last birthday?	Is (NAME) living with you?	RECORD HOUSEHOLD LINE NUMBER OF CHILD. RECORD '00' IF CHILD NOT LISTED IN HOUSEHOLD.	How old was (NAME) when (he/she) died?  <b>IF '12 MONTHS' OR '1 YR', ASK: Did (NAME) have (his/her) first birthday? THEN ASK: Exactly how many months old was (NAME) when (he/she) died</b>	On what day, month, and year did this pregnancy end?	How many months did this pregnancy last?	Did you or someone else do something to end this pregnancy?	Were there any other pregnancies between the previous pregnancy and this pregnancy?
<b>RECORD AGE IN COMPLETED YEARS.</b>			<b>RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.</b>		<b>RECORD IN COMPLETED MONTHS.</b>		
AGE IN YEARS <div><div></div><div></div></div>	YES ... 1  NO ... 2	HOUSEHOLD LINE NUMBER <div><div></div><div></div></div> (SKIP TO 221)	DAYS 1 <div><div></div><div></div></div> MONTHS 2 <div><div></div><div></div></div> YEARS 3 <div><div></div><div></div></div> (SKIP TO 221)	DAY <div><div></div><div></div></div> MONTH <div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div></div> YEAR	MONTHS <div><div></div><div></div></div>	YES ... 1  NO ... 2	YES ..... 1 (ADD PREGNANCY) ←  NO ..... 2 (NEXT PREGNANCY) ←
AGE IN YEARS <div><div></div><div></div></div>	YES ... 1  NO ... 2	HOUSEHOLD LINE NUMBER <div><div></div><div></div></div> (SKIP TO 221)	DAYS 1 <div><div></div><div></div></div> MONTHS 2 <div><div></div><div></div></div> YEARS 3 <div><div></div><div></div></div> (SKIP TO 221)	DAY <div><div></div><div></div></div> MONTH <div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div></div> YEAR	MONTHS <div><div></div><div></div></div>	YES ... 1  NO ... 2	YES ..... 1 (ADD PREGNANCY) ←  NO ..... 2 (NEXT PREGNANCY) ←
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AGE IN YEARS <div><div></div><div></div></div>	YES ... 1  NO ... 2	HOUSEHOLD LINE NUMBER <div><div></div><div></div></div> (SKIP TO 221)	DAYS 1 <div><div></div><div></div></div> MONTHS 2 <div><div></div><div></div></div> YEARS 3 <div><div></div><div></div></div> (SKIP TO 221)	DAY <div><div></div><div></div></div> MONTH <div><div></div><div></div></div> <div><div></div><div></div><div></div><div></div></div> YEAR	MONTHS <div><div></div><div></div></div>	YES ... 1  NO ... 2	YES ..... 1 (ADD PREGNANCY) ←  NO ..... 2 (NEXT PREGNANCY) ←

## SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
222	Have you had any pregnancies since the last pregnancy mentioned?	YES ..... 1 (RECORD PREGNANCY(S) IN TABLE) ← NO ..... 2	
223	COMPARE 208 WITH NUMBER OF PREGNANCIES IN PREGNANCY HISTORY  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">             NUMBERS ARE SAME ↓ <input type="checkbox"/> </div> <div style="text-align: center;">             NUMBERS ARE DIFFERENT ↓ <input type="checkbox"/> </div> </div> (PROBE AND RECONCILE) ←		
224	CHECK 215: ENTER THE NUMBER OF BIRTHS IN 2016-2019  IF NONE, RECORD '0'.	NUMBER OF BIRTHS ..... <input style="width: 50px;" type="text"/>	
225	Are you pregnant now?	YES ..... 1 NO ..... 2 UNSURE ..... 8	→ 301
226	How many months pregnant are you?  RECORD NUMBER OF COMPLETED MONTHS.	MONTHS ..... <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>	
227	When you got pregnant, did you want to get pregnant at that time?	YES ..... 1 NO ..... 2	→ 301
228	CHECK 208: TOTAL NUMBER OF BIRTHS  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">             ONE OR MORE <input type="checkbox"/>              a) Did you want to have a baby later on or did you not want any more children?           </div> <div style="width: 45%;">             NONE <input type="checkbox"/>              b) Did you want to have a baby later on or did you not want any children?           </div> </div>	LATER ..... 1 NO MORE/NONE ..... 2	

**SECTION 3. CONTRACEPTION**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301	Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy.  Have you ever heard of any (METHOD)?	YES ..... 1 NO ..... 2	→ 308
302	Have you ever used anything or tried in any way to delay or avoid getting pregnant?	YES ..... 1 NO ..... 2	→ 307
303	Which method(s) have you ever used?  <b>RECORD ALL MENTIONED</b>	FEMALE STERILIZATION ..... A MALE STERILIZATION ..... B IUD ..... C INJECTABLES ..... D IMPLANTS ..... E PILL ..... F CONDOM ..... G EMERGENCY CONTRACEPTION ..... I STANDARD DAYS METHOD ..... J LACTATIONAL AMENORRHEA METHOD ..... K RHYTHM METHOD ..... L WITHDRAWAL ..... M OTHER TRADITIONAL METHOD ..... X ANY OTHER METHOD ..... Y	→ 306
304	Have you ever experienced a side effect or problems related with the use of family planning method(s)?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
305	Were you ever told about side effects or problems you might have with family planning methods?	YES ..... 1 NO ..... 2	
306	Were you advised by a health or family planning worker about the following:  a) Help you in selecting a method? b) Explained how to use the selected method?	YES NO a) HELP SELECT METHOD ..... 1 2 b) EXPLAIN METHOD USING ..... 1 2	
307	Do you know a place where you can obtain a method of family planning?	YES ..... 1 NO ..... 2	
308	In the last 12 months, were you visited by a LHW?	YES ..... 1 NO ..... 2	→ 311
309	Did your LHW talk to you about these topics?  a) Family planning? b) Antenatal care? c) Delivery care? d) Postnatal care? e) Complications during pregnancy/child birth/postpartum period?	YES NO a) FAMILY PLANNING ..... 1 2 b) ANTENATAL CARE ..... 1 2 c) DELIVERY CARE ..... 1 2 d) POSTNATAL CARE ..... 1 2 e) COMPLICATIONS ..... 1 2	
310	Did your LHW provide you these services/ referral/ advice:  a) Treatment for malaria b) Treatment for diarrhoea c) Treatment for fever d) Referral for family planning e) Referral for antenatal care f) Referral for delivery care x) Other (Specify)	YES NO a) TREATMENT FOR MALARIA ..... 1 2 b) TREATMENT FOR DIARRHOEA ..... 1 2 c) TREATMENT FOR FEVER ..... 1 2 d) REFERRAL FOR FAMILY PLANNING ..... 1 2 e) REFERRAL FOR ANTENATAL CARE ..... 1 2 f) REFERRAL FOR DELIVERY CARE ..... 1 2 x) ..... 1 2	



**SECTION 3. CONTRACEPTION**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
311	<p>CHECK 202: CHILDREN LIVING WITH RESPONDENT</p> <p>YES <input type="checkbox"/>      NO <input type="checkbox"/></p> <p>a) In the last 12 months, have you visited a health facility for care for yourself or your children?      b) In the last 12 months, have you visited a health facility for care for yourself?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ 401
312	Did any staff member at the health facility speak to you about family planning methods?	<p>YES ..... 1</p> <p>NO ..... 2</p>	

**SECTION 4. PREGNANCY AND POSTNATAL CARE**

401	CHECK 220AB, 220AC AND 224: ONE OR MORE LIVE BIRTHS, STILLBIRTHS, MISCARRIAGE, ABORTION IN 2016-2019	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> <input type="checkbox"/>              NO LIVE BIRTHS, STILLBIRTH              MISCARRIAGE, ABORTION IN 2016-2019           </div> <div style="text-align: right;"> <input type="checkbox"/> → 636           </div> </div>
402	CHECK 212 and record pregnancy history number in 403; In 404 record result of last pregnancy in 2016-2019 and survival status in 405.  Now I would like to ask some questions about your last pregnancy that ended during last 3-years (even if it ended in still birth/ abortion/ miscarriage)	
403	PREGNANCY NUMBER FROM 212 IN PREGNANCY HISTORY.	LAST PREGNANCY  PREGNANCY NUMBER ..... <span style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; vertical-align: middle;"></span> <span style="border: 1px solid black; display: inline-block; width: 20px; height: 20px; vertical-align: middle;"></span>
404	CHECK 212B, 215, 220AB, 220AC AND 220AD PREGNANCY OUTCOME: <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;">             LIVE BIRTH  <input type="checkbox"/>              ↓           </div> <div style="text-align: center;">             STILLBIRTH  <input type="checkbox"/> </div> <div style="text-align: center;">             MISCARRIAGE  <input type="checkbox"/> </div> <div style="text-align: center;">             ABORTION  <input type="checkbox"/> </div> </div> <div style="text-align: right; margin-top: -20px;">→ 406</div>	
405	FROM 212D AND 216:	NAME _____  <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">             LIVING <input type="checkbox"/>              ↓           </div> <div style="text-align: center;">             DEAD <input type="checkbox"/>              ↓           </div> </div>
406	Did you see anyone for antenatal care for this pregnancy?	YES ..... 1 NO ..... 2 <div style="text-align: right;">(SKIP TO 414) ←</div>
407	Whom did you see?  Anyone else?   <b>PROBE TO IDENTIFY EACH TYPE OF PERSON          AND RECORD ALL MENTIONED.</b>	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/SPECIALIST ..... A DOCTOR ..... B NURSE/MIDWIFE/LHV ..... C COMMUNITY MIDWIFE ..... D  <b>OTHER PERSON</b> DAI-TBA ..... E LADY H. WORKER ..... F HOMEOPATH ..... G HAKIM ..... H DISPENSER / COMPOUNDER ..... I  OTHER _____ X <div style="text-align: center;">(SPECIFY)</div>
408	Were you satisfied with the service provided?	YES ..... 1 NO ..... 2

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____												
409	<p>Where did you receive antenatal care for this pregnancy?</p> <p>Anywhere else?</p> <p><b>PROBE TO IDENTIFY THE TYPE OF SOURCE.</b></p> <p><b>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</b></p> <p>_____ (NAME OF PLACE)</p>	<p><b>HOME</b></p> <p>HER HOME ..... A</p> <p>OTHER HOME ..... B</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVT. HOSPITAL ..... C</p> <p>RHC/MCH ..... D</p> <p>BHU/FWC ..... E</p> <p>OTHER PUBLIC SECTOR _____ F (SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/ CLINIC ..... G</p> <p>PVT. DOCTOR ..... H</p> <p>HOMEOPATH ..... I</p> <p>DISPENSER / COMPOUNDER ..... J</p> <p>OTHER PRIVATE MEDICAL SECTOR _____ K (SPECIFY)</p> <p>HAKIM ..... L</p> <p><b>OTHER</b> _____ X (SPECIFY)</p>												
410	How many months pregnant were you when you first received antenatal care for this pregnancy?	<p>MONTHS ..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>												
411	How many times did you receive antenatal care during this pregnancy?	<p>NUMBER OF TIMES ..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>												
412	<p>As part of your antenatal care during this pregnancy, were any of the following done at least once:</p> <p>a) Was your blood pressure measured?</p> <p>b) Did you give a urine sample?</p> <p>c) Did you give a blood sample?</p>	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>a) BP .....</td> <td>1</td> <td>2</td> </tr> <tr> <td>b) URINE .....</td> <td>1</td> <td>2</td> </tr> <tr> <td>c) BLOOD .....</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	a) BP .....	1	2	b) URINE .....	1	2	c) BLOOD .....	1	2
	YES	NO												
a) BP .....	1	2												
b) URINE .....	1	2												
c) BLOOD .....	1	2												
413	<p>During (any of) your antenatal care visit(s), were you advised on the following:</p> <p>a) Early initiation of breastfeeding?</p> <p>b) Exclusive breastfeeding?</p> <p>c) Balanced diet during pregnancy?</p>	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>a) EARLY BF .....</td> <td>1</td> <td>2</td> </tr> <tr> <td>b) EXCLUSIVE BF .....</td> <td>1</td> <td>2</td> </tr> <tr> <td>c) BALANCED DIET .....</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	a) EARLY BF .....	1	2	b) EXCLUSIVE BF .....	1	2	c) BALANCED DIET .....	1	2
	YES	NO												
a) EARLY BF .....	1	2												
b) EXCLUSIVE BF .....	1	2												
c) BALANCED DIET .....	1	2												
414	During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 417) ←</p> <p>DON'T KNOW ..... 8</p>												

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____
415	During this pregnancy, how many times did you get a tetanus injection?	TIMES ..... <input type="text"/> DON'T KNOW ..... 8
416	CHECK 415: 2 OR MORE TIMES <input type="checkbox"/> (SKIP TO 419)	OTHER <input type="checkbox"/>
417	At any time before this pregnancy, did you receive any tetanus injections?	YES ..... 1 NO ..... 2 (SKIP TO 419) ← DON'T KNOW ..... 8
417A	Before this pregnancy, how many times did you receive a tetanus injection?  <b>IF 7 OR MORE TIMES, RECORD '7'.</b>	TIMES ..... <input type="text"/> DON'T KNOW ..... 8
418	CHECK 417A:  <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">             ONLY <input type="checkbox"/> ONE              a) How many years ago did you receive that tetanus injection?           </div> <div style="text-align: center;">             MORE <input type="checkbox"/> THAN ONE              b) How many years ago did you receive the last tetanus injection prior to this pregnancy?           </div> </div>	YEARS AGO ..... <input type="text"/> <input type="text"/>
419	During this pregnancy, were you given or did you buy any iron tablets or iron syrup?  SHOW TABLETS/SYRUP.	YES ..... 1 NO ..... 2 (SKIP TO 421) ← DON'T KNOW ..... 8
420	During the whole pregnancy, for how many days did you take the Iron tablets or syrup?  IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	DAYS ..... <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW ..... 998
421	During this pregnancy, did you take any drug for intestinal worms?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8
422	CHECK 404 (PREGNANCY OUTCOME):  IF LIVE BIRTH/ STILLBIRTH <input type="checkbox"/>	IF ABORTION/ MISCARRIAGE <input type="checkbox"/> → 429

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____
423	<p>Who assisted with the delivery?</p> <p>Who else?</p> <p><b>PROBE FOR THE TYPE (S) OF PERSON (S) AND RECORD ALL MENTIONED</b></p>	<p><b>HEALTH PERSONNEL</b></p> <p>OBSTETRICIAN/SPECIALIST ..... A</p> <p>DOCTOR ..... B</p> <p>NURSE/MIDWIFE/LHV ..... C</p> <p>COMMUNITY MIDWIFE ..... D</p> <p><b>OTHER PERSON</b></p> <p>DAI/TRADITIONAL BIRTH ATTENDANT ..... E</p> <p>FAMILY WELFARE WK ..... F</p> <p>LADY H. WORKER ..... G</p> <p>HOMEOPATH ..... H</p> <p>HAKIM ..... I</p> <p>RELATIVE/FRIEND ..... J</p> <p>OTHER ..... X</p> <p align="center">(SPECIFY)</p> <p>NO ONE ASSISTED ..... Y</p>
424	<p>Where did you give birth to (NAME)?</p> <p><b>PROBE TO IDENTIFY THE TYPE OF SOURCE.</b></p>	<p><b>HOME</b></p> <p>HER HOME ..... 11</p> <p align="right">(SKIP TO 437A) ←</p> <p>OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ..... 21</p> <p>RHC/MCH ..... 22</p> <p>BHU/FWC ..... 23</p> <p>OTHER PUBLIC SECTOR ..... 26</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/ CLINIC ..... 31</p> <p>OTHER PRIVATE MEDICAL SECTOR ..... 36</p> <p align="center">(SPECIFY)</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p> <p align="right">(SKIP TO 437A) ←</p>
425	<p>How did delivery occur?</p>	<p>NORMAL VAGINAL DELIVERY ..... 1</p> <p>ASSISTED VAGINAL DELIVERY (USE OF FORCEPS OR VACUUM EXTRACTION) ..... 2</p> <p align="right">(SKIP TO 427) ←</p> <p>CESAREAN SECTION DELIVERY ..... 3</p>
426	<p>When was the decision made to have the caesarean section? Was it before or after your labour pains started?</p>	<p>BEFORE ..... 1</p> <p>AFTER ..... 2</p> <p align="right">(SKIP TO 428) ←</p>
427	<p>Did the baby come head first?</p>	<p>YES ..... 1</p> <p>NO (BABY CAME FEET FIRST OR SIDEWAYS) ..... 2</p> <p>DON'T KNOW ..... 8</p>

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____
428	Once your labour pains started, how long did it take to deliver the child?	LESS THAN 2 HOURS ..... 1 2-6 HOURS ..... 2 7-12 HOURS ..... 3 MORE THAN 12 HOURS ..... 4 NO LABOUR PAINS BECAUSE OF C SECTION ..... 5 DON'T KNOW/DON'T REMEMBER ..... 8 (SKIP TO 431) ←
429	Who assisted in induced abortion and/or after the abortion on miscarriage?  Who else?  <b>PROBE FOR THE TYPE(S) OF PERSONS(S) AND (RECORD ALL MENTIONED)</b>	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/ SPECIALIST ..... A DOCTOR ..... B NURSE/MIDWIFE/LHV ..... C  <b>OTHER PERSON</b> DAI/TRADITIONAL BIRTH ATTENDANT ..... D FAMILY WELFARE WK ..... E LADY H. WORKER ..... F HOMEOPATH ..... G HAKIM ..... H RELATIVE/FRIEND ..... I OTHER ..... (SPECIFY) ..... X  NO ONE ASSISTED ..... Y
430	Where did you received healthcare for induced abortion and/ or after the abortion/miscarriage?  Anywhere else?  <b>PROBE TO IDENTIFY THE TYPE OF SOURCE.</b>  <b>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</b>  _____ (NAME OF PLACE)	<b>HOME</b> HER HOME ..... A OTHER HOME ..... B  <b>PUBLIC SECTOR</b> GOVT. HOSPITAL ..... C RHC/MCH ..... D BHU/FWC ..... E  OTHER PUBLIC SECTOR ..... F (SPECIFY)  <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/ CLINIC ..... G PVT. DOCTOR ..... H HOMEOPATH ..... I DISPENSER / COMPOUNDER ..... J OTHER PRIVATE MEDICAL SECTOR ..... K (SPECIFY) HAKIM ..... L <b>OTHER</b> ..... X (SPECIFY) NO WHERE ..... Y
430A	CHECK 430:  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">             CODE "C" TO "X" CIRCLED <input type="checkbox"/> </div> <div style="text-align: center;">             CODE "A" , "B" OR "Y" CIRCLED <input type="checkbox"/> → (SKIP TO 437A)           </div> </div>	

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____						
431	I would like to talk to you about checks on your health after delivery, for example, someone asking you questions about your health or examining you. Did anyone check on your health after you gave birth or after your abortion/miscarriage?	YES ..... 1 NO ..... 2 (SKIP TO 434) ←						
432	When did you see this provider?  <b>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</b>	HOURS ..... 1 <table border="1" data-bbox="1268 403 1412 448"><tr><td></td><td></td></tr></table> DAYS ..... 2 <table border="1" data-bbox="1268 459 1412 504"><tr><td></td><td></td></tr></table> WEEKS ..... 3 <table border="1" data-bbox="1268 515 1412 560"><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998						
433	Who checked on your health at that time?  <b>PROBE FOR MOST QUALIFIED PERSON.</b>	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/SPECIALIST ..... 11 DOCTOR ..... 12 NURSE/MIDWIFE/LHV ..... 13 COMMUNITY MIDWIFE ..... 14 <b>OTHER PERSON</b> DAI-TBA ..... 15 FWV ..... 16 LADY H. WORKER ..... 17 HOMEOPATH ..... 18 HAKIM ..... 19 DISPENSER / COMPOUNDER ..... 20  OTHER ..... 96 (SPECIFY)						
434	Now I want to talk to you about what happened after you left the facility. Did anyone check on your health after you left the facility?	YES ..... 1 NO ..... 2 (SKIP TO 439) ←						
435	How long after delivery or abortion/miscarriage did that check take place?  <b>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</b>	HOURS ..... 1 <table border="1" data-bbox="1268 1142 1412 1187"><tr><td></td><td></td></tr></table> DAYS ..... 2 <table border="1" data-bbox="1268 1198 1412 1243"><tr><td></td><td></td></tr></table> WEEKS ..... 3 <table border="1" data-bbox="1268 1254 1412 1299"><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998						
436	Who checked on your health at that time?  <b>PROBE FOR MOST QUALIFIED PERSON.</b>	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/SPECIALIST ..... 11 DOCTOR ..... 12 NURSE/MIDWIFE/LHV ..... 13 COMMUNITY MIDWIFE ..... 14 <b>OTHER PERSON</b> DAI- TBA ..... 15 FWV ..... 16 LADY H.WORKER ..... 17 HOMEOPATH ..... 18 HAKIM ..... 19 DISPENSER / COMPOUNDER ..... 20  OTHER ..... 96 (SPECIFY)						

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____
437	<p>Where did the check take place?</p> <p><b>PROBE TO IDENTIFY THE TYPE OF SOURCE.</b></p> <p><b>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</b></p> <p>_____</p> <p align="center">(NAME OF PLACE)</p>	<p><b>HOME</b></p> <p>HER HOME ..... 11</p> <p>OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVT. HOSPITAL ..... 21</p> <p>RHC/MCH ..... 22</p> <p>BHU/FWC ..... 23</p> <p>OTHER PUBLIC SECTOR ..... 26</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/ CLINIC ..... 31</p> <p>OTHER PRIVATE MEDICAL SECTOR ..... 36</p> <p align="center">(SPECIFY)</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>
437A	<p>I would like to talk to you about checks on your health after delivery/abortion or miscarriage, for example, someone asking you questions about your health or examining you. Did anyone check on your health after you gave birth/abortion or miscarriage?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 439) ←</p>
438	<p>How long after delivery did the first check take place?</p> <p><b>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</b></p>	<p>HOURS ..... 1</p> <p>DAYS ..... 2</p> <p>WEEKS ..... 3</p> <p>DON'T KNOW ..... 998</p>
438A	<p>Who checked on your health at that time?</p> <p><b>PROBE FOR MOST QUALIFIED PERSON.</b></p>	<p><b>HEALTH PERSONNEL</b></p> <p>OBSTETRICIAN/SPECIALIST ..... 11</p> <p>DOCTOR ..... 12</p> <p>NURSE/MIDWIFE/LHV ..... 13</p> <p>COMMUNITY MIDWIFE ..... 14</p> <p><b>OTHER PERSON</b></p> <p>DAI- TBA ..... 21</p> <p>FWW ..... 22</p> <p>LADY H.WORKER ..... 23</p> <p>HOMEOPATH ..... 24</p> <p>HAKIM ..... 25</p> <p>DISPENSER / COMPOUNDER ..... 26</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>



SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____
438B	<p>Where did the check take place?</p> <p><b>PROBE TO IDENTIFY THE TYPE OF SOURCE.</b></p> <p><b>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</b></p> <p>_____ (NAME OF PLACE)</p>	<p><b>HOME</b></p> <p>HER HOME ..... 11</p> <p>OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVT. HOSPITAL ..... 21</p> <p>RHC/MCH ..... 22</p> <p>BHU ..... 23</p> <p>COMMUNITY MIDWIF. .... 24</p> <p>OTHER PUBLIC SECTOR ..... 26</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/ CLINIC ..... 31</p> <p>OTHER PRIVATE MEDICAL SECTOR ..... 36</p> <p align="center">(SPECIFY)</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>
439	Has your menstrual period returned since the termination of your last pregnancy?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 441) ←</p>
440	For how many months after termination of your last pregnancy did you not have a period?	<p>MONTHS ..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>
441	CHECK 225: IS RESPONDENT PREGNANT?	<p>NOT PREGNANT <input type="checkbox"/> PREGNANT OR UNSURE <input type="checkbox"/></p> <p align="center">(SKIP TO 443) ←</p>
442	Have you had sexual intercourse since the termination of your last pregnancy?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 501) ←</p>
443	For how many months after the termination of your last pregnancy did you not have sexual intercourse?	<p>MONTHS ..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>

**SECTION 5. MATERNAL MORBIDITY**

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP																																																																																																																																							
501	<p>Now I would like to ask you about any problems/illnesses that you might have suffered during your last pregnancy? What problems did you experience during your last pregnancy?</p> <p><b>WAIT FOR THE SPONTANEOUS RESPONSE. IF NOT MENTIONED, THEN PROMPT THOSE THAT ARE NOT MENTIONED.</b></p>	<table border="1"> <thead> <tr> <th></th> <th>YES (Before Prompting)</th> <th>YES (After Prompting)</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr><td>a) FEVER .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>b) FITS/ SEIZURES.....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>c) VAGINAL BLEEDING .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>d) JAUNDICE .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>e) LOWER ABDOMINAL PAIN..</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>f) EXCESSIVE VOMITING.....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>g) GENERAL ABDOMINAL PAIN .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>h) BLURRING OF VISION .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>i) SEVERE HEADACHE .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>j) FEELING OF EXTREME WEAKNESS .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>k) SHORTNESS OF BREATH AFTER EXERCISE/ WORKING ..</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>l) SHORTNESS OF BREATH EVEN AT REST .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>m) UNCONSCIOUSNESS/COMA</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>n) CHEST PAIN.....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>o) DIFFICULTY IN BREATHINGS .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>p) COUGH .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>q) HIGH BLOOD PRESSURE ..</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>r) HIGH SUGAR LEVELS DIAGNOSED AS DIABETES</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>s) LOSS OF WEIGHT .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>t) UNUSUALLY HIGH WEIGHT GAIN .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>u) BURNING OF MICTURITIONS .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>v) BLOOD OR PUS IN URINE ..</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>w) BODY-ACHES .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>x) SEVERE ANAEMIA .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>y) SWELLING OF ANKLES/ FEET .....</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> <tr><td>z) SWELLING OVER FACE ..</td><td>1</td><td>2</td><td>3</td><td>8</td></tr> </tbody> </table>		YES (Before Prompting)	YES (After Prompting)	NO	DK	a) FEVER .....	1	2	3	8	b) FITS/ SEIZURES.....	1	2	3	8	c) VAGINAL BLEEDING .....	1	2	3	8	d) JAUNDICE .....	1	2	3	8	e) LOWER ABDOMINAL PAIN..	1	2	3	8	f) EXCESSIVE VOMITING.....	1	2	3	8	g) GENERAL ABDOMINAL PAIN .....	1	2	3	8	h) BLURRING OF VISION .....	1	2	3	8	i) SEVERE HEADACHE .....	1	2	3	8	j) FEELING OF EXTREME WEAKNESS .....	1	2	3	8	k) SHORTNESS OF BREATH AFTER EXERCISE/ WORKING ..	1	2	3	8	l) SHORTNESS OF BREATH EVEN AT REST .....	1	2	3	8	m) UNCONSCIOUSNESS/COMA	1	2	3	8	n) CHEST PAIN.....	1	2	3	8	o) DIFFICULTY IN BREATHINGS .....	1	2	3	8	p) COUGH .....	1	2	3	8	q) HIGH BLOOD PRESSURE ..	1	2	3	8	r) HIGH SUGAR LEVELS DIAGNOSED AS DIABETES	1	2	3	8	s) LOSS OF WEIGHT .....	1	2	3	8	t) UNUSUALLY HIGH WEIGHT GAIN .....	1	2	3	8	u) BURNING OF MICTURITIONS .....	1	2	3	8	v) BLOOD OR PUS IN URINE ..	1	2	3	8	w) BODY-ACHES .....	1	2	3	8	x) SEVERE ANAEMIA .....	1	2	3	8	y) SWELLING OF ANKLES/ FEET .....	1	2	3	8	z) SWELLING OVER FACE ..	1	2	3	8	
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502	<p>During this pregnancy, did you have any other complications? If yes, list below:</p>	<p>a) _____</p> <p>b) _____</p> <p>c) _____</p> <p>d) _____</p> <p>NONE ..... Y</p>																																																																																																																																								
502A	<p>CHECK: 404</p> <p>LIVE BIRTH/STILLBIRTH <input type="checkbox"/></p> <p>ABORTION/MISCARRIAGE <input type="checkbox"/></p>	<p>→ 505</p>																																																																																																																																								



NO.	QUESTIONS AND FILTERS	LAST PREGNANCY				SKIP	
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505	<p>Now I would like to ask you about any problems/ illnesses that you might have suffered after the delivery/abortion/miscarriage and during the forty days after delivery/abortion/miscarriage. What problem did you experience during this postpartum period?</p> <p><b>WAIT FOR THE SPONTANEOUS RESPONSE. IF NOT MENTIONED, THEN PROMPT THOSE THAT ARE NOT MENTIONED.</b></p>		<p><b>YES (Before Prompting)</b></p>	<p><b>YES (After Prompting)</b></p>	<p><b>NO</b></p>	<p><b>DK</b></p>	
		a) FEVER .....	1	2	3	8	
		b) SEIZURES/FITS .....	1	2	3	8	
		c) HEAVY BLEEDING/ EXCESSIVE BLEEDING ..	1	2	3	8	
		d) JAUNDICE .....	1	2	3	8	
		e) VAGINAL DISCHARGE OF FOUL SMELLING MATERIAL .....	1	2	3	8	
		f) BURNING IN MICTURITION ..	1	2	3	8	
		g) INCREASED FREQUENCY OF URINE .....	1	2	3	8	
		h) FEELING OF EXTREME WEAKNESS .....	1	2	3	8	
		i) PALLOR .....	1	2	3	8	
		j) SHORTNESS OF BREATH .....	1	2	3	8	
		k) COUGH WITH DIFFICULTY IN BREATHING .....	1	2	3	8	
		l) BREASTS TENDERNESS .....	1	2	3	8	
		m) BREAST SWELLING .....	1	2	3	8	
		n) BREAST INFECTION .....	1	2	3	8	
		o) TEAR/ ULCER IN BREAST .....	1	2	3	8	
		p) SWELLING AND PAIN ONE OR BOTH LEGS .....	1	2	3	8	
		q) FEVER RELATED WITH WOUND (C/SECTION) .....	1	2	3	8	
506	<p>During the postpartum period, did you have any other complications? If yes, list below:</p>	<p>a) _____</p> <p>b) _____</p> <p>c) _____</p> <p>d) _____</p> <p>NONE ..... Y</p>					
507	<p>CHECK: 407,423,429, 433 AND 436</p> <p>HEALTH PERSONNEL/ OTHER PERSON CIRCLED <input type="checkbox"/></p> <p>NO ONE/ NOT ASKED <input type="checkbox"/></p>	<p>509</p>					
508	<p>During the course of your last pregnancy, childbirth and/or postpartum period, did any of your healthcare providers ever inform you that you had any of the following?</p> <p>a) PNEUMONIA</p> <p>b) JAUNDICE AND/OR HEPATITIS</p> <p>c) EMBOLISM</p> <p>d) POSTPARTUM INFECTION/SEPSIS</p> <p>e) HIGH BLOOD PRESSURE</p> <p>f) DIABETES</p> <p>g) ANY OTHER INFECTIOUS DISEASE DURING PREGNANCY</p> <p>h) SLOW GROWTH OF BABY INSIDE THE WOMB</p> <p>i) PROBLEMS ASSOCIATED WITH PLACENTA</p> <p>j) PROBLEMS ASSOCIATED WITH THE POSITION OF THE BABY</p> <p>k) UTERINE PROLAPSE</p> <p>l) PREECLAMPSIA (DEFINITION)</p> <p>x) OTHERS (Specify)</p>		<p><b>YES</b></p>	<p><b>NO</b></p>	<p><b>DK</b></p>		
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		x) OTHERS _____ (SPECIFY)	1	2	8		

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP																																																								
509	<p><b>During last pregnancy, childbirth or postpartum period,</b> were you treated for any of the following conditions?</p> <p>a) HIGH BLOOD PRESSURE b) DIABETES c) SEVERE NAUSEA AND VOMITING OF PREGNANCY d) CHEST INFECTION e) ANAEMIA f) ANY OTHER INFECTION g) PREECLAMPSIA (DEFINITION) h) PREMATURE FETUS i) PRETERM LABOR j) URINARY TRACT INFECTION k) JAUNDICE l) PROTEIN/ALBUMIN IN URINE x) OTHER (Specify)</p>	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>a) HIGH BLOOD PRESSURE .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) DIABETES .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>c) SEVERE NAUSEA AND VOMITING OF PREGNANCY .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>d) CHEST INFECTION .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>e) ANAEMIA .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>f) ANY OTHER INFECTION .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>g) PREECLAMPSIA (DEFINITION) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>h) PREMATURE FETUS .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>i) PRETERM LABOR .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>j) URINARY TRACT INFECTION .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>k) JAUNDICE .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>l) PROTEIN/ALBUMIN IN URINE .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>x) OTHER _____ (SPECIFY)</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		YES	NO	DK	a) HIGH BLOOD PRESSURE .....	1	2	8	b) DIABETES .....	1	2	8	c) SEVERE NAUSEA AND VOMITING OF PREGNANCY .....	1	2	8	d) CHEST INFECTION .....	1	2	8	e) ANAEMIA .....	1	2	8	f) ANY OTHER INFECTION .....	1	2	8	g) PREECLAMPSIA (DEFINITION) .....	1	2	8	h) PREMATURE FETUS .....	1	2	8	i) PRETERM LABOR .....	1	2	8	j) URINARY TRACT INFECTION .....	1	2	8	k) JAUNDICE .....	1	2	8	l) PROTEIN/ALBUMIN IN URINE .....	1	2	8	x) OTHER _____ (SPECIFY)	1	2	8	
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510	<p>Were you hospitalized for more than 24 hours stay during the last pregnancy/ childbirth/ abortion/ miscarriage or postpartum period?</p>	<p>YES ..... 1 NO ..... 2 DON'T KNOW ..... 8</p>	→ 511																																																								
510A	<p>How many times were you hospitalised for more than 24 hours during the last pregnancy/ childbirth/ abortion/ miscarriage or postpartum period?</p> <p><b>IF MORE THAN 7 RECORD '7'</b></p>	<table border="0"> <thead> <tr> <th></th> <th>NO. OF TIMES</th> </tr> </thead> <tbody> <tr> <td>a) DURING PREGNANCY .....</td> <td><input type="text"/></td> </tr> <tr> <td>b) DURING CHILDBIRTHS/ABORTION/MISCARRIAGE ....</td> <td><input type="text"/></td> </tr> <tr> <td>c) DURING POSTPARTUM PERIOD (WITHIN 40 DAYS AFTER DELIVERY, ABORTION OR MISCARRIAGE) ..</td> <td><input type="text"/></td> </tr> <tr> <td>d) AFTER POSTPARTUM PERIOD (&gt;40 DAYS AFTER THE TERMINATION OF PREGNANCY) .....</td> <td><input type="text"/></td> </tr> </tbody> </table>		NO. OF TIMES	a) DURING PREGNANCY .....	<input type="text"/>	b) DURING CHILDBIRTHS/ABORTION/MISCARRIAGE ....	<input type="text"/>	c) DURING POSTPARTUM PERIOD (WITHIN 40 DAYS AFTER DELIVERY, ABORTION OR MISCARRIAGE) ..	<input type="text"/>	d) AFTER POSTPARTUM PERIOD (>40 DAYS AFTER THE TERMINATION OF PREGNANCY) .....	<input type="text"/>																																															
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511	<p><b>Before your last pregnancy,</b> were you suffering from any of the following conditions?</p> <p>a) HIGH BLOOD PRESSURE b) DIABETES c) OBESITY d) CHEST INFECTION OTHER THAN TUBERCULOSIS e) TUBERCULOSIS f) HEPATITIS g) VARICOSE VEINS h) SEVERE ANEMIA i) KIDNEY PROBLEM j) EPILEPSY k) SEXUALLY TRANSMITTED DISEASES l) HIV/AIDS x) OTHERS (Specify)</p>	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>a) HIGH BLOOD PRESSURE .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) DIABETES .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>c) OBESITY .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>d) CHEST INFECTION OTHER THAN TUBERCULOSIS .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>e) TUBERCULOSIS .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>f) HEPATITIS .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>g) VARICOSE VEINS .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>h) SEVERE ANEMIA .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>i) KIDNEY PROBLEM .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>j) EPILEPSY .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>k) SEXUALLY TRANSMITTED DISEASES .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>l) HIV/AIDS .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>x) OTHERS _____ (SPECIFY)</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		YES	NO	DK	a) HIGH BLOOD PRESSURE .....	1	2	8	b) DIABETES .....	1	2	8	c) OBESITY .....	1	2	8	d) CHEST INFECTION OTHER THAN TUBERCULOSIS .....	1	2	8	e) TUBERCULOSIS .....	1	2	8	f) HEPATITIS .....	1	2	8	g) VARICOSE VEINS .....	1	2	8	h) SEVERE ANEMIA .....	1	2	8	i) KIDNEY PROBLEM .....	1	2	8	j) EPILEPSY .....	1	2	8	k) SEXUALLY TRANSMITTED DISEASES .....	1	2	8	l) HIV/AIDS .....	1	2	8	x) OTHERS _____ (SPECIFY)	1	2	8	
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512	<p><b>Before</b> your last pregnancy, did you ever get a surgical operation done (other than Caesarean section operation)?</p>	<p>YES ..... 1 NO ..... 2 DON'T KNOW ..... 8</p>																																																									
513	<p><b>Before</b> the last pregnancy did you smoke cigarettes/ biri every day, some days, or not at all?</p>	<p>EVERY DAY ..... 1 SOME DAYS ..... 2 NOT AT ALL ..... 3</p>	→ 515 → 516																																																								
514	<p>On average, how many cigarettes or biris did you smoke each day?</p>	<p>NUMBER OF CIGARETTES/BIDIS ..... <input type="text"/> <input type="text"/></p>																																																									

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP																																												
515	Did you stop or reduce smoking after you became pregnant?	YES STOPPED ..... 1 YES REDUCE ..... 2 NEITHER STOPED NOR REDUCED ..... 3																																													
516	<b>Before</b> last pregnancy did you smoke or use any other type of tobacco every day, some days, or not at all? (Gutka/Naswar/Hooka)	EVERY DAY ..... 1 SOME DAYS ..... 2 NOT AT ALL ..... 3	→ 519																																												
517	What other type of tobacco did you smoke or use?  <b>RECORD ALL MENTIONED</b>	PIPES FULL OF TOBACCO ..... A WATER PIPE/HUKAA/SHEESHA ..... B SNUFF BY MOUTH ..... C SNUFF BY NOSE ..... D CHEWING TOBACCO ..... E BETEL QUID/PAAN WITH TOBACCO ..... F GUTKA/ MAVA/ NASWAR ..... G OTHERS ..... X (SPECIFY)																																													
518	Did you stop or reduce smoking or use any other type of tobacco after you became pregnant?	YES STOPPED ..... 1 YES REDUCED ..... 2 NEITHER STOPED NOR REDUCED ..... 3																																													
519	Were you using any medications before you become pregnant?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 521																																												
520	A. Which medicines you were using before you become pregnant?  <b>Prob:</b> Please try to remember names or description of the medications.  <b>ASK WOMAN TO SHOW THE MEDICATION BOTTLES IF AVAILABLE WRAPPERS.</b>  B. Did you stop using this medication when become pregnant?	<table border="1"> <thead> <tr> <th rowspan="2"></th><th>A. Medicine using before pregnancy</th><th colspan="3">B. Stopped when became Pregnant</th></tr> <tr> <th></th><th>YES</th><th>NO</th><th>DK</th></tr> </thead> <tbody> <tr> <td>a</td><td></td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>b</td><td></td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>c</td><td></td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>d</td><td></td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>e</td><td></td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>f</td><td></td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>g</td><td></td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table>		A. Medicine using before pregnancy	B. Stopped when became Pregnant				YES	NO	DK	a		1	2	8	b		1	2	8	c		1	2	8	d		1	2	8	e		1	2	8	f		1	2	8	g		1	2	8	
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g		1	2	8																																											
521	Were you prescribed any medication during this pregnancy or postpartum period?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 523																																												
522	Which medications were you prescribed during pregnancy or postpartum period?  <b>RECORD ALL MENTIONED</b>	IRON/ FOLIC ACID TABLETS/ CAPSULES ..... A VITAMIN TABLETS/ CAPSULES ..... B INJECTION/ DRIP CONTAINING VITAMINS ..... C DRUGS FOR HIGH BP ..... D DRUGS FOR DIABETES ..... E DRUGS FOR REDUCING FEVER ..... F ANTIBIOTICS ..... G DRUGS TO REDUCE NAUSEA/ VOMITING ..... H OTHER ..... X (SPECIFY)																																													
523	Now I would like to ask some questions on specific complications during pregnancy, childbirth or after childbirth during 40 days.																																														

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP
524	CHECK 501(a): HAD FEVER DURING LAST PREGNANCY (CODES 1 OR 2 CIRCLED) <input type="checkbox"/> NO FEVER (CODES 3 OR 8 CIRCLED) <input type="checkbox"/>		526
525	<b>MODULE: FEVER</b> How many times during last pregnancy did you experience fever? <b>IF '7' OR MORE WR</b>	NUMBER OF TIMES ..... <input type="checkbox"/> DON'T KNOW ..... 8	
525A	During which month(s) did you experience the fever?	MONTH(S) OF PREGNANCY 1ST ..... A 2ND ..... B 3RD ..... C 4TH ..... D 5TH ..... E 6TH ..... F 7TH ..... G 8TH ..... H 9TH ..... I DON'T KNOW ..... Z	
525B	Now I would like to talk about the most recent attack of fever during last pregnancy.  How high was the fever?	LESS THAN 101 <sup>0</sup> F ..... 1 101 <sup>0</sup> F OR MORE ..... 2 DON'T KNOW EXACT TEMPERATURE ..... 8	525D
525C	At that time was the fever very high, moderately high or mild?	VERY HIGH ..... 1 MODERATELY HIGH ..... 2 MILD ..... 3 DON'T KNOW/ CANNOT SAY ..... 8	
525D	Was the fever accompanied with shivering?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
525E	Did you have any difficulty/pain/burning sensation during micturition?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
525F	Did the colour of urine change to become dark yellow, reddish or brown?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
525G	Was there blood in the urine?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
525H	Did you have vomiting during fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
525I	Did you have cough with fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
525J	Did you take any medications for the fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	525M

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY			SKIP																				
		NAME (IF LIVE BIRTH) _____																							
525K	Was your fever diagnosed as malaria?	YES .....	1																						
		NO .....	2																						
		DON'T KNOW .....	8																						
525L	Did the fever subside after you took the medications?	YES .....	1																						
		NO .....	2																						
		DON'T KNOW .....	8																						
525M	With fever did you also have:	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>a) Vaginal discharge?</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) Itching everywhere on body</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>c) Flu like symptoms? (sneezing / running nose)</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>d) Loose stools/diarrhoea?</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>				YES	NO	DK	a) Vaginal discharge?	1	2	8	b) Itching everywhere on body	1	2	8	c) Flu like symptoms? (sneezing / running nose)	1	2	8	d) Loose stools/diarrhoea?	1	2	8	
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526	CHECK 505(a): HAD FEVER IN POSTPARTUM PERIOD/ 40 DAYS AFTER TERMINATION OF PREGNANCY (CODES 1 OR 2 CIRCLED)	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 10px;"></div> <div style="text-align: center;"> NO FEVER (CODES 3 OR 8 CIRCLED) </div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-left: 10px;"></div> </div>			→ 528																				
527	When did the fever start? (how many days after delivery/termination of pregnancy?)	NUMBER OF DAYS ..... <div style="border: 1px solid black; width: 30px; height: 30px; display: inline-block;"></div>																							
		ON THE DAY OF LABOUR/ DELIVERY .....00																							
527A	How high was the fever?	LESS THAN 101°F .....	1	→ 527C																					
		101°F OR MORE .....	2																						
		DON'T KNOW EXACT TEMPERATURE .....	8																						
527B	If you don't know exact temperature, was the fever very high, moderately high or mild?	VERY HIGH .....	1																						
		MODERATELY HIGH .....	2																						
		MILD .....	3																						
		DON'T KNOW/ CANNOT SAY .....	8																						
527C	Was the fever accompanied with shivering?	YES .....	1																						
		NO .....	2																						
		DON'T KNOW .....	8																						
527D	Did you have any abnormal vaginal discharge?	YES .....	1	→ 527H																					
		NO .....	2																						
		DON'T KNOW .....	8																						
527E	What was the texture of discharge?	THICK .....	1																						
		THIN .....	2																						
		WITH CLOTS .....	3																						
		DON'T KNOW .....	8																						
527F	What was the colour of discharge?	BROWN .....	1																						
		RED .....	2																						
		YELLOW .....	3																						
		OTHER _____ SPECIFY	6																						
		DON'T KNOW .....	8																						
527G	What was the smell of discharge?	NO SMELL .....	1																						
		FOUL SMELL .....	2																						
		OTHER _____ SPECIFY	6																						
		DON'T KNOW .....	8																						
527H	Did you have any difficulty/pain/burning sensation during micturition?	YES .....	1																						
		NO .....	2																						
		DON'T KNOW .....	8																						



NO.	QUESTIONS AND FILTERS	LAST PREGNANCY		SKIP
		NAME (IF LIVE BIRTH)		
527I	Did the colour of urine change to become dark yellow, reddish or brown?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
527J	Was there blood in the urine?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
527K	Did you have vomiting during fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
527L	Did you take any medications for the fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		→ 528
527M	Were you given any injections for the fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
527N	Did the fever subside after you took the treatment?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		→ 528
527O	How long did it take for the fever to subside?	NUMBER OF DAYS ..... <input type="text"/> <input type="text"/>		
528	CHECK 501(b): HAD FITS DURING PREGNANCY (CODES 1 OR 2 CIRCLED) <input type="checkbox"/> NO FITS (CODES 3 OR 8 CIRCLED) <input type="checkbox"/>			→ 530
<b>MODULE: FITS/SEIZURES</b>				
529	In which month of pregnancy did you experience the fits?	MONTH OF PREGNANCY ..... <input type="text"/> <input type="text"/>		
529A	How severe were the fits?	VERY SEVERE ..... 1 MODERATELY SEVERE ..... 2 NOT SEVERE ..... 3 DON'T KNOW ..... 8		
529B	How long did fits last each time they occurred?	<1 MIN ..... 1 1-2 MIN ..... 2 3-5 MIN ..... 3 >5 MIN ..... 4		
529C	How frequently did fits occur?	1-2 TIMES/ DAY ..... 1 3-4 TIMES/ DAY ..... 2 >5 TIMES/ DAY ..... 3		
529D	Were you unconscious during fits?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529E	Were you disoriented during fits?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529F	Did you lose control over urine/ micturition during fits?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY		SKIP
		NAME (IF LIVE BIRTH)		
529G	Did fits affect your ability to walk, move your hand, work?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529H	Did you ever have fits when you were not pregnant?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529I	Was your blood pressure high during this pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529J	Did you have swelling over your ankles and feet?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529K	Did you have puffiness over your face?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529L	Did you have any vision problems, such as blurred vision?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529M	Did you have urinary problems such as burning or pain during micturition?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
529N	Was your urine tested and found abnormal?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
530	CHECK 501 (c): <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">             HAD BLEEDING DURING LAST PREGNANCY (CODES 1 OR 2 CIRCLED)             <div style="border: 1px solid black; width: 30px; height: 20px; margin: 10px auto;"></div> </div> <div style="text-align: center;">             NO BLEEDING (CODES 3 OR 8 CIRCLED)             <div style="border: 1px solid black; width: 30px; height: 20px; margin: 10px auto;"></div> </div> </div>			→ 532

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY	SKIP
		NAME (IF LIVE BIRTH) _____	
531	<p><b><u>MODULE: EXCESSIVE BLEEDING DURING PREGNANCY (BEFORE DELIVERY OR ABORTION)</u></b></p> <p>What type of bleeding did you experience?</p> <p><b>RECORD ALL MENTIONED</b></p>	<p>SPOTTING ..... A</p> <p>FRANK BLEEDING ..... B</p> <p>CLOTS WITH BLOOD ..... C</p> <p>DISCHARGE WITH BLOOD ..... D</p> <p>STREAKS OF FRESH BLOOD ..... E</p> <p>OTHERS _____ X</p> <p style="text-align: center;">SPECIFY</p> <p>DON'T KNOW ..... Z</p>	
531A	During which month of pregnancy did you have the bleeding for the first time?	MONTH OF PREGNANCY ..... <input type="text"/> <input type="text"/>	
531B	Was the bleeding accompanied with pain in lower abdomen?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	
531C	Did you see a healthcare provider for the treatment of bleeding?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	531E
531D	<p>What treatment was provided?</p> <p><b>RECORD ALL MENTIONED</b></p>	<p>BED REST ..... A</p> <p>INJECTION/DRIP ..... B</p> <p>PILLS ..... C</p> <p>BLOOD TRANSFUSION ..... D</p> <p>OTHERS _____ X</p> <p style="text-align: center;">SPECIFY</p>	
531E	How long did the bleeding last?	<p>NUMBER OF DAYS ..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>	
532	<p>CHECK 505 (c):</p> <p>HAD BLEEDING AFTER DELIVERY/ABORTION/ MISCARRIAGE (CODES 1 OR 2 CIRCLED) <input type="checkbox"/></p> <p>NO BLEEDING (CODES 3 OR 8 CIRCLED) <input type="checkbox"/></p>		534
533	<p><b><u>MODULE: BLEEDING AFTER DELIVERY OR ABORTION/MISCARRIAGE</u></b></p> <p>When did the bleeding start?</p>	<p>IMMEDIATELY AFTER DELIVERY/ABORTION/ MISCARRIAGE ..... 1</p> <p>NEXT DAY OF DELIVERY/ABORTION/ MISCARRIAGE ..... 2</p> <p>2-3 DAYS AFTER DELIVERY/ABORTION/MISCARRIAGE ..... 3</p> <p>DON'T KNOW ..... 8</p>	
533A	<p>How long did the bleeding last?</p> <p><b>IF LESS THAN ONE DAY WRITE "00"</b></p>	<p>NUMBER OF DAYS ..... <input type="text"/> <input type="text"/></p> <p>BLEEDING CONTINUE ..... 97</p> <p>DON'T KNOW ..... 98</p>	

NO.	QUESTIONS AND FILTERS	NAME (IF LIVE BIRTH) _____ LAST PREGNANCY _____	SKIP		
533B	What type of bleeding did you experience?  <b>Record all mentioned</b>	FRANK BLEEDING ..... A CLOTS WITH BLOOD ..... B DISCHARGE WITH BLOOD ..... C STREAKS OF FRESH BLOOD ..... D  OTHERS _____ X SPECIFY _____ DON'T KNOW ..... Z			
533C	How heavy was the bleeding?	CHANGED PADS OR CLOTH 1-2 TIMES/ DAY ..... 1 CHANGED PADS OR CLOTH 3-4 TIMES/ DAY ..... 2 CHANGED PADS OR CLOTH 5+ TIMES/ DAY ..... 3 BLEESING WAS CONTINUOUS WITH NO TIME TO CHANGE PADS/ CLOTH ..... 4  OTHER _____ 6 SPECIFY _____ DON'T KNOW/ DON'T REMEMBER ..... 8			
533D	Was the bleeding from a tear in your vaginal wall?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
533E	Was the bleeding from an episiotomy cut in your vaginal wall done by a healthcare provider during delivery?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 533H		
533F	Was the bleeding due to a miscarriage?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
533G	Was the bleeding due to an induced abortion?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
533H	Was the bleeding accompanied with pain in lower abdomen?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
533I	Did you see a healthcare provider for the treatment of bleeding?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 533L		
533J	What treatment was provided?  <b>Record all mentioned</b>	BLOOD TRANSFUSION ..... A BED REST ..... B INJECTION/DRIP ..... C PILLS ..... D PACKING OF VAGINA ..... E  OTHERS _____ X (SPECIFY) _____			
533K	Was any operation done to try to stop the bleeding?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
533L	How long did the bleeding last?  <b>IF 95 OR MORE WRITE '95'</b>	NUMBER OF DAYS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> BLEEDING CONTINUE ..... 97 DON'T KNOW ..... 98			
533M	After how many days did the bleeding completely stop?  <b>IF 95 OR MORE WRITE '95'</b>	NUMBER OF DAYS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> BLEEDING CONTINUE ..... 97 DON'T KNOW ..... 98			

NO.	QUESTIONS AND FILTERS	NAME (IF LIVE BIRTH) _____	LAST PREGNANCY	SKIP
534	CHECK 501 (d):  HAD JAUNDICE DURING LAST PREGNANCY (CODES 1 OR 2 CIRCLED) <input type="checkbox"/> NO JAUNDICE (CODES 3 OR 8 CIRCLED) <input type="checkbox"/>			536
	<b>MODULE: JAUNDICE</b>			
535	Did the colour of your eyes and/or face visibly change to yellowish?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535A	Did your urine become dark yellow?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535B	Did the colour of your stools change to dark brown or black?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535C	Did you experience nausea and/or vomiting?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535D	Did you experience loss of appetite?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535E	Did you have fever accompanied with jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535F	Did you have abdominal pain accompanied with jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535G	Did you have itching over body?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535H	Did you have fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		→ 535J
535I	Was the fever very high, moderate or mild?	VERY HIGH ..... 1 MODERATE ..... 2 MILD ..... 3 DON'T KNOW ..... 8		
535J	Did your healthcare provider tell you that your liver was enlarged?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535K	Did your healthcare provider tell you that you had hepatitis?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		
535L	Were there any blood tests done for checking your liver function?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		→ 535N

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP
535M	What was the result? (specify)	_____ _____ _____	
535N	Did you see a healthcare provider for the treatment of jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 535P
535O	What treatment was provided?  Record all mentioned	BED REST ..... A INJECTION/DRIP ..... B PILLS ..... C OTHERS _____ X (SPECIFY)	
535P	Did you fully recover from the jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
536	CHECK 505 (d):  HAD JAUNDICE AFTER DELIVER/ 40 DAYS AFTER DELIVERY (CODES 1 OR 2 CIRCLED) <input type="checkbox"/>	NO JAUNDICE <input type="checkbox"/> (CODES 3 OR 8 CIRCLED)	→ 600
537	How many days after delivery/abortion/ miscarriage did you have jaundice?	NUMBER OF DAYS ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98	
537A	Did the color of your eyes and/or face visibly change to yellowish?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
537B	Did your urine become dark yellow?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
537C	Did the colour of your stools change to dark brown or black?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
537D	Did you experience nausea and/or vomiting?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
537E	Did you have fever accompanied with jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
537F	Did you have abdominal pain accompanied with jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
537G	Did your healthcare provider tell you that your liver was enlarged?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
537H	Did your healthcare provider tell you that you had hepatitis?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY		SKIP
		NAME (IF LIVE BIRTH)		
537I	Were there any blood tests done for checking your liver function?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 537K	
537J	What was the result? (specify)	_____ _____ _____		
537K	Did you see a healthcare provider for the treatment of jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 537M	
537L	What treatment was provided?  Record all mentioned	BED REST ..... A INJECTION/DRIP ..... B PILLS ..... C OTHERS _____ X (SPECIFY)		
537M	Did you fully recover from the jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		

**SECTION 6. HEALTH SERVICES UTILIZATION**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																				
600	Did you see anyone for antenatal care for this pregnancy?	YES ..... 1 NO ..... 2																																																					
601	CHECK 406 AND 600:  IF RESPONSE IS SAME <input type="checkbox"/> ↓ IF RESPONSE IS DIFFERENT <input type="checkbox"/> ↓ PROBE AND CORRECT 406-410																																																						
602	CHECK 600:  YES <input type="checkbox"/> ↓ NO <input type="checkbox"/> → 608A																																																						
603	Before your first visit, were you suffering from any health problem or any complication associated with your pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																																																					
604	How many times did you receive antenatal care during this pregnancy?	NUMBER OF VISITS ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98																																																					
605	During any of these visits, were you suffering from any health problem or any complication associated with your pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 607																																																				
606	Whom did you see?  Anyone else?  <b>PROBE TO IDENTIFY EACH TYPE OF PERSON AND RECORD ALL MENTIONED.</b>	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/SPECIALIST ..... A DOCTOR ..... B NURSE/MIDWIFE/LHV ..... C COMMUNITY MIDWIFE ..... D <b>OTHER PERSON</b> DAI-TBA ..... E LADY H. WORKER ..... F HOMEOPATH ..... G HAKIM ..... H DISPENSER / COMPOUNDER ..... I  OTHER ..... X (SPECIFY)																																																					
607	What was done during ANC visits (regardless of which visit)	<table border="1"> <thead> <tr> <th></th><th>YES</th><th>NO</th><th>DK</th></tr> </thead> <tbody> <tr><td>a) ULTRASOUND .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>b) BP CHECK .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>c) ABDOMINAL EXAM .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>d) VAGINAL EXAM .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>e) FETOSCOPE EXAM FOR FETAL HEARTBEAT .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>f) BLOOD TEST FOR SUGAR .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>g) BLOOD TEST FOR MALARIA ..</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>h) BLOOD TEST FOR ANY OTHER REASON .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>i) URINE TEST FOR URINARY TRACT INFECTION .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>j) URINE TEST FOR ALBUMIN/ PROTEIN .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>k) URINE TEST FOR ANY OTHER REASON .....</td><td>1</td><td>2</td><td>8</td></tr> <tr><td>l) OTHER ..... (SPECIFY)</td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table>		YES	NO	DK	a) ULTRASOUND .....	1	2	8	b) BP CHECK .....	1	2	8	c) ABDOMINAL EXAM .....	1	2	8	d) VAGINAL EXAM .....	1	2	8	e) FETOSCOPE EXAM FOR FETAL HEARTBEAT .....	1	2	8	f) BLOOD TEST FOR SUGAR .....	1	2	8	g) BLOOD TEST FOR MALARIA ..	1	2	8	h) BLOOD TEST FOR ANY OTHER REASON .....	1	2	8	i) URINE TEST FOR URINARY TRACT INFECTION .....	1	2	8	j) URINE TEST FOR ALBUMIN/ PROTEIN .....	1	2	8	k) URINE TEST FOR ANY OTHER REASON .....	1	2	8	l) OTHER ..... (SPECIFY)	1	2	8	
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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
613	<p>Where did you give birth (to NAME)?</p> <p><b>PROBE TO IDENTIFY THE TYPE OF SOURCE.</b></p> <p><b>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</b></p> <p>_____</p> <p>(NAME OF PLACE)</p>	<p><b>HOME</b></p> <p>OWN HOME ..... 11</p> <p>OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ..... 21</p> <p>RHC/MCH ..... 22</p> <p>BHU/FWC ..... 23</p> <p>OTHER PUBLIC SECTOR ..... 26</p> <p>(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/ CLINIC ..... 31</p> <p>OTHER PRIVATE MEDICAL SECTOR ..... 36</p> <p>(SPECIFY)</p> <p>OTHER ..... 96</p> <p>(SPECIFY)</p>	<p>→ 620</p>
615	<p>How long after delivery did you stay there?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</p>	<p>HOURS ..... 1</p> <p>DAYS ..... 2</p> <p>WEEKS ..... 3</p> <p>DON'T KNOW ..... 998</p>	
616	<p>Was a Caesarean section done?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>→ 618</p>
617	<p>Was the delivery assisted with forceps?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	
618	<p>Did you take misoprostol tablets immediately after delivery of baby (to control the excessive bleeding)?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	
619	<p>When was the placenta delivered?</p>	<p>NUMBER OF MINUTES AFTER DELIVERY ..... </p> <p>NOT APPLICABLE ..... 97</p> <p>DON'T KNOW ..... 98</p>	
620	<p>CHECK 212B, 220AC AND 220AD:</p> <p>MISCARRIAGE <input type="checkbox"/> ABORTION/ STILLBIRTH <input type="checkbox"/> LIVE BIRTH <input type="checkbox"/></p>		<p>→ 627</p> <p>→ 636</p>
621	<p>Where were you when the miscarriage happened?</p>	<p>HOME ..... 1</p> <p>HEALTH FACILITY ..... 2</p> <p>ON THE WAY ..... 3</p> <p>OTHERS ..... 6</p> <p>(SPECIFY)</p>	
622	<p>Did you see a healthcare provider immediately after miscarriage?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>→ 624</p>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
623	Whom did you see?  Anyone else?  <b>PROBE FOR THE MOST QUALIFIED PERSON</b>	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/SPECIALIST ..... 11 DOCTOR ..... 12 NURSE/MIDWIFE/LHV ..... 13 COMMUNITY MIDWIFE ..... 14 <b>OTHER PERSON</b> DAI-TBA ..... 15 FWW ..... 16 LADY H. WORKER ..... 17 HOMEOPATH ..... 18 HAKIM ..... 19 DISPENSER / COMPOUNDER ..... 20  OTHER ..... 96 (SPECIFY)	
624	How much time after the miscarriage did you see the healthcare provider?  <b>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</b>	HOURS ..... 1 <input type="text"/> <input type="text"/>  DAYS ..... 2 <input type="text"/> <input type="text"/>  WEEKS ..... 3 <input type="text"/> <input type="text"/>  DID NOT GO ..... 997 DON'T KNOW ..... 998	→ 626
625	Did healthcare provider did surgery to remove the retained products of the pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 626
625A	Was it done under general anaesthesia?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
626	Did you have fever after the miscarriage?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
627	Did you visit a health facility for check-up after stillbirth/miscarriage/abortion?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 636
628	How long after still birth/ miscarriage/ abortion did the first check take place?	HOURS ..... 1 <input type="text"/> <input type="text"/>  DAYS ..... 2 <input type="text"/> <input type="text"/>  WEEKS ..... 3 <input type="text"/> <input type="text"/>  DON'T KNOW ..... 998	
629	How many visits did you make?	NUMBER OF VISITS ..... <input type="text"/> <input type="text"/>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
630	<p>Whom did you visit?</p> <p>Who else?</p> <p><b>PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED</b></p>	<p><b>HEALTH PERSONNEL</b></p> <p>OBSTETRICIAN/SPECIALIST ..... A</p> <p>DOCTOR ..... B</p> <p>NURSE/MIDWIFE/LHV ..... C</p> <p>COMMUNITY MIDWIFE ..... D</p> <p><b>OTHER PERSON</b></p> <p>DAI-TBA ..... E</p> <p>LADY H. WORKER ..... F</p> <p>HOMEOPATH ..... G</p> <p>HAKIM ..... H</p> <p>DISPENSER / COMPOUNDER ..... I</p> <p>OTHER ..... X</p> <p>_____ (SPECIFY)</p>									
631	<p>Where did you visit?</p> <p><b>PROBE TO IDENTIFY THE TYPE OF SOURCE.</b></p> <p><b>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</b></p> <p>_____ (NAME OF PLACE)</p>	<p><b>HOME</b></p> <p>HER HOME ..... A</p> <p>OTHER HOME ..... B</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVT. HOSPITAL ..... C</p> <p>RHC/MCH ..... D</p> <p>BHU/FWC ..... E</p> <p>OTHER PUBLIC SECTOR ..... F</p> <p>_____ (SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/ CLINIC ..... G</p> <p>PVT. DOCTOR ..... H</p> <p>HOMEOPATH ..... I</p> <p>DISPENSER / COMPOUNDER ..... J</p> <p>OTHER PRIVATE MEDICAL SECTOR ..... K</p> <p>_____ (SPECIFY)</p> <p>HAKIM ..... L</p> <p>OTHER ..... X</p> <p>_____ (SPECIFY)</p>									
632	Were you given any injections or drips?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>									
633	<p>CHECK 212B, 220AC AND 220AD:</p> <p>STILLBIRTH OR MISCARRIAGE <input type="checkbox"/></p> <p>ABORTION <input type="checkbox"/></p>		<p>→ 634</p>								
633A	Did the doctor tell you why you had the stillbirth/ miscarriage?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>									
634	Were you advised to start using a family planning method?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>→ 636</p>								
635	Did your healthcare provider give you a family planning method?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>									
636	RECORD THE TIME.	<p>HOURS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>MINUTES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p>									

INTERVIEWER'S OBSERVATIONS  
TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT INTERVIEW:

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COMMENTS ON SPECIFIC QUESTIONS:

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ANY OTHER COMMENTS:

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SUPERVISOR'S OBSERVATIONS

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EDITOR'S OBSERVATIONS

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**PAKISTAN MATERNAL MORTALITY SURVEY 2019**  
**DECEASED WOMAN'S IDENTIFICATION**  
 PAKISTAN  
 NATIONAL INSTITUTE OF POPULATION STUDIES

IDENTIFICATION				
PROVINCE (PUNJAB=1; SINDH=2; KPK=3; BALOCHISTAN=4; GB=5; AJK=6) DISTRICT _____ TEHSIL _____ CLUSTER NUMBER ..... HOUSEHOLD NUMBER ..... NAME OF HOUSEHOLD HEAD _____ NAME OF DECEASED WOMAN _____ NAME OF DECEASED WOMAN'S HUSBAND/FATHER (CIRCLE ONE) _____ DATE OF DECEASED WOMAN'S DEATH AFTER 1 JANUARY, 2016 _____	<div style="text-align: right;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div> </div>			
INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY MONTH YEAR
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER
RESULT*	_____	_____	_____	RESULT
NEXT VISIT: DATE TIME	_____	_____		TOTAL NUMBER OF VISITS
*RESULT CODES: <div style="display: flex; justify-content: space-between;"> <div>                         1 COMPLETED                          2 NOT AT HOME                          3 POSTPONED                     </div> <div>                         4 REFUSED                          5 PARTLY COMPLETED                          6 INCAPACITATED                     </div> <div>                         7 OTHER _____                          (SPECIFY)                     </div> </div>				
<div style="display: flex; justify-content: space-between;"> <div>                         LANGUAGE OF QUESTIONNAIRE**  <div style="border: 1px solid black; padding: 2px 10px; font-weight: bold;">01</div> </div> <div>                         LANGUAGE OF INTERVIEW**  <div style="border: 1px solid black; padding: 2px 10px; font-weight: bold;">ENGLISH</div> </div> <div>                         NATIVE LANGUAGE OF RESPONDENT**  <div style="border: 1px solid black; padding: 2px 10px;"></div> </div> <div>                         TRANSLATOR USED (YES = 1, NO = 2)  <div style="border: 1px solid black; padding: 2px 10px;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>                         **LANGUAGE CODES:                          01 ENGLISH                          02 URDU                     </div> <div>                         03 SINDHI                          04 PUNJABI                     </div> <div>                         05 SARAIKI                          06 BALUCHI                          07 PUSHTO                          08 OTHER                     </div> </div>				
SUPERVISOR NAME _____ DATE _____		FIELD EDITOR NAME _____ DATE _____		KEYED BY <div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div>

## INTRODUCTION AND CONSENT

AssalamoAlaikum. My name is \_\_\_\_\_ and I am working with (NIPS, Islamabad). Our institute works on population related issues. Nowadays our institute is conducting a national survey about maternal mortality issues. As you are aware that every year thousands of mothers die during pregnancy and child birth. Most of the time the real cause of death can not be known. By conducting this survey we would like to know the causes of deaths of such women. After the survey government would like to formulate plans and policies for safe motherhood and women lives can be protected. We would very much appreciate your participation in this survey. I will ask you about the death of \_\_\_\_\_ (NAME of deceased woman) . The questionnaire is long and there is repetition in questions, It will usually take about one hour to complete All of the answers you give will be kept strictly confidential and will not be shown to any other person. If I ask any question you do not want to answer, tell me and I will go to the next question; or you can stop the interview at any time. However, we hope you will participate in the survey since your views are very important, and your participation will help in saving women's lives in future.

At this time, do you want to ask me anything about the survey? May I begin the interview now?

SIGNATURE OF INTERVIEWER \_\_\_\_\_ DATE \_\_\_\_\_

RESPONDENT AGREES  
TO BE INTERVIEWED . . 1



RESPONDENT DOES NOT AGREE  
TO BE INTERVIEWED . . 2 → END



## **SECTION 1. INFORMATION ABOUT RESPONDENTS**

INTERVIEWER: ASK TO TALK TO THOSE WHO KNOW THE MOST ABOUT THE WOMAN'S LAST ILLNESS AND HER DEATH. IF A NEIGHBOR, FRIEND, OR DAI WAS PRESENT DURING HER ILLNESS OR DEATH, ASK THEM TO COME AND JOIN IN FOR INTERVIEW GET ALL THE RESPONDENTS TOGETHER FOR THE INTERVIEW AND FILL THE TABLE BELOW.

First, I have a few questions about each of you. Please tell me:

101 NO.	102 What is your name	103 Sex of respondent	104 How old are you?  COMPLETED YEARS	105 What was your relationship to (NAME) i.e deceased woman?  RELATION	106 What is your education? SEE CODES BELOW (CLASSES PASSED)	107 Were you present when (NAME) first fell ill?	108 Were you present when (NAME) was taken to hospital?	109 Were you present when (NAME) died?	110 CIRCLE LINE NO. OF MAIN RESPONDENT
1		MALE. ... 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES .... 1 NO ..... 2 NOT TAKEN 3	YES .. 1 NO ... 2	1
2		MALE ... 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES .... 1 NO ..... 2 NOT TAKEN 3	YES .. 1 NO ... 2	2
3		MALE .. 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES .... 1 NO ..... 2 NOT TAKEN 3	YES .. 1 NO ... 2	3
4		MALE .. 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES .... 1 NO ..... 2 NOT TAKEN 3	YES .. 1 NO ... 2	4
5		MALE .. 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES .... 1 NO ..... 2 NOT TAKEN 3	YES .. 1 NO ... 2	5
6		MALE .. 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES ... 1 NO .... 2	YES .... 1 NO ..... 2 NOT TAKEN 3	YES .. 1 NO ... 2	6

### **CODES FOR Q. 105: RELATIONSHIP TO DECEASED WOMAN**

02 = HUSBAND	09 = BROTHER/SISTER IN-LAW
03 = SON OR DAUGHTER	10 = NIECE/NEPHEW
04 = SON-IN-LAW OR DAUGHTER-IN-LAW	11 = GRAND PARENT
05 = GRANDCHILD	12 = AUNTS/UNCLE
06 = PARENT	13 = OTHER RELATIVE
07 = PARENT-IN-LAW	14 = ADOPTED/FOSTER/STEPCHILD
08 = BROTHER OR SISTER	15 = NOT RELATED
	16 = DOMESTIC SERVANT

### **CODES FOR Q. 106: EDUCATION CLASS**

00 = LESS THAN CLASS 1 COMPLETED  
 01 - 10 = CLASS 1 - CLASS 10 (MATRIC)  
 11 - 12 = CLASS 11 - 12  
 13 - 15 = BACHELORS DEGREE  
 16 = MASTER'S DEGREE OR MBBS, PhD, MPHIL, BSc (4 YEARS)  
 98 = DON'T KNOW

## SECTION 2. DECEASED WOMAN'S BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	RECORD THE TIME AT BEGINNING OF INTERVIEW	HOUR ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> MINUTES ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div>	
202	I want to talk about the death of (NAME). <b>WRITE WOMAN'S NAME HERE AND ON COVER PAGE</b>	_____	
203	Can you tell me the name of (NAME)'s father?	_____	
204	In what day/month and year did (NAME) die?  <b>PROBE BY ASKING HOW MANY YEARS AGO, WHETHER IT WAS IN SUMMER OR WINTER, WHETHER IT WAS BEFORE OR AFTER EID, ETC.</b>	DAY ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> DON'T KNOW ..... 98  MONTH ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> YEAR ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div>	
204A	CHECK 204: DIED IN 2016, 2017, 2018, OR 2019 <input type="checkbox"/> DIED BEFORE 2016 <input type="checkbox"/> _____ →	END	
204B	In what day/month and year did (NAME) born?  <b>PROBE BY ASKING HOW MANY YEARS AGO, WHETHER IT WAS IN SUMMER OR WINTER, WHETHER IT WAS BEFORE OR AFTER EID, ETC.</b>	DAY ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> DON'T KNOW ..... 98 MONTH ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> DON'T KNOW ..... 98 YEAR ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> DON'T KNOW ..... 9998	
205	How old was she (NAME) when she died?	AGE IN YEARS ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div>	
205A	CHECK 205: AGE AT DEATH BETWEEN 15 AND 49 YEARS <input type="checkbox"/> AGE AT DEATH 50 YEARS OR OLDER <input type="checkbox"/>	AGE AT DEATH 14 YEARS OR YOUNGER AGE AT DEATH 50 YEARS OR OLDER	END
206	At the time she died, was (NAME) a usual member of this household or was she here temporarily?	USUAL MEMBER ..... 1 HERE TEMPORARILY ..... 2	
207	Did she ever attend school?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 209
208	What is the highest class she completed?  <b>IF CLASS-1 NOT COMPLETED WRITE '00'</b> <b>IF MA, MPHIL, PHD, MBBS, BSC/4 YEARS WRITE '16'</b>	CLASS ..... <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; vertical-align: middle;"></div>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
209	Was she working for wages or salary when she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div> <div></div> <div>211</div> </div>
210	What was her occupation? That is, what kind of work did she mainly do?	<div> <div></div> <div></div> </div>	
211	What was her mother tongue?	URDU ..... 01 PUNJABI ..... 02 SINDHI ..... 03 PUSHTO ..... 04 BALOCHI ..... 05 ENGLISH ..... 06 BARAUHI ..... 07 SIRAIKI ..... 08 HINDKO ..... 09 KASHMIRI ..... 10 SHINA ..... 11 BRUSHASKI ..... 12 WAKHI ..... 13 CHITRALI/ KHWAR ..... 14 BALTI ..... 15 PAHARI ..... 16 POTOWARI ..... 17 MARWARI ..... 18 FARSI ..... 19 OTHER ..... 96	
212	At the time she died, was she married, divorced, widowed, separated or never married?	MARRIED ..... 1 DIVORCED ..... 2 WIDOWED ..... 3 SEPARATED ..... 4 NEVER MARRIED* ..... 5	<div> <div></div> <div>215</div> </div> <div> <div></div> <div>217A</div> </div>
213	What was the name of her husband?		
214	How old was her husband at the time of her death?	AGE IN YEARS ..... <div><div></div><div></div></div> DON'T KNOW ..... 98	
215	Did her (last) husband ever attend school?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div> <div></div> <div>217</div> </div>
216	What was the highest class completed by her husband?  <b>IF CLASS-1 NOT COMPLETED WRITE '00'</b> <b>IF MA, MPHIL, PHD, MBBS, BSC/ 4YEARS WRITE '16'</b>	CLASS ..... <div><div></div><div></div></div> DON'T KNOW ..... 98	
217	What was her husband's occupation? That is, what kind of work does he mainly do?	<div> <div></div> <div></div> </div> <div> <div></div> <div></div> </div> DON'T KNOW ..... 98	<div> <div></div> <div>301</div> </div>
217A	CAUTIOUSLY AND CAREFULLY TRY TO ESTABLISH IF THE WOMAN'S DEATH WAS IN ANY WAY RELATED WITH COMPLICATIONS OF PREGNANCY OR CHILDBIRTH. IF SUCH A CASE IS FOUND, PLEASE FILL SECTION 3.  (1) YES DEATH RELATED TO COMPLICATIONS OF PREGNANCY OR CHILD BIRTH <div><div></div></div> <div> <div></div> </div> (2) NOT RELATED TO PREGNANCY COMPLICATIONS OR CHILDBIRTH <div><div></div></div> <div> <div></div> </div>		<div> <div></div> <div>401</div> </div>

### SECTION 3. BIRTH AND PREGNANCY INFORMATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301	Now I would like to ask about all the births (NAME) had during her life. Did she ever have a live birth?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 10px; height: 10px; margin: 0 auto;"></div> <div style="text-align: right;">→ 304</div>
302	How many total live births did she have? (Include children who later died)	LIVE BIRTHS ..... <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	
303	How many of her sons and daughters are still alive?	TOTAL LIVING CHILDREN .. <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> BOYS ..... <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> GIRLS ..... <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	
304	Women sometimes have pregnancies that do not end in a live birth. Did (NAME) ever have a pregnancy that ended in miscarriage, abortion or stillbirth?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 10px; height: 10px; margin: 0 auto;"></div> <div style="text-align: right;">→ 306</div>
305	How many TOTAL miscarriages, abortions and stillbirths did she have? a) Number of abortions?  b) Number of stillbirths?  c) Number of miscarriages?  d) Total Pregnancy Losses	a) Number of abortions? <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> b) Number of stillbirths? <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> c) Number of miscarriages? <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> d) Total Pregnancy Losses <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	
306	CHECK 301 AND 304: AT LEAST ONE LIVE BIRTH OR PREGNANCY LOSS (301 IS 'YES' OR 304 IS 'YES') <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block; vertical-align: middle;"></div>	NO LIVE BIRTHS OR PREGNANCY LOSSES BOTH 'NO' OR 'DK' <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block; vertical-align: middle;"></div>	<div style="text-align: right;">→ 315</div>
307	Did she ever have a Caesarean section operation?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 10px; height: 10px; margin: 0 auto;"></div> <div style="text-align: right;">→ 308</div>
307A	How many caesarean sections?	NUMBER OF C-SECTION <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	
308	Did she have a pregnancy during last 3 years of her life? (regardless of the result of the pregnancy)	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 10px; height: 10px; margin: 0 auto;"></div> <div style="text-align: right;">→ 315</div>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
309	How long before her death did her last pregnancy end?  <b>IF &lt; 24 HOURS, WRITE '00' DAYS.</b> <b>IF &lt; 1 MONTH, WRITE DAYS.</b> <b>IF &lt; 1 YEARS, WRITE MONTHS.</b> <b>IF ONE OR MORE YEARS, WRITE YEARS.</b>	DAYS ..... 1  MONTHS ..... 2  YEARS ..... 3 DON'T KNOW ..... 998	
310	What was the outcome of her last pregnancy?	LIVE BIRTH ..... 1 STILLBIRTH ..... 2 MISCARRIAGE ..... 3 ABORTION ..... 4 DON'T KNOW ..... 8	→ 314 → 315
311	Is her last born child still alive?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 313
312	How old is that child now?	AGE IN YEARS .....	→ 314
313	How old was that child when died?  <b>IF &lt; 24 HOURS, WRITE '00' DAYS.</b> <b>IF &lt; 1 MONTH, WRITE DAYS.</b> <b>IF &lt; 2 YEARS, WRITE MONTHS.</b> <b>IF TWO OR MORE YEARS, WRITE YEARS.</b>	DAYS ..... 1  MONTHS ..... 2  YEARS ..... 3 DON'T KNOW ..... 998	
314	How long after her last birth / delivery / miscarriage / abortion did (NAME) die?  <b>IF &lt; 24 HOURS, WRITE '00' DAYS.</b> <b>IF &lt; 1 MONTH, WRITE DAYS.</b> <b>IF &lt; 2 YEARS, WRITE MONTHS.</b> <b>IF TWO OR MORE YEARS, WRITE YEARS.</b>	DAYS ..... 1  MONTHS ..... 2  YEARS ..... 3 DON'T KNOW ..... 998	
315	Was (NAME) pregnant at the time she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 321
316	How many months was she pregnant at the time she died?	MONTHS ..... DON'T KNOW ..... 98	
318	Did she die before labour pains began, before birth or during delivery/ abortion or miscarriage?	BEFORE LABOUR PAINS BEGAN ..... 1 AFTER LABOUR PAINS BEGAN BUT BEFORE BIRTH ..... 2 DURING DELIVERY/ABORTION/ MISCARRIAGE ..... 3 BEFORE DELIVERY OF PLACENTA ..... 4 DURING PREGNANCY ..... 5 DON'T KNOW ..... 8	→ 401
321	Did she die within 40 days of delivery, abortion or miscarriage?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	

#### **SECTION 4. VERBATIM DESCRIPTION OF ILLNESS AND DEATH**

401 Please tell me everything that happened during the last illness before (NAME)'s death, starting from the beginning of the illness and also what happened during the final hours before she died.

a. Focus on the time before any symptoms of illness were identified:

i) How was the general health of the deceased woman; ii) Did she have any apparent physical or emotional distress; iii) Did she have past history of any serious illness

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

**b.**

i) What were the symptoms? ii) Why does respondent think those were symptoms of her last illness? iii) What was done about those symptoms (treatment, rites)? iv) Was she seen by a healthcare provider (where and by whom)? v) What was the result of the management/treatment? vi) Was there a respite in the symptoms? vii) Was she taken to a hospital (where and seen by whom there)? viii) Was she hospitalized (for how long, with what results)? ix) What was the healthcare provider's opinion, remarks and advice?

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

**C.**

i) What were her last symptoms and signs? ii) Where did she die? iii) Who was her last healthcare provider (by profession or designation)? iv) What was the probable cause of death:

1. as perceived by respondent
2. as explained by healthcare provider

v. What other factors might have been responsible for her death (e.g., lack of proper and timely care; lack of resources; delay in making the decision to take the woman to hospital; lack of transport; delay in getting to a hospital; lack of facilities and/or healthcare provider at hospital; etc.)

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



**d. Relation of dead to pregnancy, childbirth or postpartum complications:**

i) Was she pregnant at the time of death, or had recently delivered or aborted? ii) Was the death related with pregnancy, childbirth or postpartum complications (in what way)? iii) Please provide information about the result and outcome of pregnancy (induced abortion, natural abortion, stillbirth, live birth, etc.)?

## SECTION 5. SYMPTOMS IDENTIFICATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																								
501	Where did (NAME) die?	HOSPITAL/CLINIC ..... 1 HUSBAND'S HOME ..... 2 HER PARENTS' HOME ..... 3 IN -TRANSIT ..... 4 OTHER ..... 5 <div style="text-align: center;">(SPECIFY)</div> DON'T KNOW ..... 8	<div style="border-left: 1px solid black; height: 40px; margin-left: 5px;"></div> <div style="text-align: right; margin-right: 5px;">→ 505</div>																																																								
502	What was the name of the hospital / clinic where she died?	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: center;">(NAME)</div>																																																									
503	Did anyone at the hospital / clinic tell you why she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border-left: 1px solid black; height: 20px; margin-left: 5px;"></div> <div style="text-align: right; margin-right: 5px;">→ 505</div>																																																								
504	What were the reasons given by the hospital / clinic as to why she died?  Any other reason?	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="border-bottom: 1px solid black; width: 100%;"></div>																																																									
505	What do you think is the main cause of her death?	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="border-bottom: 1px solid black; width: 100%;"></div>																																																									
506	Did (NAME) have any chronic disease? (Probe for each disease condition)	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th><th style="text-align: center;">Y</th><th style="text-align: center;">N</th><th style="text-align: center;">DK</th></tr> </thead> <tbody> <tr> <td>a) High blood pressure or hypertension?</td><td></td><td></td><td></td></tr> <tr> <td>b) Diabetes or high blood sugar?</td><td></td><td></td><td></td></tr> <tr> <td>c) Epilepsy?</td><td></td><td></td><td></td></tr> <tr> <td>d) Tuberculosis or TB?</td><td></td><td></td><td></td></tr> <tr> <td>e) Heart disease?</td><td></td><td></td><td></td></tr> <tr> <td>f) Blood disease?</td><td></td><td></td><td></td></tr> <tr> <td>g) Asthma?</td><td></td><td></td><td></td></tr> <tr> <td>h) Severe anaemia?</td><td></td><td></td><td></td></tr> <tr> <td>i) Jaundice?</td><td></td><td></td><td></td></tr> <tr> <td>j) Hepatitis?</td><td></td><td></td><td></td></tr> <tr> <td>k) HIV/AIDS?</td><td></td><td></td><td></td></tr> <tr> <td>l) Cancer? SPECIFY TYPE: _____</td><td></td><td></td><td></td></tr> <tr> <td>x) Any other chronic disease? SPECIFY: _____</td><td></td><td></td><td></td></tr> </tbody> </table>		Y	N	DK	a) High blood pressure or hypertension?				b) Diabetes or high blood sugar?				c) Epilepsy?				d) Tuberculosis or TB?				e) Heart disease?				f) Blood disease?				g) Asthma?				h) Severe anaemia?				i) Jaundice?				j) Hepatitis?				k) HIV/AIDS?				l) Cancer? SPECIFY TYPE: _____				x) Any other chronic disease? SPECIFY: _____				
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507	Was she ever hospitalized? I mean did she ever stay in the hospital overnight?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border-left: 1px solid black; height: 20px; margin-left: 5px;"></div> <div style="text-align: right; margin-right: 5px;">→ 511</div>																																																								
508	How long before she died was she last hospitalized?  <b>IF &lt; 24 HOURS, WRITE '00' DAYS.</b> <b>IF &lt; 1 MONTH, WRITE DAYS.</b> <b>IF &lt; 2 YEARS, WRITE MONTHS.</b> <b>IF TWO OR MORE YEARS, WRITE YEARS.</b>	DAYS ..... 1  MONTHS ..... 2  YEARS ..... 3 DON'T KNOW ..... 998	<table border="1" style="border-collapse: collapse; width: 40px; height: 40px;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>																																																								

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
509	Why was she last hospitalized?  Any other reason?	  	
510	Did she have any operation before she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 510B
510A	What type of operation?	  	
510B	Now I would like to ask about the major symptoms that she might have had during her last illness. <b>INTERVIEWER: PROBE TO GET AN ESTIMATE OF HOW LONG EACH SYMPTOM LASTED FROM WHEN IT FIRST APPEARED UNTIL IT STOPPED, EVEN IF IT STOPPED BEFORE SHE DIED.</b>		
511	Did she have <b>fever</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 512
511A	How many days or months did the fever last?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 MONTHS ..... 2 DON'T KNOW ..... 998	
511B	Was the fever continuous or on and off?	CONTINUOUS ..... 1 ON AND OFF ..... 2 DON'T KNOW ..... 8	
512	Was she <b>breathless doing light work</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
512A	Was she <b>breathless when she was lying down</b> or when she was asleep?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
513	Did she have rapid heart beat ( <b>palpitations</b> )?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
514	Did she have <b>wheezing</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
515	Did she have a <b>cough</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 516

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
515A	For how long did she have a cough?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998									
515B	Did the cough produce sputum?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
515C	Did she cough blood?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
516	Did she have <b>chest pain</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 517								
516A	How many days or months did she have chest pain?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998									
516B	Was the chest pain mild, moderate or severe?	MILD ..... 1 MODERATE ..... 2 SEVERE ..... 3 DON'T KNOW ..... 8									
516C	Did the chest pain start suddenly or gradually?	SUDDENLY ..... 1 GRADUALLY ..... 2 DON'T KNOW ..... 8									
516D	Was the pain at or near the centre of the chest?	NEAR STERNUM ..... 1 SOMEWHERE ELSE/ALL OVER ... 2 DON'T KNOW ..... 8									
517	Did she have <b>diarrhoea</b> (loose motions)?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 517B								
517A	How many times a day did she have loose motions?	TIMES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr></table> DON'T KNOW ..... 98									
517B	Was there blood in the stools?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
518	Did she have <b>poor appetite or loss of appetite</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 520								
518A	For how long did she have poor appetite?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998									
520	Did she have <b>difficulty in swallowing</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
520A	Did she have <b>pain in swallowing</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
521	Did she have <b>headache</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 522								
521A	How many days or months did she have headache?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998									
522	Did she pass <b>blood in her urine</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 523								
522A	For how many days or months did she pass blood in her urine?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998									
523	Did she have <b>pain while urinating</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 524								
523A	For how many days or months did she have pain when urinating?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 8									
524	Was she <b>unable to pass urine</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
525	Did she <b>urinate many times</b> in a day?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
526	Did she have any type of pain anywhere in the body ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
527	Did she have <b>abdominal pain</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 528								
527A	How long did the abdominal pain last?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
527B	Was the abdominal pain mild, moderate or severe?	MILD ... 1 MODERATE ... 2 SEVERE ... 3 DON'T KNOW ... 8	
527C	Was the abdominal pain in her upper belly, lower belly, or all over her belly?	UPPER ABDOMEN ... 1 LOWER ABDOMEN ... 2 ALL OVER THE ABDOMEN ... 3 DON'T KNOW ... 8	
528	Did she have <b>abdominal distension</b> ?	YES ... 1 NO ... 2 DON'T KNOW ... 8	→ 529
528A	How many days or months was her abdomen distended?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ... 1 MONTHS ... 2 DON'T KNOW ... 998	
528B	Did the distension come rapidly within days or slowly over several weeks?	RAPIDLY, WITHIN FEW DAYS ... 1 SLOWLY, OVER WEEKS ... 2 DON'T KNOW ... 8	
529	Did she have a <b>mass in her abdomen</b> ?	YES ... 1 NO ... 2 DON'T KNOW ... 8	
530	Did she have <b>vomiting</b> ?	YES ... 1 NO ... 2 DON'T KNOW ... 8	→ 531
530A	For how many days or months did she have vomiting?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ... 1 MONTHS ... 2 DON'T KNOW ... 998	
530B	Did she vomit blood?	YES ... 1 NO ... 2 DON'T KNOW ... 8	
531	Did she become <b>mentally confuse</b> ?	YES ... 1 NO ... 2 DON'T KNOW ... 8	
532	Did she <b>lose consciousness</b> ?	YES ... 1 NO ... 2 DON'T KNOW ... 8	→ 533
532A	For how long she remained unconscious?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ... 1 MONTHS ... 2 DON'T KNOW ... 998	
532B	Did she become unconscious suddenly or gradually?	SUDDENLY ... 1 GRADUALLY ... 2 DON'T KNOW ... 8	
533	Did she become <b>paralyze</b> before her death?	YES ... 1 NO ... 2 DON'T KNOW ... 8	→ 534

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
533A	How long did the paralysis last?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF &gt; 1 MONTH WRITE MONTHS</b> <b>IF ONE OR MORE YEAR WRITE YEARS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> LASTED TILL DEATH ..... 997 DON'T KNOW ..... 998									
533B	Was the paralysis on only one side of her body or both sides?	ONE SIDE ONLY ..... 1 BOTH SIDES ..... 2 DON'T KNOW ..... 8									
534	Did she have <b>stiffness in her whole body</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
535	Did she have <b>neck pain</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
536	Did she had <b>convulsion</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 15px; height: 15px; display: inline-block; vertical-align: middle;"></div> → 537								
536A	How long did the convulsion last?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998									
536B	When the fits were most frequent, how many times a day did she have fits?	TIMES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr></table> DON'T KNOW ..... 98									
537	Did she have an <b>ulcer or swelling/ lump in the breast</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
538	Did she have <b>vaginal bleeding</b> when she was not having her menstrual period?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 15px; height: 15px; display: inline-block; vertical-align: middle;"></div> → 539								
538A	For how many days or months did she have bleeding?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1- MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998									
538B	Did the bleeding persist until she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
539	Did she have <b>abnormal vaginal discharge</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
540	Did she have <b>swelling on her ankles</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
541	Did she have <b>swelling or puffiness on her hands and/or face</b> ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 15px; height: 15px; display: inline-block; vertical-align: middle;"></div> → 542								

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
541A	For how many days or months did she have swelling on her hands and/or face ?  IF < 24 HRS WRITE '00' DAYS IF < 1- MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS ..... 1 MONTHS ..... 2 DON'T KNOW ..... 998	
542	Did she lose weight?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
543	Did she have sores in her mouth?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
544	Did she have any skin disease?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
545	Did she look pale?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
545A	Did she have jaundice?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 547
546	Were her eyes yellowish in colour?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	└→ 547
546A	For how many days or months did she have yellow eyes?  IF < 24 HRS WRITE '00' DAYS IF < 1- MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS ..... 1 MONTHS ..... 2 DON'T KNOW ..... 998	
547	Did she ever complain of having blurred vision?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
548	Did she have difficulty in opening her mouth?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
549	Did she have difficulty in passing stools or constipation?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
550	Did she feel dizzy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
551	Did she have general weakness or fatigue?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	└→ 552



NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
551A	For how many days or months did she have Weakness?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1- MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 MONTHS ..... 2 DON'T KNOW ..... 998	
551B	Did she have light flashes before her eyes close at night?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
551C	Did she complain of double vision?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
552	Did she have any <b>ulcers</b> on her body?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
553	Were there any other symptom that we did not mention?	<b>PLEASE WRITE IN URDU OR ENGLISH</b>  A _____ B _____ C _____ D _____ E _____ F _____ NO ONE ..... Y	
554	Did people think she had an evil eye or shadow?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
555	Was a Faith Healer called to or she was taken give amulets or spiritual healing?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 601
556	Give details of spiritual healing:	_____ _____ _____	

## SECTION 6. DECEASED ILLNESS HISTORY

601	<b>CHECK 511:</b> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <b>YES</b> HAD FEVER <input type="checkbox"/> </div> <div style="text-align: center;"> <b>NO /</b> DON'T KNOW <input type="checkbox"/> </div> </div>	614
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**FEVER SECTION**

602	How long before she died did the fever start?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF &lt; 1 MONTH WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> DAYS ..... 2 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> WEEKS ..... 3 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> MONTHS ..... 4 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> DON'T KNOW ..... 998	
602A	When did the fever start?	BEFORE CHILD BIRTH / ABORTION / MISCARRIAGE ..... 1 AFTER CHILD BIRTH / ABORTION / MISCARRIAGE ..... 2 NOT APPLICABLE ..... 7 DON'T KNOW / REMEMBER ..... 8	603
602B	How long before/after childbirth, miscarriage or abortion did the fever start?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF &lt; 1 MONTH WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> DAYS ..... 2 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> WEEKS ..... 3 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> MONTHS ..... 4 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> DON'T KNOW ..... 998	
603	How long did it last?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF &lt; 1 MONTH WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> DAYS ..... 2 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> WEEKS ..... 3 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> MONTHS ..... 4 <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"></table> DON'T KNOW ..... 998	
604	Was the fever very high?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
605	Did she have fever with chills?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
606	Was she prescribed anti-malarial tablets for the episodes of fever and chills?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
607	Did her colour change during her last illness?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	608
607A	What was the colour?	PALLOR ..... 1 JAUNDICED ..... 2 BLUE ..... 3	
608	Had she been vomiting during her last illness?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	610

608A	How long before she died did the vomiting start?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF &lt; 1 MONTH WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 DAYS ..... 2 WEEKS ..... 3 MONTHS ..... 4 DON'T KNOW ..... 998	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>																																	
608B	Did she have severe body aches during fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																																		
609	Did she ever vomit pure blood?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																																		
610	Did she have any difficulty with urination?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		613																																
610A	Record all that apply.  <b>ASK EACH CONDITION (ONE BY ONE):</b>	<table border="0"> <tr> <td></td> <td>Y</td> <td>N</td> <td>DK</td> </tr> <tr> <td>a) UNABLE TO PASS URINE ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) TOO FREQUENT URINATION ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>c) PAINFUL URINATION ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>d) BACK PAIN WITH FEVER ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>e) BLOOD IN URINE ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>x) OTHER _____</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>(SPECIFY)</td> <td></td> <td></td> <td></td> </tr> </table>		Y	N	DK	a) UNABLE TO PASS URINE ..	1	2	8	b) TOO FREQUENT URINATION ..	1	2	8	c) PAINFUL URINATION ..	1	2	8	d) BACK PAIN WITH FEVER ..	1	2	8	e) BLOOD IN URINE ..	1	2	8	x) OTHER _____	1	2	8	(SPECIFY)					
	Y	N	DK																																	
a) UNABLE TO PASS URINE ..	1	2	8																																	
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e) BLOOD IN URINE ..	1	2	8																																	
x) OTHER _____	1	2	8																																	
(SPECIFY)																																				
613	Did she have convulsions with fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																																		
614	<b>CHECK 515:</b>  <div style="display: flex; justify-content: space-around; align-items: center;"> <div> <b>YES</b> HAD COUGH <input type="checkbox"/> </div> <div> <b>NO/ DON'T KNOW</b> <input type="checkbox"/> </div> </div>			621																																

**COUGH SECTION**

615	How long before she died did the cough start?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF &lt; 1 MONTH WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 DAYS ..... 2 WEEKS ..... 3 MONTHS ..... 4 DON'T KNOW ..... 998	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>									
616	Was there any sputum when she coughed?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		618								
617	Was there blood in it?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8		618								
617A	How much blood did the sputum contain?	FEW DARK SPECKS .. . . . 1 STREAKS OF BLOOD .. . . . 2 FRANK BLOOD . . . . . 3										
618	Did she lose weight during this illness?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8										

620	Was she short of breath?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 621								
620A	For how long?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF ONE OR MORE WEEK WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 DAYS ..... 2 WEEKS ..... 3 MONTHS ..... 4 DON'T KNOW ..... 998	<table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>								
621	<b>CHECK 526:</b>  <div style="display: flex; justify-content: space-around;"> <div>           YES <input type="checkbox"/>            HAD PAIN IN THE BODY         </div> <div>           NO /            DON'T KNOW <input type="checkbox"/> </div> </div>		→ 632								
<b>PAIN SECTION</b>											
622	What kind of pain?	CONTINUOUS ..... 1 INTERMITTENT ..... 2 VERY INTENSE ..... 3 INCREASING IN SEVERITY ..... 4 OTHER ..... 6 (SPECIFY) _____									
623	What was / were the site (s) of the pain?	HEAD ..... A ABDOMEN ..... B CHEST ..... C BREAST ..... D LEGS ..... E ALL OVER ..... F OTHERS ..... X (SPECIFY) _____									
624	How long before she died did the pain start?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF &lt; 1 MONTH WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 DAYS ..... 2 WEEKS ..... 3 MONTHS ..... 4 DON'T KNOW ..... 998	<table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>								
625	How long did it last?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF &lt; 1 MONTH WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 DAYS ..... 2 WEEKS ..... 3 MONTHS ..... 4 DON'T KNOW ..... 998	<table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>								
625A	Did she have pain in upper abdomen?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 627								

625B	When did the pain start?	BEFORE LABOUR ..... 1 AT TIME OF LABOUR ..... 2 AT THE DAY OF DELIVERY ..... 3 1 DAY AFTER DELIVERY ..... 4 2 DAYS AFTER DELIVERY ..... 5 3 DAYS OR MORE THAN 3 DAYS AFTER DELIVERY ..... 6 NOT APPLICABLE ..... 7 DON'T KNOW / DON'T REMEMBER ..... 8									
626	If it was in abdomen, which specific side?	_____ _____ _____									
627	Was there any pain in the lower abdomen?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
628	Was the pain accompanied by fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 630								
629	Was the fever mild, moderate or high?	MILD ..... 1 MODERATE ..... 2 HIGH ..... 3 DON'T KNOW ..... 8									
630	Was the pain accompanied by vomiting?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
632	<b>CHECK 536:</b>  YES <input type="checkbox"/> HAD CONVULSIONS ↓  NO/ <input type="checkbox"/> DON'T KNOW → 639										
<b>CONVULSION SECTION</b>											
633	Did she have a history of convulsions?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
634	Did she have convulsions in her last illness?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 635								
634A	For how long before death?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 WEEK WRITE DAYS</b> <b>IF &lt; 1 MONTH WRITE WEEKS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 DAYS ..... 2 WEEKS ..... 3 MONTHS ..... 4 DON'T KNOW ..... 998	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>								
635	Did she have high blood pressure before she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
636	Did she have severe headache before she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									
637	Did she have change in her vision before she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8									

638	What was her state of consciousness before she died? I mean, was she conscious, semi-conscious or unconscious? (Explain)					
638A	Did she have history of convulsions or epilepsy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 639			
638B	How frequently did she have convulsions?	TIMES ..... <table border="1"><tr><td></td><td></td></tr></table> DON'T KNOW ..... 98				
638C	CHECK 315: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">PREGNANT (CODE 1 CIRCLED) <input type="checkbox"/></div> <div style="text-align: center;">NOT PREGNANT (CODE 2 OR 8 CIRCLED) <input type="checkbox"/></div> </div>	→ 638E				
638D	When did convulsions start?	1ST TRIMESTER . . . . . 1 2ND TRIMESTER . . . . . 2 3RD TRIMESTER . . . . . 3 DON'T KNOW ..... 8				
638E	How long did convulsions last?	ABOUT 1 MINUTE . . . . . 1 LESS THAN 5 MINUTES . . . . . 2 5 MINUTES OR MORE . . . . . 3 DON'T KNOW ..... 8				
638F	Where the convulsions restricted to one part of the body or did they involve the whole body?	FOCAL . . . . . 1 GENERALISED . . . . . 2 DON'T KNOW ..... 8				
639	CHECK 540 & 541: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">YES HAD SWELLING <input type="checkbox"/></div> <div style="text-align: center;">NO / DON'T KNOW <input type="checkbox"/></div> </div>	→ 701				

**SWELLING SECTION**

640	Where was the site of swelling? (Ask for each)	YES NO DK a) ABDOMEN ..... 1 2 8 b) FACE ..... 1 2 8 c) LEGS AND FEET .... 1 2 8 d) WHOLE BODY ..... 1 2 8								
641	How long before she died did she have this swelling?  IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS ..... 1 <table border="1"><tr><td></td><td></td></tr></table> DAYS ..... 2 <table border="1"><tr><td></td><td></td></tr></table> WEEKS ..... 3 <table border="1"><tr><td></td><td></td></tr></table> MONTHS ..... 4 <table border="1"><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998								

642	<p>When did the swelling start in relation to delivery of the baby or abortion or miscarriage?</p> <p><b>IF &lt; 1 DAY WRITE HOURS</b>  <b>IF &lt; 1 WEEK WRITE DAYS</b>  <b>IF &lt; 1 MONTH WRITE WEEKS</b>  <b>IF ONE OR MORE MONTH WRITE MONTHS</b></p>	<p>HOURS ..... 1</p> <p>DAYS ..... 2</p> <p>WEEKS ..... 3</p> <p>MONTHS ..... 4</p> <p>NOT APPLICABLE ..... 997  DON'T KNOW ..... 998</p>	<table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									
643	At the time of death was she short of breath?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>										
644	Did her colour change during her last illness?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<div>→ 645</div>									
644A	Did she have yellowness of skin or face?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>										
645	Did she also have any urinary problems?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<div>→ 701</div>									
645A	<p>What were those problems?</p> <p><b>RECORD ALL THAT APPLY</b></p>	<p>Y N DK</p> <p>a) UNABLE TO PASS URINE .. 1 2 8</p> <p>b) TOO FREQUENT URINATION 1 2 8</p> <p>c) PAINFUL URINATION . .. 1 2 8</p> <p>d) BLOOD IN URINE . . . . 1 2 8</p> <p>x) OTHER _____ . .. 1 2 8</p> <p>(SPECIFY)</p>										

## SECTION 7. ANTENATAL CARE AND CHARACTERISTICS OF LAST PREGNANCY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	<b>CHECK 308 OR 315 FOR LAST PREGNANCY:</b> <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="text-align: center;"> <b>YES</b>  <input type="checkbox"/>  <b>HAD A PREGNANCY</b> </div> <div style="text-align: center;"> <b>NO/</b>  <b>DON'T KNOW</b>  <input type="checkbox"/> </div> </div>	<b>NOT ASKED</b> <input type="checkbox"/>	<div style="text-align: right;">→ 901</div> <div style="text-align: right;">→ 801</div>
702	During her last pregnancy, did (NAME) see anyone for antenatal care?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 709
703	Who did she see for antenatal care?   <b>CIRCLE ALL THAT MENTIONED</b>	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/SPECIALIS ..... A DOCTOR ..... B NURSE/MIDWIFE/LHV ..... C  <b>OTHER PERSON</b> DAI-TBA ..... D LADY H. WORKER ..... E HOMEOPATH ..... F HAKIM ..... G DISPENSER / COMPOUNDER ..... H  OTHER ..... X (SPECIFY)	
704	The first time she went for antenatal care, did she go because she had a problem or did she go for a check-up?	FOR PROBLEM ..... 1 FOR CHECK-UP ONLY ..... 2 DON'T KNOW ..... 8	→ 706
705	What was the problem she went for?		
706	How many months pregnant was she when she first saw a health provider during the last pregnancy?	MONTHS ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98	
707	How many times did she see a health provider during her last pregnancy?	TIMES ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98	
708	Was she referred by a health care provider to go to a specialist ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 710
709	Why didn't she see anyone for antenatal care during her last pregnancy?   <b>CIRCLE ALL THAT MENTIONED</b>	NOT NECESSARY ..... A COSTS TOO MUCH ..... B TOO FAR ..... C NO TRANSPORT ..... D NO ONE TO GO WITH ..... E SERVICE NOT GOOD ..... F NO TIME TO GO ..... G DID NOT KNOW WHERE TO GO ..... H DID NOT WANT TO SEE A MALE DOCTOR ..... I LONG WAITING TIME ..... J NOT ALLOWED TO GO ..... K OTHER ..... X (SPECIFY) DON'T KNOW ..... Z	
710	During her last pregnancy, did (NAME) have an injection in her arm/buttocks to prevent the baby from getting tetanus, that is, convulsions after birth?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	



NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
711	Did she have her blood pressure measured during this pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 714
712	Do you know whether her blood pressure was normal or high or low?	NORMAL ..... 1 HIGH ..... 2 LOW ..... 3 DON'T KNOW ..... 8	→ 714
713	Was she prescribed medicines for blood pressure ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
714	Was (NAME) using any family planning method before she became pregnant?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
715	Did she want this pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
716	Did she do anything to try to end this pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 719
717	What did she do to end the pregnancy?	WENT FOR ABORTION ..... 1 TOOK DRUGS ..... 2 INSERTED OBJECT INTO VAGINA ..... 3 OTHER ..... 6 (SPECIFY) DON'T KNOW ..... 8	
718	Who did she go to for help to end this pregnancy?	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/SPECIALIS ..... 01 DOCTOR ..... 02 NURSE/MIDWIFE/LHV ..... 03  <b>OTHER PERSON</b> DAI-TBA ..... 04 LADY H. WORKER ..... 05 HOMEOPATH ..... 06 HAKIM ..... 07 DISPENSER / COMPOUNDER ..... 08  OTHER ..... 96 (SPECIFY)	
719	<b>CHECK 310:</b> MISCARRIAGE OR ABORTION <input type="checkbox"/> ↓ (CODES 3 OR 4 CIRCLED)	<b>OTHER RESPONSES</b> (CODES 1,2 OR 8 CIRCLED) <input type="checkbox"/>	→ 726
719A	<b>CHECK 315:</b> CODE 2 OR 8 CIRCLED <input type="checkbox"/> ↓	<b>CODE 1 CIRCLED</b> <input type="checkbox"/>	→ 726
720	Did she have a foul-smelling discharge from her vagina after the miscarriage/abortion?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
721	Did she have fever after the miscarriage/abortion?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
722	Did she have abdominal distension after the miscarriage / abortion?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
726	During the last illness, did she have bleeding from vagina?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	└─→ 732
727	Did the bleeding wet her clothes?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
728	Did the bleeding wet the bed?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
729	Was there so much blood as to wet the floor?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
730	Was she in pain while bleeding?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
731	Did the bleeding contain clots?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
732	Did someone examine her internally during last pregnancy?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	└─→ 734
733	Did the vaginal examination cause any bleeding or make the bleeding worse?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
734	Did the bleeding persist until she died?	YES ..... 1 NO ..... 2 NOT APPLICABLE ..... 7 DON'T KNOW ..... 8	

**SECTION 8. FOR DEATHS DURING LABOUR, DELIVERY, OR WITHIN 40 DAYS AFTER DELIVERY**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	<b>CHECK 321: Death within 40 days of delivery, abortion or miscarriage?</b>  NO / DON'T KNOW/ NOT ASKED <input type="checkbox"/>	<b>"YES" (CODE 1 CIRCLED)</b> <input type="checkbox"/>	802
801A	<b>CHECK 318:</b>  CODE 1,2,3 OR 4 CIRCLED <input type="checkbox"/>	<b>CODE 5 OR 8 CIRCLED/ NOT ASKED</b> <input type="checkbox"/>	901
802	Did (NAME) have bleeding from her vagina ?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	805
803	Did the bleeding start before or after the birth / delivery ?	BEFORE ..... 1 AFTER ..... 2 DON'T KNOW ..... 8	
804	Was she in pain while bleeding?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
805	Did the pain start before the labor pains started?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
806	Where did she deliver?	<b>HOME</b> HER HOME ..... 11 OTHER HOME ..... 12 <b>PUBLIC SECTOR</b> GOVT. HOSPITAL ..... 21 RHC/MCH ..... 22 OTHER PUBLIC ..... 26 _____ (SPECIFY) <b>PRIVATE MED. SECTOR</b> PVT. HOSPITAL/CLINIC ..... 31 OTHER PRIVATE MED. .... 36 _____ (SPECIFY) OTHER ..... 96 _____ (SPECIFY) DID NOT DELIVER ..... 97	814
807	Who assisted with the delivery?	<b>HEALTH PERSONNEL</b> OBSTETRICIAN/SPECIALIST ..... 01 DOCTOR ..... 02 NURSE/MIDWIFE/LHV ..... 03  <b>OTHER PERSON</b> DAI-TBA ..... 04 LADY H. WORKER ..... 05 HOMEOPATH ..... 06 HAKIM ..... 07 DISPENSER / COMPOUNDER ..... 08  OTHER ..... 96 _____ (SPECIFY)	
808	Were any instruments used to assist in her last delivery?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP		
808A	You said that (NAME) died during (Check 318 and 321) is that correct.	DURING LABOUR ..... 1 AFTER CHILD BIRTH ..... 2			
808B	Was the delivery normal vaginal delivery or assisted vaginal delivery (use of forceps vacuum extraction) or a caesarean section?	NORMAL ..... 1 ASSISTED VAGINAL ..... 2 CAESAREAN SECTION ..... 3	→ 811		
809	During her last delivery, did someone cut her vagina to make room for the baby to come [episiotomy]?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
810	Was there a tear in her vagina after her last delivery?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
811	During the delivery, did her birth attendant examine her vagina using either hands or instruments?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
812	Did her water bag break before the labour pains started?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
813	How long was she in labour?	HOURS ..... <table border="1"><tr><td></td><td></td></tr></table> DON'T KNOW ..... 98			
814	Was (NAME) given any drugs just before or during labour?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 816		
815	What were the drugs used for?	EXPEDITE DELIVERY OF BABY ... 1 EXPEDITE PLACENTA COMING ..... 2 TO EASE PAIN ..... 3 TO REDUCE BLEEDING ..... 4 OTHER ..... 6 (SPECIFY) DON'T KNOW ..... 8			
816	Did she have a lot of bleeding <u>before</u> delivering the baby?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 820		
817	Did the bleeding wet her clothes?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
818	Did the bleeding wet the bed?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
819	Was there so much blood as to wet the floor?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
820	Did she die before or after the baby was born?	BEFORE ..... 1 AFTER ..... 2 DON'T KNOW ..... 8	→ 901		

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
821	Did she have difficulty delivering the baby?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
822	What part of the baby came out first?	HEAD ..... 1 LEGS ..... 2 SHOULDER ..... 3 ARMS ..... 4 CAESARIAN SECTION ..... 5 DON'T KNOW ..... 8	→ 826
823	Did the placenta come out?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 826
824	How long after the baby came did the placenta come out?  <b>IF &lt; 1 HOUR WRITE MINUTES</b> <b>IF ONE OR MORE HOUR WRITE HOURS</b>	MINUTES ..... 1 HOURS ..... 2 DON'T KNOW ..... 998	
825	Did all of the placenta come out or only part?	ALL ..... 1 PART ..... 2 DON'T KNOW ..... 8	
826	Did she have a lot of bleeding <u>after</u> delivering the baby?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 830
827	Did the bleeding wet her clothes?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
828	Did the bleeding wet the bed?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
829	Was there so much blood as to wet the floor?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
830	Did she have a foul-smelling discharge from her vagina after the baby was born?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
831	Did she have a pain in her legs after the baby was born?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
832	Did she have a fever after the baby was born?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 838
833	How long after the delivery did the fever start?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF ONE OR MORE DAY WRITE DAYS</b>	HOURS ..... 1 DAYS ..... 2 DON'T KNOW ..... 998	
834	Did she have any fits or rigors with the fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 836

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
835	Did the fits stop after the baby was born?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
836	How long did the fever last?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF ONE OR MORE DAY WRITE DAYS</b>	HOURS ..... 1 DAYS ..... 2 DON'T KNOW ..... 998	
837	Was she having the fever when she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
838	Was the colour of her eyes yellow after the baby was born?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
839	After the delivery, did a birth attendant examine her vagina using either hands or instruments?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
840	Did (NAME) receive (or need) a blood transfusion?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 901
841	When did she get blood transfusion?	BEFORE LABOUR ..... 1 DURING CHILDBIRTH ..... 2 AFTER CHILDBIRTH ..... 3 DID NOT GET BLOOD TRANSFUSION ..... 4	

## SECTION 9. DEATHS DUE TO INJURY / ACCIDENT / VIOLENCE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
901	Did she have any serious accident or injury before she died?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 15px; height: 15px; margin: 0 auto;"></div> → 1001
902	Please tell me what happened.  <b>WRITE IN DETAIL WHAT IS SAID.            THEN CIRCLE THE CODE THAT FITS BEST</b>  _____ _____ _____ _____ _____ _____ _____	ROAD / TRAIN ACCIDENT ..... 01 FALL ..... 02 DROWNING ..... 03 SEVERE BURNS / ACID BURNS ..... 04 POISONING ..... 05 SUFFOCATION ..... 06 CUT / STABBED ..... 07 BEATEN / PUNCHED / KICKED ..... 08 RAPE ..... 09 SHOT WITH GUN ..... 10 DOG BITE ..... 11 SNAKE BITE ..... 12 INSECT BITE ..... 13 OTHER ..... 96 <div style="text-align: center;">(SPECIFY)</div>	
903	How long before she died did this happen?  <b>IF &lt; 1-DAY WRITE '00'</b> <b>IF &lt; 1-MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	DAYS ..... 1 MONTHS ..... 2 DON'T KNOW ..... 998	<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto; display: flex; flex-direction: column; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>
904	Did she hurt herself intentionally, did someone else hurt her intentionally, or was this an accident?	HURT HERSELF INTENTIONALLY ..... 1 SOMEONE HURT HER ..... 2 ACCIDENT ..... 3 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 15px; height: 15px; margin: 0 auto;"></div> → 906
905	Do you think she was trying to commit suicide?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
906	Do you think this injury was the main cause of her death, did it contribute to her death, or was it not important?	MAIN CAUSE ..... 1 CONTRIBUTED ..... 2 NOT IMPORTANT ..... 3 DON'T KNOW ..... 8	

## SECTION 10. CARE-SEEKING BEHAVIOR

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP												
1001	<p>During her last illness, how long after she first started having symptoms, did you recognize that she was having a serious problem or illness?</p> <p><b>IF &lt; 1 DAY WRITE HOURS</b>  <b>IF &lt; 1 MONTH WRITE DAYS</b>  <b>IF ONE OR MORE MONTH WRITE MONTHS</b></p>	<p>IMMEDIATELY 000</p> <table border="1"> <tr> <td>HOURS .....</td><td>1</td><td></td><td></td></tr> <tr> <td>DAYS .....</td><td>2</td><td></td><td></td></tr> <tr> <td>MONTHS .....</td><td>3</td><td></td><td></td></tr> </table> <p>DIED IMMEDIATELY ..... 995  DON'T KNOW ..... 998</p>	HOURS .....	1			DAYS .....	2			MONTHS .....	3			
HOURS .....	1														
DAYS .....	2														
MONTHS .....	3														
1002	<p>How serious did she/her family perceive this complication or problem to be?</p>	<p>NOT SERIOUS ..... 1  SOMEWHAT SERIOUS ..... 2  VERY SERIOUS ..... 3  LIFE THREATENING ..... 4</p>	→ 1004												
1003	<p>Did she/her family think that she could have died because of her problem or illness or did you think it was not so serious at first?</p>	<p>THOUGHT SHE COULD DIE ..... 1  DID NOT THINK SHE COULD DIE ..... 2</p>													
1004	<p>During (NAME)'s last illness/problem, did she or anyone seek any kind of treatment for her illness?</p>	<p>YES ..... 1  NO ..... 2  DON'T KNOW ..... 8</p>	→ 1007												
1005	<p>Why did you <b>not</b> seek any treatment for her illness?</p> <p><b>CIRCLE ALL MENTIONED.</b></p> <p><b>WRITE DETAILS OF THE REASON GIVEN IN THE SPACE BELOW:</b></p>	<p>NO TREATMENT NECESSARY ... A  NOT CUSTOMARY ..... B  COST TOO MUCH ..... C  TOO FAR ..... D  NO TRANSPORT ..... E  NO ONE TO ACCOMPANY ..... F  FAMILY DID NOT ALLOW ..... G  GOOD CARE AT HOME ..... H  DID NOT KNOW WHERE TO GO ... I  NO TIME TO GO ..... J  HAVE TO GO TO A MALE DOCTOR K  DID NOT REALIZE SERIOUSNESS . L  OTHER ..... X  (SPECIFY)  DON'T KNOW ..... Z</p>													
1006	<p>Who was involved in making the decision that (NAME) should NOT go for treatment?</p> <p><b>CIRCLE ALL MENTIONED.</b></p>	<p>DECEASED HERSELF ..... A  HUSBAND ..... B  MOTHER IN LAW/FATHER IN LAW . C  MOTHER / FATHER ..... D  SISTER / SISTER IN LAW ..... E  OTHER HUSBAND'S FAMILY ..... F  DECEASED'S FAMILY MEMBERS . G  RELATIVES ..... H  FRIENDS /NEIGHBOURS ..... I  DAI / LHV / FIELDWORKER ..... J  OTHER ..... X  (SPECIFY)  NO ONE ..... Y  DON'T KNOW ..... Z</p>	→ H100												
1007	<p>From whom did she receive treatment?</p> <p>Anyone else?</p> <p><b>CIRCLE ALL MENTIONED.</b></p>	<p><b>HEALTH PERSONNEL</b>  OBSTETRICIAN/SPECIALIS' ..... A  DOCTOR ..... B  NURSE/MIDWIFE/LHV ..... C  COMMUNIRTY MIDWIFE ..... D</p> <p><b>OTHER PERSON</b>  DAI-TBA ..... E  LADY H. WORKER ..... F  HOMEOPATH ..... G  HAKIM ..... H  DISPENSER / COMPOUNDER ..... I</p> <p>OTHER ..... X  (SPECIFY)</p>													



NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP												
1008	Where was the treatment provided?  <b>CIRCLE ALL MENTIONED.</b>	<b>HOME</b> HER HOME ..... A OTHER HOME ..... B <b>PUBLIC SECTOR</b> GOVT. HOSPITAL ..... C RHC/MCH ..... D OTHER PUBLIC ..... E _____ (SPECIFY) <b>PRIVATE MED. SECTOR</b> PVT. HOSPITAL/CLINIC ..... F OTHER PRIVATE MED. .... G _____ (SPECIFY) OTHER ..... X _____ (SPECIFY) NO ONE ..... Y DON'T KNOW ..... Z													
1009	Who was involved in making the decision that (NAME) should go for treatment?  <b>CIRCLE ALL MENTIONED.</b>	DECEASED HERSELF ..... A HUSBAND ..... B MOTHER IN LAW/FATHER IN LAW . C MOTHER / FATHER ..... D SISTER / SISTER IN LAW ..... E OTHER HUSBAND'S FAMILY ..... F DECEASED'S FAMILY MEMBERS . G RELATIVES ..... H FRIENDS /NEIGHBOURS ..... I DAI / LHV / FIELDWORKER ..... J OTHER ..... X _____ (SPECIFY) NO ONE ..... Y DON'T KNOW ..... Z													
1010	How long after the problem was recognized, was it decided that she should go for treatment?  <b>IF &lt; 24 HRS WRITE '00' DAYS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	HOURS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DAYS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> MONTHS ..... 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DON'T KNOW ..... 998													
1011	Once you decided to go for treatment, did you try to go immediately, or did you wait?	YES, TRIED TO GO IMMEDIATELY / ALREADY AT HEALTH FACILITY 1 NO, WAITED ..... 2 DON'T KNOW ..... 8	→ 1013 → 1013												
1012	Why did you not try to go immediately?	HOSPITAL TOO FAR ..... A DID NOT REALIZE SERIOUSNESS B LACK OF FUNDS ..... C HAVE TO GO TO A MALE DOCTOR D NIGHT TIME ..... E NO TRANSPORT ..... F HUSBAND AWAY ..... G NEED PERMISSION FROM ELDERS H OTHER ..... X DON'T KNOW ..... Z													
1013	What was the time lag between first recognition of the seriousness of symptoms and taking (NAME) to hospital?  <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF ONE OR MORE DAY WRITE DAYS</b>	HOURS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DAYS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> ALREADY AT HEALTH FACILITY 997 DON'T KNOW ..... 998													



NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
1022	What treatment was given to (NAME)? Did she receive:  a) An injection in her arm? b) An injection in her buttock? c) A needle in her vein attached to a bag (drip)? d) A blood transfusion? e) An operation? f) Pills or capsules? g) Oxygen?	<div style="text-align: right;">YES NO DK</div> a) INJECTION IN ARM . 1 2 8 b) INJECTION IN BUTT 1 2 8 c) DRIP ..... 1 2 8 d) TRANSFUSION ..... 1 2 8 e) OPERATION ..... 1 2 8 f) PILLS/CAPSULES ... 1 2 8 g) OXYGEN ..... 1 2 8 x) OTHER -1 ..... 1 2 (SPECIFY) y) OTHER -2 ..... 1 2 (SPECIFY)									
1023	Did (NAME)'s condition improve after treatment in this place or did it stay the same or get worse?	IMPROVED ..... 1 STAYED SAME . ..... 2 GOT WORSE ..... 3 DIED ..... 4 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 15px; height: 15px; margin: 0 auto;"></div> → 1025 <div style="border: 1px solid black; width: 15px; height: 15px; margin: 0 auto;"></div> → 1025								
1024	How long after she arrived in the first hospital / clinic did she die?  <b>IF &lt; 1 HOUR WRITE MINUTES</b> <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF ONE OR MORE DAYS WRITE DAYS</b>	IMMEDIATELY ..... 000 MINUTES ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table> HOURS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table> DAYS ..... 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table> DON'T KNOW ..... 998							<div style="border: 1px solid black; width: 15px; height: 15px; margin: 0 auto;"></div> → 1043		
1025	Did the first hospital / clinic / provider refer (NAME) to another hospital / clinic?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<div style="border: 1px solid black; width: 15px; height: 15px; margin: 0 auto;"></div> → 1031								
1026	Where was she referred to?	<b>PUBLIC SECTOR</b> GOVT. HOSPITAL . ..... 21 RHC/MCH ..... 22 OTHER PUBLIC ..... 26 (SPECIFY) <b>PRIVATE MED. SECTOR</b> PVT. HOSPITAL/CLINIC ..... 31 OTHER PRIVATE MED. .... 36 (SPECIFY) OTHER ..... 96 (SPECIFY)									
1027	How long after she arrived in the first hospital / clinic did they refer her to the second hospital / clinic?  <b>IF &lt; 1 HOUR WRITE MINUTES</b> <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF &lt; 1 MONTH WRITE DAYS</b> <b>IF ONE OR MORE MONTH WRITE MONTHS</b>	IMMEDIATELY ..... 000 MINUTES ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table> HOURS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table> DAYS ..... 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table> MONTHS ..... 4 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table> DON'T KNOW ..... 998									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1028	Why did they refer (NAME) to the second place?	NO EQUIPMENT FOR OPERATION A HIGH BLOOD PRESSURE ..... B TO GET BETTER CARE ..... C NO DOCTOR WAS AVAILABLE ... D NO ARRANGEMENTS FOR GIVING BLOOD ..... E NO PROPER ARRANGEMENTS FOR RESOLVING PROBLEM ..... F BABY WENT HIGHER ..... G PART OF BABY CAME OUT ..... H BABY PASSED STOOL INSIDE UTERUS ..... I CERVIX DID NOT OPEN ..... J OTHER ..... X (SPECIFY) DON'T KNOW ..... Z	
1029	Did she go to the place they referred her to?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 1032 → 1031
1030	Why did she not go there for treatment?  <b>CIRCLE ALL MENTIONED.</b>  <b>BE SURE TO GET A GOOD REASON. WRITE NOTES IF NECESSARY.</b>	NO TREATMENT NECESSARY ... A NOT CUSTOMARY ..... B COST TOO MUCH ..... C TOO FAR ..... D NO TRANSPORT ..... E NO ONE TO ACCOMPANY ..... F FAMILY DID NOT ALLOW ..... G GOOD CARE AT HOME ..... H DID NOT KNOW WHERE TO GO I NO TIME TO GO ..... J HAVE TO GO TO A MALE DOCTOR K DID NOT REALIZE SERIOUSNESS L OTHER ..... X (SPECIFY) DON'T KNOW ..... Z	
1031	Did she go anywhere else for treatment?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 1043
1032	Where did she go the <u>last</u> time she got treatment for her last illness?	<b>PUBLIC SECTOR</b> GOVT. HOSPITAL ..... 21 RHC/MCH ..... 22 OTHER PUBLIC ..... 26 (SPECIFY) <b>PRIVATE MED. SECTOR</b> PVT. HOSPITAL/CLINIC ..... 31 OTHER PRIVATE MED. .... 36 (SPECIFY) OTHER ..... 96 (SPECIFY) DON'T KNOW ..... 98	
1033	Who went with her when she went to the last place for treatment?	HUSBAND ..... B MOTHER IN LAW/FATHER IN LAW C MOTHER / FATHER ..... D SISTER / SISTER IN LAW ..... E OTHER HUSBAND'S FAMILY ..... F DECEASED'S FAMILY MEMBERS G RELATIVES ..... H FRIENDS / NEIGHBOURS ..... I DAI / LHV / FIELDWORKER ..... J OTHER ..... X (SPECIFY) NO ONE ..... Y DON'T KNOW ..... Z	



NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP						
1041	Where was she referred to?	<b>PUBLIC SECTOR</b> GOVT. HOSPITAL ..... 21 RHC/MCH ..... 22 OTHER PUBLIC ..... 26 _____ (SPECIFY) <b>PRIVATE MED. SECTOR</b> PVT. HOSPITAL/CLINIC ..... 31 OTHER PRIVATE MED. .... 36 _____ (SPECIFY) OTHER ..... 96 DON'T KNOW ..... 98							
1042	Why did they refer (NAME) to this place?	NO EQUIPMENT FOR OPERATION ..... A HIGH BLOOD PRESSURE ..... B TO GET BETTER CARE ..... C NO DOCTOR WAS AVAILABLE ... D NO ARRANGEMENTS FOR GIVING BLOOD ..... E NO PROPER ARRANGEMENTS FOR RESOLVING PROBLEM .... F BABY WENT HIGHER ..... G PART OF BABY CAME OUT ..... H BABY PASSED STOOL INSIDE UTERUS ..... I CERVIX DID NOT OPEN ..... J OTHER ..... X _____ (SPECIFY) DON'T KNOW ..... Z							
1043	How much did it cost in total for the treatment for her last illness?  <b>IF &gt; 990000 WRITE 990000</b>	RUPEES <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> NO AMOUNT SPENT ..... 999997 DON'T KNOW ..... 999998							→ 1045
1044	Where did you get the funds to pay for her care?  <b>CIRCLE ALL MENTIONED</b>	FAMILY FUNDS ..... A BORROWED ..... B SOLD ASSETS ..... C GIVEN BY RELATIVES/FRIENDS ... D MORTGAGED PROPERTY ..... E OTHER ..... X _____ (SPECIFY) DON'T KNOW ..... Z							
1045	Did she die in the hospital?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 1047						
1046	Where did she die?	ON HER WAY TO NEXT HOSPITAL ..... 1 ON HER WAY BACK TO HOME ..... 2 AT HOME ..... 3 OTHERS ..... 6 DON'T KNOW ..... 8	<table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 40px;"></td> </tr> </table> → H100						
1047	How long after she died did they remove the body from the hospital / clinic?  <b>IF &lt; 1 HOUR WRITE "00"</b> <b>IF &lt; 1 DAY WRITE HOURS</b> <b>IF ONE OR MORE DAY WRITE DAYS</b>	HOURS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> DAYS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> DON'T KNOW ..... 998							

## SECTION 11: HOUSEHOLD CHARACTERISTICS

[illegible]

## SECTION 11: HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP		
H106	In the past two weeks, was the water from this source not available for at least one full day?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8			
H107	Do you do anything to the water to make it safer to drink?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ H109		
H108	What do you usually do to make the water safer to drink?Anything else?  RECORD ALL MENTIONED.	BOIL ..... A ADD BLEACH/CHLORINE ..... B STRAIN THROUGH A CLOTH ..... C USE WATER FILTER (CERAMIC/ SAND/COMPOSITE/ETC) ..... D SOLAR DISINFECTION ..... E LET IT STAND AND SETTLE ..... F  OTHER ..... X (SPECIFY) DON'T KNOW ..... Z			
H109	What kind of toilet facility do members of your household usually use?  IF NOT POSSIBLE TO DETERMINE, ASK PERMISSION TO OBSERVE THE FACILITY.	<b>FLUSH OR POUR FLUSH TOILET</b> FLUSH TO PIPED SEWER SYSTEM ..... 11 FLUSH TO SEPTIC TANK ..... 12 FLUSH TO PIT LATRINE ..... 13 FLUSH TO SOMEWHERE ELSE ..... 14 FLUSH, DON'T KNOW WHERE ..... 15 <b>PIT LATRINE</b> VENTILATED IMPROVED PIT LATRINE ..... 21 PIT LATRINE WITH SLAB ..... 22 PIT LATRINE WITHOUT SLAB/OPEN PIT ..... 23  COMPOSTING TOILET ..... 31 BUCKET TOILET ..... 41 HANGING TOILET/HANGING LATRINE ..... 51 NO FACILITY/BUSH/FIELD ..... 61  OTHER ..... 96 (SPECIFY)	→ H113		
H110	Do you share this toilet facility with other households?	YES ..... 1 NO ..... 2	→ H112		
H111	Including your own household, how many households use this toilet facility?	NO. OF HOUSEHOLDS IF LESS THAN 10 ..... <table><tr><td>0</td><td></td></tr></table> 10 OR MORE HOUSEHOLDS ..... 95 DON'T KNOW ..... 98	0		
0					
H112	Where is this toilet facility located?	IN OWN DWELLING ..... 1 IN OWN YARD/PLOT ..... 2 ELSEWHERE ..... 3			



## SECTION 11: HOUSEHOLD CHARACTERISTICS

[illegible]

**SECTION 11: HOUSEHOLD CHARACTERISTICS**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
H121	Does your household have:	YES	NO	
	a) Electricity?	a) ELECTRICITY ..... 1	2	
	b) A radio?	b) RADIO ..... 1	2	
	c) A television?	c) TELEVISION ..... 1	2	
	d) A non-mobile telephone?	d) NON-MOBILE TELEPHONE .. 1	2	
	e) A refrigerator?	e) REFRIGERATOR ..... 1	2	
	f) Almirah/cabinet?	f) ALMIRAH/CABINET ..... 1	2	
	g) Chair?	g) CHAIR ..... 1	2	
	h) Room cooler?	h) ROOM COOLER ..... 1	2	
	i) Air conditioner?	i) AIR CONDITIONER ..... 1	2	
	j) Washing machine?	j) WASHING MACHINE ..... 1	2	
	k) Water pump?	k) WATER PUMP ..... 1	2	
	l) Bed?	l) BED ..... 1	2	
	m) Clock?	m) CLOCK ..... 1	2	
	n) Sofa?	n) SOFA ..... 1	2	
	o) Camera?	o) CAMERA ..... 1	2	
	p) Sewing machine?	p) SEWING MACHINE ..... 1	2	
	q) Computer?	q) COMPUTER ..... 1	2	
	r) Internet connection?	r) INTERNET CONNECTION ..... 1	2	
H122	Does any member of this household own:	YES	NO	
	a) A watch?	a) WATCH ..... 1	2	
	b) A mobile phone?	b) MOBILE PHONE ..... 1	2	
	c) A bicycle?	c) BICYCLE ..... 1	2	
	d) A motorcycle or motor scooter?	d) MOTORCYCLE/SCOOTER ..... 1	2	
	e) An animal-drawn cart?	e) ANIMAL-DRAWN CART ..... 1	2	
	f) A car or truck or bus?	f) CAR/TRUCK/BUS ..... 1	2	
	g) A tractor?	g) TRACTOR ..... 1	2	
	h) A boat with a motor?	h) BOAT WITH MOTOR ..... 1	2	
	i) A boat without a motor?	i) BOAT WITHOUT MOTOR ..... 1	2	
	j) A Rickshaw/chingchi ?	j) RICKSHAW/CHINGCHI ..... 1	2	

**SECTIONS 11: ADDITIONAL HOUSEHOLD CHARACTERISTICS**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
H142	<p>OBSERVE MAIN MATERIAL OF THE FLOOR OF THE DWELLING.</p> <p>RECORD OBSERVATION.</p>	<p><b>NATURAL FLOOR</b></p> <p>EARTH/SAND ..... 11</p> <p>DUNG ..... 12</p> <p><b>RUDIMENTARY FLOOR</b></p> <p>WOOD PLANKS ..... 21</p> <p>PALM/BAMBOO ..... 22</p> <p><b>FINISHED FLOOR</b></p> <p>PARQUET OR POLISHED WOOD ..... 31</p> <p>VINYL OR ASPHALT STRIPS ..... 32</p> <p>CERAMIC TILES ..... 33</p> <p>CEMENT ..... 34</p> <p>CARPET ..... 35</p> <p>CHIPS/TERRAZZO ..... 36</p> <p>BRICKS ..... 37</p> <p>MATS ..... 38</p> <p>MARBLE ..... 39</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>									
H143	<p>OBSERVE MAIN MATERIAL OF THE ROOF OF THE DWELLING.</p> <p>RECORD OBSERVATION.</p>	<p><b>NATURAL ROOFING</b></p> <p>NO ROOF ..... 11</p> <p>THATCH/PALM LEAF ..... 12</p> <p>SOD/GRASS ..... 13</p> <p><b>RUDIMENTARY ROOFING</b></p> <p>RUSTIC MAT ..... 21</p> <p>PALM/BAMBOO ..... 22</p> <p>WOOD PLANKS ..... 23</p> <p>CARDBOARD ..... 24</p> <p><b>FINISHED ROOFING</b></p> <p>ASBESTOS ..... 31</p> <p>REINFORCED BRICK CEMENT/RCC ..... 32</p> <p>METAL ..... 33</p> <p>WOOD ..... 34</p> <p>CALAMINE/CEMENT FIBER ..... 35</p> <p>CERAMIC TILES ..... 36</p> <p>CEMENT/RCC ..... 37</p> <p>ROOFING SHINGLES ..... 38</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>									
H144	<p>OBSERVE MAIN MATERIAL OF THE EXTERIOR WALLS OF THE DWELLING.</p> <p>RECORD OBSERVATION.</p>	<p><b>NATURAL WALLS</b></p> <p>NO WALLS ..... 11</p> <p>CANE/PALM/TRUNKS ..... 12</p> <p>DIRT ..... 13</p> <p>MUD/STONES ..... 14</p> <p>BAMBOO/STICKS/MUD ..... 15</p> <p><b>RUDIMENTARY WALLS</b></p> <p>UNBAKED BRICKS/MUD ..... 21</p> <p>BAMBOO WITH MUD ..... 22</p> <p>STONE WITH MUD ..... 23</p> <p>UNCOVERED ADOBE ..... 24</p> <p>PLYWOOD ..... 25</p> <p>REUSED WOOD ..... 26</p> <p><b>FINISHED WALLS</b></p> <p>CEMENT ..... 31</p> <p>STONE WITH LIME/CEMENT ..... 32</p> <p>BRICKS ..... 33</p> <p>CEMENT BLOCKS ..... 34</p> <p>COVERED ADOBE ..... 35</p> <p>WOOD PLANKS/SHINGLES ..... 36</p> <p>OTHER ..... 96</p> <p align="center">(SPECIFY)</p>									
H146	<p>RECORD THE TIME.</p>	<p>HOURS ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table></p> <p>MINUTES ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr><tr><td style="width: 30px; height: 30px;"></td><td style="width: 30px; height: 30px;"></td></tr></table></p>									

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

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COMMENTS ON SPECIFIC QUESTIONS:

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ANY OTHER COMMENTS:

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SUPERVISOR'S OBSERVATIONS

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NAME OF SUPERVISOR: \_\_\_\_\_ DATE: \_\_\_\_\_

EDITOR'S OBSERVATIONS

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NAME OF EDITOR: \_\_\_\_\_ DATE: \_\_\_\_\_

**PAKISTAN MATERNAL MORTALITY SURVEY 2019**  
**COMMUNITY QUESTIONNAIRE**  
**(FOR RURAL SAMPLE CLUSTERS ONLY)**  
 PAKISTAN  
 NATIONAL INSTITUTE OF POPULATION STUDIES

IDENTIFICATION			
PROVINCE/REGION (PUNJAB=1; SINDH=2; KP=3; BALOCHISTAN=4; GB=5; AJK=6) .....			<input style="width: 20px; height: 20px;" type="text"/>
DISTRICT .....			<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
TEHSIL .....			
CLUSTER NUMBER .....			<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
INTERVIEW RESULT			
<p><b>*RESULT CODES:</b></p> <p>1 COMPLETED</p> <p>2 UNABLE TO FIND SUITABLE RESPONDENTS</p> <p>9 OTHER _____</p> <p style="text-align: center;">(SPECIFY)</p>			<div style="display: flex; flex-direction: column; align-items: center;"> <div>DAY</div> <div>MONTH</div> <div>YEAR</div> <div>INT. NO</div> </div> <div style="display: flex; flex-direction: column; align-items: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div>
NAME OF PERSONS INTERVIEWED  1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____	SEX (M=1; F=2) <div style="display: flex; flex-direction: column;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div>	POSITION (WRITE POSITION, E.G., VILLAGE LEADER, NAZIM/ MAYOR/ UC LEADER, COUNCILLOR, RELIGIOUS LEADER, CHOWKIDAR, LOCAL FEMALE OR MALE TEACHER, LHV OR LHW)  _____ _____ _____ _____ _____ _____ _____	
<div style="display: flex; justify-content: space-between;"> <div>                         LANGUAGE OF QUESTIONNAIRE** <span style="border: 1px solid black; padding: 2px 10px;"><b>0</b> <b>1</b></span> </div> <div>                         LANGUAGE OF INTERVIEW** <span style="border: 1px solid black; padding: 2px 10px;"><b>ENGLISH</b></span> </div> <div>                         NATIVE LANGUAGE OF RESPONDENT** <span style="border: 1px solid black; padding: 2px 10px;"></span> </div> <div>                         TRANSLATOR USED (YES=1, NO=2) <span style="border: 1px solid black; padding: 2px 10px;"></span> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>                         LANGUAGE OF QUESTIONNAIRE**                     </div> <div>                         **LANGUAGE CODES:                          01 ENGLISH                          02 URDU                     </div> <div>                         03 SINDHI                          04 PUNJABI                     </div> <div>                         05 SARAIKI                          06 BALUCHI                          07 PUSHTO                          08 OTHER                     </div> </div>			
SUPERVISOR  _____ NAME		FIELD EDITOR  _____ NAME	
<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> NUMBER		<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> NUMBER	
KEYED BY  <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> NUMBER			

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## INTRODUCTION AND CONSENT

AFTER ASSEMBLING THE INFORMANTS, READ THE FOLLOWING GREETING:

Asalum-o-Alaikum. My name is \_\_\_\_\_. I am working with National Institute of Population Studies. We are conducting a survey about health of women and other topics all over Pakistan. The information we collect will help the government to plan health services.

We are collecting information with communities to get a picture of infrastructure available in the community, services available to the communities and to understand the access to the people. I would like to ask you some questions about your community and about sources of health care in it and around it as a way of better understanding how to serve the population. Please be assured that this discussion is strictly confidential. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time. In case you need more information about the survey, you may contact the person listed on this card.

GIVE CARD WITH CONTACT INFORMATION

Do you have any questions?  
May I begin the interview now?

SIGNATURE OF INTERVIEWER \_\_\_\_\_ DATE \_\_\_\_\_

RESPONDENTS AGREE  
TO BE INTERVIEWED . .

1

↓  
101

RESPONDENTS DO NOT AGREE  
TO BE INTERVIEWED . . 2 → END

HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	How far is the district headquarter from this village?  <b>ASK FROM THE CENTER OF THE LARGEST SETTLEMENT OF THE VILLAGE</b>	<div> <div> KILOMETERS ..... <div> <div></div> <div></div> </div> </div> <div> 95 KMS. OR MORE ..... 95 </div> </div>	
102	Is the road that goes to the district headquarter mainly a katcha road or a pakka road?	<div> MAINLY KATCHA ..... 1 </div> <div> MAINLY PAKKA ..... 2 </div>	
103	How far is it from this village to the road that goes to the district headquarter?  <b>ASK FROM THE CENTER OF THE LARGEST SETTLEMENT OF THE VILLAGE</b>	<div> LESS THAN 1 KM. .... 00 </div> <div> KILOMETERS ..... <div> <div></div> <div></div> </div> </div> <div> 95 KMS. OR MORE ..... 95 </div>	
104	How do most people get from here to the road that goes to the district headquarter?	<div> WALK ..... 01 </div> <div> RICKSHAW ..... 02 </div> <div> BICYCLE ..... 03 </div> <div> MOTORBIKE ..... 04 </div> <div> PRIVATE CAR / TAXI / SUZUKI VAN ..... 05 </div> <div> TRACTOR TROLLY ..... 06 </div> <div> TONGA/CATTLE CART ..... 07 </div> <div> BUS / TRUCK ..... 07 </div> <div> OTHER ..... 96 </div> <div> (SPECIFY) </div>	
105	How far is the nearest city/town from this village?	<div> LESS THAN 1 KM. .... 00 </div> <div> KILOMETERS ..... <div> <div></div> <div></div> </div> </div> <div> 95 KMS. OR MORE ..... 95 </div>	
106	Are most of the streets/galies of this village paved, cemented, bricks solling or kutcha?	<div> PAVED ..... 1 </div> <div> CEMENTED ..... 2 </div> <div> BRICKS SOLLING ..... 3 </div> <div> KUTCHA ..... 4 </div> <div> OTHERS ..... 6 </div> <div> (SPECIFY) </div>	
107	What means of transport are available in this village?	<div> BUS ..... A </div> <div> WAGON ..... B </div> <div> PRIVATE CAR ..... C </div> <div> PICK-UP SUZUKI ..... D </div> <div> RIKSHAW ..... E </div> <div> MOTORBIKE ..... F </div> <div> TONGA ..... G </div> <div> OTHERS ..... X </div> <div> (SPECIFY) </div>	
108	Is transport available during the night time?	<div> YES ..... 1 </div> <div> NO ..... 2 </div> <div> DOES NOT KNOW/NOT SURE ..... 8 </div>	



## HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP			
109	If a woman in this village has a serious problem with her pregnancy, where would she go for treatment?  _____ (NAME OF PLACE)	DHQ HOSPITAL ..... 01 THQ HOSPITAL ..... 02 MCH CENTRE ..... 03 RHC ..... 04 BHU ..... 05 PRIVATE CLINIC / HOSPITAL ..... 06 DAI / BIRTH ATTENDANT ..... 07 LADY HEALTH WORKER ..... 08				
110	How would she reach (NAME OF PLACE IN 109)?	WALK ..... 01 RICKSHAW ..... 02 BICYCLE ..... 03 MOTORBIKE ..... 04 PRIVATE CAR / TAXI / SUZUKI VAN ..... TRACTOR TROLLY ..... 05 TONGA/CATTLE CART ..... 06 BUS / TRUCK ..... 07  OTHER _____ 96 (SPECIFY)				
111	How long would it take to reach the facility using this means?	MINUTES ..... <table border="1"><tr><td></td><td></td><td></td></tr></table> DOES NOT KNOW ..... 998				
112	Is there a Lady Health Worker in this village?	YES ..... 1 NO ..... 2 DOES NOT KNOW/NOT SURE ..... 8	<table border="1"><tr><td></td><td></td><td>→ 115</td></tr></table>			→ 115
		→ 115				
113	What services does she provide?  <b>CIRCLE ALL MENTIONED.</b>	ANTENATAL CARE ..... A DELIVERY ..... B CHILD IMMUNIZATIONS ..... C CHILD CARE SERVICES ..... D POSTNATAL CARE ..... E FAMILY PLANNING ..... F GENERAL AILMENTS ..... G  OTHER _____ X (SPECIFY)				
114	Does the LHW make house visits on a regular basis?	YES ..... 1 NO ..... 2 DO NOT KNOW/NOT SURE ..... 8				
115	Where births are registered?	UNION COUNCIL ..... A TOWN COMMITTEE ..... B MUNICIPAL CORPORATION ..... C  OTHER _____ X (SPECIFY)				
116	How many women from this village get financial support through BISP?  <b>IF NO WOMAN IS GETTING BISP FINANCIAL SUPPPORT 'RECORDERE 00'</b>	NO. OF WOMEN ..... <table border="1"><tr><td></td><td></td></tr></table>				
117	What type of economic activities are available for women in this village?	AGRICULTURE ..... A LIVESTOCK ..... B STITCHING/EMBROIDERY ..... C HANDICRAFT MAKING ..... D  OTHER _____ X (SPECIFY)				

HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
118	<p>In this village, do the following social organizations</p> <p>a) Panchayat?</p> <p>b) Cooperative society?</p> <p>c) Social welfare society?</p> <p>d) School committee?</p> <p>e) None of them?</p>	<p>PANCHAYAT ..... A</p> <p>COOPERATIVE SOCIETY ..... B</p> <p>SOCIAL WELFARE SOCIETY ..... C</p> <p>SCHOOL COMMITTEE ..... D</p> <p>NONE OF THEM ..... Y</p>	→ 120
119	Do the women of this village usually participate in these organizations?	<p>YES ..... 1</p> <p>NO ..... 2</p>	
120	Is there any campaign for the use of mosquito nets and their distribution in this village?	<p>YES ..... 1</p> <p>NO ..... 2</p>	
121	Are medicines easily available in this village?	<p>EASILY AVAILABLE ..... 1</p> <p>SOMETIME AVAILABLE ..... 2</p> <p>NEVER AVAILABLE ..... 3</p>	
122	Is there any natural disaster occurred in this village during last 5 years?	<p>NOT OCCURRED ..... A</p> <p>FLOOD ..... B</p> <p>HEAVY RAINS ..... C</p> <p>DROUGHT ..... D</p> <p>EARTH QUAKE ..... E</p> <p>OTHER _____ X</p> <p align="center">(SPECIFY)</p>	

AVAILABILITY OF FACILITIES AND SERVICES

<b>201</b>	Now I would like to ask you about facilities and other services that may be available in this village or at some distance.		
<b>NO.</b>	<b>TYPE OF FACILITY/SERVICE</b>	<b>LOCATION</b>	<b>DISTANCE</b>
	<b>202</b>	<b>203</b>	<b>204</b>
	Please specify the types of facilities:	Is the (FACILITY/SERVICE) in this village?	How far away is (FACILITY/SERVICE) from this village? <b>IF &gt;95 KMS, WRITE 95.</b>
a.	Medical store?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
b.	General store or shop?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
c.	Motorized public transport?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
d.	Non-motorized public transport?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
e.	Post office?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
f.	Courier services ?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
g.	Bank?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
h.	Primary school for <b>boys</b> ?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
i.	Primary school for <b>girls</b> ?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
j.	Secondary school for <b>boys</b> ?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
k.	Secondary school for <b>girls</b> ?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
l.	Degree college for boys or girls?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
m.	Any ambulance service?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
n.	Ultrasound services for pregnant women?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
o.	NADRA Office ?	YES ..... 1      NO ..... 2      →	KMS ..... <input type="text"/> <input type="text"/>
p.	A waste water drainage scheme?	YES ..... 1      NO ..... 2	
q.	A sewerage system?	YES ..... 1      NO ..... 2	
r.	A drinking water scheme?	YES ..... 1      NO ..... 2	
s.	Television signal/service?	YES ..... 1      NO ..... 2	
t.	Cable television connections ?	YES ..... 1      NO ..... 2	
u.	Any land-line telephone service?	YES ..... 1      NO ..... 2	
v.	Mobile telephone coverage?	YES ..... 1      NO ..... 2	
w.	Electricity?	YES ..... 1      NO ..... 2	
x.	Gas connection?	YES ..... 1      NO ..... 2	
y.	Any public call office (PCO)?	YES ..... 1      NO ..... 2	

AVAILABILITY OF HEALTH FACILITIES

<b>301</b>	Please tell me how far away each of the following facilities are from here?	
	<b>ASK FROM THE CENTER OF THE (LARGEST) SETTLEMENT</b>	<b>IF LESS THAN 1 KM PUT 00 IF 95 KMS. OR MORE PUT 95</b>
a.	Dai?	KMS ..... <input type="text"/> <input type="text"/>
b.	A <b>functioning</b> * basic health unit (BHU)?	KMS ..... <input type="text"/> <input type="text"/>
c.	A rural health centre (RHC)?	KMS ..... <input type="text"/> <input type="text"/>
d.	A functioning government dispensary.	KMS ..... <input type="text"/> <input type="text"/>
e.	A <b>functioning</b> * MCH Centre.	KMS ..... <input type="text"/> <input type="text"/>
f.	A female doctor.	KMS ..... <input type="text"/> <input type="text"/>
g.	A private doctor.	KMS ..... <input type="text"/> <input type="text"/>
h.	A dispenser or a compounder.	KMS ..... <input type="text"/> <input type="text"/>
i.	A family welfare centre (FWC) or somewhere else to get family planning services.	KMS ..... <input type="text"/> <input type="text"/>
j.	A hakeem.	KMS ..... <input type="text"/> <input type="text"/>
k.	A homeopath	KMS ..... <input type="text"/> <input type="text"/>
l.	A hospital.	KMS ..... <input type="text"/> <input type="text"/>

\* **Functioning** facility: Presence of LHV or Midwife to provide required services on regular basis.

(A) INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT INTERVIEW:

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COMMENTS ON SPECIFIC QUESTIONS:

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ANY OTHER COMMENTS:

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(B) SUPERVISOR'S OBSERVATIONS

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(C) EDITOR'S OBSERVATIONS

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PAKISTAN MATERNAL MORTALITY SURVEY 2019  
FIELDWORKER QUESTIONNAIREPAKISTAN  
NATIONAL INSTITUTE OF POPULATION STUDIESLANGUAGE OF  
QUESTIONNAIRE **ENGLISH**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
100	What is your name?	NAME _____	
101	RECORD FIELDWORKER NUMBER	NUMBER ..... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<b>INSTRUCTIONS</b> Information on all Pakistan DHS field workers is collected as part of the Pakistan DHS survey. Please fill out the questions below. The information you provide will be part of the survey data file; however, your name will be removed and will not be part of the data file. Thank you for providing the information needed.			
102	In what province do you live?	PUNJAB ..... 01 SINDH ..... 02 KPK ..... 03 BALOCHISTAN ..... 04 GB ..... 05 ICT ..... 06 AJK ..... 07 FATA ..... 08	
103	Do you live in urban or rural area?	URBAN ..... 1 RURAL ..... 2	
104	How old are you? RECORD AGE IN COMPLETED YEARS.	AGE ..... <input type="text"/> <input type="text"/>	
105	Are you male or female?	MALE ..... 1 FEMALE ..... 2	
106	What is your current marital status?	CURRENTLY MARRIED ..... 1 WIDOWED ..... 3 DIVORCED ..... 4 SEPARATED ..... 5 NEVER MARRIED ..... 6	
107	How many living children do you have? INCLUDE ONLY CHILDREN WHO ARE YOUR BIOLOGICAL CHILDREN.	LIVING CHILDREN ..... <input type="text"/> <input type="text"/>	
108	Have you ever had a child who died?	YES ..... 1 NO ..... 2	
110	What is the highest class you have completed?  IF MA, MPHIL, PHD, MBBS, OR BSC/4 YEARS, WRITE '16'.	CLASS ..... <input type="text"/> <input type="text"/>	
111	What is your religion?	MUSLIM ..... 01 HINDU ..... 02 CHRISTIAN ..... 03 PARSİ ..... 04 NO RELIGION ..... 95 OTHER ..... 96 (SPECIFY)	
112	What is your ethnicity?	PUNJABI ..... 01 PATHAN ..... 02 SINDHI ..... 03 MUHAJIR ..... 04 BALOCHI ..... 05 SARAİKI ..... 06 OTHER	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
		(SPECIFY) 96	
113	What languages can you speak?  RECORD ALL LANGUAGES YOU CAN SPEAK.	ENGLISH ..... A URDU ..... B SINDHI ..... C PUNJABI ..... D SARAIKI ..... E BALUCHI ..... F PASHTO ..... H  OTHER ..... X (SPECIFY)	
114	What is your mother tongue/native language (language spoken at home growing up)?	ENGLISH ..... 01 URDU ..... 02 SINDHI ..... 03 PUNJABI ..... 04 SARAIKI ..... 05 BALUCHI ..... 06 PASHTO ..... 07  OTHER ..... 96 (SPECIFY)	
115	Have you ever worked on a DHS survey prior to this one?	YES ..... 1 NO ..... 2	
116	Have you ever worked on any other survey prior to this one (not a DHS)?	YES ..... 1 NO ..... 2	
117	Were you already working for the National Institute of Population Studies (NIPS) at the time you were employed to work on this DHS?	YES ..... 1 NO ..... 2	→ 119
118	Are you a permanent or temporary employee of the National Institute of Population Studies (NIPS)?	PERMANENT ..... 1 TEMPORARY ..... 2	
119	If you have comments, please write them here.		