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) . . . . . [ ]

DISTRICT _____ [ ][ ][ ]

TEHSIL _____

NAME OF HOUSEHOLD HEAD _____

CLUSTER NUMBER . . . . . [ ][ ][ ][ ]

HOUSEHOLD NUMBER . . . . . [ ][ ][ ][ ]

NAME AND LINE NUMBER OF WOMAN _____ [ ][ ]

INTERVIEWER VISITS

	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY [ ][ ]
				MONTH [ ][ ]
				YEAR [ ][ ][ ][ ]
INTERVIEWER'S NAME	_____	_____	_____	INT. NO. [ ][ ][ ][ ]
RESULT*	_____	_____	_____	RESULT* [ ][ ]
NEXT VISIT: DATE	_____	_____		TOTAL NUMBER OF VISITS [ ][ ]
TIME	_____	_____		

*RESULT CODES: 1 COMPLETED; 2 NOT AT HOME; 3 POSTPONED; 4 REFUSED; 5 PARTLY COMPLETED; 6 INCAPACITATED; 7 OTHER _____ SPECIFY

LANGUAGE OF QUESTIONNAIRE** [0][1] LANGUAGE OF INTERVIEW** [ ][ ] NATIVE LANGUAGE OF RESPONDENT** [ ][ ] TRANSLATOR USED (YES = 1, NO = 2) [ ]

LANGUAGE OF QUESTIONNAIRE** **ENGLISH**

**LANGUAGE CODES:
01 ENGLISH
02 URDU
03 SINDHI
04 PUNJABI
05 SARAIKI
06 BALUCHI
07 PUSHTO
08 OTHER

SUPERVISOR	FIELD EDITOR	KEYED BY
NAME _____	NAME _____	
NUMBER [ ][ ][ ][ ]	NUMBER [ ][ ][ ][ ]	NUMBER [ ][ ]

INTRODUCTION AND CONSENT

Asalum-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? **COMPARE AND CORRECT 102 AND 103 IF INCONSISTENT.**	AGE IN COMPLETED YEARS . . . . . ☐☐	
104	Have you ever attended school?	YES . . . . . 1 NO 2	→ 107
105	What is the highest class you completed? **IF COMPLETED LESS THAN CLASS ONE, RECORD '00'. IF MA, MPHIL, PHD, MBBS, OR BSC/4 YEARS, WRITE `16'.**	CLASS . . . . . ☐☐	
106	CHECK 105: CLASS 00-09 ☐ ↓ CLASS 10 OR HIGHER ☐ →		108
107	Now I would like you to read this sentence to me. **SHOW CARD TO RESPONDENT.** **IF RESPONDENT CANNOT READ WHOLE SENTENCE,** **PROBE: Can you read any part of the sentence to me?**	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? **IF NONE, RECORD '00'.**	a) SONS AT HOME . . . . . [ ][ ] b) DAUGHTERS AT HOME . . . . . [ ][ ]	
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? **IF NONE, RECORD '00'.**	a) SONS ELSEWHERE . . . . . [ ][ ] b) DAUGHTERS ELSEWHERE . . . . . [ ][ ]	
206	Have you ever given birth to a boy or girl who was born alive but later died? **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?**	YES . . . . . 1 NO 2	→ 207AA
207	a) How many boys have died? b) And how many girls have died? **IF NONE, RECORD '00'.**	a) BOYS DEAD . . . . . [ ][ ] b) GIRLS DEAD . . . . . [ ][ ]	
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 . . . . . [ ][ ]	
208	**SUM ANSWERS TO 203, 205, 207, AND 207BB, AND ENTER TOTAL. IF NONE, RECORD '00'.**	TOTAL PREGNANCIES . . . . . [ ][ ]	
209	CHECK 208: Just to make sure that I have this right: you have had in TOTAL _____ pregnancies during your life. Is that correct? YES ☐ NO ☐ → PROBE AND CORRECT 201-208 AS NECESSARY		
210	CHECK 208: ONE OR MORE PREGNANCIES ☐ NO PREGNANCIES ☐		→ 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 PREG-NANCY HISTORY NUMBER	212A Think back to your first pregnancy. Was that a single or multiple pregnancy?	212B Was the baby born alive, born dead, or lost before birth?	212C Did that baby cry, move, or breathe when it was born?	212D What name was given to the child? **RECORD NAME**	213 Is (NAME) a boy or a girl?	215 On what day, month, and year was (NAME) born? PROBE: When is his/her birthday?	216 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 ☐☐ MONTH ☐☐ ☐☐☐☐ 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 ☐☐ MONTH ☐☐ ☐☐☐☐ 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 ☐☐ MONTH ☐☐ ☐☐☐☐ 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 ☐☐ MONTH ☐☐ ☐☐☐☐ 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 ☐☐ MONTH ☐☐ ☐☐☐☐ YEAR	YES . . 1 NO . . . 2 (SKIP TO 220)

212 PREG-NANCY HISTORY NUMBER	212A Think back to your first pregnancy. Was that a single or multiple pregnancy?	212B Was the baby born alive, born dead, or lost before birth?	212C Did that baby cry, move, or breathe when it was born?	212D What name was given to the child? **RECORD NAME**	213 Is (NAME) a boy or a girl?	215 On what day, month, and year was (NAME) born? PROBE: When is his/her birthday?	216 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 ☐☐ MONTH ☐☐ ☐☐☐☐ 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 ☐☐ MONTH ☐☐ ☐☐☐☐ 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 ☐☐ MONTH ☐☐ ☐☐☐☐ 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 ☐☐ MONTH ☐☐ ☐☐☐☐ 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 ☐☐ MONTH ☐☐ ☐☐☐☐ YEAR	YES . . 1 NO . . . 2 (SKIP TO 220)

217 IF ALIVE: How old was (NAME) at (NAME)'s last birthday? **RECORD AGE IN COMP-LETED YEARS.**	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? **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** **RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.**	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? **RECORD IN COMP-LETED MONTHS.**	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 [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (NEXT PREGNANCY)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (NEXT PREGNANCY)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	
AGE IN YEARS [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	YES . . . . . . 1 (ADD PREGNANCY) NO . . . . 2 (NEXT PREGNANCY)
AGE IN YEARS [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	YES . . . . . . 1 (ADD PREGNANCY) NO . . . . 2 (NEXT PREGNANCY)
AGE IN YEARS [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	YES . . . . . . 1 (ADD PREGNANCY) NO . . . . 2 (NEXT PREGNANCY)
AGE IN YEARS [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	YES . . . . . . 1 (ADD PREGNANCY) NO . . . . 2 (NEXT PREGNANCY)

217 IF ALIVE: How old was (NAME) at (NAME)'s last birthday? **RECORD AGE IN COMP-LETED YEARS.**	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? **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** **RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.**	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? **RECORD IN COMP-LETED MONTHS.**	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 [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	YES . . . . . . 1 (ADD PREGNANCY) NO . . . . 2 (NEXT PREGNANCY)
AGE IN YEARS [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	YES . . . . . . 1 (ADD PREGNANCY) NO . . . . 2 (NEXT PREGNANCY)
AGE IN YEARS [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	YES . . . . . . 1 (ADD PREGNANCY) NO . . . . 2 (NEXT PREGNANCY)
AGE IN YEARS [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	YES . . . 1 NO 2	YES . . . . . . 1 (ADD PREGNANCY) NO . . . . 2 (NEXT PREGNANCY)
AGE IN YEARS [ ][ ]	YES . . 1 NO . . . 2	HOUSEHOLD LINE NUMBER [ ][ ] (SKIP TO 221)	DAYS 1 [ ][ ] MONTHS 2 [ ][ ] YEARS 3 [ ][ ] (SKIP TO 221)	DAY [ ][ ] MONTH [ ][ ] [ ][ ][ ][ ] YEAR	MONTHS [ ][ ]	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 NUMBERS ARE SAME ☐ NUMBERS ARE DIFFERENT ☐ **(PROBE AND RECONCILE)**		
224	CHECK 215: ENTER THE NUMBER OF BIRTHS IN 2016-2019 IF NONE, RECORD `0'.	NUMBER OF BIRTHS . . . . . ☐☐	
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 . . . . . ☐☐	
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 ONE OR MORE ☐ → a) Did you want to have a baby later on or did you not want any more children? NONE ☐ → b) Did you want to have a baby later on or did you not want any children?	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? **RECORD ALL MENTIONED**	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) _____	

SECTION 3. CONTRACEPTION

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

SECTION 4. PREGNANCY AND POSTNATAL CARE

401	CHECK 220AB, 220AC AND 224: ONE OR MORE LIVE BIRTHS, STILLBIRTHS, MISCARRIAGE, ABORTION IN 2016-2019 ☐ NO LIVE BIRTHS, STILLBIRTH MISCARRIAGE, ABORTION IN 2016-2019 ☐ → 636	
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 . . . . . ☐☐
404	CHECK 212B, 215, 220AB, 220AC AND 220AD PREGNANCY OUTCOME: LIVE BIRTH ☐ STILLBIRTH ☐ MISCARRIAGE ☐ ABORTION ☐ → 406	
405	FROM 212D AND 216:	NAME _____ LIVING ☐ DEAD ☐
406	Did you see anyone for antenatal care for this pregnancy?	YES . . . . . 1 NO . . . . . 2 (SKIP TO 414)
407	Whom did you see? Anyone else? **PROBE TO IDENTIFY EACH TYPE OF PERSON AND RECORD ALL MENTIONED.**	**HEALTH PERSONNEL** OBSTETRICIAN/SPECIALIST . . . . . A DOCTOR . . . . . B NURSE/MIDWIFE/LHV . . . . . C COMMUNITY MIDWIFE D **OTHER PERSON** DAI-TBA . . . . . E LADY H. WORKER . . . . . F HOMEOPATH . . . . . G HAKIM . . . . . H DISPENSER / COMPOUNDER . . . . . I OTHER _____ X (SPECIFY)
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	Where did you receive antenatal care for this pregnancy? Anywhere else? **PROBE TO IDENTIFY THE TYPE OF SOURCE.** **IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.** _____ (NAME OF PLACE)	**HOME** HER HOME . . . . . A OTHER HOME . . . . . B **PUBLIC SECTOR** GOVT. HOSPITAL . . . . . C RHC/MCH . . . . . D BHU/FWC . . . . . E OTHER PUBLIC SECTOR _____ F (SPECIFY) **PRIVATE MEDICAL SECTOR** PRIVATE HOSPITAL/ CLINIC G PVT. DOCTOR . . . . . H HOMEOPATH . . . . . I DISPENSER / COMPOUNDER . . . . . J OTHER PRIVATE MEDICAL SECTOR _____ K (SPECIFY) HAKIM . . . . . L **OTHER** _____ X (SPECIFY)
410	How many months pregnant were you when you first received antenatal care for this pregnancy?	MONTHS . . . . . [ ][ ] DON'T KNOW 98
411	How many times did you receive antenatal care during this pregnancy?	NUMBER OF TIMES . . . . . [ ][ ] DON'T KNOW 98
412	As part of your antenatal care during this pregnancy, were any of the following done at least once: a) Was your blood pressure measured? b) Did you give a urine sample? c) Did you give a blood sample?	YES NO a) BP . . . . . 1 2 b) URINE . . . . . 1 2 c) BLOOD 1 2
413	During (any of) your antenatal care visit(s), were you advised on the following: a) Early initiation of breastfeeding? b) Exclusive breastfeeding? c) Balanced diet during pregnancy?	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?	YES . . . . . 1 NO . . . . . 2 (SKIP TO 417) DON'T KNOW 8

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 . . . . . ☐ DON'T KNOW 8
416	CHECK 415: 2 OR MORE TIMES ☐ → (SKIP TO 419) OTHER ☐ ↓	
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? **IF 7 OR MORE TIMES, RECORD '7'.**	TIMES . . . . . ☐ DON'T KNOW 8
418	CHECK 417A: ONLY ONE ☐ ↓ a) How many years ago did you receive that tetanus injection? MORE THAN ONE ☐ ↓ b) How many years ago did you receive the last tetanus injection prior to this pregnancy?	YEARS AGO . . . . . ☐☐
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 . . . . . ☐☐☐ 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 ☐ ↓	IF ABORTION/ MISCARRIAGE ☐ → 429

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

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? **PROBE FOR THE TYPE(S) OF PERSONS(S) AND (RECORD ALL MENTIONED)**	**HEALTH PERSONNEL** OBSTETRICIAN/ SPECIALIST . . . . . A DOCTOR . . . . . B NURSE/MIDWIFE/LHV . . . . . C **OTHER PERSON** 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? **PROBE TO IDENTIFY THE TYPE OF SOURCE.** **IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.** _____ (NAME OF PLACE)	**HOME** HER HOME . . . . . A OTHER HOME . . . . . B **PUBLIC SECTOR** GOVT. HOSPITAL . . . . . C RHC/MCH . . . . . D BHU/FWC . . . . . E OTHER PUBLIC SECTOR _____ (SPECIFY) F **PRIVATE MEDICAL SECTOR** PRIVATE HOSPITAL/ CLINIC . . . . . G PVT. DOCTOR . . . . . H HOMEOPATH . . . . . I DISPENSER / COMPOUNDER . . . . . J OTHER PRIVATE MEDICAL SECTOR _____ (SPECIFY) K HAKIM . . . . . L **OTHER** _____ (SPECIFY) X NO WHERE . . . . . Y
430A	CHECK 430: CODE **"C"** TO **"X"** CIRCLED →	CODE **"A"** , **"B" OR "Y"** CIRCLED → (SKIP TO 437A)

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? **IF LESS THAN ONE DAY, RECORD HOURS;** **IF LESS THAN ONE WEEK, RECORD DAYS.**	HOURS . . . . . 1 ☐☐ DAYS . . . . . 2 ☐☐ WEEKS . . . . . 3 ☐☐ DON'T KNOW 998
433	Who checked on your health at that time? **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** OBSTETRICIAN/SPECIALIST . . . . . 11 DOCTOR . . . . . 12 NURSE/MIDWIFE/LHV . . . . . 13 COMMUNITY MIDWIFE . . . . . 14 **OTHER PERSON** DAI-TBA . . . . . 15 FWW . . . . . 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? **IF LESS THAN ONE DAY, RECORD HOURS;** **IF LESS THAN ONE WEEK, RECORD DAYS.**	HOURS . . . . . 1 ☐☐ DAYS . . . . . 2 ☐☐ WEEKS . . . . . 3 ☐☐ DON'T KNOW 998
436	Who checked on your health at that time? **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** OBSTETRICIAN/SPECIALIST . . . . . 11 DOCTOR . . . . . 12 NURSE/MIDWIFE/LHV . . . . . 13 COMMUNITY MIDWIFE . . . . . 14 **OTHER PERSON** DAI- TBA . . . . . 15 FWW . . . . . 16 LADY H.WORKER . . . . . 17 HOMEOPATH . . . . . 18 HAKIM . . . . . 19 DISPENSER / COMPOUNDER . . . . . 20 OTHER _____ 96 (SPECIFY)

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____
437	Where did the check take place? **PROBE TO IDENTIFY THE TYPE OF SOURCE.** **IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.** _____ (NAME OF PLACE)	**HOME** HER HOME . . . . . 11 OTHER HOME . . . . . 12 **PUBLIC SECTOR** GOVT. HOSPITAL . . . . . 21 RHC/MCH . . . . . 22 BHU/FWC . . . . . 23 OTHER PUBLIC SECTOR _____ 26 (SPECIFY) **PRIVATE MEDICAL SECTOR** PRIVATE HOSPITAL/ CLINIC . . . . . 31 OTHER PRIVATE MEDICAL SECTOR _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY) → 439
437A	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?	YES . . . . . 1 NO . . . . . 2 (SKIP TO 439)
438	How long after delivery did the first check take place? **IF LESS THAN ONE DAY, RECORD HOURS;** **IF LESS THAN ONE WEEK, RECORD DAYS.**	HOURS . . . . . 1 ☐☐ DAYS . . . . . 2 ☐☐ WEEKS . . . . . 3 ☐☐ DON'T KNOW 998
438A	Who checked on your health at that time? **PROBE FOR MOST QUALIFIED PERSON.**	**HEALTH PERSONNEL** OBSTETRICIAN/SPECIALIST . . . . . 11 DOCTOR . . . . . 12 NURSE/MIDWIFE/LHV . . . . . 13 COMMUNITY MIDWIFE . . . . . 14 **OTHER PERSON** DAI- TBA . . . . . 21 FWW . . . . . 22 LADY H.WORKER . . . . . 23 HOMEOPATH . . . . . 24 HAKIM . . . . . 25 DISPENSER / COMPOUNDER . . . . . 26 OTHER _____ 96 (SPECIFY)

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

SECTION 5. MATERNAL MORBIDITY

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP
501	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? **WAIT FOR THE SPONTANEOUS RESPONSE. IF NOT MENTIONED, THEN PROMPT THOSE THAT ARE NOT MENTIONED.**	**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	
502	During this pregnancy, did you have any other complications? If yes, list below:	a) _____ b) _____ c) _____ d) _____ NONE . . . . . Y	
502A	CHECK: 404 LIVE BIRTH/STILLBIRTH ☐ ↓ ABORTION/MISCARRIAGE ☐ → 505		

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP
502B	How long did the labour pains last?	<12 HOURS . . . . . 1 12-24 HOURS . . . . . 2 >24 HOURS . . . . . 3 NOT LIVE BIRTH OR STILL BIRTH/NO LABOUR PAINS . . . . . 7 DON'T KNOW 8	
503	Now I would like to ask you about any problems/ illnesses that you might have suffered during childbirth (labour and delivery). What Problems did you experience during labour and delivery? **WAIT FOR THE SPONTANEOUS RESPONSE. IF NOT MENTIONED, THEN PROMPT THOSE THAT ARE NOT MENTIONED.**	**YES (Before Prompting)** / **YES (After Prompting)** / **NO** / **DK** a) PROLONGED LABOUR PAINS (LABOUR PAINS CONTINUED >12 HOURS) . . . . . 1 2 3 8 b) EXCESSIVE BLEEDING BEFORE THE BABY CAME OUT . . . . . 1 2 3 8 c) EXCESSIVE BLEEDING AFTER THE BABY CAME OUT BUT BEFORE DELIVERY OF PLACENTA . . . . . 1 2 3 8 d) EXCESSIVE BLEEDING AFTER THE DELIVERY OF THE PLACENTA . . . . . 1 2 3 8 e) RETAINED PLACENTA (PART OF PLACENTA DID NOT COME OUT; PLACENTA WAS TORN) 1 2 3 8 f) THE UMBILICAL CORD WAS WRAPPED AROUND THE BABY'S NECK . . . . . 1 2 3 8 g) *THE BABY DID NOT BREATHE AFTER DELIVERY AND REQUIRED RESUSCITATION 1 2 3 8 h) *THE BABY WAS PREMATURE AT BIRTH . . . . . 1 2 3 8 i) THERE WAS A LACERATION (TEAR) IN THE VAGINA AT THE TIME OF DELIVERY . . 1 2 3 8 j) THE BABY'S PRESENTATION WAS BREECH . . . . . 1 2 3 8 k) THE BABY'S PRESENTATION WAS HAND FIRST 1 2 3 8	
504	During this delivery, did you have any other complications? If yes, list below:	a) _____ b) _____ c) _____ d) _____ NONE . . . . . Y	

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP
505	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? **WAIT FOR THE SPONTANEOUS RESPONSE. IF NOT MENTIONED, THEN PROMPT THOSE THAT ARE NOT MENTIONED.**	**YES (Before Prompting)** / **YES (After Prompting)** / **NO** / **DK** 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	During the postpartum period, did you have any other complications? If yes, list below:	a) _____ b) _____ c) _____ d) _____ NONE . . . . . Y	
507	CHECK: 407,423,429, 433 AND 436 HEALTH PERSONNEL/ OTHER PERSON CIRCLED ☐ NO ONE/ NOT ASKED ☐ →		509
508	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? a) PNEUMONIA b) JAUNDICE AND/OR HEPATITIS c) EMBOLISM d) POSTPARTUM INFECTION/SEPSIS e) HIGH BLOOD PRESSURE f) DIABETES g) ANY OTHER INFECTIOUS DISEASE DURING PREGNANCY h) SLOW GROWTH OF BABY INSIDE THE WOMB i) PROBLEMS ASSOCIATED WITH PLACENTA j) PROBLEMS ASSOCIATED WITH THE POSITION OF THE BABY k) UTERINE PROLAPSE l) PREECLAMPSIA (DEFINITION) x) OTHERS (Specify)	**YES** / **NO** / **DK** a) PNEUMONIA . . . . . 1 / 2 / 8 b) JAUNDICE AND/OR HEPATITIS . . . . . 1 / 2 / 8 c) EMBOLISM . . . . . 1 / 2 / 8 d) POSTPARTUM INFECTION/SEPSIS . . . . . 1 / 2 / 8 e) HIGH BLOOD PRESSURE . . . . . 1 / 2 / 8 f) DIABETES . . . . . 1 / 2 / 8 g) ANY OTHER INFECTIOUS DISEASE DURING PREGNANCY . . . . . 1 / 2 / 8 h) SLOW GROWTH OF BABY INSIDE THE WOMB . . . . . 1 / 2 / 8 i) PROBLEMS ASSOCIATED WITH PLACENTA . . 1 / 2 / 8 j) PROBLEMS ASSOCIATED WITH THE POSITION OF THE BABY . . . . . 1 / 2 / 8 k) UTERINE PROLAPSE . . . . . 1 / 2 / 8 l) PREECLAMPSIA (DEFINITION) . . . . . 1 / 2 / 8 x) OTHERS _____ (SPECIFY) 1 / 2 / 8	

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP
509	**During last pregnancy,** childbirth or postpartum period, were you treated for any of the following conditions? 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)	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 _____ 1 2 8 (SPECIFY)	
510	Were you hospitalized for more than 24 hours stay during the last pregnancy/ childbirth/ abortion/ miscarriage or postpartum period?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 511
510A	How many times were you hospitalised for more that 24 hours during the last pregnancy/ childbirth/ abortion/ miscarriage or postpartum period? **IF MORE THAN 7 RECORD '7'**	**NO. OF TIMES** a) DURING PREGNANCY . . . . . [ ] b) DURING CHILDBIRTHS/ABORTION/MISCARRIAGE . . . . [ ] c) DURING POSTPARTUM PERIOD (WITHIN 40 DAYS AFTER DELIVERY, ABORTION OR MISCARRIAGE) . . [ ] d) AFTER POSTPARTUM PERIOD (>40 DAYS AFTER THE TERMINATION OF PREGNANCY) . . . . . [ ]	
511	**Before your last pregnancy,** were your suffering from any of the following conditions? 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)	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 _____ 1 2 8 (SPECIFY)	
512	**Before** your last pregnancy, did you ever get a surgical operation done (other than Caesarean section operation)?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
513	**Before** the last pregnancy did you smoke cigarettes/ biri every day, some days, or not at all?	EVERY DAY . . . . . 1 SOME DAYS . . . . . 2 → 515 NOT AT ALL . . . . . 3 → 516	
514	On average, how many cigarettes or biris did you smoke each day?	NUMBER OF CIGARETTES/BIDIS . . . . . [ ][ ]	

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	**Before** 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? **RECORD ALL MENTIONED**	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? **Prob:** Please try to remember names or description of the medications. **ASK WOMAN TO SHOW THE MEDICATION** **BOTTLES IF AVAILABLE WRAPPERS.** B. Did you stop using this medication when become pregnant?		

	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

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? **RECORD ALL MENTIONED**	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) ☐ ↓ NO FEVER (CODES 3 OR 8 CIRCLED) ☐ →		526
	MODULE: FEVER		
525	How many times during last pregnancy did you experience fever? **IF '7' OR MORE WR**	NUMBER OF TIMES . . . . . ☐ 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 101^0F . . . . . 1 101^0F 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 NAME (IF LIVE BIRTH) _____	SKIP
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: a) Vaginal discharge? b) Itching everywhere on body c) Flu like symptoms? (sneezing / running nose) d) Loose stools/diarrhoea?	**YES NO DK** a) VAGINAL DISCHARGE . . . . . 1 2 8 b) ITCHING ON BODY . . . . . 1 2 8 c) FLU LIKE SYMPTOMS (SNEEZING/ RUNNING NOSE) . . . . . 1 2 8 d) LOOSE STOOLS/ DIARRHOEA 1 2 8	
526	CHECK 505(a): HAD FEVER IN POSTPARTUM PERIOD/ 40 DAYS AFTER TERMINATION OF PREGNANCY (CODES 1 OR 2 CIRCLED) ☐ NO FEVER (CODES 3 OR 8 CIRCLED) ☐ → 528		
527	When did the fever start? (how many days after delivery/termination of pregnancy?	NUMBER OF DAYS . . . . . ☐☐ ON THE DAY OF LABOUR/ DELIVERY 00	
527A	How high was the fever?	LESS THAN 101^{0}F . . . . . 1 101^{0}F OR MORE . . . . . 2 DON'T KNOW EXACT TEMPERATURE 8	→ 527C
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 NO . . . . . 2 DON'T KNOW 8	→ 527H
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 _____ 6 SPECIFY DON'T KNOW 8	
527G	What was the smell of discharge?	NO SMELL . . . . . 1 FOUL SMELL . . . . . 2 OTHER _____ 6 SPECIFY 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 NAME (IF LIVE BIRTH) _____	SKIP
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 . . . . . ☐☐	
528	CHECK 501(b): HAD FITS DURING PREGNANCY (CODES 1 OR 2 CIRCLED) ↓ NO FITS (CODES 3 OR 8 CIRCLED) ☐ → 530		
	MODULE: FITS/SEIZURES		
529	In which month of pregnancy did you experience the fits?	MONTH OF PREGNANCY . . . . . ☐☐	
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 NAME (IF LIVE BIRTH) _____	SKIP
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): HAD BLEEDING DURING LAST PREGNANCY (CODES 1 OR 2 CIRCLED) ☐ NO BLEEDING (CODES 3 OR 8 CIRCLED) ☐ → 532		

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

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP
533B	What type of bleeding did you experience? **Record all mentioned**	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? Record all mentioned	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? **IF 95 OR MORE WRITE '95'**	NUMBER OF DAYS . . . . . ☐☐ BLEEDING CONTINUE . . . . . 97 DON'T KNOW 98	
533M	After how many days did the bleeding completely stop? **IF 95 OR MORE WRITE '95'**	NUMBER OF DAYS . . . . . ☐☐ BLEEDING CONTINUE. . . . . 97 DON'T KNOW 98	

NO.	QUESTIONS AND FILTERS	LAST PREGNANCY NAME (IF LIVE BIRTH) _____	SKIP
534	CHECK 501 (d): HAD JAUNDICE DURING LAST PREGNANCY (CODES 1 OR 2 CIRCLED) ☐ ↓ NO JAUNDICE (CODES 3 OR 8 CIRCLED) ☐ →		536
	MODULE: JAUNDICE		
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) ☐ ↓ NO JAUNDICE (CODES 3 OR 8 CIRCLED) ☐ → 600		
537	How many days after delivery/abortion/ miscarriage did you have jaundice?	NUMBER OF DAYS . . . . . ☐☐ 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 NAME (IF LIVE BIRTH) _____	SKIP
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 ☐ IF RESPONSE IS DIFFERENT PROBE AND CORRECT 406-410 ☐		
602	CHECK 600: YES ☐ NO ☐		→ 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 . . . . . ☐☐ 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? **PROBE TO IDENTIFY EACH TYPE OF PERSON AND RECORD ALL MENTIONED.**	**HEALTH PERSONNEL** OBSTETRICIAN/SPECIALIST . . . . . A DOCTOR . . . . . B NURSE/MIDWIFE/LHV . . . . . C COMMUNITY MIDWIFE . . . . . D **OTHER PERSON** 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)	**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 _____ 1 2 8 (SPECIFY)	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
608	In any of the ANC visits, did your healthcare provider inform you about possible complications of pregnancy, childbirth and postpartum?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
608A	During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
609	CHECK 414 AND 608A: IF RESPONSE IS SAME ☐ IF RESPONSE IS DIFFERENT PROBE AND CORRECT 414-416 ☐		
609A	CHECK 608A: YES ☐ NO ☐ → 611		
610	How many times were you immunized against tetanus during this pregnancy?	NUMBER OF TIMES . . . . . ☐ DON'T KNOW 8	
611	CHECK 423: NO ONE ASSISTED **CODE "Y" CIRCLED** ☐ OTHER RESPONSE **NO CODE CIRCLED** ☐ → 620		
612	Who assisted with the delivery (of NAME)? Anyone else? **PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED.** **IF RESPONDENT SAYS NO ONE ASSISTED, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.**	**HEALTH PERSONNEL** OBSTETRICIAN/SPECIALIST . . . . . A DOCTOR . . . . . B NURSE/MIDWIFE/LHV . . . . . C COMMUNITY MIDWIFE . . . . . D **OTHER PERSON** DAI/TRADITIONAL BIRTH ATTENDANT . . . . . E FAMILY WELFARE WORKER . . . . . F LADY H. WORKER . . . . . G HOMEOPATH . . . . . H HAKIM . . . . . I RELATIVE/FRIEND . . . . . J OTHERS _____ (SPECIFY) X NO ONE ASSISTED . . . . . Y	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
613	Where did you give birth (to NAME)? **PROBE TO IDENTIFY THE TYPE OF SOURCE.** **IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.** _____ (NAME OF PLACE)	**HOME** OWN HOME . . . . . 11 OTHER HOME . . . . . 12 **PUBLIC SECTOR** GOVERNMENT HOSPITAL . . . . . 21 RHC/MCH . . . . . 22 BHU/FWC . . . . . 23 OTHER PUBLIC SECTOR _____ 26 (SPECIFY) **PRIVATE MEDICAL SECTOR** PRIVATE HOSPITAL/ CLINIC . . . . . 31 OTHER PRIVATE MEDICAL SECTOR _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY)	→ 620
615	How long after delivery did you stay there? IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.	HOURS . . . . . 1 ☐☐ DAYS . . . . . 2 ☐☐ WEEKS . . . . . 3 ☐☐ DON'T KNOW 998	
616	Was a Caesarean section done?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 618
617	Was the delivery assisted with forceps?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
618	Did you take misoprostol tablets immediately after delivery of baby (to control the excessive bleeding)?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	
619	When was the placenta delivered?	NUMBER OF MINUTES AFTER DELIVERY . . . . . ☐☐ NOT APPLICABLE . . . . . 97 DON'T KNOW 98	
620	CHECK 212B, 220AC AND 220AD: MISCARRIAGE ☐ ABORTION/ STILLBIRTH ☐ LIVE BIRTH ☐		→ 627 → 636
621	Where were you when the miscarriage happened?	HOME . . . . . 1 HEALTH FACILITY . . . . . 2 ON THE WAY . . . . . 3 OTHERS _____ 6 (SPECIFY)	
622	Did you see a healthcare provider immediately after miscarriage?	YES . . . . . 1 NO . . . . . 2 DON'T KNOW 8	→ 624

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
623	Whom did you see? Anyone else? **PROBE FOR THE MOST QUALIFIED PERSON**	**HEALTH PERSONNEL** OBSTETRICIAN/SPECIALIST . . . . . 11 DOCTOR . . . . . 12 NURSE/MIDWIFE/LHV . . . . . 13 COMMUNITY MIDWIFE . . . . . 14 **OTHER PERSON** 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? **IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.**	HOURS . . . . . **1** ☐☐ DAYS . . . . . **2** ☐☐ WEEKS . . . . . **3** ☐☐ 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** ☐☐ DAYS . . . . . **2** ☐☐ WEEKS . . . . . **3** ☐☐ DON'T KNOW 998	
629	How many visits did you make?	NUMBER OF VISITS . . . . . ☐☐	

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

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT INTERVIEW:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

EDITOR'S OBSERVATIONS