

SIERRA LEONE DEMOGRAPHIC AND HEALTH SURVEY 2019  
WOMAN'S QUESTIONNAIRE

SIERRA LEONE  
STATISTICS SIERRA LEONE

IDENTIFICATION														
LOCALITY NAME _____														
LOCAL COUNCIL _____														
NAME OF HOUSEHOLD HEAD _____														
DISTRICT CODE .....								[ ]	[ ]					
PROVINCE NAME AND CODE _____														
CHIEFDOM CODE .....								[ ]	[ ]					
SECTION CODE .....								[ ]	[ ]					
CLUSTER NUMBER .....								[ ]	[ ]					
ENUMERATION AREA CODE .....								[ ]	[ ]					
RURAL(1)/URBAN(2) .....								[ ]	[ ]					
HOUSEHOLD NUMBER .....								[ ]	[ ]					
NAME AND LINE NUMBER OF WOMAN _____														
CHECK COVER PAGE OF HOUSEHOLD QUESTIONNAIRE: HOUSEHOLD SELECTED FOR MAN'S SURVEY? (1=YES, 2=NO)														
NOTE: IF HOUSEHOLD SELECTED FOR MAN'S SURVEY, THEN HOUSEHOLD SELECTED FOR DV MODULE (1=YES, 2=NO)														
INTERVIEWER VISITS														
	1	2	3	FINAL VISIT										
DATE	[ ]	[ ]	[ ]	DAY	[ ]	[ ]	[ ]	[ ]	[ ]					
				MONTH	[ ]	[ ]	[ ]	[ ]	[ ]					
INTERVIEWER'S NAME	[ ]	[ ]	[ ]	YEAR	[ ]	[ ]	[ ]	[ ]	[ ]					
RESULT*	[ ]	[ ]	[ ]	INT. NO.	[ ]	[ ]	[ ]	[ ]	[ ]					
NEXT VISIT: DATE	[ ]	[ ]		TOTAL NUMBER OF VISITS [ ]										
TIME	[ ]	[ ]												
*RESULT CODES: 1 COMPLETED      4 REFUSED 2 NOT AT HOME      5 PARTLY COMPLETED      7 OTHER _____ 3 POSTPONED      6 INCAPACITATED      SPECIFY _____														
LANGUAGE OF QUESTIONNAIRE**		0	1	LANGUAGE OF INTERVIEW**		[ ]	[ ]	NATIVE LANGUAGE OF RESPONDENT**		[ ]	[ ]	TRANSLATOR USED (YES = 1, NO = 2)		[ ]
LANGUAGE OF QUESTIONNAIRE**		<b>ENGLISH</b>		**LANGUAGE CODES: 01 ENGLISH      03 TEMNE      05 LIMBA 02 KRIO      04 MENDE      06 OTHER										
SUPERVISOR				FIELD EDITOR				OFFICE EDITOR		KEYED BY				
[ ] [ ] [ ] [ ]				[ ] [ ] [ ] [ ]				[ ] [ ]		[ ] [ ]				
NAME      NUMBER				NAME      NUMBER				NUMBER		NUMBER				

## INTRODUCTION AND CONSENT

Hello. My name is \_\_\_\_\_. I am working with Statistics Sierra Leone. We are conducting a survey about health and other topics all over Sierra Leone. The information we collect will help the government to plan health services. Your household was selected for the survey. The questions usually take about 30 to 60 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 ..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> MINUTES ..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	
102	How long have you been living continuously in (NAME OF CURRENT CITY, TOWN OR VILLAGE OF RESIDENCE)?  IF LESS THAN ONE YEAR, RECORD '00' YEARS.	YEARS ..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> ALWAYS ..... 95 VISITOR ..... 96	→ 105
103	Just before you moved here, did you live in a city, in a town, or in a rural area?	CITY ..... 1 TOWN ..... 2 RURAL AREA ..... 3	
104	Before you moved here, which province did you live in?	EASTERN PROVINCE ..... 01 NORTHERN PROVINCE ..... 02 SOUTHERN PROVINCE ..... 03 NORTH WEST PROVINCE ..... 04 WESTERN AREA ..... 05 OUTSIDE OF SIERRA LEONE ..... 96	
105	In what month and year were you born?	MONTH ..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> DON'T KNOW MONTH ..... 98 YEAR ..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> DON'T KNOW YEAR ..... 9998	
106	How old were you at your last birthday?  COMPARE AND CORRECT 105 AND/OR 106 IF INCONSISTENT.	AGE IN COMPLETED YEARS ..... <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>	
107	Have you ever attended school?	YES ..... 1 NO ..... 2	→ 111
108	What is the highest level of school you attended: primary, secondary, or higher?	PRIMARY ..... 1 JUNIOR SECONDARY ..... 2 SENIOR SECONDARY ..... 3 VOCATIONAL/COMMERCIAL/NURSING TECHNICAL/TEACHING ..... 4 HIGHER ..... 5	

SECTION 1. RESPONDENT'S BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
109	What is the highest [GRADE/FORM/YEAR] you completed at that level?  IF COMPLETED LESS THAN ONE YEAR AT THAT LEVEL, RECORD '00'.	GRADE/FORM/YEAR ..... <input type="text"/> <input type="text"/>	
110	CHECK 108:  PRIMARY OR SECONDARY <input type="checkbox"/> VOCATIONAL/COMMERCIAL/NURSING TECHNICAL/TEACHING <input type="checkbox"/>	HIGHER <input type="checkbox"/> → 113	
111	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	
112	CHECK 111:  CODE '2', '3' OR '4' <input type="checkbox"/> CIRCLED ↓	CODE '1' OR '5' <input type="checkbox"/> CIRCLED → 114	
113	Do you read a newspaper or magazine at least once a week, less than once a week or not at all?	AT LEAST ONCE A WEEK ..... 1 LESS THAN ONCE A WEEK ..... 2 NOT AT ALL ..... 3	
114	Do you listen to the radio at least once a week, less than once a week or not at all?	AT LEAST ONCE A WEEK ..... 1 LESS THAN ONCE A WEEK ..... 2 NOT AT ALL ..... 3	
115	Do you watch television at least once a week, less than once a week or not at all?	AT LEAST ONCE A WEEK ..... 1 LESS THAN ONCE A WEEK ..... 2 NOT AT ALL ..... 3	
116	Do you own a mobile telephone?	YES ..... 1 NO ..... 2	→ 118
117	Do you use your mobile phone for any financial transactions?	YES ..... 1 NO ..... 2	
118	Do you have an account in a bank or other financial institution that you yourself use?	YES ..... 1 NO ..... 2	
119	Have you ever used the internet?	YES ..... 1 NO ..... 2	→ 122
120	In the last 12 months, have you used the internet?  IF NECESSARY, PROBE FOR USE FROM ANY LOCATION, WITH ANY DEVICE.	YES ..... 1 NO ..... 2	→ 122
121	During the last one month, how often did you use the internet: almost every day, at least once a week, less than once a week, or not at all?	ALMOST EVERY DAY ..... 1 AT LEAST ONCE A WEEK ..... 2 LESS THAN ONCE A WEEK ..... 3 NOT AT ALL ..... 4	

SECTION 1. RESPONDENT'S BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
122	What is your religion?	CHRISTIAN ..... 1 ISLAM ..... 2 BAHAI ..... 3 TRADITIONAL ..... 4 NONE ..... 5 OTHER ..... 6 <div style="text-align: center;">_____ SPECIFY</div>	
123	What is your ethnic group?	CREOLE ..... 11 FULLAH ..... 12 KONO ..... 13 LIMBA ..... 14 LOKO ..... 15 MANDINGO ..... 16 MENDE ..... 17 SHERBRO ..... 18 TEMNE ..... 19 OTHER SIERRA LEONE ..... 95 <div style="text-align: center;">_____ SPECIFY</div> OTHER FOREIGN ..... 96 <div style="text-align: center;">_____ SPECIFY</div>	
124	In the last 12 months, how many times have you been away from home for one or more nights?	NUMBER OF TIMES ..... <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> NONE ..... 00	→ 201
125	In the last 12 months, have you been away from home for more than one month at a time?	YES ..... 1 NO ..... 2	

SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
201	Now 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 ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> 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? IF NONE, RECORD '00'.	a) SONS ELSEWHERE ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> 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?  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	→ 208								
207	a) How many boys have died? b) And how many girls have died? IF NONE, RECORD '00'.	a) BOYS DEAD ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> 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>									
208	SUM ANSWERS TO 203, 205, AND 207, AND ENTER TOTAL. IF NONE, RECORD '00'.	TOTAL BIRTHS ..... <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 ____ births during your life. Is that correct?  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> YES  <input type="checkbox"/>  ↓ </div> <div style="text-align: center;"> 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 style="text-align: center;"> ONE OR MORE  BIRTHS <input type="checkbox"/>  ↓ </div> <div style="text-align: center;"> NO BIRTHS <input type="checkbox"/> </div> </div>		→ 226								

SECTION 2. REPRODUCTION

211 Now I would like to record the names of all your births, whether still alive or not, starting with the first one you had.  
RECORD NAMES OF ALL THE BIRTHS 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	213	214	215	216	217	218	219	220	221
What name was given to your (first/next) baby?	Is (NAME) a boy or a girl?	Were any of these births twins?	On what day, month, and year was (NAME) born?	Is (NAME) still alive?	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?  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.	Were there any other live births between (NAME OF PREVIOUS BIRTH) and (NAME), including any children who died after birth?
RECORD NAME.					RECORD AGE IN COMPLETED YEARS.				
BIRTH HISTORY NUMBER.									
01	BOY 1 GIRL 2	SING 1 MULT 2	DAY <input type="text"/> MONTH <input type="text"/> YEAR <input type="text"/>	YES 1 NO 2 ↓ (SKIP TO	AGE IN YEARS <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> (NEXT BIRTH)	DAYS 1 <input type="text"/> MONTHS 2 <input type="text"/> YEARS 3 <input type="text"/>	
02	BOY 1 GIRL 2	SING 1 MULT 2	DAY <input type="text"/> MONTH <input type="text"/> YEAR <input type="text"/>	YES 1 NO 2 ↓ (SKIP TO	AGE IN YEARS <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> (SKIP TO 221)	DAYS 1 <input type="text"/> MONTHS 2 <input type="text"/> YEARS 3 <input type="text"/>	YES (ADD BIRTH) 1 NO (NEXT BIRTH) 2
03	BOY 1 GIRL 2	SING 1 MULT 2	DAY <input type="text"/> MONTH <input type="text"/> YEAR <input type="text"/>	YES 1 NO 2 ↓ (SKIP TO	AGE IN YEARS <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> (SKIP TO 221)	DAYS 1 <input type="text"/> MONTHS 2 <input type="text"/> YEARS 3 <input type="text"/>	YES (ADD BIRTH) 1 NO (NEXT BIRTH) 2
04	BOY 1 GIRL 2	SING 1 MULT 2	DAY <input type="text"/> MONTH <input type="text"/> YEAR <input type="text"/>	YES 1 NO 2 ↓ (SKIP TO	AGE IN YEARS <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> (SKIP TO 221)	DAYS 1 <input type="text"/> MONTHS 2 <input type="text"/> YEARS 3 <input type="text"/>	YES (ADD BIRTH) 1 NO (NEXT BIRTH) 2
05	BOY 1 GIRL 2	SING 1 MULT 2	DAY <input type="text"/> MONTH <input type="text"/> YEAR <input type="text"/>	YES 1 NO 2 ↓ (SKIP TO	AGE IN YEARS <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> (SKIP TO 221)	DAYS 1 <input type="text"/> MONTHS 2 <input type="text"/> YEARS 3 <input type="text"/>	YES (ADD BIRTH) 1 NO (NEXT BIRTH) 2



SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
222	Have you had any live births since the birth of (NAME OF LAST BIRTH)?	YES ..... 1 (RECORD BIRTH(S) IN TABLE) ← NO ..... 2	
223	COMPARE 208 WITH NUMBER OF BIRTHS IN BIRTH HISTORY  <div style="display: flex; justify-content: space-around;"> <div>             NUMBERS ARE SAME  <input type="checkbox"/>              ↓           </div> <div>             NUMBERS ARE DIFFERENT <input type="checkbox"/>              (PROBE AND RECONCILE) ←           </div> </div>		
224	CHECK 215: ENTER THE NUMBER OF BIRTHS IN 2014-2019	NUMBER OF BIRTHS ..... <input type="text"/> NONE ..... 0	→ 226
225	<b>C</b> FOR EACH BIRTH IN 2014-2019, ENTER 'B' IN THE MONTH OF BIRTH IN THE CALENDAR. WRITE THE NAME OF THE CHILD TO THE LEFT OF THE 'B' CODE. FOR EACH BIRTH, ASK THE NUMBER OF COMPLETED MONTHS THE PREGNANCY LASTED AND RECORD 'P' IN EACH OF THE PRECEDING MONTHS ACCORDING TO THE DURATION OF PREGNANCY. (NOTE: THE NUMBER OF 'P's MUST BE ONE LESS THAN THE NUMBER OF MONTHS THAT THE PREGNANCY LASTED.)		
226	Are you pregnant now?	YES ..... 1 NO ..... 2 UNSURE ..... 8	→ 230
227	How many months pregnant are you?  RECORD NUMBER OF COMPLETED MONTHS.  <b>C</b> ENTER 'P's IN THE CALENDAR, BEGINNING WITH THE MONTH OF INTERVIEW AND FOR THE TOTAL NUMBER OF COMPLETED MONTHS.	MONTHS ..... <input type="text"/> <input type="text"/>	
228	When you got pregnant, did you want to get pregnant at that time?	YES ..... 1 NO ..... 2	→ 230
229	CHECK 208: TOTAL NUMBER OF BIRTHS  <div style="display: flex; justify-content: space-around;"> <div>             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>             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	
230	Have you ever had a pregnancy that miscarried, was aborted, or ended in a stillbirth?	YES ..... 1 NO ..... 2	→ 239
231	When did the last such pregnancy end?	MONTH ..... <input type="text"/> <input type="text"/> YEAR ..... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	



SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP
232	<p>CHECK 231:</p> <p>LAST PREGNANCY ENDED IN 2014-2019 <input type="checkbox"/></p> <p>LAST PREGNANCY ENDED IN 2013 OR EARLIER <input type="checkbox"/></p>			<p>→ 234</p> <p>→ 239</p>
LINE NO.	233 In what month and year did the preceding such pregnancy end?	234 How many months pregnant were you when that pregnancy ended?	235 Since January 2014, have you had any other pregnancies that did not result in a live birth?	
01		<div><input type="text"/><input type="text"/></div> <p>NUMBER OF MONTHS</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	<p>→ NEXT LINE</p> <p>→ 236</p>
02	<div><input type="text"/><input type="text"/></div> MONTH <div><input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> YEAR	<div><input type="text"/><input type="text"/></div> <p>NUMBER OF MONTHS</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	<p>→ NEXT LINE</p> <p>→ 236</p>
03	<div><input type="text"/><input type="text"/></div> MONTH <div><input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> YEAR	<div><input type="text"/><input type="text"/></div> <p>NUMBER OF MONTHS</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	<p>→ NEXT LINE</p> <p>→ 236</p>
04	<div><input type="text"/><input type="text"/></div> MONTH <div><input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> YEAR	<div><input type="text"/><input type="text"/></div> <p>NUMBER OF MONTHS</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	<p>→ 236</p>
236	<p><b>C</b> FOR EACH PREGNANCY THAT DID NOT END IN A LIVE BIRTH IN 2014-2019 OR LATER, ENTER 'T' IN THE CALENDAR IN THE MONTH THAT THE PREGNANCY TERMINATED AND 'P' FOR THE REMAINING NUMBER OF COMPLETED MONTHS OF PREGNANCY.</p> <p>IF THERE ARE MORE THAN FOUR PREGNANCIES THAT DID NOT END IN A LIVE BIRTH, USE AN ADDITIONAL QUESTIONNAIRE STARTING ON THE SECOND LINE.</p>			
237	Did you have any miscarriages, abortions or stillbirths that ended before 2014?	<p>YES ..... 1</p> <p>NO ..... 2</p>		→ 239
238	When did the last such pregnancy that terminated before 2014 end?	<p>MONTH ..... <div><input type="text"/><input type="text"/></div></p> <p>YEAR ..... <div><input type="text"/><input type="text"/><input type="text"/><input type="text"/></div></p>		

SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
239	<p>When did your last menstrual period start?</p> <p>_____</p> <p align="center">(DATE, IF GIVEN)</p>	<p>DAYS AGO ..... 1</p> <p>WEEKS AGO ..... 2</p> <p>MONTHS AGO ..... 3</p> <p>YEARS AGO ..... 4</p> <p>IN MENOPAUSE/ HAS HAD HYSTERECTOMY ..... 994</p> <p>BEFORE LAST BIRTH ..... 995</p> <p>NEVER MENSTRUATED ..... 996</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>								
240	<p>From one menstrual period to the next, are there certain days when a woman is more likely to become pregnant?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>→ 242</p>								
241	<p>Is this time just before her period begins, during her period, right after her period has ended, or halfway between two periods?</p>	<p>JUST BEFORE HER PERIOD BEGINS ..... 1</p> <p>DURING HER PERIOD ..... 2</p> <p>RIGHT AFTER HER PERIOD HAS ENDED ..... 3</p> <p>HALFWAY BETWEEN TWO PERIODS ..... 4</p> <p>OTHER ..... 6</p> <p align="center">(SPECIFY)</p> <p>DON'T KNOW ..... 8</p>									
242	<p>After the birth of a child, can a woman become pregnant before her menstrual period has returned?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>									

SECTION 3. CONTRACEPTION

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 (METHOD)?	
01	Female Sterilization. PROBE: Women can have an operation to avoid having any more children.	YES ..... 1 NO ..... 2
02	Male Sterilization. PROBE: Men can have an operation to avoid having any more children.	YES ..... 1 NO ..... 2
03	IUD. PROBE: Women can have a loop or coil placed inside them by a doctor or a nurse which can prevent pregnancy for one or more years.	YES ..... 1 NO ..... 2
04	Injectables. PROBE: Women can have an injection by a health provider that stops them from becoming pregnant for one or more months.	YES ..... 1 NO ..... 2
05	Implants. PROBE: Women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.	YES ..... 1 NO ..... 2
06	Pill. PROBE: Women can take a pill every day to avoid becoming pregnant.	YES ..... 1 NO ..... 2
07	Condom. PROBE: Men can put a rubber sheath on their penis before sexual intercourse.	YES ..... 1 NO ..... 2
08	Female Condom. PROBE: Women can place a sheath in their vagina before sexual intercourse.	YES ..... 1 NO ..... 2
09	Emergency Contraception. PROBE: As an emergency measure, within three days after they have unprotected sexual intercourse, women can take special pills to prevent pregnancy.	YES ..... 1 NO ..... 2
10	Standard Days Method. PROBE: A woman uses a string of colored beads to know the days she can get pregnant. On the days she can get pregnant, she uses a condom or does not have sexual intercourse.	YES ..... 1 NO ..... 2
11	Lactational Amenorrhea Method (LAM). PROBE: Up to six months after childbirth, before the menstrual period has returned, women use a method requiring frequent breastfeeding day and night.	YES ..... 1 NO ..... 2
12	Rhythm Method. PROBE: To avoid pregnancy, women do not have sexual intercourse on the days of the month they think they can get pregnant.	YES ..... 1 NO ..... 2
13	Withdrawal. PROBE: Men can be careful and pull out before climax.	YES ..... 1 NO ..... 2
14	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	<p>YES, MODERN METHOD</p> <p>_____ A</p> <p align="center">(SPECIFY)</p> <p>YES, TRADITIONAL METHOD</p> <p>_____ B</p> <p align="center">(SPECIFY)</p> <p>NO ..... Y</p>

### SECTION 3. CONTRACEPTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
302	CHECK 226:  <div style="display: flex; justify-content: space-around; align-items: center;"> <div>NOT PREGNANT <input type="checkbox"/> OR UNSURE ↓</div> <div>PREGNANT <input type="checkbox"/> →</div> </div>		312
303	Are you or your partner currently doing something or using any method to delay or avoid getting pregnant?	YES ..... 1 NO ..... 2	312
304	Which method are you using?  RECORD ALL MENTIONED.  IF MORE THAN ONE METHOD MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD IN LIST.	FEMALE STERILIZATION ..... A MALE STERILIZATION ..... B IUD ..... C INJECTABLES ..... D IMPLANTS ..... E PILL ..... F CONDOM ..... G FEMALE CONDOM ..... H EMERGENCY CONTRACEPTION ..... I STANDARD DAYS METHOD ..... J LACTATIONAL AMENORRHEA METHOD ..... K RHYTHM METHOD ..... L WITHDRAWAL ..... M OTHER MODERN METHOD ..... X OTHER TRADITIONAL METHOD ..... Y	307 309 306 309
305	What is the brand name of the pills you are using?  IF DON'T KNOW THE BRAND, ASK TO SEE THE PACKAGE.	MICROGYNON..... 01 MICROLUTE ..... 02 ZINNIAF ..... 03 OTHER ..... 96 <div style="text-align: center;">(SPECIFY)</div> DON'T KNOW ..... 98	309
306	What is the brand name of the condoms you are using?  IF DON'T KNOW THE BRAND, ASK TO SEE THE PACKAGE.	MALE CONDOMS LATEX ..... 01 PROTECTOR PLUS ..... 02 LOVE ..... 03 ROUGH RIDER ..... 04 IQUON ..... 05 STRAWBERRY ..... 06 OTHER ..... 96 <div style="text-align: center;">(SPECIFY)</div> DON'T KNOW ..... 98	309

SECTION 3. CONTRACEPTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP												
307	<p>In what facility did the sterilization take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p align="center">(NAME OF PLACE)</p>	<p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ..... 11</p> <p>GOVERNMENT HEALTH CENTER ..... 12</p> <p>FAMILY PLANNING CLINIC ..... 13</p> <p>MOBILE CLINIC ..... 14</p> <p>OTHER PUBLIC SECTOR</p> <p>_____ 16</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/CLINIC ..... 21</p> <p>PRIVATE DOCTOR'S OFFICE ..... 22</p> <p>MOBILE CLINIC ..... 23</p> <p>OTHER PRIVATE MEDICAL SECTOR</p> <p>_____ 26</p> <p align="center">(SPECIFY)</p> <p>OTHER _____ 96</p> <p align="center">(SPECIFY)</p> <p>DON'T KNOW ..... 98</p>													
308	<p>In what month and year was the sterilization performed?</p>	<p>MONTH ..... <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>YEAR ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table></p>													<p>→ 310</p>
309	<p>Since what month and year have you been using (CURRENT METHOD) without stopping?</p> <p>PROBE: For how long have you been using (CURRENT METHOD) now without stopping?</p>	<p>MONTH ..... <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>YEAR ..... <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table></p>													
310	<p>CHECK 308 AND 309, 215 AND 231: ANY BIRTH OR PREGNANCY TERMINATION AFTER MONTH AND YEAR OF START OF USE OF CONTRACEPTION IN 308 OR 309</p> <p>NO <input type="checkbox"/></p> <p align="right">YES <input type="checkbox"/></p> <p align="center">GO BACK TO 308 OR 309, PROBE AND RECORD MONTH AND YEAR AT START OF CONTINUOUS USE OF CURRENT METHOD (MUST BE AFTER LAST BIRTH OR PREGNANCY TERMINATION).</p>														

SECTION 3. CONTRACEPTION (CAPI OPTION)

311	<p>CHECK 308 AND 309:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p align="center">YEAR IS 2014-2019 <input type="checkbox"/></p> <p><b>C</b> ENTER CODE FOR METHOD USED IN MONTH OF INTERVIEW IN THE CALENDAR AND IN EACH MONTH BACK TO THE DATE STARTED USING.</p> <p align="center">THEN CONTINUE ↓</p> </div> <div style="width: 48%; border-left: 1px dashed black; padding-left: 10px;"> <p align="center">YEAR IS 2013 OR EARLIER <input type="checkbox"/></p> <p><b>C</b> ENTER CODE FOR METHOD USED IN MONTH OF INTERVIEW IN THE CALENDAR AND EACH MONTH BACK TO JANUARY 2014 .</p> <p align="center">THEN ↓ (SKIP TO 324) ←</p> </div> </div>																																												
312	<p>I would like to ask you some questions about the times you or your partner may have used a method to avoid getting pregnant during the last few years.</p> <p><b>C</b> USE CALENDAR TO PROBE FOR EARLIER PERIODS OF USE AND NONUSE, STARTING WITH MOST RECENT USE, BACK TO JANUARY 2014. USE NAMES OF CHILDREN, DATES OF BIRTH, AND PERIODS OF PREGNANCY AS REFERENCE POINTS.</p>																																												
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;"></th><th style="width:25%; text-align: center;">COLUMN 1</th><th style="width:25%; text-align: center;">COLUMN 2</th><th style="width:25%; text-align: center;">COLUMN 3</th></tr> </thead> <tbody> <tr> <td style="text-align: center; vertical-align: top;">312A</td><td style="padding: 5px;"> MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td><td style="padding: 5px;"> MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td><td style="padding: 5px;"> MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td></tr> <tr> <td style="text-align: center; vertical-align: top;">312B</td><td style="padding: 5px;"> Between (EVENT) in (MONTH/YEAR) and (EVENT) in (MONTH/YEAR), did you or your partner use any method of contraception?  YES ..... 1  NO ..... 2  (SKIP TO 312I) ← </td><td style="padding: 5px;"> YES ..... 1  NO ..... 2  (SKIP TO 312I) ← </td><td style="padding: 5px;"> YES ..... 1  NO ..... 2  (SKIP TO 312I) ← </td></tr> <tr> <td style="text-align: center; vertical-align: top;">312C</td><td style="padding: 5px;"> Which method was that?  METHOD CODE .. <input style="width: 40px;" type="text"/> </td><td style="padding: 5px;"> METHOD CODE .. <input style="width: 40px;" type="text"/> </td><td style="padding: 5px;"> METHOD CODE .. <input style="width: 40px;" type="text"/> </td></tr> <tr> <td style="text-align: center; vertical-align: top;">312D</td><td style="padding: 5px;"> How many months after (EVENT) in (MONTH/YEAR) did you start to use (METHOD)?  CIRCLE '95' IF RESPONDENT GIVES THE DATE OF STARTING TO USE THE METHOD.  IMMEDIATELY ..... 00  MONTHS .. <input style="width: 40px;" type="text"/>  (SKIP TO 312F) ←  DATE GIVEN ..... 95 </td><td style="padding: 5px;"> IMMEDIATELY ..... 00  MONTHS .. <input style="width: 40px;" type="text"/>  (SKIP TO 312F) ←  DATE GIVEN ..... 95 </td><td style="padding: 5px;"> IMMEDIATELY ..... 00  MONTHS .. <input style="width: 40px;" type="text"/>  (SKIP TO 312F) ←  DATE GIVEN ..... 95 </td></tr> <tr> <td style="text-align: center; vertical-align: top;">312E</td><td style="padding: 5px;"> RECORD MONTH AND YEAR RESPONDENT STARTED USING METHOD.  MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td><td style="padding: 5px;"> MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td><td style="padding: 5px;"> MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td></tr> <tr> <td style="text-align: center; vertical-align: top;">312F</td><td style="padding: 5px;"> For how many months did you use (METHOD)?  CIRCLE '95' IF RESPONDENT GIVES THE DATE OF TERMINATION OF USE.  MONTHS .. <input style="width: 40px;" type="text"/>  (SKIP TO 312H) ←  DATE GIVEN ..... 95 </td><td style="padding: 5px;"> MONTHS .. <input style="width: 40px;" type="text"/>  (SKIP TO 312H) ←  DATE GIVEN ..... 95 </td><td style="padding: 5px;"> MONTHS .. <input style="width: 40px;" type="text"/>  (SKIP TO 312H) ←  DATE GIVEN ..... 95 </td></tr> <tr> <td style="text-align: center; vertical-align: top;">312G</td><td style="padding: 5px;"> RECORD MONTH AND YEAR RESPONDENT STOPPED USING METHOD.  MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td><td style="padding: 5px;"> MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td><td style="padding: 5px;"> MONTH <input style="width: 40px;" type="text"/>  <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/>  YEAR </td></tr> <tr> <td style="text-align: center; vertical-align: top;">312H</td><td style="padding: 5px;"> Why did you stop using (METHOD)?  REASON STOPPED ..... <input style="width: 40px;" type="text"/> </td><td style="padding: 5px;"> REASON STOPPED ..... <input style="width: 40px;" type="text"/> </td><td style="padding: 5px;"> REASON STOPPED ..... <input style="width: 40px;" type="text"/> </td></tr> <tr> <td style="text-align: center; vertical-align: top;">312I</td><td style="padding: 5px;"></td><td style="padding: 5px;"> GO BACK TO 312A IN NEXT COLUMN; OR, IF NO MORE GAPS, GO TO 313. </td><td style="padding: 5px;"> GO BACK TO 312A IN NEXT COLUMN; OR, IF NO MORE GAPS, GO TO 313. </td></tr> <tr> <td></td><td></td><td style="padding: 5px;"> GO BACK TO 312A IN NEW QUESTIONNAIRE; OR, IF NO MORE GAPS, GO TO 313. </td><td></td></tr> </tbody> </table>		COLUMN 1	COLUMN 2	COLUMN 3	312A	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	312B	Between (EVENT) in (MONTH/YEAR) and (EVENT) in (MONTH/YEAR), did you or your partner use any method of contraception? YES ..... 1 NO ..... 2 (SKIP TO 312I) ←	YES ..... 1 NO ..... 2 (SKIP TO 312I) ←	YES ..... 1 NO ..... 2 (SKIP TO 312I) ←	312C	Which method was that? METHOD CODE .. <input style="width: 40px;" type="text"/>	METHOD CODE .. <input style="width: 40px;" type="text"/>	METHOD CODE .. <input style="width: 40px;" type="text"/>	312D	How many months after (EVENT) in (MONTH/YEAR) did you start to use (METHOD)? CIRCLE '95' IF RESPONDENT GIVES THE DATE OF STARTING TO USE THE METHOD. IMMEDIATELY ..... 00 MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312F) ← DATE GIVEN ..... 95	IMMEDIATELY ..... 00 MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312F) ← DATE GIVEN ..... 95	IMMEDIATELY ..... 00 MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312F) ← DATE GIVEN ..... 95	312E	RECORD MONTH AND YEAR RESPONDENT STARTED USING METHOD. MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	312F	For how many months did you use (METHOD)? CIRCLE '95' IF RESPONDENT GIVES THE DATE OF TERMINATION OF USE. MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312H) ← DATE GIVEN ..... 95	MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312H) ← DATE GIVEN ..... 95	MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312H) ← DATE GIVEN ..... 95	312G	RECORD MONTH AND YEAR RESPONDENT STOPPED USING METHOD. MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	312H	Why did you stop using (METHOD)? REASON STOPPED ..... <input style="width: 40px;" type="text"/>	REASON STOPPED ..... <input style="width: 40px;" type="text"/>	REASON STOPPED ..... <input style="width: 40px;" type="text"/>	312I		GO BACK TO 312A IN NEXT COLUMN; OR, IF NO MORE GAPS, GO TO 313.	GO BACK TO 312A IN NEXT COLUMN; OR, IF NO MORE GAPS, GO TO 313.			GO BACK TO 312A IN NEW QUESTIONNAIRE; OR, IF NO MORE GAPS, GO TO 313.	
	COLUMN 1	COLUMN 2	COLUMN 3																																										
312A	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR																																										
312B	Between (EVENT) in (MONTH/YEAR) and (EVENT) in (MONTH/YEAR), did you or your partner use any method of contraception? YES ..... 1 NO ..... 2 (SKIP TO 312I) ←	YES ..... 1 NO ..... 2 (SKIP TO 312I) ←	YES ..... 1 NO ..... 2 (SKIP TO 312I) ←																																										
312C	Which method was that? METHOD CODE .. <input style="width: 40px;" type="text"/>	METHOD CODE .. <input style="width: 40px;" type="text"/>	METHOD CODE .. <input style="width: 40px;" type="text"/>																																										
312D	How many months after (EVENT) in (MONTH/YEAR) did you start to use (METHOD)? CIRCLE '95' IF RESPONDENT GIVES THE DATE OF STARTING TO USE THE METHOD. IMMEDIATELY ..... 00 MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312F) ← DATE GIVEN ..... 95	IMMEDIATELY ..... 00 MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312F) ← DATE GIVEN ..... 95	IMMEDIATELY ..... 00 MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312F) ← DATE GIVEN ..... 95																																										
312E	RECORD MONTH AND YEAR RESPONDENT STARTED USING METHOD. MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR																																										
312F	For how many months did you use (METHOD)? CIRCLE '95' IF RESPONDENT GIVES THE DATE OF TERMINATION OF USE. MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312H) ← DATE GIVEN ..... 95	MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312H) ← DATE GIVEN ..... 95	MONTHS .. <input style="width: 40px;" type="text"/> (SKIP TO 312H) ← DATE GIVEN ..... 95																																										
312G	RECORD MONTH AND YEAR RESPONDENT STOPPED USING METHOD. MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR	MONTH <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> YEAR																																										
312H	Why did you stop using (METHOD)? REASON STOPPED ..... <input style="width: 40px;" type="text"/>	REASON STOPPED ..... <input style="width: 40px;" type="text"/>	REASON STOPPED ..... <input style="width: 40px;" type="text"/>																																										
312I		GO BACK TO 312A IN NEXT COLUMN; OR, IF NO MORE GAPS, GO TO 313.	GO BACK TO 312A IN NEXT COLUMN; OR, IF NO MORE GAPS, GO TO 313.																																										
		GO BACK TO 312A IN NEW QUESTIONNAIRE; OR, IF NO MORE GAPS, GO TO 313.																																											

**SECTION 3. CONTRACEPTION**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
313	CHECK THE CALENDAR FOR USE OF ANY CONTRACEPTIVE METHOD IN ANY MONTH  NO METHOD USED <input type="checkbox"/> ANY METHOD USED <input type="checkbox"/>		→ 315
314	Have you ever used anything or tried in any way to delay or avoid getting pregnant?	YES ..... 1 NO ..... 2	→ 326
315	CHECK 304:  CIRCLE METHOD CODE:  IF MORE THAN ONE METHOD CODE CIRCLED IN 304, CIRCLE CODE FOR HIGHEST METHOD IN LIST.	NO CODE CIRCLED ..... 00 FEMALE STERILIZATION ..... 01 MALE STERILIZATION ..... 02 IUD ..... 03 INJECTABLES ..... 04 IMPLANTS ..... 05 PILL ..... 06 CONDOM ..... 07 FEMALE CONDOM ..... 08 EMERGENCY CONTRACEPTION ..... 09 STANDARD DAYS METHOD ..... 10 LACTATIONAL AMENORRHEA METHOD ..... 11 RHYTHM METHOD ..... 12 WITHDRAWAL ..... 13 OTHER MODERN METHOD ..... 95 OTHER TRADITIONAL METHOD ..... 96	→ 326 → 319 → 327        → 323
316	You first started using (CURRENT METHOD) in (DATE FROM 309). Where did you get it at that time?  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)	<b>PUBLIC SECTOR</b> GOVERNMENT HOSPITAL ..... 11 GOVERNMENT HEALTH CENTER ..... 12 FAMILY PLANNING CLINIC ..... 13 MOBILE CLINIC ..... 14 FIELDWORKER ..... 15 OTHER PUBLIC SECTOR ..... 16 _____ (SPECIFY)  <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/CLINIC ..... 21 PHARMACY ..... 22 PRIVATE DOCTOR ..... 23 MOBILE CLINIC ..... 24 FIELDWORKER ..... 25 OTHER PRIVATE MEDICAL SECTOR ..... 26 _____ (SPECIFY)  <b>OTHER SOURCE</b> SHOP ..... 31 CHURCH ..... 32 FRIEND/RELATIVE ..... 33 OTHER ..... 96 _____ (SPECIFY)	
317	CHECK 304:  CIRCLE METHOD CODE:  IF MORE THAN ONE METHOD CODE CIRCLED IN 304, CIRCLE CODE FOR HIGHEST METHOD IN LIST.	IUD ..... 03 INJECTABLES ..... 04 IMPLANTS ..... 05 PILL ..... 06 CONDOM ..... 07 FEMALE CONDOM ..... 08 EMERGENCY CONTRACEPTION ..... 09 STANDARD DAYS METHOD ..... 10 OTHER MODERN METHOD ..... 95 OTHER TRADITIONAL METHOD ..... 96	→ 323 → 322 → 323

SECTION 3. CONTRACEPTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
318	At that time, were you told about side effects or problems you might have with the method?	YES ..... 1 NO ..... 2	→ 321 → 320
319	When you got sterilized, were you told about side effects or problems you might have with the method?	YES ..... 1 NO ..... 2	→ 321
320	Were you ever told by a health or family planning worker about side effects or problems you might have with the method?	YES ..... 1 NO ..... 2	→ 322
321	Were you told what to do if you experienced side effects or problems?	YES ..... 1 NO ..... 2	
322	CHECK 318 AND 319:  <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;">             ANY <input type="checkbox"/>              'YES'              ↓           </div> <div style="border-left: 1px dashed black; padding-left: 10px; text-align: center;">             OTHER <input type="checkbox"/>              ↓           </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">             a) At that time, were you told about other methods of family planning that you could use?           </div> <div style="width: 45%;">             b) When you obtained (CURRENT METHOD FROM 315) from (SOURCE OF METHOD FROM 307 OR 316), were you told about other methods of family planning that you could use?           </div> </div>	YES ..... 1 NO ..... 2	→ 324
323	Were you ever told by a health or family planning worker about other methods of family planning that you could use?	YES ..... 1 NO ..... 2	
324	CHECK 304:  CIRCLE METHOD CODE:  IF MORE THAN ONE METHOD CODE CIRCLED IN 304, CIRCLE CODE FOR HIGHEST METHOD IN LIST.	FEMALE STERILIZATION ..... 01 MALE STERILIZATION ..... 02 IUD ..... 03 INJECTABLES ..... 04 IMPLANTS ..... 05 PILL ..... 06 CONDOM ..... 07 FEMALE CONDOM ..... 08 EMERGENCY CONTRACEPTION ..... 09 STANDARD DAYS METHOD ..... 10 LACTATIONAL AMENORRHEA METHOD ..... 11 RHYTHM METHOD ..... 12 WITHDRAWAL ..... 13 OTHER MODERN METHOD ..... 95 OTHER TRADITIONAL METHOD ..... 96	→ 327           <div style="display: flex; align-items: center;"> <input type="checkbox"/> → 327         </div> → 327



**SECTION 3. CONTRACEPTION**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
325	<p>Where did you obtain (CURRENT METHOD) the last time?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p align="center">(NAME OF PLACE)</p>	<p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ..... 11</p> <p>GOVERNMENT HEALTH CENTER ..... 12</p> <p>FAMILY PLANNING CLINIC ..... 13</p> <p>MOBILE CLINIC ..... 14</p> <p>FIELDWORKER ..... 15</p> <p>OTHER PUBLIC SECTOR</p> <p>_____ 16</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/CLINIC ..... 21</p> <p>PHARMACY ..... 22</p> <p>PRIVATE DOCTOR ..... 23</p> <p>MOBILE CLINIC ..... 24</p> <p>FIELDWORKER ..... 25</p> <p>OTHER PRIVATE MEDICAL SECTOR</p> <p>_____ 26</p> <p align="center">(SPECIFY)</p> <p><b>OTHER SOURCE</b></p> <p>SHOP ..... 31</p> <p>CHURCH ..... 32</p> <p>FRIEND/RELATIVE ..... 33</p> <p>OTHER _____ 96</p> <p align="center">(SPECIFY)</p>	<p>→ 327</p>
326	Do you know of a place where you can obtain a method of family planning?	<p>YES ..... 1</p> <p>NO ..... 2</p>	
327	In the last 12 months, were you visited by a fieldworker?	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ 329
328	Did the fieldworker talk to you about family planning?	<p>YES ..... 1</p> <p>NO ..... 2</p>	
329	<p>CHECK 202: CHILDREN LIVING WITH THE</p> <p align="center">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
330	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	<p>CHECK 224:</p> <p align="center">             ONE OR MORE BIRTHS <input type="checkbox"/> IN 2014-2019             <span style="margin-left: 100px;">NO BIRTHS IN <input type="checkbox"/> 2014-2019</span> <span style="float: right;">→ 648</span> </p>		
402	<p>CHECK 215. RECORD THE BIRTH HISTORY NUMBER IN 403 AND THE NAME AND SURVIVAL STATUS IN 404 FOR EACH BIRTH IN 2014-2019. ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH. IF THERE ARE MORE THAN 2 BIRTHS, USE LAST COLUMN OF ADDITIONAL QUESTIONNAIRE(S).</p> <p>Now I would like to ask some questions about your children born in the last five years. (We will talk about each separately.)</p>		
403	BIRTH HISTORY NUMBER FROM 212 IN BIRTH HISTORY.	<p align="center">LAST BIRTH</p> <p>BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/></p>	<p align="center">NEXT-TO-LAST BIRTH</p> <p>BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/></p>
404	FROM 212 AND 216:	<p>NAME _____</p> <p>LIVING <input type="checkbox"/> DEAD <input type="checkbox"/></p>	<p>NAME _____</p> <p>LIVING <input type="checkbox"/> DEAD <input type="checkbox"/></p>
405	When you got pregnant with (NAME), did you want to get pregnant at that time?	<p>YES ..... 1</p> <p align="center">(SKIP TO 408) ←</p> <p>NO ..... 2</p>	<p>YES ..... 1</p> <p align="center">(SKIP TO 426) ←</p> <p>NO ..... 2</p>
406	<p>CHECK 208:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p align="center">ONLY ONE BIRTH <input type="checkbox"/></p> <p>a) Did you want to have a baby later on, or did you not want any children?</p> </div> <div style="width: 45%;"> <p align="center">MORE THAN ONE BIRTH <input type="checkbox"/></p> <p>b) Did you want to have a baby later on, or did you not want any more children?</p> </div> </div>	<p>LATER ..... 1</p> <p>NO MORE/NONE ..... 2</p> <p align="center">(SKIP TO 408) ←</p>	<p>LATER ..... 1</p> <p>NO MORE/NONE ..... 2</p> <p align="center">(SKIP TO 426) ←</p>
407	How much longer did you want to wait?	<p>MONTHS ..... 1 <input type="text"/> <input type="text"/></p> <p>YEARS ..... 2 <input type="text"/> <input type="text"/></p> <p>DON'T KNOW .....998</p>	<p>MONTHS ..... 1 <input type="text"/> <input type="text"/></p> <p>YEARS ..... 2 <input type="text"/> <input type="text"/></p> <p>DON'T KNOW .....998</p>
408	Did you see anyone for antenatal care for this pregnancy?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 414) ←</p>	
409	<p>Whom did you see?</p> <p>Anyone else?</p> <p>PROBE TO IDENTIFY EACH TYPE OF PERSON AND RECORD ALL MENTIONED.</p>	<p><b>HEALTH PERSONNEL</b></p> <p>DOCTOR ..... A</p> <p>NURSE/MIDWIFE ..... B</p> <p>AUXILIARY MIDWIFE ..... C</p> <p><b>OTHER PERSON</b></p> <p>TRADITIONAL BIRTH ATTENDANT ..... D</p> <p>COMMUNITY/ VILLAGE HEALTH WORKER..... E</p> <p>OTHER _____ X</p> <p align="center">(SPECIFY)</p>	

**SECTION 4. PREGNANCY AND POSTNATAL CARE**

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____												
410	<p>Where did you receive antenatal care for this pregnancy?</p> <p>Anywhere else?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p align="center">(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>GOVERNMENT HOSPITAL ... C</p> <p>GOVERNMENT HEALTH CENTER ..... D</p> <p>GOVERNMENT HEALTH POST ..... E</p> <p>OTHER PUBLIC SECTOR</p> <p>_____ F</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/CLINIC ..... G</p> <p>OTHER PRIVATE MEDICAL SECTOR</p> <p>_____ H</p> <p align="center">(SPECIFY)</p> <p>OTHER _____ X</p> <p align="center">(SPECIFY)</p>													
411	<p>How many months pregnant were you when you first received antenatal care for this pregnancy?</p>	<p>MONTHS ..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>													
412	<p>How many times did you receive antenatal care during this pregnancy?</p>	<p>NUMBER OF TIMES ..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>													
413	<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 align="center">YES</th> <th align="center">NO</th> </tr> </thead> <tbody> <tr> <td>a) BP .....</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>b) URINE .....</td> <td align="center">1</td> <td align="center">2</td> </tr> <tr> <td>c) BLOOD .....</td> <td align="center">1</td> <td align="center">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													
414	<p>During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 417) ←</p> <p>DON'T KNOW ..... 8</p>													
415	<p>During this pregnancy, how many times did you get a tetanus injection?</p>	<p>TIMES ..... <input type="text"/></p> <p>DON'T KNOW ..... 8</p>													
416	<p>CHECK 415:</p>	<p>2 OR MORE TIMES <input type="checkbox"/></p> <p>OTHER <input type="checkbox"/></p> <p align="center">(SKIP TO 420) ←</p>													

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
417	At any time before this pregnancy, did you receive any tetanus injections?	YES ..... 1 NO ..... 2 (SKIP TO 420) ← DON'T KNOW ..... 8	
418	Before this pregnancy, how many times did you receive a tetanus injection?  IF 7 OR MORE TIMES, RECORD '7'.	TIMES ..... <input type="text"/>  DON'T KNOW ..... 8	
419	CHECK 418:  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> ONLY <input type="checkbox"/> ONE ↓ a) How many years ago did you receive that tetanus injection? </div> <div style="width: 45%;"> 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"/>	
420	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 422) ← DON'T KNOW ..... 8	
421	During the whole pregnancy, for how many days did you take the 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	
422	During this pregnancy, did you take any drug for intestinal worms?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
423	During this pregnancy, did you take SP/Fansidar to keep you from getting malaria?	YES ..... 1 NO ..... 2 (SKIP TO 426) ← DON'T KNOW ..... 8	
424	How many times did you take SP/Fansidar during this pregnancy?	TIMES ..... <input type="text"/> <input type="text"/>	
425	Did you get the SP/Fansidar during any antenatal care visit, during another visit to a health facility or from another source?  IF MORE THAN ONE SOURCE, RECORD THE HIGHEST SOURCE ON THE LIST.	ANTENATAL VISIT ..... 1 ANOTHER FACILITY VISIT ..... 2 OTHER SOURCE ..... 6	

**SECTION 4. PREGNANCY AND POSTNATAL CARE**

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
426	When (NAME) was born, was (NAME) very large, larger than average, average, smaller than average, or very small?	VERY LARGE ..... 1 LARGER THAN AVERAGE ..... 2 AVERAGE ..... 3 SMALLER THAN AVERAGE ..... 4 VERY SMALL ..... 5 DON'T KNOW ..... 8	VERY LARGE ..... 1 LARGER THAN AVERAGE ..... 2 AVERAGE ..... 3 SMALLER THAN AVERAGE ..... 4 VERY SMALL ..... 5 DON'T KNOW ..... 8
427	Was (NAME) weighed at birth?	YES ..... 1 NO ..... 2 (SKIP TO 429) ← DON'T KNOW ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 429) ← DON'T KNOW ..... 8
428	How much did (NAME) weigh?  RECORD WEIGHT IN KILOGRAMS FROM HEALTH CARD, IF AVAILABLE.	KG FROM CARD 1 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> KG FROM RECALL 2 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW ..... 99998	KG FROM CARD 1 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> KG FROM RECALL 2 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW ..... 99998
429	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.	<b>HEALTH PERSONNEL</b> DOCTOR ..... A NURSE/MIDWIFE ..... B AUXILIARY MIDWIFE ..... C <b>OTHER PERSON</b> TRADITIONAL BIRTH ATTENDANT ..... D RELATIVE/FRIEND ..... E OTHER _____ X (SPECIFY) NO ONE ASSISTED ..... Y	<b>HEALTH PERSONNEL</b> DOCTOR ..... A NURSE/MIDWIFE ..... B AUXILIARY MIDWIFE ..... C <b>OTHER PERSON</b> TRADITIONAL BIRTH ATTENDANT ..... D RELATIVE/FRIEND ..... E OTHER _____ X (SPECIFY) NO ONE ASSISTED ..... Y

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
430	<p>Where did you give birth to (NAME)?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p align="center">(NAME OF PLACE)</p>	<p><b>HOME</b></p> <p>HER HOME ..... 11</p> <p align="right">(SKIP TO 434) ←</p> <p>OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ... 21</p> <p>GOVERNMENT HEALTH CENTER ..... 22</p> <p>GOVERNMENT HEALTH POST ..... 23</p> <p>OTHER PUBLIC SECTOR</p> <p>_____ 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</p> <p>_____ 36</p> <p align="center">(SPECIFY)</p> <p>OTHER _____ 96</p> <p align="right">(SKIP TO 434) ←</p>	<p><b>HOME</b></p> <p>HER HOME ..... 11</p> <p align="right">(SKIP TO 434) ←</p> <p>OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ... 21</p> <p>GOVERNMENT HEALTH CENTER ..... 22</p> <p>GOVERNMENT HEALTH POST ..... 23</p> <p>OTHER PUBLIC SECTOR</p> <p>_____ 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</p> <p>_____ 36</p> <p align="center">(SPECIFY)</p> <p>OTHER _____ 96</p> <p align="right">(SKIP TO 434) ←</p>
431	<p>How long after (NAME) was delivered did you stay there?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS;</p> <p>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>	
432	<p>Was (NAME) delivered by caesarean, that is, did they cut your belly open to take the baby out?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 434) ←</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 434) ←</p>
433	<p>When was the decision made to have the caesarean section? Was it before or after your labor pains started?</p>	<p>BEFORE ..... 1</p> <p>AFTER ..... 2</p>	<p>BEFORE ..... 1</p> <p>AFTER ..... 2</p>
434	<p>Immediately after the birth, was (NAME) put on your chest?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 434B) ←</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 459) ←</p> <p>DON'T KNOW ..... 8</p>
434A	<p>Was (NAME)'s bare skin touching your bare skin?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>
434B	<p>CHECK 430: PLACE OF DELIVERY</p>	<p>CODE</p> <p>11, 12, OR 96</p> <p>CIRCLED <input type="checkbox"/></p> <p>OTHER <input type="checkbox"/></p> <p align="center">(SKIP TO 449) ←</p>	

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____						
435	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 while you were still in the facility?	YES ..... 1 NO ..... 2 (SKIP TO 438) ←							
436	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 <table border="1" data-bbox="911 450 1050 506"><tr><td></td><td></td></tr></table> DAYS ..... 2 <table border="1" data-bbox="911 510 1050 566"><tr><td></td><td></td></tr></table> WEEKS ..... 3 <table border="1" data-bbox="911 571 1050 627"><tr><td></td><td></td></tr></table> DON'T KNOW .....998							
437	Who checked on your health at that time?  PROBE FOR MOST QUALIFIED PERSON.	<b>HEALTH PERSONNEL</b> DOCTOR ..... 11 NURSE/MIDWIFE ..... 12 AUXILIARY MIDWIFE ..... 13 <b>OTHER PERSON</b> TRADITIONAL BIRTH ATTENDANT ..... 21 COMMUNITY/ VILLAGE HEALTH WORKER ..... 22 OTHER ..... 96 (SPECIFY)							
438	Now I would like to talk to you about checks on (NAME)'s health after delivery – for example, someone examining (NAME), checking the cord, or seeing if (NAME) is OK. Did anyone check on (NAME)'s health while you were still in the facility?	YES ..... 1 NO ..... 2 (SKIP TO 441) ← DON'T KNOW ..... 8							
439	How long after delivery was (NAME)'s health first checked?  IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.	HOURS ..... 1 <table border="1" data-bbox="911 1341 1050 1397"><tr><td></td><td></td></tr></table> DAYS ..... 2 <table border="1" data-bbox="911 1402 1050 1458"><tr><td></td><td></td></tr></table> WEEKS ..... 3 <table border="1" data-bbox="911 1462 1050 1518"><tr><td></td><td></td></tr></table> DON'T KNOW .....998							
440	Who checked on (NAME)'s health at that time?  PROBE FOR MOST QUALIFIED PERSON.	<b>HEALTH PERSONNEL</b> DOCTOR ..... 11 NURSE/MIDWIFE ..... 12 AUXILIARY MIDWIFE ..... 13 <b>OTHER PERSON</b> TRADITIONAL BIRTH ATTENDANT ..... 21 COMMUNITY/ VILLAGE HEALTH WORKER ..... 22 OTHER ..... 96 (SPECIFY)							

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____						
441	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 445) ←							
442	How long after delivery did that check take place?  IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.	HOURS ..... 1 <table border="1" data-bbox="911 398 1050 450"><tr><td></td><td></td></tr></table> DAYS ..... 2 <table border="1" data-bbox="911 450 1050 501"><tr><td></td><td></td></tr></table> WEEKS ..... 3 <table border="1" data-bbox="911 501 1050 553"><tr><td></td><td></td></tr></table> DON'T KNOW .....998							
443	Who checked on your health at that time?  PROBE FOR MOST QUALIFIED PERSON.	<b>HEALTH PERSONNEL</b> DOCTOR ..... 11 NURSE/MIDWIFE ..... 12 AUXILIARY MIDWIFE ..... 13 <b>OTHER PERSON</b> TRADITIONAL BIRTH ATTENDANT ..... 21 COMMUNITY/ VILLAGE HEALTH WORKER ..... 22  OTHER ..... 96 (SPECIFY)							
444	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)	<b>HOME</b> HER HOME ..... 11 OTHER HOME ..... 12  <b>PUBLIC SECTOR</b> GOVERNMENT HOSPITAL .. 21 GOVERNMENT HEALTH CENTER ..... 22 GOVERNMENT HEALTH POST ..... 23 OTHER PUBLIC SECTOR ..... 26 (SPECIFY)  <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/ CLINIC ..... 31 OTHER PRIVATE MEDICAL SECTOR ..... 36 (SPECIFY)  OTHER ..... 96 (SPECIFY)							
445	I would like to talk to you about checks on (NAME)'s health after you left (FACILITY IN 430). Did any health care provider or a traditional birth attendant check on (NAME)'s health in the two months after you left (FACILITY IN 430)?	YES ..... 1 NO ..... 2 (SKIP TO 457) ← DON'T KNOW ..... 8							



SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____												
446	<p>How many hours, days or weeks after the birth of (NAME) did that check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</p>	<p>HOURS ..... 1 <table border="1" data-bbox="911 259 1050 309"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DAYS ..... 2 <table border="1" data-bbox="911 315 1050 365"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>WEEKS ..... 3 <table border="1" data-bbox="911 371 1050 421"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW .....998</p>													
447	<p>Who checked on (NAME)'s health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p><b>HEALTH PERSONNEL</b>            DOCTOR ..... 11            NURSE/MIDWIFE ..... 12            AUXILIARY            MIDWIFE ..... 13  <b>OTHER PERSON</b>            TRADITIONAL BIRTH            ATTENDANT ..... 21            COMMUNITY/            VILLAGE HEALTH            WORKER ..... 22            OTHER ..... 96            (SPECIFY) _____</p>													
448	<p>Where did this check of (NAME) take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p>(NAME OF PLACE)</p>	<p><b>HOME</b>            HER HOME ..... 11            OTHER HOME ..... 12  <b>PUBLIC SECTOR</b>            GOVERNMENT HOSPITAL . . 21            GOVERNMENT HEALTH            CENTER ..... 22            GOVERNMENT HEALTH            POST ..... 23            OTHER PUBLIC SECTOR            ..... 26            (SPECIFY) _____  <b>PRIVATE MEDICAL SECTOR</b>            PRIVATE HOSPITAL/            CLINIC ..... 31            OTHER PRIVATE            MEDICAL SECTOR            ..... 36            (SPECIFY) _____            OTHER ..... 96            (SPECIFY) _____            (SKIP TO 457) ←</p>													
449	<p>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 to (NAME)?</p>	<p>YES ..... 1            NO ..... 2            (SKIP TO 453) ←</p>													

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____						
450	<p>How long after delivery did the first check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</p>	<p>HOURS ..... 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><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr><tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table></p> <p>DAYS ..... 2</p> <p>WEEKS ..... 3</p> <p>DON'T KNOW .....998</p>							
451	<p>Who checked on your health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p><b>HEALTH PERSONNEL</b></p> <p>DOCTOR ..... 11</p> <p>NURSE/MIDWIFE ..... 12</p> <p>AUXILIARY</p> <p>MIDWIFE ..... 13</p> <p><b>OTHER PERSON</b></p> <p>TRADITIONAL BIRTH ATTENDANT ..... 21</p> <p>COMMUNITY/VILLAGE HEALTH WORKER ..... 22</p> <p>OTHER ..... 96 (SPECIFY)</p>							
452	<p>Where did this first check take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</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>GOVERNMENT HOSPITAL ... 21</p> <p>GOVERNMENT HEALTH CENTER ..... 22</p> <p>GOVERNMENT HEALTH POST ..... 23</p> <p>OTHER PUBLIC SECTOR</p> <p>_____ 26 (SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/CLINIC ..... 31</p> <p>OTHER PRIVATE MEDICAL SECTOR</p> <p>_____ 36 (SPECIFY)</p> <p>OTHER ..... 96 (SPECIFY)</p>							
453	<p>I would like to talk to you about checks on (NAME)'s health after delivery – for example, someone examining (NAME), checking the cord, or seeing if (NAME) is OK. In the two months after (NAME) was born, did any health care provider or a traditional birth attendant check on (NAME)'s health?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 457) ←</p> <p>DON'T KNOW ..... 8</p>							

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____						
454	<p>How many hours, days or weeks after the birth of (NAME) did the first check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</p>	<p>HOURS AFTER BIRTH ..... 1 <table border="1" data-bbox="914 259 1050 309"><tr><td></td><td></td></tr></table></p> <p>DAYS AFTER BIRTH ..... 2 <table border="1" data-bbox="914 311 1050 360"><tr><td></td><td></td></tr></table></p> <p>WEEKS AFTER BIRTH ..... 3 <table border="1" data-bbox="914 362 1050 412"><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW .....998</p>							
455	<p>Who checked on (NAME)'s health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p><b>HEALTH PERSONNEL</b>  DOCTOR ..... 11  NURSE/MIDWIFE ..... 12  AUXILIARY  MIDWIFE ..... 13  <b>OTHER PERSON</b>  TRADITIONAL BIRTH ATTENDANT ..... 21  COMMUNITY/  VILLAGE HEALTH WORKER ..... 22    OTHER ..... 96  (SPECIFY)</p>							
456	<p>Where did this first check of (NAME) take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p>(NAME OF PLACE)</p>	<p><b>HOME</b>  HER HOME ..... 11  OTHER HOME ..... 12    <b>PUBLIC SECTOR</b>  GOVERNMENT HOSPITAL ... 21  GOVERNMENT HEALTH CENTER ..... 22  GOVERNMENT HEALTH POST ..... 23  OTHER PUBLIC SECTOR  _____ 26  (SPECIFY)    <b>PRIVATE MEDICAL SECTOR</b>  PRIVATE HOSPITAL/  CLINIC ..... 31  OTHER PRIVATE MEDICAL SECTOR  _____ 36  (SPECIFY)    OTHER ..... 96  SPECIFY</p>							

## SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH		NEXT-TO-LAST BIRTH	
		NAME		NAME	
457	During the first two days after (NAME)'s birth, did any health care provider do the following: a) Examine the cord? b) Measure (NAME)'s temperature? c) Counsel you on danger signs for newborns? d) Counsel you on breastfeeding? e) Observe (NAME) breastfeeding?		<div>YES NO DK</div> <div>a) CORD ..... 1 2 8</div> <div>b) TEMP. .... 1 2 8</div> <div>c) SIGNS .... 1 2 8</div> <div>d) COUNSEL BREAST-FEED ..... 1 2 8</div> <div>e) OBSERVE BREAST-FEED ..... 1 2 8</div>		
458	Has your menstrual period returned since the birth of (NAME)?	YES ..... 1 (SKIP TO 460) ←			
		NO ..... 2 (SKIP TO 461) ←			
459	Did your period return between the birth of (NAME) and your next pregnancy?			YES ..... 1 NO ..... 2 (SKIP TO 463) ←	
460	For how many months after the birth of (NAME) did you not have a period?	MONTHS ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98		MONTHS ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98	
461	CHECK 226: IS RESPONDENT PREGNANT?	NOT PREGNANT <input type="checkbox"/> ↓ PREGNANT OR UNSURE <input type="checkbox"/> (SKIP TO 463) ←			
462	Have you had sexual intercourse since the birth of (NAME)?	YES ..... 1 NO ..... 2 (SKIP TO 464) ←			
463	For how many months after the birth of (NAME) did you not have sexual intercourse?	MONTHS ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98		MONTHS ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98	
464	Did you ever breastfeed (NAME)?	YES ..... 1 (SKIP TO 466) ← NO ..... 2		YES ..... 1 NO ..... 2	
465	CHECK 404: IS CHILD LIVING?	LIVING <input type="checkbox"/> DEAD <input type="checkbox"/> (SKIP TO 470) ← (SKIP TO 471) ←			
466	How long after birth did you first put (NAME) to the breast?  IF LESS THAN 1 HOUR, RECORD '00' HOURS; IF LESS THAN 24 HOURS, RECORD HOURS; OTHERWISE, RECORD DAYS.	IMMEDIATELY ..... 000  HOURS ..... 1 <input type="text"/> <input type="text"/> DAYS ..... 2 <input type="text"/> <input type="text"/>			
467	In the first three days after delivery, was (NAME) given anything to drink other than breast milk?	YES ..... 1 NO ..... 2			

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
468	CHECK 404: IS CHILD LIVING?	<div> <div>LIVING</div> <div>DEAD</div> <div>(SKIP TO 471) ←</div> </div>	<div> <div>LIVING</div> <div>DEAD</div> <div>(SKIP TO 471) ←</div> </div>
469	Are you still breastfeeding (NAME)?	<div>YES ..... 1</div> <div>NO ..... 2</div>	
470	Did (NAME) drink anything from a bottle with a nipple yesterday or last night?	<div>YES ..... 1</div> <div>NO ..... 2</div> <div>DON'T KNOW ..... 8</div>	<div>YES ..... 1</div> <div>NO ..... 2</div> <div>DON'T KNOW ..... 8</div>
471		GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501A.	GO BACK TO 405 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 501A.

SECTION 5A. CHILD IMMUNIZATION (LAST BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501A	CHECK 215 IN THE BIRTH HISTORY: ANY BIRTHS IN 2016-2019? ONE OR MORE BIRTHS IN 2016-2019 <input type="checkbox"/> NO BIRTHS IN 2016-2019 <input type="checkbox"/>		→ 601
502A	RECORD THE NAME AND BIRTH HISTORY NUMBER FROM 212 OF THE LAST CHILD BORN IN 2016-2019. NAME OF LAST BIRTH _____ BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/>		
503A	CHECK 216 FOR CHILD: LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>		→ 501B
504A	Do you have a card or other document where (NAME)'s vaccinations are written down?	YES, HAS ONLY A CARD ..... 1 YES, HAS ONLY ANOTHER DOCUMENT ..... 2 YES, HAS CARD AND OTHER DOCUMENT ..... 3 NO, NO CARD AND NO OTHER DOCUMENT .. 4	→ 507A → 507A
505A	Did you ever have a vaccination card for (NAME)?	YES ..... 1 NO ..... 2	
506A	CHECK 504A: CODE '2' CIRCLED <input type="checkbox"/> CODE '4' CIRCLED <input type="checkbox"/>		→ 511A
507A	May I see the card or other document where (NAME)'s vaccinations are written down?	YES, ONLY CARD SEEN ..... 1 YES, ONLY OTHER DOCUMENT SEEN ..... 2 YES, CARD AND OTHER DOCUMENT SEEN .. 3 NO CARD AND NO OTHER DOCUMENT SEEN .. 4	→ 511A

## SECTION 5A. CHILD IMMUNIZATION (LAST BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																																											
	NAME OF LAST BIRTH _____	BIRTH HISTORY NUMBER ..... <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>																																																																												
508A	<p>COPY DATES FROM THE CARD. WRITE '44' IN 'DAY' COLUMN IF CARD SHOWS THAT A DOSE WAS GIVEN, BUT NO DATE IS RECORDED.</p> <table border="1"> <thead> <tr> <th></th> <th>DAY</th> <th>MONTH</th> <th>YEAR</th> </tr> </thead> <tbody> <tr><td>BCG</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 1</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 2</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 3</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP.B-HIB (PENTAVALENT) 1</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP.B-HIB (PENTAVALENT) 2</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP.B-HIB (PENTAVALENT) 3</td><td></td><td></td><td></td></tr> <tr><td>PNEUMOCOCCAL 1</td><td></td><td></td><td></td></tr> <tr><td>PNEUMOCOCCAL 2</td><td></td><td></td><td></td></tr> <tr><td>PNEUMOCOCCAL 3</td><td></td><td></td><td></td></tr> <tr><td>INACTIVATED POLIO VIRUS (IPV)</td><td></td><td></td><td></td></tr> <tr><td>ROTAVIRUS 1</td><td></td><td></td><td></td></tr> <tr><td>ROTAVIRUS 2</td><td></td><td></td><td></td></tr> <tr><td>MEASLES 1</td><td></td><td></td><td></td></tr> <tr><td>MEASLES 2</td><td></td><td></td><td></td></tr> <tr><td>YELLOW FEVER</td><td></td><td></td><td></td></tr> <tr><td>VITAMIN A (MOST RECENT)</td><td></td><td></td><td></td></tr> </tbody> </table>		DAY	MONTH	YEAR	BCG				ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)				ORAL POLIO VACCINE (OPV) 1				ORAL POLIO VACCINE (OPV) 2				ORAL POLIO VACCINE (OPV) 3				DPT-HEP.B-HIB (PENTAVALENT) 1				DPT-HEP.B-HIB (PENTAVALENT) 2				DPT-HEP.B-HIB (PENTAVALENT) 3				PNEUMOCOCCAL 1				PNEUMOCOCCAL 2				PNEUMOCOCCAL 3				INACTIVATED POLIO VIRUS (IPV)				ROTAVIRUS 1				ROTAVIRUS 2				MEASLES 1				MEASLES 2				YELLOW FEVER				VITAMIN A (MOST RECENT)				
	DAY	MONTH	YEAR																																																																											
BCG																																																																														
ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)																																																																														
ORAL POLIO VACCINE (OPV) 1																																																																														
ORAL POLIO VACCINE (OPV) 2																																																																														
ORAL POLIO VACCINE (OPV) 3																																																																														
DPT-HEP.B-HIB (PENTAVALENT) 1																																																																														
DPT-HEP.B-HIB (PENTAVALENT) 2																																																																														
DPT-HEP.B-HIB (PENTAVALENT) 3																																																																														
PNEUMOCOCCAL 1																																																																														
PNEUMOCOCCAL 2																																																																														
PNEUMOCOCCAL 3																																																																														
INACTIVATED POLIO VIRUS (IPV)																																																																														
ROTAVIRUS 1																																																																														
ROTAVIRUS 2																																																																														
MEASLES 1																																																																														
MEASLES 2																																																																														
YELLOW FEVER																																																																														
VITAMIN A (MOST RECENT)																																																																														
509A	<p>CHECK 508A: 'BCG' TO 'MEASLES ALL RECORDED?</p> <p>NO <input type="checkbox"/> <span style="margin-left: 100px;">YES <input type="checkbox"/></span></p> <p style="text-align: right;">→ 525A</p>																																																																													
510A	<p>In addition to what is recorded on (this document/these documents), did (NAME) receive any other vaccinations, including vaccinations received in campaigns or immunization days or child health days?</p> <p>RECORD 'YES' ONLY IF THE RESPONDENT MENTIONS AT LEAST ONE OF THE VACCINATIONS IN 508A THAT ARE NOT RECORDED AS HAVING BEEN GIVEN.</p>	<p>YES ..... 1</p> <p>(PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 508A THEN WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN)</p> <p>(THEN SKIP TO 525A)</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p> <p>(WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN)</p> <p>(THEN SKIP TO 525A)</p>																																																																												

SECTION 5A. CHILD IMMUNIZATION (LAST BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	NAME OF LAST BIRTH _____	BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/>	
511A	Did (NAME) ever receive any vaccinations to prevent (NAME) from getting diseases, including vaccinations received in campaigns or immunization days or child health days?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 525A
512A	Has (NAME) ever received a BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
514A	Has (NAME) ever received oral polio vaccine, that is, about two drops in the mouth to prevent polio?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 517A
515A	Did (NAME) receive the first oral polio vaccine in the first two weeks after birth or later?	FIRST TWO WEEKS ..... 1 LATER ..... 2	
516A	How many times did (NAME) receive the oral polio vaccine?	NUMBER OF TIMES ..... <input type="text"/>	
516A1	The last time (NAME) receive the polio drops, did (NAME) also get an IPV injection in the arm to protect against polio?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
517A	Has (NAME) ever received a pentavalent vaccination, that is, an injection given in the thigh sometimes at the same time as polio drops?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 519A
518A	How many times did (NAME) receive the pentavalent vaccine?	NUMBER OF TIMES ..... <input type="text"/>	



SECTION 5A. CHILD IMMUNIZATION (LAST BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	NAME OF LAST BIRTH _____	BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/>	
519A	Has (NAME) ever received a pneumococcal vaccination, that is, an injection in the thigh to prevent pneumonia?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 521A
520A	How many times did (NAME) receive the pneumococcal vaccine?	NUMBER OF TIMES ..... <input type="text"/>	
521A	Has (NAME) ever received a rotavirus vaccination, that is, liquid in the mouth to prevent diarrhea?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 523A
522A	How many times did (NAME) receive the rotavirus vaccine?	NUMBER OF TIMES ..... <input type="text"/>	
523A	Has (NAME) ever received a measles vaccination, that is, an injection in the arm to prevent measles?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 524A1
524A	How many times did (NAME) receive the measles vaccine?	NUMBER OF TIMES ..... <input type="text"/>	
524A1	Has (NAME) ever received a yellow fever vaccination, that is, an injection in the upper right arm to prevent yellow fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
525A	In the last 7 days was (NAME) given:	<div style="text-align: right;">YES   NO   DK</div> a) READY TO USE THERAPEUTIC FOOD AS PLUMPY'NUT?      b) PLUMPY'NUT ..... 1   2   8 b) SUPPLEMENTAL FOOD SUCH AS PLUMPY'DOZ      c) PLUMPY'DOZ ..... 1   2   8	
526A	CONTINUE WITH 501B.		

SECTION 5B. CHILD IMMUNIZATION (NEXT-TO-LAST BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501B	CHECK 215 IN THE BIRTH HISTORY: ANY MORE BIRTHS IN 2016-2019? <div> MORE BIRTHS IN 2016-2019 <input type="checkbox"/> NO MORE BIRTHS IN 2016-2019 <input type="checkbox"/> </div>		→ 601
502B	RECORD THE NAME AND BIRTH HISTORY NUMBER FROM 212 OF THE NEXT-TO-LAST CHILD BORN IN 2016-2019. NAME OF NEXT-TO-LAST BIRTH _____ BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/>		
503B	CHECK 216 FOR CHILD: <div> LIVING <input type="checkbox"/> DEAD <input type="checkbox"/> </div>		→ 526B
504B	Do you have a card or other document where (NAME)'s vaccinations are written down?	YES, HAS ONLY A CARD ..... 1 YES, HAS ONLY ANOTHER DOCUMENT ..... 2 YES, HAS CARD AND OTHER DOCUMENT ..... 3 NO, NO CARD AND NO OTHER DOCUMENT .. 4	→ 507B → 507B
505B	Did you ever have a vaccination card for (NAME)?	YES ..... 1 NO ..... 2	
506B	CHECK 504B: <div> CODE '2' CIRCLED <input type="checkbox"/> CODE '4' CIRCLED <input type="checkbox"/> </div>		→ 511B
507B	May I see the card or other document where (NAME)'s vaccinations are written down?	YES, ONLY CARD SEEN ..... 1 YES, ONLY OTHER DOCUMENT SEEN ..... 2 YES, CARD AND OTHER DOCUMENT SEEN .. 3 NO CARD AND NO OTHER DOCUMENT SEEN .. 4	→ 511B

SECTION 5B. CHILD IMMUNIZATION (NEXT-TO-LAST BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																																												
	NAME OF NEXT-TO-LAST BIRTH _____ <div style="float: right;">BIRTH HISTORY NUMBER ..... <span style="border: 1px solid black; padding: 0 5px;">  </span> <span style="border: 1px solid black; padding: 0 5px;">  </span></div>																																																																														
508B	<p>COPY DATES FROM THE CARD. WRITE '44' IN 'DAY' COLUMN IF CARD SHOWS THAT A DOSE WAS GIVEN, BUT NO DATE IS RECORDED.</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">DAY</th> <th style="text-align: center;">MONTH</th> <th style="text-align: center;">YEAR</th> </tr> </thead> <tbody> <tr><td>BCG ( AT BIRTH)</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 1</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 2</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 3</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>DPT-HEP.B-HIB (PENTAVALENT) 1</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>DPT-HEP.B-HIB (PENTAVALENT) 2</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>DPT-HEP.B-HIB (PENTAVALENT) 3</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>PNEUMOCOCCAL 1</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>PNEUMOCOCCAL 2</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>PNEUMOCOCCAL 3</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>INACTIVATED POLIO VIRUS (IPV)</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>ROTAVIRUS 1</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>ROTAVIRUS 2</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>MEASLES 1</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>MEASLES 2</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>YELLOW FEVER</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> <tr><td>VITAMIN A (MOST RECENT)</td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td><td><div style="border: 1px solid black; width: 20px; height: 20px;"></div></td></tr> </tbody> </table>		DAY	MONTH	YEAR	BCG ( AT BIRTH)	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	ORAL POLIO VACCINE (OPV) 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	ORAL POLIO VACCINE (OPV) 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	ORAL POLIO VACCINE (OPV) 3	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	DPT-HEP.B-HIB (PENTAVALENT) 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	DPT-HEP.B-HIB (PENTAVALENT) 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	DPT-HEP.B-HIB (PENTAVALENT) 3	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	PNEUMOCOCCAL 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	PNEUMOCOCCAL 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	PNEUMOCOCCAL 3	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	INACTIVATED POLIO VIRUS (IPV)	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	ROTAVIRUS 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	ROTAVIRUS 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	MEASLES 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	MEASLES 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	YELLOW FEVER	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	VITAMIN A (MOST RECENT)	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>		
	DAY	MONTH	YEAR																																																																												
BCG ( AT BIRTH)	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
ORAL POLIO VACCINE (OPV) 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
ORAL POLIO VACCINE (OPV) 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
ORAL POLIO VACCINE (OPV) 3	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
DPT-HEP.B-HIB (PENTAVALENT) 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
DPT-HEP.B-HIB (PENTAVALENT) 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
DPT-HEP.B-HIB (PENTAVALENT) 3	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
PNEUMOCOCCAL 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
PNEUMOCOCCAL 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
PNEUMOCOCCAL 3	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
INACTIVATED POLIO VIRUS (IPV)	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
ROTAVIRUS 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
ROTAVIRUS 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
MEASLES 1	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
MEASLES 2	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
YELLOW FEVER	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
VITAMIN A (MOST RECENT)	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>																																																																												
509B	<p>CHECK 508B: 'BCG' TO 'MEASLES ALL RECORDED?</p> <p align="center">NO <input type="checkbox"/> <span style="margin-left: 100px;">YES <input type="checkbox"/></span></p> <p align="center">↓ <span style="margin-left: 150px;">→ 525B</span></p>																																																																														
510B	<p>In addition to what is recorded on (this document/these documents), did (NAME) receive any other vaccinations, including vaccinations received in campaigns or immunization days or child health days?</p> <p>RECORD 'YES' ONLY IF THE RESPONDENT MENTIONS AT LEAST ONE OF THE VACCINATIONS IN 508B THAT ARE NOT RECORDED AS HAVING BEEN GIVEN.</p>	<p>YES ..... 1</p> <p>(PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 508B THEN WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN)</p> <p align="right">(THEN SKIP TO 525B) ←</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p> <p>(WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN)</p> <p align="right">(THEN SKIP TO 525B) ←</p>																																																																													

SECTION 5B. CHILD IMMUNIZATION (NEXT-TO-LAST BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	NAME OF NEXT-TO-LAST BIRTH _____	BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/>	
511B	Did (NAME) ever receive any vaccinations to prevent (NAME) from getting diseases, including vaccinations received in campaigns or immunization days or child health days?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 525B
512B	Has (NAME) ever received a BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
514B	Has (NAME) ever received oral polio vaccine, that is, about two drops in the mouth to prevent polio?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 517B
515B	Did (NAME) receive the first oral polio vaccine in the first two weeks after birth or later?	FIRST TWO WEEKS ..... 1 LATER ..... 2	
516B	How many times did (NAME) receive the oral polio vaccine?	NUMBER OF TIMES ..... <input type="text"/>	
516B1	The last time (NAME) receive the polio drops, did (NAME) also get an IPV injection in the arm to protect against polio?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
517B	Has (NAME) ever received a pentavalent vaccination, that is, an injection given in the thigh sometimes at the same time as polio drops?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 519B
518B	How many times did (NAME) receive the pentavalent vaccine?	NUMBER OF TIMES ..... <input type="text"/>	

SECTION 5B. CHILD IMMUNIZATION (NEXT-TO-LAST BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP												
	NAME OF NEXT-TO-LAST BIRTH _____	BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/>													
519B	Has (NAME) ever received a pneumococcal vaccination, that is, an injection in the thigh to prevent pneumonia?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 521B												
520B	How many times did (NAME) receive the pneumococcal vaccine?	NUMBER OF TIMES ..... <input type="text"/>													
521B	Has (NAME) ever received a rotavirus vaccination, that is, liquid in the mouth to prevent diarrhea?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 523B												
522B	How many times did (NAME) receive the rotavirus vaccine?	NUMBER OF TIMES ..... <input type="text"/>													
523B	Has (NAME) ever received a measles vaccination, that is, an injection in the arm to prevent measles?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 523B1												
524B	How many times did (NAME) receive the measles vaccine?	NUMBER OF TIMES ..... <input type="text"/>													
524B1	Has (NAME) ever received a yellow fever vaccination, that is, an injection in the upper right arm to prevent yellow fever?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8													
525B	In the last 7 days was (NAME) given:	<table border="0"> <tr> <td></td> <td align="center">YES</td> <td align="center">NO</td> <td align="center">DK</td> </tr> <tr> <td>a) READY TO USE THERAPEUTIC FOOD AS PLUMPY'NUT?</td> <td>b) PLUMPY'NUT ..... 1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) SUPPLEMENTAL FOOD SUCH AS PLUMPY'DOZ</td> <td>c) PLUMPY'DOZ ..... 1</td> <td>2</td> <td>8</td> </tr> </table>		YES	NO	DK	a) READY TO USE THERAPEUTIC FOOD AS PLUMPY'NUT?	b) PLUMPY'NUT ..... 1	2	8	b) SUPPLEMENTAL FOOD SUCH AS PLUMPY'DOZ	c) PLUMPY'DOZ ..... 1	2	8	
	YES	NO	DK												
a) READY TO USE THERAPEUTIC FOOD AS PLUMPY'NUT?	b) PLUMPY'NUT ..... 1	2	8												
b) SUPPLEMENTAL FOOD SUCH AS PLUMPY'DOZ	c) PLUMPY'DOZ ..... 1	2	8												
527B	CHECK 215 IN BIRTH HISTORY: ANY MORE BIRTHS IN 2016-2019?  <div style="display: flex; justify-content: space-between;"> <div>                         MORE BIRTHS IN 2016-2019 <input type="checkbox"/>                          (GO TO 502B IN AN ADDITIONAL QUESTIONNAIRE)                     </div> <div>                         NO MORE BIRTHS IN 2016-2019 <input type="checkbox"/> → 601                     </div> </div>														

## SECTION 6. CHILD HEALTH AND NUTRITION

601	CHECK 224:  <div style="display: flex; justify-content: space-between;"> <div style="text-align: center;">             ONE OR MORE BIRTHS IN 2014-2019             <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto; position: relative;"> <div style="position: absolute; top: -5px; left: 50%; transform: translateX(-50%);">↓</div> </div> </div> <div style="text-align: center;">             NO BIRTHS IN 2014-2019             <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto; position: relative;"> <div style="position: absolute; top: -5px; left: 50%; transform: translateX(-50%);">→ 648</div> </div> </div> </div>		
602	CHECK 215: RECORD THE BIRTH HISTORY NUMBER IN 603 AND THE NAME AND SURVIVAL STATUS IN 604 FOR EACH BIRTH IN 2014-2019. ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH. IF THERE ARE MORE THAN 2 BIRTHS, USE LAST COLUMN OF ADDITIONAL QUESTIONNAIRE(S).  Now I would like to ask some questions about your children born in the last five years. (We will talk about each separately.)		
603	BIRTH HISTORY NUMBER FROM 212 IN BIRTH HISTORY.	LAST BIRTH  BIRTH HISTORY NUMBER ..... <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	NEXT-TO-LAST BIRTH  BIRTH HISTORY NUMBER ..... <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>
604	FROM 212 AND 216:	NAME .....  <div style="display: flex; justify-content: space-between;"> <div style="text-align: center;">             LIVING  <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto; position: relative;"> <div style="position: absolute; top: -5px; left: 50%; transform: translateX(-50%);">↓</div> </div> </div> <div style="text-align: center;">             DEAD <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>              (SKIP TO 646) ←           </div> </div>	NAME .....  <div style="display: flex; justify-content: space-between;"> <div style="text-align: center;">             LIVING  <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 auto; position: relative;"> <div style="position: absolute; top: -5px; left: 50%; transform: translateX(-50%);">↓</div> </div> </div> <div style="text-align: center;">             DEAD <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>              (SKIP TO 646) ←           </div> </div>
605	In the last six months, was (NAME) given a vitamin A dose like [this/any of these]?  SHOW COMMON TYPES OF AMPULES/CAPSULES/SYRUPS.	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8
606	In the last seven days, was (NAME) given iron pills, sprinkles with iron, or iron syrup like [this/any of these]? SHOW COMMON TYPES OF PILLS/SPRINKLES/SYRUPS.	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8
607	Was (NAME) given any drug for intestinal worms in the last six months?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8
608	Has (NAME) had diarrhea in the last 2 weeks?	YES ..... 1 NO ..... 2 <div style="text-align: center;">(SKIP TO 618) ←</div> DON'T KNOW ..... 8	YES ..... 1 NO ..... 2 <div style="text-align: center;">(SKIP TO 618) ←</div> DON'T KNOW ..... 8

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
609	<p>CHECK 469: CURRENTLY BREASTFEEDING?</p> <p>YES <input type="checkbox"/> ↓      NO/ NOT <input type="checkbox"/> ASKED ↓</p> <p>a) Now I would like to know how much (NAME) was given to drink during the diarrhea including breastmilk. Was (NAME) given less than usual to drink, about the same amount, or more than usual to drink?</p> <p>IF LESS, PROBE: Was (NAME) given much less than usual to drink or somewhat less?</p> <p>b) Now I would like to know how much (NAME) was given to drink during the diarrhea. Was (NAME) given less than usual to drink, about the same amount, or more than usual to drink?</p> <p>IF LESS, PROBE: Was (NAME) given much less than usual to drink or somewhat less?</p>	<p>MUCH LESS ..... 1</p> <p>SOMEWHAT LESS ..... 2</p> <p>ABOUT THE SAME ..... 3</p> <p>MORE ..... 4</p> <p>NOTHING TO DRINK ..... 5</p> <p>DON'T KNOW ..... 8</p>	<p>MUCH LESS ..... 1</p> <p>SOMEWHAT LESS ..... 2</p> <p>ABOUT THE SAME ..... 3</p> <p>MORE ..... 4</p> <p>NOTHING TO DRINK ..... 5</p> <p>DON'T KNOW ..... 8</p>
610	<p>When (NAME) had diarrhea, was (NAME) given less than usual to eat, about the same amount, more than usual, or nothing to eat?</p> <p>IF LESS, PROBE: Was (NAME) given much less than usual to eat or somewhat less?</p>	<p>MUCH LESS ..... 1</p> <p>SOMEWHAT LESS ..... 2</p> <p>ABOUT THE SAME ..... 3</p> <p>MORE ..... 4</p> <p>STOPPED FOOD ..... 5</p> <p>NEVER GAVE FOOD ..... 6</p> <p>DON'T KNOW ..... 8</p>	<p>MUCH LESS ..... 1</p> <p>SOMEWHAT LESS ..... 2</p> <p>ABOUT THE SAME ..... 3</p> <p>MORE ..... 4</p> <p>STOPPED FOOD ..... 5</p> <p>NEVER GAVE FOOD ..... 6</p> <p>DON'T KNOW ..... 8</p>
611	<p>Did you seek advice or treatment for the diarrhea from any source?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 615) ←</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="right">(SKIP TO 615) ←</p>

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
612	<p>Where did you seek advice or treatment?</p> <p>Anywhere else?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE(S).</p> <p>_____</p> <p align="center">(NAME OF PLACE(S))</p>	<p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ... A</p> <p>GOVERNMENT HEALTH CENTER ..... B</p> <p>GOVERNMENT HEALTH POST ..... C</p> <p>MOBILE CLINIC ..... D</p> <p>FIELDWORKER ..... E</p> <p>OTHER PUBLIC SECTOR _____ F</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/CLINIC ..... G</p> <p>PHARMACY ..... H</p> <p>PRIVATE DOCTOR ..... I</p> <p>MOBILE CLINIC ..... J</p> <p>FIELDWORKER ..... K</p> <p>OTHER PRIVATE MEDICAL SECTOR _____ L</p> <p align="center">(SPECIFY)</p> <p><b>OTHER SOURCE</b></p> <p>SHOP ..... M</p> <p>TRADITIONAL PRACTITIONER ..... N</p> <p>MARKET ..... O</p> <p>ITINERANT DRUG SELLER ..... P</p> <p>OTHER _____ X</p> <p align="center">(SPECIFY)</p>	<p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ... A</p> <p>GOVERNMENT HEALTH CENTER ..... B</p> <p>GOVERNMENT HEALTH POST ..... C</p> <p>MOBILE CLINIC ..... D</p> <p>FIELDWORKER ..... E</p> <p>OTHER PUBLIC SECTOR _____ F</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/CLINIC ..... G</p> <p>PHARMACY ..... H</p> <p>PRIVATE DOCTOR ..... I</p> <p>MOBILE CLINIC ..... J</p> <p>FIELDWORKER ..... K</p> <p>OTHER PRIVATE MEDICAL SECTOR _____ L</p> <p align="center">(SPECIFY)</p> <p><b>OTHER SOURCE</b></p> <p>SHOP ..... M</p> <p>TRADITIONAL PRACTITIONER ..... N</p> <p>MARKET ..... O</p> <p>ITINERANT DRUG SELLER ..... P</p> <p>OTHER _____ X</p> <p align="center">(SPECIFY)</p>
613	CHECK 612:	<p>TWO OR MORE CODES CIRCLED <input type="checkbox"/></p> <p>ONLY ONE CODE CIRCLED <input type="checkbox"/></p> <p align="center">(SKIP TO 615) ←</p>	<p>TWO OR MORE CODES CIRCLED <input type="checkbox"/></p> <p>ONLY ONE CODE CIRCLED <input type="checkbox"/></p> <p align="center">(SKIP TO 615) ←</p>
614	<p>Where did you first seek advice or treatment?</p> <p>USE LETTER CODE FROM 612.</p>	FIRST PLACE ..... <input type="checkbox"/>	FIRST PLACE ..... <input type="checkbox"/>



**SECTION 6. CHILD HEALTH AND NUTRITION**

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
615	<p>Was (NAME) given any of the following at any time since (NAME) started having the diarrhea:</p> <p>a) A fluid made from a special packet called (ORS)?</p> <p>b) A pre-packed ORS liquid such as (PARENT CHOICE, ELECTORUSH)</p> <p>c) A government-recommended homemade fluid?</p> <p>d) Zinc tablets or syrup?</p>	<p align="center">YES NO DK</p> <p>a) FLUID FROM ORS      1      2      8</p> <p>b) ORS LIQUID .. 1      2      8</p> <p>c) HOMEMADE FLUID ..... 1      2      8</p> <p>d) ZINC ..... 1      2      8</p>	<p align="center">YES NO DK</p> <p>a) FLUID FROM ORS      1      2      8</p> <p>b) ORS LIQUID .. 1      2      8</p> <p>c) HOMEMADE FLUID ..... 1      2      8</p> <p>d) ZINC ..... 1      2      8</p>
616	<p>CHECK 615:</p> <p>ANY 'YES' <input type="checkbox"/>      ALL 'NO' OR 'DK' <input type="checkbox"/></p> <p>a) Was anything else given to treat the diarrhea?</p> <p>b) Was anything given to treat the diarrhea?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 618) ←</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 618) ←</p> <p>DON'T KNOW ..... 8</p>
617	<p>CHECK 615:</p> <p>ANY 'YES' <input type="checkbox"/>      ALL 'NO' OR 'DK' <input type="checkbox"/></p> <p>a) What else was given to treat the diarrhea?</p> <p>b) What was given to treat the diarrhea?</p> <p>Anything else?      Anything else?</p> <p>RECORD ALL TREATMENTS GIVEN.</p>	<p><b>PILL OR SYRUP</b></p> <p>ANTIBIOTIC ..... A</p> <p>ANTIMOTILITY ..... B</p> <p>OTHER (NOT ANTIBIOTIC OR ANTIMOTILITY) ..... C</p> <p>UNKNOWN PILL OR SYRUP ..... D</p> <p><b>INJECTION</b></p> <p>ANTIBIOTIC ..... E</p> <p>NON-ANTIBIOTIC ..... F</p> <p>UNKNOWN INJECTION ..... G</p> <p>(IV) INTRAVENOUS ..... H</p> <p>HOME REMEDY/ HERBAL MEDICINE ..... I</p> <p>OTHER ..... X</p> <p align="center">(SPECIFY)</p>	<p><b>PILL OR SYRUP</b></p> <p>ANTIBIOTIC ..... A</p> <p>ANTIMOTILITY ..... B</p> <p>OTHER (NOT ANTIBIOTIC OR ANTIMOTILITY) ..... C</p> <p>UNKNOWN PILL OR SYRUP ..... D</p> <p><b>INJECTION</b></p> <p>ANTIBIOTIC ..... E</p> <p>NON-ANTIBIOTIC ..... F</p> <p>UNKNOWN INJECTION ..... G</p> <p>(IV) INTRAVENOUS ..... H</p> <p>HOME REMEDY/ HERBAL MEDICINE ..... I</p> <p>OTHER ..... X</p> <p align="center">(SPECIFY)</p>
618	Has (NAME) been ill with a fever at any time in the last 2 weeks?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 620) ←</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 620) ←</p> <p>DON'T KNOW ..... 8</p>
619	At any time during the illness, did (NAME) have blood taken from (NAME)'s finger or heel for testing?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>
620	Has (NAME) had an illness with a cough at any time in the last 2 weeks?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>
621	Has (NAME) had fast, short, rapid breaths or difficulty breathing at any time in the last 2 weeks?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 623) ←</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p align="center">(SKIP TO 623) ←</p> <p>DON'T KNOW ..... 8</p>

## SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	LAST BIRTH	NEXT-TO-LAST BIRTH
		NAME _____	NAME _____
622	Was the fast or difficult breathing due to a problem in the chest or to a blocked or runny nose?	CHEST ONLY ..... 1 NOSE ONLY ..... 2 BOTH ..... 3  OTHER ..... 6 (SPECIFY) DON'T KNOW ..... 8 (SKIP TO 624) ←	CHEST ONLY ..... 1 NOSE ONLY ..... 2 BOTH ..... 3  OTHER ..... 6 (SPECIFY) DON'T KNOW ..... 8 (SKIP TO 624) ←
623	CHECK 618: HAD FEVER?	YES NO OR DK ↓                  ↓ (SKIP TO 646) ←	YES NO OR DK ↓                  ↓ (SKIP TO 646) ←
624	Did you seek advice or treatment for the illness from any source?	YES ..... 1 NO ..... 2 (SKIP TO 629) ←	YES ..... 1 NO ..... 2 (SKIP TO 629) ←
625	Where did you seek advice or treatment?  Anywhere else?  PROBE TO IDENTIFY THE TYPE OF SOURCE.  IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE(S).  _____ (NAME OF PLACE(S))	<b>PUBLIC SECTOR</b> GOVERNMENT HOSPITAL .. A GOVERNMENT HEALTH CENTER ..... B GOVERNMENT HEALTH POST ..... C MOBILE CLINIC ..... D FIELDWORKER/CHW ..... E OTHER PUBLIC SECTOR _____ F (SPECIFY) <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/ CLINIC ..... G PHARMACY ..... H PRIVATE DOCTOR ..... I MOBILE CLINIC ..... J FIELDWORKER/CHW ..... K OTHER PRIVATE MEDICAL SECTOR _____ L (SPECIFY) <b>OTHER SOURCE</b> SHOP ..... M TRADITIONAL PRACTITIONER ..... N MARKET ..... O ITINERANT DRUG SELLER ..... P OTHER ..... X (SPECIFY)	<b>PUBLIC SECTOR</b> GOVERNMENT HOSPITAL .. A GOVERNMENT HEALTH CENTER ..... B GOVERNMENT HEALTH POST ..... C MOBILE CLINIC ..... D FIELDWORKER/CHW ..... E OTHER PUBLIC SECTOR _____ F (SPECIFY) <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/ CLINIC ..... G PHARMACY ..... H PRIVATE DOCTOR ..... I MOBILE CLINIC ..... J FIELDWORKER/CHW ..... K OTHER PRIVATE MEDICAL SECTOR _____ L (SPECIFY) <b>OTHER SOURCE</b> SHOP ..... M TRADITIONAL PRACTITIONER ..... N MARKET ..... O ITINERANT DRUG SELLER ..... P OTHER ..... X (SPECIFY)
626	CHECK 625:	TWO OR MORE CODES CIRCLED ↓ ONLY ONE CODE CIRCLED (SKIP TO 628) ←	TWO OR MORE CODES CIRCLED ↓ ONLY ONE CODE CIRCLED (SKIP TO 628) ←

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
627	Where did you first seek advice or treatment?  USE LETTER CODE FROM 625.	FIRST PLACE ..... <input type="text"/>	FIRST PLACE ..... <input type="text"/>
628	How many days after the illness began did you first seek advice or treatment for (NAME)? IF THE SAME DAY RECORD '00'.	DAYS ..... <input type="text"/> <input type="text"/>	DAYS ..... <input type="text"/> <input type="text"/>
629	At any time during the illness, did (NAME) take any drugs for the illness?	YES ..... 1 NO ..... 2 (SKIP TO 646) ← DON'T KNOW ..... 8	YES ..... 1 NO ..... 2 (SKIP TO 646) ← DON'T KNOW ..... 8
630	What drugs did (NAME) take?  Any other drugs?  RECORD ALL MENTIONED.	<b>ANTIMALARIAL DRUGS</b> ARTEMISININ COMBINATION THERAPY (ACT) ..... A SP/FANSIDAR ..... B CHLOROQUINE ..... C AMODIAQUINE ..... D QUININE PILLS ..... E INJECTION/IV ..... F ARTESUNATE RECTAL ..... G INJECTION/IV ..... H  OTHER ANTIMALARIAL ..... I (SPECIFY)  <b>ANTIBIOTIC DRUGS</b> PILL/SYRUP ..... J INJECTION/IV ..... K  <b>OTHER DRUGS</b> ASPIRIN ..... L ACETAMINOPHEN ..... M IBUPROFEN ..... N  OTHER ..... X (SPECIFY) DON'T KNOW ..... Z	<b>ANTIMALARIAL DRUGS</b> ARTEMISININ COMBINATION THERAPY (ACT) ..... A SP/FANSIDAR ..... B CHLOROQUINE ..... C AMODIAQUINE ..... D QUININE PILLS ..... E INJECTION/IV ..... F ARTESUNATE RECTAL ..... G INJECTION/IV ..... H  OTHER ANTIMALARIAL ..... I (SPECIFY)  <b>ANTIBIOTIC DRUGS</b> PILL/SYRUP ..... J INJECTION/IV ..... K  <b>OTHER DRUGS</b> ASPIRIN ..... L ACETAMINOPHEN ..... M IBUPROFEN ..... N  OTHER ..... X (SPECIFY) DON'T KNOW ..... Z

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
631	CHECK 630: ANY CODE A-I CIRCLED?	YES <input type="checkbox"/> ↓ NO <input type="checkbox"/> (SKIP TO 646) ←	YES <input type="checkbox"/> ↓ NO <input type="checkbox"/> (SKIP TO 646) ←
632	CHECK 630: ARTEMISININ COMBINATION THERAPY ('A') GIVEN	CODE 'A' CIRCLED <input type="checkbox"/> ↓ CODE 'A' NOT CIRCLED <input type="checkbox"/> (SKIP TO 634) ←	CODE 'A' CIRCLED <input type="checkbox"/> ↓ CODE 'A' NOT CIRCLED <input type="checkbox"/> (SKIP TO 634) ←
633	How long after the fever started did (NAME) first take an artemisinin combination therapy?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER FEVER ..... 2 THREE OR MORE DAYS AFTER FEVER ..... 3 DON'T KNOW ..... 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER FEVER ..... 2 THREE OR MORE DAYS AFTER FEVER ..... 3 DON'T KNOW ..... 8
634	CHECK 630: SP/FANSIDAR ('B') GIVEN	CODE 'B' CIRCLED <input type="checkbox"/> ↓ CODE 'B' NOT CIRCLED <input type="checkbox"/> (SKIP TO 636) ←	CODE 'B' CIRCLED <input type="checkbox"/> ↓ CODE 'B' NOT CIRCLED <input type="checkbox"/> (SKIP TO 636) ←
635	How long after the fever started did (NAME) first take SP/Fansidar?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER FEVER ..... 2 THREE OR MORE DAYS AFTER FEVER ..... 3 DON'T KNOW ..... 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER FEVER ..... 2 THREE OR MORE DAYS AFTER FEVER ..... 3 DON'T KNOW ..... 8
636	CHECK 630: CHLOROQUINE ('C') GIVEN	CODE 'C' CIRCLED <input type="checkbox"/> ↓ CODE 'C' NOT CIRCLED <input type="checkbox"/> (SKIP TO 638) ←	CODE 'C' CIRCLED <input type="checkbox"/> ↓ CODE 'C' NOT CIRCLED <input type="checkbox"/> (SKIP TO 638) ←
637	How long after the fever started did (NAME) first take chloroquine?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER FEVER ..... 2 THREE OR MORE DAYS AFTER FEVER ..... 3 DON'T KNOW ..... 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER FEVER ..... 2 THREE OR MORE DAYS AFTER FEVER ..... 3 DON'T KNOW ..... 8
638	CHECK 630: AMODIAQUINE ('D') GIVEN	CODE 'D' CIRCLED <input type="checkbox"/> ↓ CODE 'D' NOT CIRCLED <input type="checkbox"/> (SKIP TO 640) ←	CODE 'D' CIRCLED <input type="checkbox"/> ↓ CODE 'D' NOT CIRCLED <input type="checkbox"/> (SKIP TO 640) ←
639	How long after the fever started did (NAME) first take amodiaquine?	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER FEVER ..... 2 THREE OR MORE DAYS AFTER FEVER ..... 3 DON'T KNOW ..... 8	SAME DAY ..... 0 NEXT DAY ..... 1 TWO DAYS AFTER FEVER ..... 2 THREE OR MORE DAYS AFTER FEVER ..... 3 DON'T KNOW ..... 8

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
640	CHECK 630: QUININE ('E' OR 'F') GIVEN	<div style="display: flex; justify-content: space-between;"> <div>CODE 'E' OR 'F' CIRCLED <input type="checkbox"/> ↓</div> <div>CODE 'E' OR 'F' NOT CIRCLED <input type="checkbox"/> ↓</div> </div> <div style="text-align: center;">(SKIP TO 642) ←</div>	<div style="display: flex; justify-content: space-between;"> <div>CODE 'E' OR 'F' CIRCLED <input type="checkbox"/> ↓</div> <div>CODE 'E' OR 'F' NOT CIRCLED <input type="checkbox"/> ↓</div> </div> <div style="text-align: center;">(SKIP TO 642) ←</div>
641	How long after the fever started did (NAME) first take quinine?	<div style="display: flex; justify-content: space-between;"> <div>SAME DAY ..... 0</div> <div>NEXT DAY ..... 1</div> <div>TWO DAYS AFTER FEVER ..... 2</div> <div>THREE OR MORE DAYS AFTER FEVER ..... 3</div> <div>DON'T KNOW ..... 8</div> </div>	<div style="display: flex; justify-content: space-between;"> <div>SAME DAY ..... 0</div> <div>NEXT DAY ..... 1</div> <div>TWO DAYS AFTER FEVER ..... 2</div> <div>THREE OR MORE DAYS AFTER FEVER ..... 3</div> <div>DON'T KNOW ..... 8</div> </div>
642	CHECK 630: ARTESUNATE ('G' OR 'H') GIVEN	<div style="display: flex; justify-content: space-between;"> <div>CODE 'G' OR 'H' CIRCLED <input type="checkbox"/> ↓</div> <div>CODE 'G' OR 'H' NOT CIRCLED <input type="checkbox"/> ↓</div> </div> <div style="text-align: center;">(SKIP TO 644) ←</div>	<div style="display: flex; justify-content: space-between;"> <div>CODE 'G' OR 'H' CIRCLED <input type="checkbox"/> ↓</div> <div>CODE 'G' OR 'H' NOT CIRCLED <input type="checkbox"/> ↓</div> </div> <div style="text-align: center;">(SKIP TO 644) ←</div>
643	How long after the fever started did (NAME) first take artesunate?	<div style="display: flex; justify-content: space-between;"> <div>SAME DAY ..... 0</div> <div>NEXT DAY ..... 1</div> <div>TWO DAYS AFTER FEVER ..... 2</div> <div>THREE OR MORE DAYS AFTER FEVER ..... 3</div> <div>DON'T KNOW ..... 8</div> </div>	<div style="display: flex; justify-content: space-between;"> <div>SAME DAY ..... 0</div> <div>NEXT DAY ..... 1</div> <div>TWO DAYS AFTER FEVER ..... 2</div> <div>THREE OR MORE DAYS AFTER FEVER ..... 3</div> <div>DON'T KNOW ..... 8</div> </div>
644	CHECK 630: OTHER ANTIMALARIAL ('I') GIVEN	<div style="display: flex; justify-content: space-between;"> <div>CODE 'I' CIRCLED <input type="checkbox"/> ↓</div> <div>CODE 'I' NOT CIRCLED <input type="checkbox"/> ↓</div> </div> <div style="text-align: center;">(SKIP TO 646) ←</div>	<div style="display: flex; justify-content: space-between;"> <div>CODE 'I' CIRCLED <input type="checkbox"/> ↓</div> <div>CODE 'I' NOT CIRCLED <input type="checkbox"/> ↓</div> </div> <div style="text-align: center;">(SKIP TO 646) ←</div>
645	How long after the fever started did (NAME) first take (OTHER ANTIMALARIAL)?	<div style="display: flex; justify-content: space-between;"> <div>SAME DAY ..... 0</div> <div>NEXT DAY ..... 1</div> <div>TWO DAYS AFTER FEVER ..... 2</div> <div>THREE OR MORE DAYS AFTER FEVER ..... 3</div> <div>DON'T KNOW ..... 8</div> </div>	<div style="display: flex; justify-content: space-between;"> <div>SAME DAY ..... 0</div> <div>NEXT DAY ..... 1</div> <div>TWO DAYS AFTER FEVER ..... 2</div> <div>THREE OR MORE DAYS AFTER FEVER ..... 3</div> <div>DON'T KNOW ..... 8</div> </div>
646		GO BACK TO 604 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 647.	GO TO 604 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 647.

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
647	<p>CHECK 615(a) AND 615(b), ALL COLUMNS:</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>NO CHILD RECEIVED FLUID FROM ORS PACKET OR PRE-PACKAGED ORS LIQUID</p> <input type="checkbox"/> </div> <div style="text-align: center;"> <p>ANY CHILD RECEIVED FLUID FROM ORS PACKET OR PRE-PACKAGED ORS LIQUID</p> <input type="checkbox"/> </div> </div>		→ 649
648	<p>Have you ever heard of a special product called Parent Choice/Electrorush you can get for the treatment of diarrhea?</p>	<p>YES ..... 1 NO ..... 2</p>	
649	<p>CHECK 215 AND 218, ALL ROWS: NUMBER OF CHILDREN BORN IN 2017-2019 LIVING WITH THE RESPONDENT</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>ONE OR MORE <input type="checkbox"/></p> <p>↓</p> </div> <div style="text-align: center;"> <p>NONE <input type="checkbox"/></p> </div> </div> <p>_____</p> <p>(NAME OF YOUNGEST CHILD LIVING WITH HER)</p> <p>↓</p>		→ 653A

## SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
650	Now I would like to ask you about liquids or foods that (NAME FROM 649) had yesterday during the day or at night. I am interested in whether your child had the item I mention even if it was combined with other foods. Did (NAME FROM 649) drink or eat:	YES NO DK	
	a) Plain water?	a) ..... 1 2 8	
	b) Juice or juice drinks?	b) ..... 1 2 8	
	c) Clear broth?	c) ..... 1 2 8	
	d) Milk such as tinned, powdered, or fresh animal milk? IF YES: How many times did (NAME) drink milk?  IF 7 OR MORE TIMES, RECORD '7'.	d) ..... 1 2 8  NUMBER OF TIMES DRANK <input type="text"/>	
	e) Infant formula? IF YES: How many times did (NAME) drink infant formula? IF 7 OR MORE TIMES, RECORD '7'.	e) ..... 1 2 8  NUMBER OF TIMES DRANK <input type="text"/>	
	f) Any other liquids?	f) ..... 1 2 8	
	g) Yogurt? IF YES: How many times did (NAME) eat yogurt?  IF 7 OR MORE TIMES, RECORD '7'.	g) ..... 1 2 8  NUMBER OF TIMES ATE <input type="text"/>	
	h) Any commercially fortified baby food like Cerelac, Bennimix or Frisocream?	h) ..... 1 2 8	
	i) Bread, rice, noodles, porridge, or other foods made from grains?	i) ..... 1 2 8	
	j) Pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside?	j) ..... 1 2 8	
	k) White potatoes, white yams, manioc, cassava, or any other foods made from roots?	k) ..... 1 2 8	
	l) Any dark green, leafy vegetables?	l) ..... 1 2 8	
	m) Ripe mangoes, papayas, etc?	m) ..... 1 2 8	
	n) Any other fruits or vegetables?	n) ..... 1 2 8	
	o) Liver, kidney, heart, or other organ meats?	o) ..... 1 2 8	
	p) Any meat, such as beef, pork, lamb, goat, chicken, or duck?	p) ..... 1 2 8	
	q) Eggs?	q) ..... 1 2 8	
	r) Fresh or dried fish or shellfish?	r) ..... 1 2 8	
	s) Any foods made from beans, peas, lentils, or nuts?	s) ..... 1 2 8	
	t) Cheese or other food made from milk?	t) ..... 1 2 8	
	u) Any other solid, semi-solid, or soft food?	u) ..... 1 2 8	
651	CHECK 650 (CATEGORIES 'g' THROUGH 'u'):  NOT A SINGLE 'YES' <input type="checkbox"/> AT LEAST ONE 'YES' <input type="checkbox"/>		→ 653

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																												
652	<p>Did (NAME FROM 649) eat any solid, semi-solid, or soft foods yesterday during the day or at night?</p> <p>IF 'YES' PROBE: What kind of solid, semi-solid or soft foods did (NAME) eat?</p>	<p>YES ..... 1</p> <p align="center">(GO BACK TO 650 TO RECORD FOOD EATEN YESTERDAY)</p> <p align="center">(THEN CONTINUE TO 653)</p> <p>NO ..... 2</p>	<p>→ 653A</p>																																												
653	<p>How many times did (NAME FROM 649) eat solid, semi-solid, or soft foods yesterday during the day or at night?</p> <p>IF 7 OR MORE TIMES, RECORD '7'.</p>	<p>NUMBER OF TIMES ..... <input type="text"/></p> <p>DON'T KNOW ..... 8</p>																																													
653A	<p>Now I would like to ask you about foods and drinks that you ate or drank yesterday during the day or night, whether you ate it at home or anywhere else.</p> <p>I am interested in whether you had the food items I will mention even if they were combined with other foods. For example, if you had a soup made with carrots, potatoes and meat, you should reply "yes" for each of these ingredients when I read you the list. However, if you consumed only the broth of a soup, but not the meat or vegetable, do not say "yes" for the meat or vegetable.</p> <p>As I ask you about foods and drinks, please think of foods and drinks you had as snacks or small meals as well as during any main meals. Please also remember foods you may have eaten while preparing meals or preparing food for others.</p> <p>Please do not include any food used in a small amount for seasoning or condiments (like spices, herbs or crayfish powder). I will ask you about those foods separately.</p> <p>Yesterday during the day or at night, did you eat or drink:</p>	<table border="1"> <thead> <tr> <th></th><th>YES</th><th>NO</th><th>DK</th></tr> </thead> <tbody> <tr> <td><b>Any foods made from cereal grains, like:</b></td><td></td><td></td><td></td></tr> <tr> <td>a) Wheat, oats, maize, rice, sorghum (guinea corn), millet, couscous, spaghetti, macaroni, noodles, bread or other foods made from cereal grains?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td><b>Any vegetables or roots that are orange coloured inside like:</b></td><td></td><td></td><td></td></tr> <tr> <td>b) Squash that is orange inside, pumpkin, carrot, red sweet pepper, sweet potato that is orange inside (orange flesh sweet potatoes), cassava?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td><b>Any white roots and tubers or plantains, such as:</b></td><td></td><td></td><td></td></tr> <tr> <td>c) Yam, three leaf yam, water yam, aerial yam, cocoyam, irish potato, garri, fufu, cassava, tapioca, tigernut flour, white or yellow fleshed sweet potato, native potato, plantain?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td><b>Any dark green leafy vegetables, such as:</b></td><td></td><td></td><td></td></tr> <tr> <td>d) Bitter leaf, Moringa, Sorrel leaves, sweet potato leaves, cassava leaves, cocoyam leaves, amaranthus/spinach, water leaf, lettuce, wild spinach, young okro leaves, egg plant leaves, other green leaves eaten?</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td><b>Any fruits that are dark yellow or orange inside, like:</b></td><td></td><td></td><td></td></tr> <tr> <td>e) Ripe pawpaw, ripe mango, ripe passion fruit, locust bean fruit, red palm fruit, hog plum, ripe cantaloupe, musk melon, monkey cola, bush mango fruit?</td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table>		YES	NO	DK	<b>Any foods made from cereal grains, like:</b>				a) Wheat, oats, maize, rice, sorghum (guinea corn), millet, couscous, spaghetti, macaroni, noodles, bread or other foods made from cereal grains?	1	2	8	<b>Any vegetables or roots that are orange coloured inside like:</b>				b) Squash that is orange inside, pumpkin, carrot, red sweet pepper, sweet potato that is orange inside (orange flesh sweet potatoes), cassava?	1	2	8	<b>Any white roots and tubers or plantains, such as:</b>				c) Yam, three leaf yam, water yam, aerial yam, cocoyam, irish potato, garri, fufu, cassava, tapioca, tigernut flour, white or yellow fleshed sweet potato, native potato, plantain?	1	2	8	<b>Any dark green leafy vegetables, such as:</b>				d) Bitter leaf, Moringa, Sorrel leaves, sweet potato leaves, cassava leaves, cocoyam leaves, amaranthus/spinach, water leaf, lettuce, wild spinach, young okro leaves, egg plant leaves, other green leaves eaten?	1	2	8	<b>Any fruits that are dark yellow or orange inside, like:</b>				e) Ripe pawpaw, ripe mango, ripe passion fruit, locust bean fruit, red palm fruit, hog plum, ripe cantaloupe, musk melon, monkey cola, bush mango fruit?	1	2	8	
	YES	NO	DK																																												
<b>Any foods made from cereal grains, like:</b>																																															
a) Wheat, oats, maize, rice, sorghum (guinea corn), millet, couscous, spaghetti, macaroni, noodles, bread or other foods made from cereal grains?	1	2	8																																												
<b>Any vegetables or roots that are orange coloured inside like:</b>																																															
b) Squash that is orange inside, pumpkin, carrot, red sweet pepper, sweet potato that is orange inside (orange flesh sweet potatoes), cassava?	1	2	8																																												
<b>Any white roots and tubers or plantains, such as:</b>																																															
c) Yam, three leaf yam, water yam, aerial yam, cocoyam, irish potato, garri, fufu, cassava, tapioca, tigernut flour, white or yellow fleshed sweet potato, native potato, plantain?	1	2	8																																												
<b>Any dark green leafy vegetables, such as:</b>																																															
d) Bitter leaf, Moringa, Sorrel leaves, sweet potato leaves, cassava leaves, cocoyam leaves, amaranthus/spinach, water leaf, lettuce, wild spinach, young okro leaves, egg plant leaves, other green leaves eaten?	1	2	8																																												
<b>Any fruits that are dark yellow or orange inside, like:</b>																																															
e) Ripe pawpaw, ripe mango, ripe passion fruit, locust bean fruit, red palm fruit, hog plum, ripe cantaloupe, musk melon, monkey cola, bush mango fruit?	1	2	8																																												



SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<b>Any other fruits:</b> f) Apple, banana, lemon, watermelon, tangerine, grapes, avocado pear, oranges, pears, melon, dates, strawberries, guava, pineapple, grapefruit, coconut, sugar cane, African cherry/African star apple, breadfruit, lime, cashew fruit, soursop, tamarind, melon, golden melon, baobab fruit, figs, shea fruit, pomegranate, tamarind fruit, doum palm fruit?	f) ..... 1                      2                      8	
	<b>Any other vegetables:</b> g) Cabbage, cucumber, cauliflower, fresh tomato, onion, green beans, green pepper, radish, red chili pepper, okro, garden egg, eggplant, green peas, boiled or roasted fresh corn, beets, mushroom?	g) ..... 1                      2                      8	
	<b>Any meat made from animal organs, such as:</b> h) Liver, kidney, heart, gizzard?	h) ..... 1                      2                      8	
	<b>Any other types of meat or poultry, like:</b> i) Beef, mutton, goat, rabbit, chicken, goose, turkey, quail, pork, lamb, grass cutter, guinea fowl, hawk, monitor lizard, pigeon, small kangaroo, dove, squirrel, guinea pig, deer, alligator lizard, crocodile, peacock, camel, antelope, bat, bush rat, and other bush meat/bird, horse, camel, duck, ox tail, cow leg, cow skin, biscuit bones, lung, stomach, intestines, tongue, brain, spleen, frog, toad, porcupine, dog, monkey, snake?	i) ..... 1                      2                      8	
	<b>Any eggs</b> j) Quail eggs, chicken eggs, duck eggs, guinea fowl eggs, eggs from any other bird?	j) ..... 1                      2                      8	
	<b>Any fish or seafood, whether fresh or dried</b> k) Fresh fish, frozen fish (e.g. mackerel/Titus), canned fish (sardine, Geisha), smoked fish, dried fish, crab, lobster, cray fish, shrimp, stock fish, bonga fish, mud fish, tilapia, cat fish, barracuda, any other type of fish?	k) ..... 1                      2                      8	
	<b>Any beans or peas, such as:</b> l) Brown beans, white beans, all kinds of cowpea (iron beans), chickpeas, soya beans, bambara nut, mucuna beans/velvet beans, pigeon pea, African yam bean, kidney bean, lima bean, Jack bean, winged bean, ground bean?	l) ..... 1                      2                      8	
	<b>Any nuts or seeds, like:</b> m) Sesame seed/beniseed, melon seed (egusi), almonds, pumpkin seeds, sunflower seeds, walnuts, groundnuts, shea nut, cashew nuts, bush mango seeds, significant quantity of locust bean seed, african oil bean seed, bread fruit seed?	m) ..... 1                      2                      8	
	<b>Any milk or milk products, such as:</b> n) Milk, sour milk, skim milk, yogurt, ice-cream, cheese, powdered milk, condensed milk, evaporated milk, goat milk, camel milk, but NOT including butter, ice cream, cream or sour cream?	n) ..... 1                      2                      8	

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<p><b>Any insects and other small protein foods, such as:</b></p> <p>o) Winged termite, cricket, snails, sea snails, periwinkle, African palm weevil larva, other edible insect larvae?</p>	<p>o) ..... 1                      2                      8</p>	
	<p><b>Any red palm oil:</b></p> <p>p) Foods made with red palm oil, red palm nut, or red palm nut pulp sauces</p>	<p>p) ..... 1                      2                      8</p>	
	<p><b>Any other oils and fats:</b></p> <p>q) Oil, fats or butter added to food or used for cooking, including vegetable oil, any other type of oil, butter, margarine (blue band), mayonnaise, shea butter, manshanu, extracted oils from nuts, fruits and seeds, and all animal fat. Does not include red palm oil.</p>	<p>q) ..... 1                      2                      8</p>	
	<p><b>Any savory and fried snacks such as:</b></p> <p>r) Crisps and chips, fried dough (puffpuff), other fried snacks (beans akara, cheese straw), pop corn</p>	<p>r) ..... 1                      2                      8</p>	
	<p><b>Any sweets such as:</b></p> <p>s) Sugary foods, such as chocolates, candies, cookies/sweet biscuits and cakes, jam, sweet pastries or ice cream, honey</p>	<p>s) ..... 1                      2                      8</p>	
	<p><b>Any sugar-sweetened beverages such as:</b></p> <p>t) Soft drinks and all drinks with added sugar, such as sweetened fruit juices and "juice drinks", soft drinks/fizzy drinks, chocolate drinks(milo), malt drinks, yoghurt drinks, sweet tea or coffee with sugar</p>	<p>t) ..... 1                      2                      8</p>	
	<p><b>Any condiments and seasonings, such as:</b></p> <p>u) Salt, chicken/beef stock cubes (e.g. Maggi, Knorr), black pepper, alligator pepper, nutmeg, pottash, bay leaf, scent leaves as seasoning, thyme, curry, ginger, garlic, cloves, mint leaves, lemon grass, tomato paste, crayfish powder, locust bean used as seasoning?</p>	<p>u) ..... 1                      2                      8</p>	

SECTION 6. CHILD HEALTH AND NUTRITION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	<b>Any other beverages and foods:</b> v) Coffee without milk, black tea (lipton), green tea, alcohol, clear broth, soup broth, olives, picked cucumbers, herbal beverages/infusions, water, kolanut, bitter kola	v) ..... 1                      2                      8	
654	The last time (NAME FROM 649) passed stools, what was done to dispose of the stools?	CHILD USED TOILET OR LATRINE ..... 01 PUT/RINSED INTO TOILET OR LATRINE ..... 02 PUT/RINSED INTO DRAIN OR DITCH ..... 03 THROWN INTO GARBAGE ..... 04 BURIED ..... 05 LEFT IN THE OPEN ..... 06  OTHER _____ 96 (SPECIFY)	

SECTION 7. MARRIAGE AND SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	Are you currently married or living together with a man as if married?	YES, CURRENTLY MARRIED ..... 1 YES, LIVING WITH A MAN ..... 2 NO, NOT IN UNION ..... 3	<input type="checkbox"/> → 704
702	Have you ever been married or lived together with a man as if married?	YES, FORMERLY MARRIED ..... 1 YES, LIVED WITH A MAN ..... 2 NO ..... 3	<input type="checkbox"/> → 712
703	What is your marital status now: are you widowed, divorced, or separated?	WIDOWED ..... 1 DIVORCED ..... 2 SEPARATED ..... 3	<input type="checkbox"/> → 709
704	Is your (husband/partner) living with you now or is he staying elsewhere?	LIVING WITH HER ..... 1 STAYING ELSEWHERE ..... 2	
705	RECORD THE HUSBAND'S/PARTNER'S NAME AND LINE NUMBER FROM THE HOUSEHOLD QUESTIONNAIRE. IF HE IS NOT LISTED IN THE HOUSEHOLD, RECORD '00'.	NAME .....  LINE NO. .... <input type="text"/> <input type="text"/>	
706	Does your (husband/partner) have other wives or does he live with other women as if married?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	<input type="checkbox"/> → 709
707	Including yourself, in total, how many wives or live-in partners does he have?	TOTAL NUMBER OF WIVES AND LIVE-IN PARTNERS ..... <input type="text"/> <input type="text"/>  DON'T KNOW ..... 98	
708	Are you the first, second, ... wife?	RANK ..... <input type="text"/> <input type="text"/>	
709	Have you been married or lived with a man only once or more than once?	ONLY ONCE ..... 1 MORE THAN ONCE ..... 2	
710	CHECK 709:  <div style="display: flex; justify-content: space-between;"> <div style="text-align: center;"> MARRIED/ LIVED WITH A MAN ONLY ONCE ↓ <input type="checkbox"/> </div> <div style="text-align: center;"> MARRIED/ LIVED WITH A MAN MORE THAN ONCE ↓ <input type="checkbox"/> </div> </div> <p>a) In what month and year did you start living with your (husband/partner)?</p> <p>b) Now I would like to ask about your first (husband/partner). In what month and year did you start living with him?</p>	MONTH ..... <input type="text"/> <input type="text"/> DON'T KNOW MONTH ..... 98  YEAR ..... <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW YEAR ..... 9998	<input type="checkbox"/> → 712
711	How old were you when you first started living with him?	AGE ..... <input type="text"/> <input type="text"/>	

SECTION 7. MARRIAGE AND SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
712	<b>CHECK FOR PRESENCE OF OTHERS. BEFORE CONTINUING, MAKE EVERY EFFORT TO ENSURE PRIVACY.</b>		
713	Now I would like to ask some questions about sexual activity in order to gain a better understanding of some important life issues. Let me assure you again that your answers are completely confidential and will not be told to anyone. If we should come to any question that you don't want to answer, just let me know and we will go to the next question. How old were you when you had sexual intercourse for the very first time?	<p>NEVER HAD SEXUAL INTERCOURSE ..... 00</p> <p>AGE IN YEARS ..... <input type="text"/> <input type="text"/></p>	<p>→ 731</p>
714	<p>I would like to ask you about your recent sexual activity. When was the last time you had sexual intercourse?</p> <p>IF LESS THAN 12 MONTHS, ANSWER MUST BE RECORDED IN DAYS, WEEKS OR MONTHS. IF 12 MONTHS (ONE YEAR) OR MORE, ANSWER MUST BE RECORDED IN YEARS.</p>	<p>DAYS AGO ..... 1 <input type="text"/> <input type="text"/></p> <p>WEEKS AGO ..... 2 <input type="text"/> <input type="text"/></p> <p>MONTHS AGO ..... 3 <input type="text"/> <input type="text"/></p> <p>YEARS AGO ..... 4 <input type="text"/> <input type="text"/></p>	<p>→ 716</p> <p>→ 727</p>

SECTION 7. MARRIAGE AND SEXUAL ACTIVITY

		LAST SEXUAL PARTNER	SECOND-TO-LAST SEXUAL PARTNER	THIRD-TO-LAST SEXUAL PARTNER
715	When was the last time you had sexual intercourse with this person?		DAYS AGO .. 1 <input type="text"/> <input type="text"/> WEEKS AGO .. 2 <input type="text"/> <input type="text"/> MONTHS AGO .. 3 <input type="text"/> <input type="text"/>	DAYS AGO .. 1 <input type="text"/> <input type="text"/> WEEKS AGO .. 2 <input type="text"/> <input type="text"/> MONTHS AGO .. 3 <input type="text"/> <input type="text"/>
716	The last time you had sexual intercourse with this person, was a condom used?	YES ..... 1 NO ..... 2 (SKIP TO 718) ←	YES ..... 1 NO ..... 2 (SKIP TO 718) ←	YES ..... 1 NO ..... 2 (SKIP TO 718) ←
717	Was a condom used every time you had sexual intercourse with this person in the last 12 months?	YES ..... 1 NO ..... 2	YES ..... 1 NO ..... 2	YES ..... 1 NO ..... 2
718	What was your relationship to this person with whom you had sexual intercourse?  IF BOYFRIEND: Were you living together as if married?  IF YES, RECORD '2'. IF NO, RECORD '3'.	HUSBAND ..... 1 LIVE-IN PARTNER ..... 2 BOYFRIEND NOT LIVING WITH RESPONDENT ..... 3 CASUAL ACQUAINTANCE .. 4 CLIENT/SEX WORKER .. 5 OTHER ..... 6 (SPECIFY)	HUSBAND ..... 1 LIVE-IN PARTNER ..... 2 BOYFRIEND NOT LIVING WITH RESPONDENT ..... 3 CASUAL ACQUAINTANCE .. 4 CLIENT/SEX WORKER .. 5 OTHER ..... 6 (SPECIFY)	HUSBAND ..... 1 LIVE-IN PARTNER ..... 2 BOYFRIEND NOT LIVING WITH RESPONDENT ..... 3 CASUAL ACQUAINTANCE .. 4 CLIENT/SEX WORKER .. 5 OTHER ..... 6 (SPECIFY)
719	How long ago did you first have sexual intercourse with this person?	DAYS AGO .. 1 <input type="text"/> <input type="text"/> WEEKS AGO .. 2 <input type="text"/> <input type="text"/> MONTHS AGO .. 3 <input type="text"/> <input type="text"/> YEARS AGO .. 4 <input type="text"/> <input type="text"/>	DAYS AGO .. 1 <input type="text"/> <input type="text"/> WEEKS AGO .. 2 <input type="text"/> <input type="text"/> MONTHS AGO .. 3 <input type="text"/> <input type="text"/> YEARS AGO .. 4 <input type="text"/> <input type="text"/>	DAYS AGO .. 1 <input type="text"/> <input type="text"/> WEEKS AGO .. 2 <input type="text"/> <input type="text"/> MONTHS AGO .. 3 <input type="text"/> <input type="text"/> YEARS AGO .. 4 <input type="text"/> <input type="text"/>
720	How many times during the last 12 months did you have sexual intercourse with this person? IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF TIMES IS 95 OR MORE, RECORD '95'.	NUMBER OF TIMES ..... <input type="text"/> <input type="text"/>	NUMBER OF TIMES ..... <input type="text"/> <input type="text"/>	NUMBER OF TIMES ..... <input type="text"/> <input type="text"/>
721	How old is this person?	AGE OF PARTNER <input type="text"/> <input type="text"/>  DON'T KNOW ..... 98	AGE OF PARTNER <input type="text"/> <input type="text"/>  DON'T KNOW ..... 98	AGE OF PARTNER <input type="text"/> <input type="text"/>  DON'T KNOW ..... 98
722	Apart from this person, have you had sexual intercourse with any other person in the last 12 months?	YES ..... 1 (GO BACK TO 715 IN NEXT COLUMN) ← NO ..... 2 (SKIP TO 724) ←	YES ..... 1 (GO BACK TO 715 IN NEXT COLUMN) ← NO ..... 2 (SKIP TO 724) ←	
723	In total, with how many different people have you had sexual intercourse in the last 12 months? IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF PARTNERS IS 95 OR MORE, RECORD '95'.			NUMBER OF PARTNERS LAST 12 MONTHS .. <input type="text"/> <input type="text"/>  DON'T KNOW ..... 98

## SECTION 7. MARRIAGE AND SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
724	CHECK 106:  AGE 15-24 <input type="checkbox"/> ↓	AGE 25-49 <input type="checkbox"/> →	727
725	CHECK 701:  NOT <input type="checkbox"/> IN A UNION ↓	CURRENTLY MARRIED/ LIVING WITH A MAN <input type="checkbox"/> →	727
726	In the past 12 months have you had sex or been sexually involved with anyone because he gave you or told you he would give you gifts, cash, or anything else?	YES ..... 1 NO ..... 2	
727	In total, with how many different people have you had sexual intercourse in your lifetime?  IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE. IF NUMBER OF PARTNERS IS 95 OR MORE, RECORD '95'.	NUMBER OF PARTNERS IN LIFETIME ..... <input type="text"/> <input type="text"/>  DON'T KNOW ..... 98	
728	CHECK 716, MOST RECENT PARTNER (FIRST COLUMN):  YES, <input type="checkbox"/> CONDOM USED ↓	NO, <input type="checkbox"/> → CONDOM NOT USED NOT <input type="checkbox"/> ASKED →	731   731
729	You told me that a condom was used the last time you had sex. What is the brand name of the condom used at that time?        IF BRAND NOT KNOWN, ASK TO SEE THE PACKAGE.	LATEX ..... 01 PROTECTOR PLUS ..... 02 LOVE ..... 03 ROUGH RIDER ..... 04 IQUON ..... 05 STRAWBERRY ..... 06  OTHER ..... 96 (SPECIFY) DON'T KNOW ..... 98	

SECTION 7. MARRIAGE AND SEXUAL ACTIVITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP												
730	<p>From where did you obtain the condom the last time?</p> <p>PROBE TO IDENTIFY TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p align="center">(NAME OF PLACE)</p>	<p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL ..... 11</p> <p>GOVERNMENT HEALTH CENTER ..... 12</p> <p>FAMILY PLANNING CLINIC ..... 13</p> <p>MOBILE CLINIC ..... 14</p> <p>FIELDWORKER ..... 15</p> <p>OTHER PUBLIC SECTOR</p> <p>_____ 16</p> <p align="center">(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/CLINIC ..... 21</p> <p>PHARMACY ..... 22</p> <p>PRIVATE DOCTOR ..... 23</p> <p>MOBILE CLINIC ..... 24</p> <p>FIELDWORKER ..... 25</p> <p>OTHER PRIVATE MEDICAL SECTOR</p> <p>_____ 26</p> <p align="center">(SPECIFY)</p> <p><b>OTHER SOURCE</b></p> <p>SHOP ..... 31</p> <p>CHURCH ..... 32</p> <p>FRIEND/RELATIVE ..... 33</p> <p>OTHER _____ 96</p> <p align="center">(SPECIFY)</p> <p>DON'T KNOW ..... 98</p>													
731	<p>PRESENCE OF OTHERS DURING THIS SECTION.</p>	<table> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>CHILDREN &lt;10 .....</td> <td>1</td> <td>2</td> </tr> <tr> <td>MALE ADULTS .....</td> <td>1</td> <td>2</td> </tr> <tr> <td>FEMALE ADULTS .....</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	CHILDREN <10 .....	1	2	MALE ADULTS .....	1	2	FEMALE ADULTS .....	1	2	
	YES	NO													
CHILDREN <10 .....	1	2													
MALE ADULTS .....	1	2													
FEMALE ADULTS .....	1	2													



SECTION 8. FERTILITY PREFERENCES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	CHECK 304:  NEITHER <input type="checkbox"/> STERILIZED ↓	HE OR SHE <input type="checkbox"/> STERILIZED →	813
802	CHECK 226:  PREGNANT <input type="checkbox"/> ↓	NOT PREGNANT <input type="checkbox"/> OR UNSURE →	804
803	Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?	HAVE ANOTHER CHILD ..... 1 NO MORE ..... 2 UNDECIDED/DON'T KNOW ..... 8	→ 805 → 812
804	Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?	HAVE (A/ANOTHER) CHILD ..... 1 NO MORE/NONE ..... 2 SAYS SHE CAN'T GET PREGNANT ..... 3 UNDECIDED/DON'T KNOW ..... 8	→ 807 → 813 → 811
805	CHECK 226:  NOT PREGNANT <input type="checkbox"/> OR UNSURE ↓ a) How long would you like to wait from now before the birth of (a/another) child?  PREGNANT <input type="checkbox"/> ↓ b) After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?	MONTHS ..... 1 YEARS ..... 2 SOON/NOW ..... 993 SAYS SHE CAN'T GET PREGNANT ..... 994 AFTER MARRIAGE ..... 995 OTHER ..... 996 (SPECIFY) DON'T KNOW ..... 998	→ 811 → 813 → 811
806	CHECK 226:  NOT PREGNANT <input type="checkbox"/> OR UNSURE ↓	PREGNANT <input type="checkbox"/> →	812
807	CHECK 303: USING A CONTRACEPTIVE METHOD?  NOT <input type="checkbox"/> CURRENTLY USING ↓	CURRENTLY <input type="checkbox"/> USING →	813
808	CHECK 805:  '24' OR MORE MONTHS <input type="checkbox"/> OR '02' OR MORE YEARS ↓	NOT <input type="checkbox"/> ASKED ↓	'00-23' MONTHS <input type="checkbox"/> OR '00-01' YEAR →
809	CHECK 714:  DAYS, WEEKS OR <input type="checkbox"/> MONTHS AGO ↓	YEARS <input type="checkbox"/> AGO →	→ 811 NOT <input type="checkbox"/> ASKED →

**SECTION 8. FERTILITY PREFERENCES**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
810	<p>CHECK 804:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>WANTS TO HAVE A/ANOTHER CHILD <input type="checkbox"/></p> <p>a) You have said that you do not want (a/another) child soon. Can you tell me why you are not using a method to prevent pregnancy?</p> <p>Any other reason? _____</p> </div> <div style="width: 45%;"> <p>WANTS NO MORE/ NONE <input type="checkbox"/></p> <p>b) You have said that you do not want any (more) children. Can you tell me why you are not using a method to prevent pregnancy?</p> <p>Any other reason? _____</p> </div> </div> <p align="center">RECORD ALL REASONS MENTIONED.</p>	<p>NOT MARRIED ..... A</p> <p><b>FERTILITY-RELATED REASONS</b></p> <p>NOT HAVING SEX ..... B</p> <p>INFREQUENT SEX ..... C</p> <p>MENOPAUSAL/HYSTERECTOMY ..... D</p> <p>CAN'T GET PREGNANT ..... E</p> <p>NOT MENSTRUATED SINCE LAST BIRTH ..... F</p> <p>BREASTFEEDING ..... G</p> <p>UP TO GOD/FATALISTIC ..... H</p> <p><b>OPPOSITION TO USE</b></p> <p>RESPONDENT OPPOSED ..... I</p> <p>HUSBAND/PARTNER OPPOSED ..... J</p> <p>OTHERS OPPOSED ..... K</p> <p>RELIGIOUS PROHIBITION ..... L</p> <p><b>LACK OF KNOWLEDGE</b></p> <p>KNOWS NO METHOD ..... M</p> <p>KNOWS NO SOURCE ..... N</p> <p><b>METHOD-RELATED REASONS</b></p> <p>SIDE EFFECTS/HEALTH CONCERNS ..... O</p> <p>LACK OF ACCESS/TOO FAR ..... P</p> <p>COSTS TOO MUCH ..... Q</p> <p>PREFERRED METHOD NOT AVAILABLE ..... R</p> <p>NO METHOD AVAILABLE ..... S</p> <p>INCONVENIENT TO USE ..... T</p> <p>INTERFERES WITH BODY'S NORMAL PROCESSES ..... U</p> <p>OTHER _____ X (SPECIFY)</p> <p>DON'T KNOW ..... Z</p>	
811	<p>CHECK 303: USING A CONTRACEPTIVE METHOD?</p> <div style="display: flex; justify-content: space-around;"> <p>NOT ASKED <input type="checkbox"/></p> <p>NO, NOT CURRENTLY USING <input type="checkbox"/></p> <p>YES, CURRENTLY USING <input type="checkbox"/></p> </div>		→ 813
812	<p>Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	
813	<p>CHECK 216:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>HAS LIVING CHILDREN <input type="checkbox"/></p> <p>a) If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be?</p> </div> <div style="width: 45%;"> <p>NO LIVING CHILDREN <input type="checkbox"/></p> <p>b) If you could choose exactly the number of children to have in your whole life, how many would that be?</p> </div> </div> <p align="center">PROBE FOR A NUMERIC RESPONSE.</p>	<p>NONE ..... 00</p> <p>NUMBER ..... <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/></p> <p>OTHER _____ 96 (SPECIFY)</p>	<p>→ 815</p> <p>→ 815</p>
814	<p>How many of these children would you like to be boys, how many would you like to be girls and for how many would it not matter if it's a boy or a girl?</p>	<div style="display: flex; justify-content: space-around; margin-bottom: 5px;"> <p>BOYS</p> <p>GIRLS</p> <p>EITHER</p> </div> <p>NUMBER .. <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/> <input style="width: 40px; border: 1px solid black;" type="text"/></p> <p>OTHER _____ 96 (SPECIFY)</p>	

SECTION 8. FERTILITY PREFERENCES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
815	In the last few months have you: a) Heard about family planning on the radio? b) Seen anything about family planning on the television? c) Read about family planning in a newspaper or magazine? d) Received a voice or text message about family planning on a mobile phone?	<div style="text-align: right;">YES NO</div> a) RADIO ..... 1 2 b) TELEVISION ..... 1 2 c) NEWSPAPER OR MAGAZINE ..... 1 2 d) MOBILE PHONE ..... 1 2	
816	Please tell me which family planning messages you have heard or seen in the past few months?  PROBE: Any others?	AS FOR ME AND MY PARTNER WE USE FEMALE CONDOM ..... A UNSPACED CHILDREN MAKES THE GOING TOUGH FOR THE LOVE OF YOUR FAMILY, GO FOR CHILD SPACING TODAY ..... B WELL-SPACED CHILDREN ARE EVERY PARENT'S JOY ..... C IT'S NOT TOO LATE TO PREVENT UNWANTED PREGNANCY ..... D WHY IS YOUR WIFE LOOKING SO GOOD? ..... E OTHER _____ X (SPECIFY)	
817	CHECK 701:  <div style="display: flex; justify-content: space-around; align-items: center;"> <div>YES, <input type="checkbox"/> CURRENTLY MARRIED</div> <div>YES, <input type="checkbox"/> LIVING WITH A MAN</div> <div>NO, <input type="checkbox"/> NOT IN A UNION</div> </div>		→ 901
818	CHECK 303: USING A CONTRACEPTIVE METHOD?  <div style="display: flex; justify-content: space-around; align-items: center;"> <div>CURRENTLY <input type="checkbox"/> USING</div> <div>NOT CURRENTLY <input type="checkbox"/> USING</div> <div>NOT <input type="checkbox"/> ASKED</div> </div>		→ 820 → 822
819	Would you say that using contraception is mainly your decision, mainly your (husband's/partner's) decision, or did you both decide together?	MAINLY RESPONDENT ..... 1 MAINLY HUSBAND/PARTNER ..... 2 JOINT DECISION ..... 3 OTHER _____ 6 (SPECIFY)	→ 821
820	Would you say that not using contraception is mainly your decision, mainly your (husband's/partner's) decision, or did you both decide together?	MAINLY RESPONDENT ..... 1 MAINLY HUSBAND/PARTNER ..... 2 JOINT DECISION ..... 3 OTHER _____ 6 (SPECIFY)	
821	CHECK 304:  <div style="display: flex; justify-content: space-around; align-items: center;"> <div>NEITHER ARE <input type="checkbox"/> STERILIZED</div> <div>HE OR SHE ARE <input type="checkbox"/> STERILIZED</div> </div>		→ 901
822	Does your (husband/partner) want the same number of children that you want, or does he want more or fewer than you want?	SAME NUMBER ..... 1 MORE CHILDREN ..... 2 FEWER CHILDREN ..... 3 DON'T KNOW ..... 8	

SECTION 9. HUSBAND'S BACKGROUND AND WOMAN'S WORK

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
901	CHECK 701:  CURRENTLY MARRIED/ LIVING WITH A MAN <input type="checkbox"/>	NOT IN <input type="checkbox"/> UNION	→ 909
902	How old was your (husband/partner) on his last birthday?	AGE IN COMPLETED YEARS ..... <input type="text"/> <input type="text"/>	
903	Did your (husband/partner) ever attend school?	YES ..... 1 NO ..... 2	→ 906
904	What was the highest level of school he attended: primary, secondary, or higher?	PRIMARY ..... 1 JUNIOR SECONDARY ..... 2 SENIOR SECONDARY ..... 3 VOCATIONAL/COMMERCIAL/NURSING TECHNICAL/TEACHING ..... 4 HIGHER ..... 5 DON'T KNOW ..... 8	→ 906
905	What was the highest [GRADE/FORM/YEAR] he completed at that level? IF COMPLETED LESS THAN ONE YEAR AT THAT LEVEL, RECORD '00'.	[GRADE/FORM/YEAR] ..... <input type="text"/> <input type="text"/> DON'T KNOW ..... 98	
906	Has your (husband/partner) done any work in the last 7 days?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 908
907	Has your (husband/partner) done any work in the last 12 months?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 909
908	What is your (husband's/partner's) occupation? That is, what kind of work does he mainly do?	_____ _____ _____ <input type="text"/> <input type="text"/>	
909	Aside from your own housework, have you done any work in the last seven days?	YES ..... 1 NO ..... 2	→ 913
910	As you know, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. In the last seven days, have you done any of these things or any other work?	YES ..... 1 NO ..... 2	→ 913
911	Although you did not work in the last seven days, do you have any job or business from which you were absent for leave, illness, vacation, maternity leave, or any other such reason?	YES ..... 1 NO ..... 2	→ 913
912	Have you done any work in the last 12 months?	YES ..... 1 NO ..... 2	→ 917
913	What is your occupation? That is, what kind of work do you mainly do?	_____ _____ _____ <input type="text"/> <input type="text"/>	

SECTION 9. HUSBAND'S BACKGROUND AND WOMAN'S WORK

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
914	Do you do this work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER ..... 1 FOR SOMEONE ELSE ..... 2 SELF-EMPLOYED ..... 3	
915	Do you usually work throughout the year, or do you work seasonally, or only once in a while?	THROUGHOUT THE YEAR ..... 1 SEASONALLY/PART OF THE YEAR ..... 2 ONCE IN A WHILE ..... 3	
916	Are you paid in cash or kind for this work or are you not paid at all?	CASH ONLY ..... 1 CASH AND KIND ..... 2 IN KIND ONLY ..... 3 NOT PAID ..... 4	
917	CHECK 701:  CURRENTLY <input type="checkbox"/> MARRIED/LIVING WITH A MAN ↓  NOT IN UNION <input type="checkbox"/> → 925		
918	CHECK 916:  CODE '1' OR '2' <input type="checkbox"/> CIRCLED ↓  OTHER <input type="checkbox"/> → 921		
919	Who usually decides how the money you earn will be used: you, your (husband/partner), or you and your (husband/partner) jointly?	RESPONDENT ..... 1 HUSBAND/PARTNER ..... 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY ..... 3  OTHER _____ 6 (SPECIFY)	
920	Would you say that the money that you earn is more than what your (husband/partner) earns, less than what he earns, or about the same?	MORE THAN HIM ..... 1 LESS THAN HIM ..... 2 ABOUT THE SAME ..... 3 HUSBAND/PARTNER HAS NO EARNINGS ..... 4 DON'T KNOW ..... 8	→ 922
921	Who usually decides how your (husband's/partner's) earnings will be used: you, your (husband/partner), or you and your (husband/partner) jointly?	RESPONDENT ..... 1 HUSBAND/PARTNER ..... 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY ..... 3 HUSBAND/PARTNER HAS NO EARNINGS ..... 4  OTHER _____ 6 (SPECIFY)	
922	Who usually makes decisions about health care for yourself: you, your (husband/partner), you and your (husband/partner) jointly, or someone else?	RESPONDENT ..... 1 HUSBAND/PARTNER ..... 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY ..... 3 SOMEONE ELSE ..... 4 OTHER ..... 6	
923	Who usually makes decisions about making major household purchases?	RESPONDENT ..... 1 HUSBAND/PARTNER ..... 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY ..... 3 SOMEONE ELSE ..... 4 OTHER ..... 6	

**SECTION 9. HUSBAND'S BACKGROUND AND WOMAN'S WORK**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
924	Who usually makes decisions about visits to your family or relatives?	RESPONDENT ..... 1 HUSBAND/PARTNER ..... 2 RESPONDENT AND HUSBAND/PARTNER JOINTLY ..... 3 SOMEONE ELSE ..... 4 OTHER ..... 6	
925	Do you own this or any other house either alone or jointly with someone else?	ALONE ONLY ..... 1 JOINTLY ONLY ..... 2 BOTH ALONE AND JOINTLY ..... 3 DOES NOT OWN ..... 4	→ 928
926	Do you have a title deed for any house you own?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 928
927	Is your name on the title deed?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
928	Do you own any agricultural or non-agricultural land either alone or jointly with someone else?	ALONE ONLY ..... 1 JOINTLY ONLY ..... 2 BOTH ALONE AND JOINTLY ..... 3 DOES NOT OWN ..... 4	→ 931
929	Do you have a title deed for any land you own?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	→ 931
930	Is your name on the title deed?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
931	PRESENCE OF OTHERS AT THIS POINT (PRESENT AND LISTENING, PRESENT BUT NOT LISTENING, OR NOT PRESENT)	<div> <div></div> <div>PRES./</div> <div>PRES./</div> <div>NOT</div> <div>NOT</div> </div> <div> <div></div> <div>LISTEN.</div> <div>LISTEN.</div> <div>PRES.</div> <div>PRES.</div> </div> CHILDREN < 10 ..... 1 ..... 2 ..... 3 HUSBAND ..... 1 ..... 2 ..... 3 OTHER MALES ..... 1 ..... 2 ..... 3 OTHER FEMALES ..... 1 ..... 2 ..... 3	
932	In your opinion, is a husband justified in hitting or beating his wife in the following situations:  a) If she goes out without telling him? b) If she neglects the children? c) If she argues with him? d) If she refuses to have sex with him? e) If she burns the food?	<div> <div></div> <div>YES</div> <div>NO</div> <div>DK</div> </div> a) GOES OUT ..... 1 ..... 2 ..... 8 b) NEGLECTS CHILDREN .. 1 ..... 2 ..... 8 c) ARGUES ..... 1 ..... 2 ..... 8 d) REFUSES SEX ..... 1 ..... 2 ..... 8 e) BURNS FOOD ..... 1 ..... 2 ..... 8	

SECTION 10. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																
1001	Now I would like to talk about something else. Have you ever heard of HIV or AIDS?	YES ..... 1 NO ..... 2	→ 1042																
1002	HIV is the virus that can lead to AIDS. Can people reduce their chance of getting HIV by having just one uninfected sex partner who has no other sex partners?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																	
1003	Can people get HIV from mosquito bites?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																	
1004	Can people reduce their chance of getting HIV by using a condom every time they have sex?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																	
1005	Can people get HIV by sharing food with a person who has HIV?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																	
1006	Can people get HIV because of witchcraft or other supernatural means?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																	
1007	Is it possible for a healthy-looking person to have HIV?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																	
1008	Can HIV be transmitted from a mother to her baby:  a) During pregnancy? b) During delivery? c) By breastfeeding?	<table border="0"> <tr> <td></td><td align="center">YES</td><td align="center">NO</td><td align="center">DK</td></tr> <tr> <td>a) DURING PREGNANCY ..</td><td align="center">1</td><td align="center">2</td><td align="center">8</td></tr> <tr> <td>b) DURING DELIVERY .....</td><td align="center">1</td><td align="center">2</td><td align="center">8</td></tr> <tr> <td>c) BREASTFEEDING .....</td><td align="center">1</td><td align="center">2</td><td align="center">8</td></tr> </table>		YES	NO	DK	a) DURING PREGNANCY ..	1	2	8	b) DURING DELIVERY .....	1	2	8	c) BREASTFEEDING .....	1	2	8	
	YES	NO	DK																
a) DURING PREGNANCY ..	1	2	8																
b) DURING DELIVERY .....	1	2	8																
c) BREASTFEEDING .....	1	2	8																
1009	CHECK 1008:  <div style="display: flex; justify-content: space-around;"> <div>AT LEAST ONE 'YES' <input type="checkbox"/></div> <div>OTHER <input type="checkbox"/> → 1011</div> </div>																		
1010	Are there any special drugs that a doctor or a nurse can give to a woman infected with HIV to reduce the risk of transmission to the baby?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8																	
1011	CHECK 208 AND 215:  <div style="display: flex; justify-content: space-around;"> <div>LAST BIRTH IN 2017-2019 <input type="checkbox"/></div> <div>NO BIRTHS <input type="checkbox"/> → 1027</div> </div> <div style="display: flex; justify-content: space-around;"> <div></div> <div>LAST BIRTH IN 2016 OR EARLIER <input type="checkbox"/> → 1027</div> </div>																		
1012	CHECK 408 FOR LAST BIRTH:  <div style="display: flex; justify-content: space-around;"> <div>HAD ANTENATAL CARE <input type="checkbox"/></div> <div>NO ANTENATAL CARE <input type="checkbox"/> → 1020</div> </div>																		
1013	<b>CHECK FOR PRESENCE OF OTHERS. BEFORE CONTINUING, MAKE EVERY EFFORT TO ENSURE PRIVACY.</b>																		
1014	During any of the antenatal visits for your last birth were you given any information about:  a) Babies getting HIV from their mother? b) Things that you can do to prevent getting HIV? c) Getting tested for HIV?	<table border="0"> <tr> <td></td><td align="center">YES</td><td align="center">NO</td><td align="center">DK</td></tr> <tr> <td>a) HIV FROM MOTHER ..</td><td align="center">1</td><td align="center">2</td><td align="center">8</td></tr> <tr> <td>b) THINGS TO DO .....</td><td align="center">1</td><td align="center">2</td><td align="center">8</td></tr> <tr> <td>c) TESTED FOR HIV .....</td><td align="center">1</td><td align="center">2</td><td align="center">8</td></tr> </table>		YES	NO	DK	a) HIV FROM MOTHER ..	1	2	8	b) THINGS TO DO .....	1	2	8	c) TESTED FOR HIV .....	1	2	8	
	YES	NO	DK																
a) HIV FROM MOTHER ..	1	2	8																
b) THINGS TO DO .....	1	2	8																
c) TESTED FOR HIV .....	1	2	8																

SECTION 10. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1015	Were you offered a test for HIV as part of your antenatal care?	YES ..... 1 NO ..... 2	
1016	I don't want to know the results, but were you tested for HIV as part of your antenatal care?	YES ..... 1 NO ..... 2	→ 1020
1017	Where was the test done?  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)	<b>PUBLIC SECTOR</b> GOVERNMENT HOSPITAL ..... 11 GOVERNMENT HEALTH CENTER ..... 12 STAND-ALONE HTC CENTER ..... 13 FAMILY PLANNING CLINIC ..... 14 MOBILE HTC SERVICES ..... 15 OTHER PUBLIC SECTOR ..... 16 _____ (SPECIFY) <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR ..... 21 STAND-ALONE HTC CENTER ..... 22 PHARMACY ..... 23 MOBILE HTC SERVICES ..... 24 OTHER PRIVATE MEDICAL SECTOR ..... 26 _____ (SPECIFY) <b>OTHER SOURCE</b> HOME ..... 31 WORKPLACE ..... 32 CORRECTIONAL FACILITY ..... 33 OTHER ..... 96 _____ (SPECIFY)	
1018	I don't want to know the results, but did you get the results of the test?	YES ..... 1 NO ..... 2	→ 1020
1019	All women are supposed to receive counseling after being tested. After you were tested, did you receive counseling?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
1020	CHECK 430 FOR LAST BIRTH:  ANY CODE <input type="checkbox"/> '21-36' CIRCLED OTHER <input type="checkbox"/> _____		→ 1024
1021	Between the time you went for delivery but before the baby was born, were you offered an HIV test?	YES ..... 1 NO ..... 2	
1022	I don't want to know the results, but were you tested for HIV at that time?	YES ..... 1 NO ..... 2	→ 1024
1023	I don't want to know the results, but did you get the results of the test?	YES ..... 1 NO ..... 2	→ 1025
1024	CHECK 1016:  YES <input type="checkbox"/> NO OR NOT ASKED <input type="checkbox"/> _____		→ 1027
1025	Have you been tested for HIV since that time you were tested during your pregnancy?	YES ..... 1 NO ..... 2	→ 1028
1026	How many months ago was your most recent HIV test?	MONTHS AGO ..... <input type="text"/> <input type="text"/> TWO OR MORE YEARS ..... 95	→ 1033



SECTION 10. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1027	I don't want to know the results, but have you ever been tested for HIV?	YES ..... 1 NO ..... 2	→ 1031
1028	How many months ago was your most recent HIV test?	MONTHS AGO ..... <input type="text"/> <input type="text"/> TWO OR MORE YEARS ..... 95	
1029	I don't want to know the results, but did you get the results of the test?	YES ..... 1 NO ..... 2	
1030	Where was the test done?  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)	<b>PUBLIC SECTOR</b> GOVERNMENT HOSPITAL ..... 11 GOVERNMENT HEALTH CENTER ..... 12 STAND-ALONE HTC CENTER ..... 13 FAMILY PLANNING CLINIC ..... 14 MOBILE HTC SERVICES ..... 15 OTHER PUBLIC SECTOR ..... 16 _____ (SPECIFY) <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR ..... 21 STAND-ALONE HTC CENTER ..... 22 PHARMACY ..... 23 MOBILE HTC SERVICES ..... 24 OTHER PRIVATE MEDICAL SECTOR ..... 26 _____ (SPECIFY) <b>OTHER SOURCE</b> HOME ..... 31 WORKPLACE ..... 32 CORRECTIONAL FACILITY ..... 33 OTHER ..... 96 _____ (SPECIFY)	→ 1033
1031	Do you know of a place where people can go to get an HIV test?	YES ..... 1 NO ..... 2	→ 1033
1032	Where is that?  Any other 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)	<b>PUBLIC SECTOR</b> GOVERNMENT HOSPITAL ..... A GOVERNMENT HEALTH CENTER ..... B STAND-ALONE HTC CENTER ..... C FAMILY PLANNING CLINIC ..... D MOBILE HTC SERVICES ..... E OTHER PUBLIC SECTOR ..... F _____ (SPECIFY) <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR ..... G STAND-ALONE HTC CENTER ..... H PHARMACY ..... I MOBILE HTC SERVICES ..... J OTHER PRIVATE MEDICAL SECTOR ..... K _____ (SPECIFY) OTHER ..... X _____ (SPECIFY)	

SECTION 10. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1033	Have you heard of test kits people can use to test themselves for HIV?	YES ..... 1 NO ..... 2	→ 1035
1034	Have you ever tested yourself for HIV using a self-test kit?	YES ..... 1 NO ..... 2	
1035	Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had HIV?	YES ..... 1 NO ..... 2 DON'T KNOW/NOT SURE/DEPENDS ..... 8	
1036	Do you think children living with HIV should be allowed to attend school with children who do not have HIV?	YES ..... 1 NO ..... 2 DON'T KNOW/NOT SURE/DEPENDS ..... 8	
1037	Do you think people hesitate to take an HIV test because they are afraid of how other people will react if the test result is positive for HIV?	YES ..... 1 NO ..... 2 DON'T KNOW/NOT SURE/DEPENDS ..... 8	
1038	Do people talk badly about people living with HIV, or who are thought to be living with HIV?	YES ..... 1 NO ..... 2 DON'T KNOW/NOT SURE/DEPENDS ..... 8	
1039	Do people living with HIV, or thought to be living with HIV, lose the respect of other people?	YES ..... 1 NO ..... 2 DON'T KNOW/NOT SURE/DEPENDS ..... 8	
1040	Do you agree or disagree with the following statement: I would be ashamed if someone in my family had HIV.	AGREE ..... 1 DISAGREE ..... 2 DON'T KNOW/NOT SURE/DEPENDS ..... 8	
1041	Do you fear that you could get HIV if you come into contact with the saliva of a person living with HIV?	YES ..... 1 NO ..... 2 SAYS SHE HAS HIV ..... 3 DON'T KNOW/NOT SURE/DEPENDS ..... 8	
1042	CHECK 1001:  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> HEARD ABOUT <input type="checkbox"/> HIV OR AIDS ↓  a) Apart from HIV, have you heard about other infections that can be transmitted through sexual contact? </div> <div style="width: 45%;"> NOT HEARD ABOUT <input type="checkbox"/> HIV OR AIDS ↓  b) Have you heard about infections that can be transmitted through sexual contact? </div> </div>	YES ..... 1 NO ..... 2	
1043	CHECK 713:  <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">HAS HAD SEXUAL <input type="checkbox"/> INTERCOURSE ↓</div> <div style="text-align: center;">NEVER HAD SEXUAL <input type="checkbox"/> INTERCOURSE</div> </div>		→ 1051
1044	CHECK 1042: HEARD ABOUT OTHER SEXUALLY TRANSMITTED INFECTIONS?  <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">YES <input type="checkbox"/> ↓</div> <div style="text-align: center;">NO <input type="checkbox"/> →</div> </div>		→ 1046

SECTION 10. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1045	Now I would like to ask you some questions about your health in the last 12 months. During the last 12 months, have you had a disease which you got through sexual contact?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
1046	Sometimes women experience a bad-smelling abnormal genital discharge. During the last 12 months, have you had a bad-smelling abnormal genital discharge?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
1047	Sometimes women have a genital sore or ulcer. During the last 12 months, have you had a genital sore or ulcer?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
1048	CHECK 1045, 1046, AND 1047:  <div style="display: flex; justify-content: space-around;"> <div>                         HAS HAD AN <input type="checkbox"/>                          INFECTION                          (ANY 'YES')                     </div> <div>                         HAS NOT HAD AN <input type="checkbox"/>                          INFECTION OR                          DOES NOT KNOW                     </div> </div>		→ 1051
1049	The last time you had (PROBLEM FROM 1045/1046/1047), did you seek any kind of advice or treatment?	YES ..... 1 NO ..... 2	→ 1051
1050	Where did you go?  Any other place?  PROBE TO IDENTIFY THE TYPE OF SOURCE.  IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.  <div style="border-bottom: 1px solid black; width: 100%;"></div> (NAME OF PLACE)	<b>PUBLIC SECTOR</b> GOVERNMENT HOSPITAL ..... A GOVERNMENT HEALTH CENTER ..... B STAND-ALONE HTC CENTER ..... C FAMILY PLANNING CLINIC ..... D MOBILE HTC SERVICES ..... E OTHER PUBLIC SECTOR ..... F <div style="border-bottom: 1px solid black; width: 100%;"></div> (SPECIFY) <b>PRIVATE MEDICAL SECTOR</b> PRIVATE HOSPITAL/CLINIC/ ..... G PRIVATE DOCTOR ..... H STAND-ALONE HTC CENTER ..... I PHARMACY ..... J MOBILE HTC SERVICES ..... K OTHER PRIVATE MEDICAL SECTOR ..... L <div style="border-bottom: 1px solid black; width: 100%;"></div> (SPECIFY) <b>OTHER SOURCE</b> SHOP ..... X OTHER ..... X <div style="border-bottom: 1px solid black; width: 100%;"></div> (SPECIFY)	
1051	If a wife knows her husband has a disease that she can get during sexual intercourse, is she justified in asking that they use a condom when they have sex?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	
1052	Is a wife justified in refusing to have sex with her husband when she knows he has sex with other women?	YES ..... 1 NO ..... 2 DON'T KNOW ..... 8	

SECTION 10. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1053	<p>CHECK 701:</p> <p>CURRENTLY MARRIED/ LIVING WITH A MAN <input type="checkbox"/></p> <p>NOT IN UNION <input type="checkbox"/></p>	<p>→ 1101</p>	
1054	Can you say no to your (husband/partner) if you do not want to have sexual intercourse?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DEPENDS/NOT SURE ..... 8</p>	
1055	Could you ask your (husband/partner) to use a condom if you wanted him to?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DEPENDS/NOT SURE ..... 8</p>	

SECTION 11. OTHER HEALTH ISSUES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1101	<p>Now I would like to ask you some other questions relating to health matters. Have you had an injection for any reason in the last 12 months?</p> <p>IF YES: How many injections have you had?</p> <p>IF NUMBER OF INJECTIONS IS 90 OR MORE, OR DAILY FOR 3 MONTHS OR MORE, RECORD '90'. IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE.</p>	<p>NUMBER OF INJECTIONS ..... <input type="text"/> <input type="text"/></p> <p>NONE ..... 00</p>	→ 1104
1102	<p>Among these injections, how many were administered by a doctor, a nurse, a pharmacist, a dentist, or any other health worker?</p> <p>IF NUMBER OF INJECTIONS IS 90 OR MORE, OR DAILY FOR 3 MONTHS OR MORE, RECORD '90'. IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE.</p>	<p>NUMBER OF INJECTIONS ..... <input type="text"/> <input type="text"/></p> <p>NONE ..... 00</p>	→ 1104
1103	The last time you got an injection from a health worker, did he/she take the syringe and needle from a new, unopened package?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	
1104	Do you currently smoke cigarettes every day, some days, or not at all?	<p>EVERY DAY ..... 1</p> <p>SOME DAYS ..... 2</p> <p>NOT AT ALL ..... 3</p>	→ 1106
1105	On average, how many cigarettes do you currently smoke each day?	NUMBER OF CIGARETTES ..... <input type="text"/> <input type="text"/>	
1106	Do you currently smoke or use any other type of tobacco every day, some days, or not at all?	<p>EVERY DAY ..... 1</p> <p>SOME DAYS ..... 2</p> <p>NOT AT ALL ..... 3</p>	→ 1107A
1107	<p>What other type of tobacco do you currently smoke or use?</p> <p>RECORD ALL MENTIONED.</p>	<p>KRETEKS ..... A</p> <p>PIPES FULL OF TOBACCO ..... B</p> <p>CIGARS, CHEROOTS, OR CIGARILLOS ..... C</p> <p>WATER PIPE ..... D</p> <p>SNUFF BY MOUTH ..... E</p> <p>SNUFF BY NOSE ..... F</p> <p>CHEWING TOBACCO ..... G</p> <p>BETEL QUID WITH TOBACCO ..... H</p> <p>OTHER ..... X</p> <p align="center">(SPECIFY)</p>	
1107A	Have you ever heard of an illness called tuberculosis or TB?	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ 1108
1107B	<p>What are the common symptoms of TB ?</p> <p>RECORD ALL MENTIONED.</p>	<p>COUGH FOR MORE THAN 2 WEEKS ..... A</p> <p>FEVER IN THE EVENINGS ..... B</p> <p>CHEST PAIN ..... C</p> <p>LOSS OF WEIGHT ..... D</p> <p>LOSS OF APPETITE ..... E</p> <p>HEMOPTYSIS ..... F</p> <p>OTHER ..... X</p> <p align="center">(SPECIFY)</p> <p>DON'T KNOW ..... Z</p>	

**SECTION 11. OTHER HEALTH ISSUES**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP															
1107C	<p>How does tuberculosis spread from one person to another?</p> <p>RECORD ALL MENTIONED.</p>	<p>THROUGH THE AIR WHEN COUGHING OR SNEEZING ..... A</p> <p>THROUGH SHARING UTENSILS ..... B</p> <p>THROUGH TOUCHING A PERSON WITH TB ..... C</p> <p>THROUGH FOOD ..... D</p> <p>THROUGH SEXUAL CONTACT ..... E</p> <p>THROUGH MOSQUITO BITES ..... F</p> <p>THROUGH SPIT ..... G</p> <p>THROUGH GENES ..... H</p> <p>OTHER ..... X (SPECIFY)</p> <p>DON'T KNOW ..... Z</p>																
1107D	<p>If you were sick with TB, where would you prefer to seek care?</p> <p>RECORD ALL MENTIONED.</p>	<p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL/CLINIC ..... A</p> <p>PRIMARY HEALTH CARE CENTER ..... B</p> <p>HEALTH POST/SUB- HEALTH POST ..... C</p> <p>PHC OUTREACH CLINIC ..... D</p> <p>MOBILE CAMP ..... E</p> <p>FCHV ..... F</p> <p>OTHER ..... G (SPECIFY)</p> <p><b>NON-GOVT. (NGO) SECTOR</b></p> <p>FPAN ..... H</p> <p>MARIE STOPES ..... I</p> <p>OTHER NGO FACILITIES ..... J (SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL/ NURSING HOME ..... K</p> <p>PRIVATE CLINIC ..... L</p> <p>PHARMACY ..... M</p> <p>OTHER PRIVATE MEDICAL FACILITIES ..... N (SPECIFY)</p> <p><b>OTHER SOURCE</b></p> <p>SHOP ..... O</p> <p>FRIEND/RELATIVE ..... P</p> <p>TRADITIONAL HEALER ..... Q</p> <p>OTHER ..... X (SPECIFY)</p> <p>DON'T KNOW ..... Z</p>																
1107E	<p>If a member of your family got tuberculosis, would you want it to remain a secret or not?</p>	<p>YES, REMAIN A SECRET ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW/UNSURE ..... 8</p>																
1108	<p>Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not a big problem:</p> <p>a) Getting permission to go to the doctor?</p> <p>b) Getting money needed for advice or treatment?</p> <p>c) The distance to the health facility?</p> <p>d) Not wanting to go alone?</p>	<table border="0"> <thead> <tr> <th></th><th>BIG PROBLEM</th><th>NOT A BIG PROBLEM</th></tr> </thead> <tbody> <tr> <td>a) PERMISSION TO GO</td><td>1</td><td>2</td></tr> <tr> <td>b) GETTING MONEY</td><td>1</td><td>2</td></tr> <tr> <td>c) DISTANCE</td><td>1</td><td>2</td></tr> <tr> <td>d) GO ALONE</td><td>1</td><td>2</td></tr> </tbody> </table>		BIG PROBLEM	NOT A BIG PROBLEM	a) PERMISSION TO GO	1	2	b) GETTING MONEY	1	2	c) DISTANCE	1	2	d) GO ALONE	1	2	
	BIG PROBLEM	NOT A BIG PROBLEM																
a) PERMISSION TO GO	1	2																
b) GETTING MONEY	1	2																
c) DISTANCE	1	2																
d) GO ALONE	1	2																

SECTION 11. OTHER HEALTH ISSUES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1109	Are you covered by any health insurance?	YES ..... 1 NO ..... 2	→ 1201
1110	What type of health insurance are you covered by?  RECORD ALL MENTIONED.	MUTUAL HEALTH ORGANIZATION/ COMMUNITY-BASED HEALTH INSURANCE ..... A HEALTH INSURANCE THROUGH EMPLOYER ..... B SOCIAL SECURITY ..... C OTHER PRIVATELY PURCHASED COMMERCIAL HEALTH INSURANCE ..... D OTHER _____ X (SPECIFY)	

## SECTION 12. FEMALE GENITAL CUTTING/MUTILATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1201	<p>Now I would like to ask some questions about a practice known as female circumcision, that is, a practice in which a girl may have part of her genitals cut, for example, excision of the clitoris and the labia minora, scraping of tissue surrounding the vaginal orifice or cutting of the vagina and even use of corrosive sunstances or herbs into vagina to tighten or narrow it or to cause bleeding.</p> <p>Have you ever heard about any of these practices?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ 1301
1202	In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ 1301
1203	Have you yourself ever been circumcised?	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ 1209
1204	Now I would like to ask you what was done to you at that time. Was any flesh removed from the genital area?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	→ 1206
1205	Was the genital area just nicked without removing any flesh?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	
1206	Was your genital area sewn closed?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	
1207	<p>How old were you when you were circumcised?</p> <p>IF THE RESPONDENT DOES NOT KNOW THE EXACT AGE, PROBE TO GET AN ESTIMATE.</p>	<p>AGE IN COMPLETED YEARS ..... <input type="text"/> <input type="text"/></p> <p>AS A BABY/DURING INFANCY ..... 95</p> <p>DON'T KNOW ..... 98</p>	
1208	Who performed the circumcision?	<p><b>TRADITIONAL</b></p> <p>TRAD. CIRCUMCISER ..... 11</p> <p>TRAD. BIRTH ATTENDANT ..... 12</p> <p>OTHER TRAD. _____ 16 (SPECIFY)</p> <p><b>HEALTH PROFESSIONAL</b></p> <p>DOCTOR ..... 21</p> <p>NURSE/MIDWIFE ..... 22</p> <p>OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)</p> <p>DON'T KNOW ..... 98</p>	
1209	<p>CHECK 213, 215 AND 216:</p> <p>HAS ONE OR MORE LIVING DAUGHTERS BORN IN 2004 OR LATER <input type="checkbox"/></p> <p>HAS NO LIVING DAUGHTERS BORN IN 2004 OR LATER <input type="checkbox"/></p>		→ 1216



SECTION 12. FEMALE GENITAL CUTTING/MUTILATION

1209A	<p>CHECK 213, 215 AND 216: ENTER IN THE TABLE THE BIRTH HISTORY NUMBER AND NAME OF EACH LIVING DAUGHTER BORN IN 2004 OR LATER. ASK THE QUESTIONS ABOUT ALL OF THESE DAUGHTERS. BEGIN WITH THE YOUNGEST DAUGHTER. (IF THERE ARE MORE THAN 3 DAUGHTERS, USE ADDITIONAL QUESTIONNAIRES).</p> <p>Now I would like to ask you some questions about your (daughter/daughters).</p>			
1210	<p>BIRTH HISTORY NUMBER AND NAME OF EACH LIVING DAUGHTER BORN IN 2004 OR LATER.</p>	<p>YOUNGEST LIVING DAUGHTER</p> <p>BIRTH HISTORY NUMBER .. <input type="text"/> <input type="text"/></p> <p>NAME .....</p>	<p>NEXT-TO-YOUNGEST LIVING DAUGHTER</p> <p>BIRTH HISTORY NUMBER .. <input type="text"/> <input type="text"/></p> <p>NAME .....</p>	<p>SECOND-TO-YOUNGEST LIVING DAUGHTER</p> <p>BIRTH HISTORY NUMBER .. <input type="text"/> <input type="text"/></p> <p>NAME .....</p>
1211	<p>Is (NAME OF DAUGHTER) circumcised?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>(GO TO 1211 IN NEXT COLUMN; OR IF NO MORE DAUGHTERS, GO TO GC1216)</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>(GO TO 1211 IN NEXT COLUMN; OR IF NO MORE DAUGHTERS, GO TO GC1216)</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>(GO TO 1211 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR IF NO MORE DAUGHTERS, GO TO GC1216)</p>
1212	<p>How old was (NAME OF DAUGHTER) when she was circumcised?</p> <p>IF THE RESPONDENT DOES NOT KNOW THE AGE, PROBE TO GET AN ESTIMATE.</p>	<p>AGE IN COMPLETED YRS .. <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>	<p>AGE IN COMPLETED YRS .. <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>	<p>AGE IN COMPLETED YRS .. <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>
1213	<p>Was her genital area sewn closed?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>
1214	<p>Who performed the circumcision?</p>	<p><b>TRADITIONAL</b></p> <p>TRADITIONAL CIRCUMCISER .. 11</p> <p>TRAD. BIRTH ATTENDANT .. 12</p> <p>OTHER TRAD. .... 16</p> <p>(SPECIFY)</p> <p><b>HEALTH PROFESSIONAL</b></p> <p>DOCTOR ..... 21</p> <p>NURSE/MIDWIFE .. 22</p> <p>OTHER HEALTH PROFESSIONAL ..... 26</p> <p>(SPECIFY)</p> <p>DON'T KNOW ..... 98</p>	<p><b>TRADITIONAL</b></p> <p>TRADITIONAL CIRCUMCISER .. 11</p> <p>TRAD. BIRTH ATTENDANT .. 12</p> <p>OTHER TRAD. .... 16</p> <p>(SPECIFY)</p> <p><b>HEALTH PROFESSIONAL</b></p> <p>DOCTOR ..... 21</p> <p>NURSE/MIDWIFE .. 22</p> <p>OTHER HEALTH PROFESSIONAL ..... 26</p> <p>(SPECIFY)</p> <p>DON'T KNOW ..... 98</p>	<p><b>TRADITIONAL</b></p> <p>TRADITIONAL CIRCUMCISER .. 11</p> <p>TRAD. BIRTH ATTENDANT .. 12</p> <p>OTHER TRAD. .... 16</p> <p>(SPECIFY)</p> <p><b>HEALTH PROFESSIONAL</b></p> <p>DOCTOR ..... 21</p> <p>NURSE/MIDWIFE .. 22</p> <p>OTHER HEALTH PROFESSIONAL ..... 26</p> <p>(SPECIFY)</p> <p>DON'T KNOW ..... 98</p>
1215		<p>GO BACK TO 1211 IN NEXT COLUMN; OR, IF NO MORE DAUGHTERS, GO TO 1216.</p>	<p>GO BACK TO 1211 IN NEXT COLUMN; OR, IF NO MORE DAUGHTERS, GO TO 1216.</p>	<p>GO TO 1211 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR IF NO MORE DAUGHTERS, GO TO 1216.</p>

SECTION 12. FEMALE GENITAL CUTTING/MUTILATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1216	Do you believe that female circumcision is required by your religion?	YES ..... 1 NO ..... 2 NO RELIGION ..... 3 DON'T KNOW ..... 8	
1217	Do you think that female circumcision should be continued, or should it be stopped?	CONTINUED ..... 1 STOPPED ..... 2 DEPENDS ..... 3 DON'T KNOW ..... 8	

**SECTION 14. ADULT AND MATERNAL MORTALITY**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																												
1401	<p>Now I would like to ask you some questions about your brothers and sisters born to your natural mother, including those who are living with you, those living elsewhere and those who have died. From our experience in prior surveys, we know it may sometimes be difficult to establish a complete list of all the children born to your natural mother. We will work together to draw the most complete list and work to recall all your siblings. Could you please now give me the names of all of your brothers and sisters born to your natural mother.</p> <p>DO NOT FILL IN THE ORDER NUMBER YET.</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">NAME</th> <th style="width:15%;">ORDER NUMBER</th> <th style="width:30%;">NAME</th> <th style="width:15%;">ORDER NUMBER</th> </tr> </thead> <tbody> <tr><td>a _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>k _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>b _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>l _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>c _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>m _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>d _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>n _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>e _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>o _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>f _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>p _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>g _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>q _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>h _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>r _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>i _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>s _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> <tr><td>j _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td><td>t _____</td><td><div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></td></tr> </tbody> </table>	NAME	ORDER NUMBER	NAME	ORDER NUMBER	a _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	k _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	b _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	l _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	c _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	m _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	d _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	n _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	e _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	o _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	f _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	p _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	g _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	q _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	h _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	r _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	i _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	s _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	j _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	t _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>		
NAME	ORDER NUMBER	NAME	ORDER NUMBER																																												
a _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	k _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
b _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	l _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
c _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	m _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
d _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	n _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
e _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	o _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
f _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	p _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
g _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	q _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
h _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	r _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
i _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	s _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
j _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>	t _____	<div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div>																																												
1402	<p>CHECK 1401:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <p>ONE OR MORE BROTHERS OR SISTERS LISTED</p> <input style="width: 20px; height: 20px;" type="checkbox"/> </div> <div style="text-align: center;"> <p>NO BROTHERS OR SISTERS LISTED</p> <input style="width: 20px; height: 20px;" type="checkbox"/> </div> </div> <p style="text-align: right; margin-top: -20px;">→ 1404</p>																																														
1403	<p>READ THE NAMES OF THE BROTHERS AND SISTERS TO THE RESPONDENT AND AFTER THE LAST ONE ASK: Are there any other brothers and sisters from the same mother that you have not mentioned?</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <p>NO <input style="width: 20px; height: 20px;" type="checkbox"/></p> <p>YES <input style="width: 20px; height: 20px;" type="checkbox"/></p> </div> <p style="text-align: right; margin-top: -20px;">→ LIST ADDITIONAL BROTHERS AND SISTERS IN 1401.</p>																																														
1404	<p>Sometimes people forget to mention children born to their natural mother because they do not live with them or they do not see them very often. Are there any brothers or sisters who do not live with you that you have not mentioned?</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <p>NO <input style="width: 20px; height: 20px;" type="checkbox"/></p> <p>YES <input style="width: 20px; height: 20px;" type="checkbox"/></p> </div> <p style="text-align: right; margin-top: -20px;">→ LIST ADDITIONAL BROTHERS AND SISTERS IN 1401.</p>																																														
1405	<p>Sometimes people forget to mention children born to their natural mother because they have died. Are there any brothers or sisters who died that you have not mentioned?</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <p>NO <input style="width: 20px; height: 20px;" type="checkbox"/></p> <p>YES <input style="width: 20px; height: 20px;" type="checkbox"/></p> </div> <p style="text-align: right; margin-top: -20px;">→ LIST ADDITIONAL BROTHERS AND SISTERS IN 1401.</p>																																														
1406	<p>Some people have brothers or sisters from the same mother but a different father. Are there any brothers or sisters born to your natural mother, but who have a different natural father, that you have not mentioned?</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <p>NO <input style="width: 20px; height: 20px;" type="checkbox"/></p> <p>YES <input style="width: 20px; height: 20px;" type="checkbox"/></p> </div> <p style="text-align: right; margin-top: -20px;">→ LIST ADDITIONAL BROTHERS AND SISTERS IN 1401.</p>																																														
1407	<p>COUNT THE NUMBER OF BROTHERS AND SISTERS RECORDED IN 1401.</p>	<p>TOTAL BROTHERS AND SISTERS ... <div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;">  </div></p>																																													

SECTION 14. ADULT AND MATERNAL MORTALITY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1408	<p>CHECK 1407:</p> <p>Just to make make sure that I have this right: Your mother had in TOTAL _____ births, excluding you, during her lifetime. Is that correct?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/> → PROBE AND CORRECT 1401 AND/OR 1407.</p>		
1409	<p>CHECK 1407:</p> <p>ONE OR MORE <input type="checkbox"/> NO <input type="checkbox"/></p> <p>BROTHERS/SISTERS BROTHER OR SISTER → 1425</p>		
1410	<p>Please tell me, which brother or sister was born first? And which was born next?</p> <p>RECORD '01' FOR THE ORDER NUMBER IN MM01 FOR THE FIRST BROTHER OR SISTER, '02' FOR THE SECOND, AND SO ON UNTIL YOU HAVE RECORDED THE ORDER NUMBER FOR ALL BROTHERS AND SISTERS.</p>		
1411	<p>How many births did your mother have before you were born?</p>	<p>NUMBER OF PRECEDING BIRTHS .. <input type="text"/> <input type="text"/></p>	

SECTION 14. ADULT AND MATERNAL MORTALITY

1412	LIST THE BROTHERS AND SISTERS ACCORDING TO THE ORDER NUMBER IN 1401. ASK 1413 TO 1424 FOR ONE BROTHER OR SISTER BEFORE ASKING ABOUT THE NEXT BROTHER OR SISTER. IF THERE ARE MORE THAN 12 BROTHERS AND SISTERS, USE AN ADDITIONAL QUESTIONNAIRE.						
1413	NAME OF BROTHER OR SISTER.	(01) _____	(02) _____	(03) _____	(04) _____	(05) _____	(06) _____
1414	Is (NAME) male or female?	MALE .... 1 FEMALE . 2	MALE .... 1 FEMALE . 2	MALE .... 1 FEMALE . 2	MALE .... 1 FEMALE . 2	MALE .... 1 FEMALE . 2	MALE .... 1 FEMALE . 2
1415	Is (NAME) still alive?	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (02) ←	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (03) ←	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (04) ←	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (05) ←	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (06) ←	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (07) ←
1416	How old is (NAME)?	<input type="text"/> <input type="text"/> GO TO (02)	<input type="text"/> <input type="text"/> GO TO (03)	<input type="text"/> <input type="text"/> GO TO (04)	<input type="text"/> <input type="text"/> GO TO (05)	<input type="text"/> <input type="text"/> GO TO (06)	<input type="text"/> <input type="text"/> GO TO (07)
1417	How many years ago did (NAME) die?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
1418	How old was (NAME) when (he/she) died? IF DON'T KNOW, PROBE AND ASK ADDITIONAL QUESTIONS TO GET AN ESTIMATE.	<input type="text"/> <input type="text"/> IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/> IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/> IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/> IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/> IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/> IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423
1419	Was (NAME) pregnant when she died?	YES ..... 1 GO TO 1423 ← NO ..... 2	YES ..... 1 GO TO 1423 ← NO ..... 2	YES ..... 1 GO TO 1423 ← NO ..... 2	YES ..... 1 GO TO 1423 ← NO ..... 2	YES ..... 1 GO TO 1423 ← NO ..... 2	YES ..... 1 GO TO 1423 ← NO ..... 2
1420	Did (NAME) die during childbirth?	YES ..... 1 GO TO (02) ← NO ..... 2	YES ..... 1 GO TO (03) ← NO ..... 2	YES ..... 1 GO TO (04) ← NO ..... 2	YES ..... 1 GO TO (05) ← NO ..... 2	YES ..... 1 GO TO (06) ← NO ..... 2	YES ..... 1 GO TO (07) ← NO ..... 2
1421	Did (NAME) die within two months after the end of a pregnancy or childbirth?	YES ..... 1 NO ..... 2 GO TO 1423 ←	YES ..... 1 NO ..... 2 GO TO 1423 ←	YES ..... 1 NO ..... 2 GO TO 1423 ←	YES ..... 1 NO ..... 2 GO TO 1423 ←	YES ..... 1 NO ..... 2 GO TO 1423 ←	YES ..... 1 NO ..... 2 GO TO 1423 ←
1422	How many days after the end of the pregnancy did (NAME) die?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

1423	Was (NAME)'s death due to an act of violence?	YES ..... 1 GO TO (02) ← NO ..... 2	YES ..... 1 GO TO (03) ← NO ..... 2	YES ..... 1 GO TO (04) ← NO ..... 2	YES ..... 1 GO TO (05) ← NO ..... 2	YES ..... 1 GO TO (06) ← NO ..... 2	YES ..... 1 GO TO (07) ← NO ..... 2	
1424	Was (NAME)'s death due to an accident?	YES ..... 1 NO ..... 2  GO TO (02)	YES ..... 1 NO ..... 2  GO TO (03)	YES ..... 1 NO ..... 2  GO TO (04)	YES ..... 1 NO ..... 2  GO TO (05)	YES ..... 1 NO ..... 2  GO TO (06)	YES ..... 1 NO ..... 2  GO TO (07)	
IF NO MORE BROTHERS OR SISTERS, COTINUE TO DV IF HOUSEHOLD WAS SELCTED FOR DV OR RECORD TIME.								
1425	RECORD THE TIME.		HOURS	<div><div></div><div></div></div>	MINUTES			

SECTION 14. ADULT AND MATERNAL MORTALITY

1412	LIST THE BROTHERS AND SISTERS ACCORDING TO THE ORDER NUMBER IN 1401. ASK 1413 TO 1424 FOR ONE BROTHER OR SISTER BEFORE ASKING ABOUT THE NEXT BROTHER OR SISTER. IF THERE ARE MORE THAN 12 BROTHERS AND SISTERS, USE AN ADDITIONAL QUESTIONNAIRE.						
1413	NAME OF BROTHER OR SISTER.	(07) _____	(08) _____	(09) _____	(10) _____	(11) _____	(12) _____
1414	Is (NAME) male or female?	MALE ..... 1 FEMALE ..... 2	MALE ..... 1 FEMALE ..... 2	MALE ..... 1 FEMALE ..... 2	MALE ..... 1 FEMALE ..... 2	MALE ..... 1 FEMALE ..... 2	MALE ..... 1 FEMALE ..... 2
1415	Is (NAME) still alive?	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (08)	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (09)	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (10)	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (11)	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (12)	YES ..... 1 NO ..... 2 GO TO 1417 DK ..... 8 GO TO (07)
1416	How old is (NAME)?	<input type="text"/> <input type="text"/> GO TO (02)	<input type="text"/> <input type="text"/> GO TO (03)	<input type="text"/> <input type="text"/> GO TO (04)	<input type="text"/> <input type="text"/> GO TO (05)	<input type="text"/> <input type="text"/> GO TO (06)	<input type="text"/> <input type="text"/> GO TO (07)
1417	How many years ago did (NAME) die?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
1418	How old was (NAME) when (he/she) died? IF DON'T KNOW, PROBE AND ASK ADDITIONAL QUESTIONS TO GET AN ESTIMATE.	<input type="text"/> <input type="text"/>  IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/>  IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/>  IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/>  IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/>  IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423	<input type="text"/> <input type="text"/>  IF MALE OR DIED BEFORE 12 YEARS OF AGE, GO TO 1423
1419	Was (NAME) pregnant when she died?	YES ..... 1 GO TO 1423 NO ..... 2	YES ..... 1 GO TO 1423 NO ..... 2	YES ..... 1 GO TO 1423 NO ..... 2	YES ..... 1 GO TO 1423 NO ..... 2	YES ..... 1 GO TO 1423 NO ..... 2	YES ..... 1 GO TO 1423 NO ..... 2
1420	Did (NAME) die during childbirth?	YES ..... 1 GO TO (02) NO ..... 2	YES ..... 1 GO TO (03) NO ..... 2	YES ..... 1 GO TO (04) NO ..... 2	YES ..... 1 GO TO (05) NO ..... 2	YES ..... 1 GO TO (06) NO ..... 2	YES ..... 1 GO TO (07) NO ..... 2
1421	Did (NAME) die within two months after the end of a pregnancy or childbirth?	YES ..... 1 NO ..... 2 GO TO 1423	YES ..... 1 NO ..... 2 GO TO 1423	YES ..... 1 NO ..... 2 GO TO 1423	YES ..... 1 NO ..... 2 GO TO 1423	YES ..... 1 NO ..... 2 GO TO 1423	YES ..... 1 NO ..... 2 GO TO 1423
1422	How many days after the end of the pregnancy did (NAME) die?	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
1423	Was (NAME)'s death due to an act of violence?	YES ..... 1 GO TO (02) NO ..... 2	YES ..... 1 GO TO (03) NO ..... 2	YES ..... 1 GO TO (04) NO ..... 2	YES ..... 1 GO TO (05) NO ..... 2	YES ..... 1 GO TO (06) NO ..... 2	YES ..... 1 GO TO (07) NO ..... 2
1424	Was (NAME)'s death due to an accident?	YES ..... 1 NO ..... 2 GO TO (02)	YES ..... 1 NO ..... 2 GO TO (03)	YES ..... 1 NO ..... 2 GO TO (04)	YES ..... 1 NO ..... 2 GO TO (05)	YES ..... 1 NO ..... 2 GO TO (06)	YES ..... 1 NO ..... 2 GO TO (07)

IF NO MORE BROTHERS OR SISTERS, GO TO THE NEXT SECTION.

SECTION 15: DOMESTIC VIOLENCE MODULE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																								
1500	CHECK COVER PAGE: WOMAN SELECTED FOR DV MODULE?  WOMAN SELECTED <input type="checkbox"/> FOR THIS SECTION ↓	WOMAN <input type="checkbox"/> NOT SELECTED →	1533																								
1501	CHECK FOR PRESENCE OF OTHERS: DO NOT CONTINUE UNTIL PRIVACY IS ENSURED.  PRIVACY OBTAINED ..... 1 ↓	PRIVACY NOT POSSIBLE ..... 2 →	1532																								
1501A	READ TO THE RESPONDENT: Now I would like to ask you questions about some other important aspects of a woman's life. You may find some of these questions very personal. However, your answers are crucial for helping to understand the condition of women in Sierra Leone. Let me assure you that your answers are completely confidential and will not be told to anyone and no one else in your household will know that you were asked these questions. 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.																										
1502	CHECK 701 AND 702:  CURRENTLY MARRIED/LIVING WITH A MAN <input type="checkbox"/> ↓	FORMERLY MARRIED/LIVED WITH A MAN (READ IN PAST TENSE AND USE 'LAST' WITH 'HUSBAND/PARTNER') <input type="checkbox"/> ↓	NEVER MARRIED/NEVER LIVED WITH A MAN <input type="checkbox"/> → 1516																								
1503	First, I am going to ask you about some situations which happen to some women. Please tell me if these apply to your relationship with your (last) (husband/partner)?  a) He (is/was) jealous or angry if you (talk/talked) to other b) He frequently (accuses/accused) you of being unfaithful? c) He (does/did) not permit you to meet your female friends? d) He (tries/tried) to limit your contact with your family? e) He (insists/insisted) on knowing where you (are/were) at all times?	<table border="1"> <thead> <tr> <th></th><th>YES</th><th>NO</th><th>DK</th></tr> </thead> <tbody> <tr> <td>JEALOUS .....</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>ACCUSES .....</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>NOT MEET FRIENDS ..</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>NO FAMILY .....</td><td>1</td><td>2</td><td>8</td></tr> <tr> <td>WHERE YOU ARE .....</td><td>1</td><td>2</td><td>8</td></tr> </tbody> </table>		YES	NO	DK	JEALOUS .....	1	2	8	ACCUSES .....	1	2	8	NOT MEET FRIENDS ..	1	2	8	NO FAMILY .....	1	2	8	WHERE YOU ARE .....	1	2	8	
	YES	NO	DK																								
JEALOUS .....	1	2	8																								
ACCUSES .....	1	2	8																								
NOT MEET FRIENDS ..	1	2	8																								
NO FAMILY .....	1	2	8																								
WHERE YOU ARE .....	1	2	8																								
1504	Now I need to ask some more questions about your relationship with your (last) (husband/partner).  A. Did your (last) (husband/partner) ever:  a) say or do something to humiliate you in front of others?  b) threaten to hurt or harm you or someone you care about?  c) insult you or make you feel bad about yourself?	<table border="1"> <thead> <tr> <th>EVER</th><th>OFTEN</th><th>SOME-TIMES</th><th>NOT IN LAST 12 MONTHS</th></tr> </thead> <tbody> <tr> <td>YES 1 NO 2 ↓</td><td>→ 1</td><td>2</td><td>3</td></tr> <tr> <td>YES 1 NO 2 ↓</td><td>→ 1</td><td>2</td><td>3</td></tr> <tr> <td>YES 1 NO 2 ↓</td><td>→ 1</td><td>2</td><td>3</td></tr> </tbody> </table>	EVER	OFTEN	SOME-TIMES	NOT IN LAST 12 MONTHS	YES 1 NO 2 ↓	→ 1	2	3	YES 1 NO 2 ↓	→ 1	2	3	YES 1 NO 2 ↓	→ 1	2	3	B. How often did this happen during the last 12 months: often, only sometimes, or not at all?								
EVER	OFTEN	SOME-TIMES	NOT IN LAST 12 MONTHS																								
YES 1 NO 2 ↓	→ 1	2	3																								
YES 1 NO 2 ↓	→ 1	2	3																								
YES 1 NO 2 ↓	→ 1	2	3																								



**SECTION 15: DOMESTIC VIOLENCE MODULE**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP
1505	A. Did your (last) (husband/partner) ever do any of the following things to you:	B. How often did this happen during the last 12 months: often, only sometimes, or not at all?			
		EVER	OFTEN	SOME-TIMES	NOT IN LAST 12 MONTHS
	a) push you, shake you, or throw something at you?	YES 1 NO 2	→ 1	2	3
	b) slap you?	YES 1 NO 2	→ 1	2	3
	c) twist your arm or pull your hair?	YES 1 NO 2	→ 1	2	3
	d) punch you with his fist or with something that could hurt you?	YES 1 NO 2	→ 1	2	3
	e) kick you, drag you, or beat you up?	YES 1 NO 2	→ 1	2	3
	f) try to choke you or burn you on purpose?	YES 1 NO 2	→ 1	2	3
	g) threaten or attack you with a knife, gun, or other weapon?	YES 1 NO 2	→ 1	2	3
	h) physically force you to have sexual intercourse with him when you did not want to?	YES 1 NO 2	→ 1	2	3
	i) physically force you to perform any other sexual acts you did not want to?	YES 1 NO 2	→ 1	2	3
	j) force you with threats or in any other way to perform sexual acts you did not want to?	YES 1 NO 2	→ 1	2	3
1506	CHECK 1505A (a-j):  AT LEAST ONE <input type="checkbox"/> 'YES' ↓	NOT A SINGLE <input type="checkbox"/> 'YES' →			1509
1507	How long after you first (got married/started living together) with your (last) (husband/partner) did (this/any of these things) first happen?  IF LESS THAN ONE YEAR, RECORD '00'.	NUMBER OF YEARS ..... <input type="text"/> <input type="text"/>  BEFORE MARRIAGE/BEFORE LIVING TOGETHER ..... 95			
1508	Did the following ever happen as a result of what your (last) (husband/partner) did to you:				
	a) You had cuts, bruises, or aches?	YES ..... 1 NO ..... 2			
	b) You had eye injuries, sprains, dislocations, or burns?	YES ..... 1 NO ..... 2			
	c) You had deep wounds, broken bones, broken teeth, or any other serious injury?	YES ..... 1 NO ..... 2			
1509	Have you ever hit, slapped, kicked, or done anything else to physically hurt your (last) (husband/partner) at times when he was not already beating or physically hurting you?	YES ..... 1 NO ..... 2			→ 1511
1510	In the last 12 months, how often have you done this to your (last) (husband/partner): often, only sometimes, or not at all?	OFTEN ..... 1 SOMETIMES ..... 2 NOT AT ALL ..... 3			

**SECTION 15: DOMESTIC VIOLENCE MODULE**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																
1511	Does (did) your (last) (husband/partner) drink alcohol?	YES ..... 1 NO ..... 2	→ 1513																
1512	How often does (did) he get drunk: often, only sometimes, or never?	OFTEN ..... 1 SOMETIMES ..... 2 NEVER ..... 3																	
1513	Are (Were) you afraid of your (last) (husband/partner): most of the time, sometimes, or never?	MOST OF THE TIME AFRAID ..... 1 SOMETIMES AFRAID ..... 2 NEVER AFRAID ..... 3																	
1514	CHECK 709:  <div style="display: flex; justify-content: space-around;"> <span>MARRIED MORE THAN ONCE <input type="checkbox"/></span> <span>MARRIED ONLY ONCE <input type="checkbox"/></span> </div>		→ 1516																
1515	A. So far we have been talking about the behavior of your (current/last) (husband/partner). Now I want to ask you about the behavior of any previous (husband/partner).  <div style="display: flex;"> <div style="flex: 1;"> <p>a) Did any previous (husband/partner) ever hit, slap, kick, or do anything else to hurt you physically?</p> <p>b) Did any previous (husband/partner) physically force you to have intercourse or perform any other sexual acts against your will?</p> <p>c) Did any previous (husband/partner) humiliate you in front of others, threaten to hurt you or someone you care about, or insult you or make you feel bad about yourself?</p> </div> <div style="flex: 0.2; text-align: center;"> <p>EVER</p> <p>YES 1 NO 2 ↓</p> <p>YES 1 NO 2 ↓</p> <p>YES 1 NO 2 ↓</p> </div> <div style="flex: 1;"> <p>B. How long ago did this last happen?</p> <table border="1"> <thead> <tr> <th></th><th>0 - 11 MONTHS AGO</th><th>12+ MONTHS AGO</th><th>DON'T REMEMBER</th></tr> </thead> <tbody> <tr> <td>→</td><td>1</td><td>2</td><td>3</td></tr> <tr> <td>→</td><td>1</td><td>2</td><td>3</td></tr> <tr> <td>→</td><td>1</td><td>2</td><td>3</td></tr> </tbody> </table> </div> </div>		0 - 11 MONTHS AGO	12+ MONTHS AGO	DON'T REMEMBER	→	1	2	3	→	1	2	3	→	1	2	3		
	0 - 11 MONTHS AGO	12+ MONTHS AGO	DON'T REMEMBER																
→	1	2	3																
→	1	2	3																
→	1	2	3																
1516	CHECK 701 AND 702:  <div style="display: flex;"> <div style="flex: 1;"> <p>EVER MARRIED/EVER LIVED WITH A MAN <input type="checkbox"/></p> <p>a) From the time you were 15 years old has anyone other than (your/any) (husband/partner) hit you, slapped you, kicked you, or done anything else to hurt you physically?</p> </div> <div style="flex: 1;"> <p>NEVER MARRIED/NEVER LIVED WITH A MAN <input type="checkbox"/></p> <p>b) From the time you were 15 years old has anyone hit you, slapped you, kicked you, or done anything else to hurt you physically?</p> </div> </div>	YES ..... 1 NO ..... 2 REFUSED TO ANSWER/ NO ANSWER ..... 3	→ 1519																
1517	Who has hurt you in this way?  Anyone else?  RECORD ALL MENTIONED.	MOTHER/STEP-MOTHER ..... A FATHER/STEP-FATHER ..... B SISTER/BROTHER ..... C DAUGHTER/SON ..... D OTHER RELATIVE ..... E CURRENT BOYFRIEND ..... F FORMER BOYFRIEND ..... G MOTHER-IN-LAW ..... H FATHER-IN-LAW ..... I OTHER IN-LAW ..... J TEACHER ..... K EMPLOYER/SOMEONE AT WORK ..... L POLICE/SOLDIER ..... M  OTHER _____ X <div style="text-align: center;">(SPECIFY)</div>																	

SECTION 15: DOMESTIC VIOLENCE MODULE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1518	In the last 12 months, how often has (this person/have these persons) physically hurt you: often, only sometimes, or not at all?	OFTEN ..... 1 SOMETIMES ..... 2 NOT AT ALL ..... 3	
1519	CHECK 201, 226, AND 230:  EVER BEEN PREGNANT <input type="checkbox"/> ('YES' ON 201 OR 226 OR 230) ↓	NEVER BEEN PREGNANT <input type="checkbox"/> →	1522
1520	Has any one ever hit, slapped, kicked, or done anything else to hurt you physically while you were pregnant?	YES ..... 1 NO ..... 2	→ 1522
1521	Who has done any of these things to physically hurt you while you were pregnant?  Anyone else?  RECORD ALL MENTIONED.	CURRENT HUSBAND/PARTNER ..... A MOTHER/STEP-MOTHER ..... B FATHER/STEP-FATHER ..... C SISTER/BROTHER ..... D DAUGHTER/SON ..... E OTHER RELATIVE ..... F FORMER HUSBAND/PARTNER ..... G CURRENT BOYFRIEND ..... H FORMER BOYFRIEND ..... I MOTHER-IN-LAW ..... J FATHER-IN-LAW ..... K OTHER IN-LAW ..... L TEACHER ..... M EMPLOYER/SOMEONE AT WORK ..... N POLICE/SOLDIER ..... O  OTHER ..... X (SPECIFY)	
1522	CHECK 701 AND 702:  EVER MARRIED/EVER LIVED WITH A MAN <input type="checkbox"/> ↓	NEVER MARRIED/NEVER LIVED WITH A MAN <input type="checkbox"/> →	1522B
1522A	Now I want to ask you about things that may have been done to you by someone other than (your/any) (husband/partner). At any time in your life, as a child or as an adult, has anyone ever forced you in any way to have sexual intercourse or perform any other sexual acts when you did not want to?	YES ..... 1 NO ..... 2 REFUSED TO ANSWER/ NO ANSWER ..... 3	→ 1523 → 1524A
1522B	At any time in your life, as a child or as an adult, has anyone ever forced you in any way to have sexual intercourse or perform any other sexual acts when you did not want to?	YES ..... 1 NO ..... 2 REFUSED TO ANSWER/ NO ANSWER ..... 3	→ 1526
1523	Who was the person who was forcing you the very first time this happened?	CURRENT HUSBAND/PARTNER ..... 01 FORMER HUSBAND/PARTNER ..... 02 CURRENT/FORMER BOYFRIEND ..... 03 FATHER/STEP-FATHER ..... 04 BROTHER/STEP-BROTHER ..... 05 OTHER RELATIVE ..... 06 IN-LAW ..... 07 OWN FRIEND/ACQUAINTANCE ..... 08 FAMILY FRIEND ..... 09 TEACHER ..... 10 EMPLOYER/SOMEONE AT WORK ..... 11 POLICE/SOLDIER ..... 12 PRIEST/RELIGIOUS LEADER ..... 13 STRANGER ..... 14  OTHER ..... 96 (SPECIFY)	

**SECTION 15: DOMESTIC VIOLENCE MODULE**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																
1524	<p>CHECK 701 AND 702:</p> <p>EVER MARRIED/EVER LIVED WITH A MAN <input type="checkbox"/> NEVER MARRIED/NEVER LIVED WITH A MAN <input type="checkbox"/></p> <p>a) In the last 12 months, has anyone other than (your/any) (husband/partner) physically forced you to have sexual intercourse when you did not want to?</p> <p>b) In the last 12 months has anyone physically forced you to have sexual intercourse when you did not want to?</p>	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ 1525																
1524A	<p>CHECK 1505A (h-j) and 1515A(b)</p> <p>AT LEAST ONE 'YES' <input type="checkbox"/></p> <p>NOT A SINGLE 'YES' <input type="checkbox"/></p>		→ 1526																
1525	<p>CHECK 701 AND 702:</p> <p>EVER MARRIED/EVER LIVED WITH A MAN <input type="checkbox"/> NEVER MARRIED/NEVER LIVED WITH A MAN <input type="checkbox"/></p> <p>a) How old were you the first time you were forced to have sexual intercourse or perform any other sexual acts by anyone, including (your/any) husband/partner?</p> <p>b) How old were you the first first time you were forced to have sexual intercourse or perform any other sexual acts?</p>	<p>AGE IN COMPLETED YEARS ..... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW ..... 98</p>																	
1526	<p>CHECK 1505A (a-j), 1515A (a,b), 1516, 1520, 1522A, AND 1522B:</p> <p>AT LEAST ONE 'YES' <input type="checkbox"/></p> <p>NOT A SINGLE 'YES' <input type="checkbox"/></p>		→ 1530																
1527	Thinking about what you yourself have experienced among the different things we have been talking about, have you ever tried to seek help?	<p>YES ..... 1</p> <p>NO ..... 2</p>	→ 1529																
1528	<p>From whom have you sought help?</p> <p>Anyone else?</p> <p>RECORD ALL MENTIONED.</p>	<p>OWN FAMILY ..... A</p> <p>HUSBAND'S/PARTNER'S FAMILY ..... B</p> <p>CURRENT/FORMER HUSBAND/PARTNER ..... C</p> <p>CURRENT/FORMER BOYFRIEND ..... D</p> <p>FRIEND ..... E</p> <p>NEIGHBOR ..... F</p> <p>RELIGIOUS LEADER ..... G</p> <p>DOCTOR/MEDICAL PERSONNEL ..... H</p> <p>POLICE ..... I</p> <p>LAWYER ..... J</p> <p>SOCIAL SERVICE ORGANIZATION ..... K</p> <p>OTHER ..... X</p> <p align="center">(SPECIFY)</p>	→ 1530																
1529	Have you ever told any one about this?	<p>YES ..... 1</p> <p>NO ..... 2</p>																	
1530	As far as you know, did your father ever beat your mother?	<p>YES ..... 1</p> <p>NO ..... 2</p> <p>DON'T KNOW ..... 8</p>																	
	THANK THE RESPONDENT FOR HER COOPERATION AND REASSURE HER ABOUT THE CONFIDENTIALITY OF HER ANSWERS. FILL OUT THE QUESTIONS BELOW WITH REFERENCE TO THE DOMESTIC VIOLENCE																		
1531	DID YOU HAVE TO INTERRUPT THE INTERVIEW BECAUSE SOME ADULT WAS TRYING TO LISTEN, OR CAME INTO THE ROOM, OR INTERFERED IN ANY OTHER WAY?	<table> <thead> <tr> <th></th><th>YES, ONCE</th><th>YES, MORE THAN ONCE</th><th>NO</th></tr> </thead> <tbody> <tr> <td>HUSBAND .....</td><td>1</td><td>2</td><td>3</td></tr> <tr> <td>OTHER MALE ADL .....</td><td>1</td><td>2</td><td>3</td></tr> <tr> <td>FEMALE ADUL .....</td><td>1</td><td>2</td><td>3</td></tr> </tbody> </table>		YES, ONCE	YES, MORE THAN ONCE	NO	HUSBAND .....	1	2	3	OTHER MALE ADL .....	1	2	3	FEMALE ADUL .....	1	2	3	
	YES, ONCE	YES, MORE THAN ONCE	NO																
HUSBAND .....	1	2	3																
OTHER MALE ADL .....	1	2	3																
FEMALE ADUL .....	1	2	3																

SECTION 15: DOMESTIC VIOLENCE MODULE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP				
1532	INTERVIEWER'S COMMENTS/EXPLANATION FOR NOT COMPLETING THE DOMESTIC VIOLENCE MODULE. <hr/> <hr/> <hr/>						
1533	RECORD THE TIME.	<div> <div>HOURS</div> <div>MINUTES</div> </div> <div> <table border="1"> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table> </div>					

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

---

---

---

---

---

INSTRUCTIONS:

ONLY ONE CODE SHOULD APPEAR IN ANY BOX.  
COLUMN 1 REQUIRES A CODE IN EVERY MONTH.

CODES FOR EACH COLUMN:

COLUMN 1: BIRTHS, PREGNANCIES, CONTRACEPTIVE USE

- B BIRTHS  
P PREGNANCIES  
T TERMINATIONS
- 0 NO METHOD  
1 FEMALE STERILIZATION  
2 MALE STERILIZATION  
3 IUD  
4 INJECTABLES  
5 IMPLANTS  
6 PILL  
7 CONDOM  
8 FEMALE CONDOM  
9 EMERGENCY CONTRACEPTION  
J STANDARD DAYS METHOD  
K LACTATIONAL AMENORRHEA METHOD  
L RHYTHM METHOD
- M WITHDRAWAL  
X OTHER MODERN METHOD  
Y OTHER TRADITIONAL METHOD

COLUMN 2: DISCONTINUATION OF CONTRACEPTIVE USE

- 0 INFREQUENT SEX/HUSBAND AWAY  
1 BECAME PREGNANT WHILE USING  
2 WANTED TO BECOME PREGNANT  
3 HUSBAND/PARTNER DISAPPROVED  
4 WANTED MORE EFFECTIVE METHOD  
5 SIDE EFFECTS/HEALTH CONCERNS  
6 LACK OF ACCESS/TOO FAR  
7 COSTS TOO MUCH  
8 INCONVENIENT TO USE  
F UP TO GOD/FATALISTIC  
A DIFFICULT TO GET PREGNANT/MENOPAUSAL  
D MARITAL DISSOLUTION/SEPARATION  
X OTHER

(SPECIFY)

- Z DON'T KNOW

NOTE:

THIS CALENDAR IS INCLUDED IN THE PRINTED QUESTIONNAIRE FOR EASE OF UNDERSTANDING WHAT INFORMATION RELATED TO THE MONTHLY CALENDAR WAS INCLUDED IN THE SURVEY.

THE CAPI PROGRAM COLLECTS ALL OF THIS CALENDAR INFORMATION, ALTHOUGH THE INTERVIEWERS DO NOT EXPLICITLY USE THE CALENDAR FORMAT WHEN COLLECTING THE DATA.

			COL. 1	COL. 2
	12	DEC	01	
	11	NOV	02	
	10	OCT	03	
<b>2</b>	09	SEP	04	<b>2</b>
	08	AUG	05	
<b>0</b>	07	JUL	06	<b>0</b>
<b>1</b>	06	JUN	07	<b>1</b>
<b>9</b>	05	MAY	08	<b>9</b>
	04	APR	09	
	03	MAR	10	
	02	FEB	11	
	01	JAN	12	
	12	DEC	13	
	11	NOV	14	
	10	OCT	15	
<b>2</b>	09	SEP	16	<b>2</b>
	08	AUG	17	
<b>0</b>	07	JUL	18	<b>0</b>
<b>1</b>	06	JUN	19	<b>1</b>
<b>8</b>	05	MAY	20	<b>8</b>
	04	APR	21	
	03	MAR	22	
	02	FEB	23	
	01	JAN	24	
	12	DEC	25	
	11	NOV	26	
	10	OCT	27	
<b>2</b>	09	SEP	28	<b>2</b>
	08	AUG	29	
<b>0</b>	07	JUL	30	<b>0</b>
<b>1</b>	06	JUN	31	<b>1</b>
<b>7</b>	05	MAY	32	<b>7</b>
	04	APR	33	
	03	MAR	34	
	02	FEB	35	
	01	JAN	36	
	12	DEC	37	
	11	NOV	38	
	10	OCT	39	
<b>2</b>	09	SEP	40	<b>2</b>
	08	AUG	41	
<b>0</b>	07	JUL	42	<b>0</b>
<b>1</b>	06	JUN	43	<b>1</b>
<b>6</b>	05	MAY	44	<b>6</b>
	04	APR	45	
	03	MAR	46	
	02	FEB	47	
	01	JAN	48	
	12	DEC	49	
	11	NOV	50	
	10	OCT	51	
<b>2</b>	09	SEP	52	<b>2</b>
	08	AUG	53	
<b>0</b>	07	JUL	54	<b>0</b>
<b>1</b>	06	JUN	55	<b>1</b>
<b>5</b>	05	MAY	56	<b>5</b>
	04	APR	57	
	03	MAR	58	
	02	FEB	59	
	01	JAN	60	
	12	DEC	61	
	11	NOV	62	
	10	OCT	63	
<b>2</b>	09	SEP	64	<b>2</b>
	08	AUG	65	
<b>0</b>	07	JUL	66	<b>0</b>
<b>1</b>	06	JUN	67	<b>1</b>
<b>4</b>	05	MAY	68	<b>4</b>
	04	APR	69	
	03	MAR	70	
	02	FEB	71	
	01	JAN	72	

