13 ACTIVITIES OF DAILY LIVING

FOR ALL FEMALE HOUSEHOLD MEMBERS 15-49 YEARS OLD

RESPONDENT: SELF

ID CODE	(13.01) If you had to carry a heavy load, such as a bucket of water, for 20 meters, could you do it easily, with some difficulty, with much difficulty or not at all?	(13.02) How long have you had difficulty/been unable to carry a heavy load?	(13.03) Why are you unable to carry a heavy load?	(13.04) If you had to walk 5 km, could you do it easily, with some difficulty, with much difficulty or not at all?	(13.05) How long have you had difficulty to walk 5 km?	(13.06) Why are you unable to walk 5 km?
	EASILY 1 ► (13.04) WITH SOME DIFFICULTY 2 WITH MUCH DIFFICULTY 3 UNABLE TO DO 4	LESS THAN ONE WEEK 1 1 TO 4 WEEKS 2 1 TO 6 MONTHS 3 6 TO 12 MONTHS 4 MORE THAN 12 MONTHS 5	DISABLED 01 PREGNANT 02 TOO WEAK 03 TOO SICK 04 TOO INJURED 05 OTHER(SPECIFY) 96	EASILY 1 ► NEXT MODULE WITH SOME DIFFICULTY 2 WITH MUCH DIFFICULTY 3 UNABLE TO DO 4	LESS THAN ONE WEEK 1 1 TO 4 WEEKS 2 1 TO 6 MONTHS 3 6 TO 12 MONTHS 4 MORE THAN 12 MONTHS 5	DISABLED 01 PREGNANT 02 TOO WEAK 03 TOO SICK 04 TOO INJURED 05 OTHER(SPECIFY) 96
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14						
15						

14 MENTAL HEALTH

FOR ALL FEMALE HOUSEHOLD MEMBERS 15-49 YEARS OLD

RESPONDENT: SELF

(14.01) Now I will read five statements about how a person might be feeling. For each of the five statements, please indicate whether in the last two weeks, you have been feeling this way all the time, most of the time, more than half of the time, less than half of the time, some of the time, or at no time.

ALL OF THE TIME	1
MOST OF THE TIME	2
MORE THAN HALF OF THE TIME	3
LESS THAN HALF OF THE TIME	4
SOME OF THE TIME	5
AT NO TIME	6

(14.02) In the last 12 months, did you ever seek any help from health workers because you felt sad, hopeless or anxious?

YES 1
NO 2 ► (14.04)

(14.03) Where did you seek help?

CENTRAL DISTRICT HOSPITAL	01
DISTRICT HEALTH CENTRE (DHC)	02
RURAL HEALTH CENTRE (RHC)	03
HEALTH HOUSE (HH)	04
PRIVATE CLINIC	05
TRADITIONAL HEALER	06
OTHER, SPECIFY	96

(14.04) Are you currently taking any medication to treat depression or anxiety?

YES 1
NO 2

ID CODE	A. I have felt cheerful and in good spirits	B. I have felt calm and relaxed	C. I have felt active and vigorous	D. I woke up feeling fresh and rested	E. My daily life has been filled with things that interest me	(14.02)	(14.03)	(14.04)
01								
02								
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14								
15								

15 PREGNANCY HISTORY

FOR ALL FEMALE HOUSEHOLD MEMBERS 15-49 YEARS OLD
RESPONDENT: SELF

ID CODE	(15.01) Have you ever been pregnant, including pregnancies that may have ended in miscarriage, abortion or stillbirth (born dead)?	(15.02) Are you pregnant now?	(15.03) How many months pregnant are you?	(15.04) Do you have any children to whom you have given birth who are now living with you?	(15.05) A. How many sons live with you?	(15.05) B. How many daughters live with you?	(15.06) Do you have any children to whom you have given birth who are still alive but do not live with you?	(15.07) A. How many sons live elsewhere?	(15.07) B. How many daughters live elsewhere?	(15.08) Have you ever given birth to a child who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?	(15.09) A. How many sons died?	(15.09) B. How many daughters died?	(15.10) SUM THE ANSWERS TO (15.05) (15.07) (15.09) ENTER TOTAL HERE. IF NONE, WRITE 00.	(15.11) Please confirm the total number of children you have given birth to is… [NUMBER IN QUESTION (15.10)] IF NOT CORRECT, PROBE AND CORRECT AS NECESSARY
	YES 1 NO 2 ► NEXT MODULE NO, I'M NOT MARRIED 3 ► NEXT MODULE	YES 1 NO 2 ► (15.04) NOT SURE 3 ► (15.04)	MONTHS	YES 1 NO 2 ► (15.06)	SONS	DAUGHTERS	YES 1 NO 2 ► (15.08)	SONS	DAUGHTERS	YES 1 NO 2 ► (15.10)	SONS	DAUGHTERS		YES 1 NO 2
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02														
03														
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15 PREGNANCY HISTORY

FOR ALL FEMALE HOUSEHOLD MEMBERS 15-49 YEARS OLD
RESPONDENT: SELF

ID CODE	(15.12) IS THE NUMBER OF LIVE BIRTHS IN (15.10) AT LEAST ONE? YES 1 NO 2 ► (15.14)	(15.13) When was the last time that you gave birth to a child that was born alive? MONTH (MM)	YEAR (YYYY)	(15.14) Have you ever had a pregnancy that ended in stillbirth, that is when pregnancy has lasted at least 28 weeks but the baby died before it is born? YES 1 NO 2 ► (15.17)	(15.15) How many pregnancies have ended in a stillbirth? NUMBER	(15.16) When was the last time you had a stillbirth? MONTH (MM)	YEAR (YYYY)	(15.17) Have you ever had a pregnancy that ended in a miscarriage or abortion, that is when the pregnancy lasted less than 28 weeks? YES 1 NO 2 ► (15.20)	(15.18) How many pregnancies have ended in a miscarriage or abortion? NUMBER	(15.19) When was the last time you had a miscarriage or abortion? MONTH (MM)	YEAR (YYYY)	(15.20) IN THE LAST 24 MONTHS, DID THE WOMAN HAVE AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION? CHECK INFORMATION FROM CELLS (15.13) (15.16) (15.19) YES 1 NO 2 ► MODULE 17
01												
02												
03												
04												
05												
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07												
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10												
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16 ANTENATAL AND POSTNATAL CARE

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW
INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
RESPONDENT: SELF

			ANTENATAL CARE					
(16.01)	(16.01)a		(16.02)	(16.03)			(16.04)	(16.05)
INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	INTERVIEWER: CONFIRM TOTAL NUMBER OF LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN THE LAST 24 MONTHS.	PREGNANCY NUMBER	Now I am going to ask you some questions about your last pregnancy/the previous pregnancy that ended in live birth, still birth, miscarriage or abortion. Did you consult any health care provider for antenatal care for this pregnancy? FOR WOMEN WHOSE LAST PREGNANCY WAS A STILLBIRTH, MISCARRIAGE OR ABORTION, THE LAST PREGNANCY IS THE PREGNANCY THAT ENDED IN STILLBIRTH, MISCARRIAGE OR ABORTION YES 1 ► (16.04) NO 2	Why didn't you consult any health care provider for antenatal care for this pregnancy? RECORD UP TO 3 REASONS. TOO EXPENSIVE 01; TOO FAR 02; TOO BUSY (WORK, CHILDREN) 03; SELF-TREATED 04; WAS TOO EARLY IN PREGNANCY 05; FACILITY HAS POOR STRUCTURE 06; FACILITY POORLY STOCKED 07; POOR STAFF ATTITUDE 08; POOR STAFF KNOWLEDGE 09; POOR QUALITY OF CARE 10; SERVICE NOT AVAILABLE 11; NO TRANSPORTATION 12; DID NOT NEED 13; INCONVENIENT HOURS 14; LONG WAITING TIMES 15; PREFER HOME CARE 16; FAMILY DIDN'T WANT ME TO GO 17; OTHER (SPECIFY) 96 ► (16.17)			Did you ever try to go for antenatal care but the facility staff told you to go away and come back another day? YES 1 NO 2	What kind of provider did you see for antenatal care for this pregnancy? IF MORE THAN ONE PROVIDER, WRITE THE PROVIDER THAT IS HIGHEST ON THE LIST. FAMILY DOCTO 01; FAMILY NURSE 02; FELDSHER 03; HOSPITAL DOC 04; SPECIALIST AT 05; OBSTETRICIAN 06; MIDWIFE 07; TRADITIONAL B 08; PRIVATE DOCT 09; TRADITIONAL H 10; OTHER, SPECIF 96
				FIRST	SECOND	THIRD		
		1						
		2						
		3						
		1						
		2						
		3						
		1						
		2						
		3						
		1						
		2						
		3						
		1						
		2						
		3						

16 ANTENATAL AND POSTNATAL CARE

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW

INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.

RESPONDENT: SELF

		ANTENATAL CARE				
(16.01)		(16.06)	(16.07)	(16.08)	(16.09)	(16.10)
INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	PREGNANCY NUMBER	In what kind of facility or location did you see this health care provider? *IF MORE THAN ONE, WRITE FACILITY CORRESPONDING TO PROVIDER IN CELL (16.05)*	IF HOSPITAL, CLINIC OR HEALTH POST, PROBE FOR NAME OF FACILITY AND RECORD CODE. *INTERVIEWER: BELOW INSTRUCTIONS ARE FOR DATA ENTRY ONLY. DO NOT RECORD CODES 66666 OR 99999. RECORD HEALTH FACILITY CODE.*	How many months pregnant were you when you first received antenatal care for this pregnancy? INTERVIEWER ROUND MONTHS	How many times did you receive antenatal care for this pregnancy? *IF ONCE, RECORD 1 AND ► (16.11)*	How many months pregnant were you when you last received antenatal care for this pregnancy? INTERVIEWER ROUND MONTHS
		CENTRAL DISTRICT HOSPITAL 01 DISTRICT HEALTH CENTRE (DHC) 02 RURAL HEALTH CENTRE (RHC) 03 HEALTH HOUSE (HH) 04 PRIVATE CLINIC 05 TRADITIONAL HEALER'S HOUS/PLACE 06 OTHER, SPECIFY 96 ► (16.08)	HEALTH CENTER COULD NOT BE IDENTIFIED BY INTERVIEWEF 66666 HEALTH CENTER IS OUTSIDE THE STUDY AREA 99999	NUMBER OF MONTHS	NUMBER OF TIMES	NUMBER OF MONTHS
			NAME / CODE			
	1					
	2					
	3					
	1					
	2					
	3					
	1					
	2					
	3					
	1					
	2					
	3					
	1					
	2					
	3					

16 ANTENATAL AND POSTNATAL CARE 16

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW
INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
RESPONDENT: SELF

ANTENATAL CARE

(16.11) Now I would like to ask you about things that may have been done during the antenatal care visits for your last pregnancy. During those visits, was the following done during at least one visit?

YES 1
NO 2

(16.01) INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	PREGNANCY NUMBER	A. Were you weighed?	B. Was your height measured?	C. Was your blood pressure measured?	D. Did you give a urine sample?	E. Did you give a blood sample?	F. Did you schedule your delivery in the facility?	G. Did the provider palpate your tummy?	H. Did the health worker estimate your due date?	I. Was your uterine height measured (this is when the provider measures your tummy using a measurement tape)?	J. Did the health worker ask for your blood type and Rhesus?	K. Did you receive advice on the diet during your pregnancy?	L. Did you receive advice on what to do in case of an emergency?	(16.01) INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.
	1													
	2													
	3													
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ANTENATAL AND POSTNATAL CARE

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW
INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
RESPONDENT: SELF

PREGNANCY NUMBER	AIDS			IRON		PREGNANCY RESULT					DELIVERY			
	(16.12) During this pregnancy, were you offered counseling and testing for the virus that causes AIDS?	(16.13) I will not ask you the result, but were you tested?	(16.14) I will not ask you the result, but did you receive the result?	(16.15) During this pregnancy, were you given or did you buy any iron tablets or iron syrup?	(16.16) During the pregnancy, for how many days did you take the iron tablets or iron syrup?	(16.17) When did this pregnancy end? INTERVIEWER: RECORD END DATE OF PREGNANCY REGARDLESS OF RESULT (LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION). RECORD ANY MISSING ELEMENT OF THE DATE AS "DK".			(16.18) What was the result of this pregnancy?	(16.19) Who assisted with the delivery for this pregnancy?	(16.20) Where did you deliver?		(16.21) IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.	
						DD	MM	YYYY					NAME	CODE
1	YES 1 / NO 2 ► (16.15)	YES 1 / NO 2 ► (16.15)	YES 1 / NO 2	YES 1 / NO 2 ► (16.17)	NUMBER OF DAYS				BORN ALIVE, SINGLE BIRTH 1 BORN ALIVE, MULTIPLE BIRTH - 2 BORN ALIVE, MULTI 3 STILL BIRTH 4 ► (16.34) MISCARRIAGE 5 ► (16.34) ABORTION 6 ► (16.34)	FAMILY DOCTOR 01 FAMILY NURSE 02 FELDSHER 03 HOSPITAL DOCTOR 04 SPECIALIST AT PHC 05 OBSTETRICIAN/GYNECOL 06 MIDWIFE 07 TRADITIONAL BIRTH ATTENDANT 08 PRIVATE DOCTOR 09 TRADITIONAL HEALER 10 FAMILY MEMBER 11 FRIEND/NEIGHBOR 12 NO ONE 13 OTHER (SPECIFY) 96	HOSPITAL/ MATERNITY 01 DISTRICT HEALTH CENTRE (DHC) 02 RURAL HEALTH CENTRE (RHC) 03 HEALTH HOUSE (HH) 04 PRIVATE CLINIC 05 AT HOME 06 ► (16.22) OTHER, SPECIFY 96 ► (16.22)	► (16.23)	
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3														
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16 ANTENATAL AND POSTNATAL CARE

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW
INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
RESPONDENT: SELF

		DELIVERY												
(16.01)		(16.22)			(16.23)	(16.24)			(16.25)			(16.26)		
INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	PREGNANCY NUMBER	Why didn't you deliver in a formal health facility for this pregnancy? RECORD UP TO 3 REASONS. TOO EXPENSIVE 01 TOO FAR 02 WAS TOO LATE IN DELIVERY 03 FACILITY HAS POOR STRUCTURE 04 FACILITY POORLY STOCKED 05 POOR STAFF ATTITUDE 06 POOR STAFF KNOWLEDGE 07 POOR QUALITY OF CARE 08 SERVICE NOT AVAILABLE 09 NO TRANSPORTATION 10 DID NOT NEED 11 INCONVENIENT HOURS 12 LONG WAITING TIME 13 PREFER HOME DELIVERY 14 FAMILY DIDN'T WANT ME TO GO 15 OTHER (SPECIFY) 96			Was the birth delivered by caesarean section, that is did they cut your belly open to take the baby out? YES 1 NO 2	Was the infant(s) a boy or a girl? MALE 01 FEMALE 02			Was the infant(s) weighed at birth? YES 1 NO 2 ► (16.28)			How much did the infant(s) weigh? RECORD WEIGHT IN KILOGRAMS		
						A.	B.	C.	A.	B.	C.	A.	B.	C.
						FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD
		FIRST	SECOND	THIRD								KGS	KGS	KGS
	1											__ . __ __	__ . __ __	__ . __ __
	2											__ . __ __	__ . __ __	__ . __ __
	3											__ . __ __	__ . __ __	__ . __ __
	1											__ . __ __	__ . __ __	__ . __ __
	2											__ . __ __	__ . __ __	__ . __ __
	3											__ . __ __	__ . __ __	__ . __ __
	1											__ . __ __	__ . __ __	__ . __ __
	2											__ . __ __	__ . __ __	__ . __ __
	3											__ . __ __	__ . __ __	__ . __ __
	1											__ . __ __	__ . __ __	__ . __ __
	2											__ . __ __	__ . __ __	__ . __ __
	3											__ . __ __	__ . __ __	__ . __ __
	1											__ . __ __	__ . __ __	__ . __ __
	2											__ . __ __	__ . __ __	__ . __ __
	3											__ . __ __	__ . __ __	__ . __ __

16 ANTENATAL AND POSTNATAL CARE

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW
INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
RESPONDENT: SELF

		INFANT CHARACTERISTICS						FEEDING																	
(16.01)		(16.27)			(16.28)			(16.29)			(16.30)			(16.31)			(16.32)								
INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	PREGNANCY NUMBER	CONFIRM: IS THE SOURCE FOR WEIGHT RECALL OR HEALTH CARD? RECALL 1 HEALTH CARD 2			When the infant(s) was born for this pregnancy, was he/she 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 OTHER (SPECIFY) 96			Did you ever breastfeed the infant? YES 1 NO 2 ► (16.34)			After the infant was born, how much time did it take before you started breastfeeding him/her? WRITE THE ANSWER IN HOURS IF LESS THAN ONE HOURS, RECORD 00			In the first 3 days after delivery, was the infant given anything to drink other than breast milk? YES 1 NO 2 ► (16.33)			What was the infant given to drink other than breastmilk? INTERVIEWER: RECORD UP TO 3 RESPONSES. MILK (OTHER THAN BREASTMILK) 01 PLAIN WATER 02 SUGAR/GLUCOSE WATER 03 SUGAR-SALT-WATER SOLUTION 04 FRUIT JUICE 05 INFANT FORMULA 06 GRIPE 07 TEA/INFUSIONS 08 HONEY 09 COFFEE 10 OTHER (SPECIFY) 96								
		A.	B.	C.	A.	B.	C.	A.	B.	C.	A.	B.	C.	A.	B.	C.	A.			B.			C.		
		FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD			SECOND CHILD			THIRD CHILD		
											HOURS	HOURS	HOURS				1	2	3	1	2	3	1	2	3
	1																								
	2																								
	3																								
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16 ANTENATAL AND POSTNATAL CARE

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTER'

INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANC

RESPONDENT: SELF

		FEEDING			POSTNATAL CARE			
(16.01)		(16.33)			(16.34)	(16.35)	(16.36)	(16.37)
INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	PREGNANCY NUMBER	For how many months did you breastfeed? RECORD IN MONTHS. IF LESS THAN ONE MONTH 00. STILL BREASTFEEDING 98			After the birth/miscarriage, did a health professional check on your health? *PLEASE SPECIFY. IF CHECK ON PATIENT'S HEALTH WAS CARRIED OUT BY HEALTH PROFESSIONAL WITHIN THREE DAYS AFTER BIRTH AT HOME OR AFTER COMING FROM THE MATERNITY HOSPITAL*	How many post-natal check ups did you attend/receive in the first 2 months after the birth / miscarriage?	How long after the birth/miscarriage did you receive the first post-natal check? WRITE THE ANSWER IN DAYS. IF LESS THAN A DAY, WRITE 00	Who checked on your health the first time?
		A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD	YES 1 / NO 2	QUANTITY	DAYS	FAMILY DOCTOR 01; FAMILY NURSE 02; FELDSHER 03; HOSPITAL DOCTOR 04; SPECIALIST AT PHC 05; OBSTETRICIAN/GYNECOL 06; MIDWIFE 07; TRADITIONAL BIRTH ATTENDANT 08; PRIVATE DOCTOR 09; TRADITIONAL HEALER 10; FAMILY MEMBER 11; FRIEND/NEIGHBOR 12; OTHER, SPECIFY 96
		MONTHS	MONTHS	MONTHS				
	1							
	2							
	3							
	1							
	2							
	3							
	1							
	2							
	3							
	1							
	2							
	3							
	1							
	2							
	3							

16 ANTENATAL AND POSTNATAL CARE

VIEW Y. FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW

INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.

RESPONDENT: SELF

POSTNATAL CARE

(16.01) INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.

PREGNANCY NUMBER

(16.38) Where did this check take place?

HOSPITAL	01
DISTRICT HEALTH CENTRE (DHC)	02
RURAL HEALTH CENTRE (RHC)	03
HEALTH HOUSE (HH)	04
PRIVATE CLINIC	05
HOME	06 ► (16.40)
OTHER, SPECIFY	96

(16.39) IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE.

► (16.41)

(16.40) Why didn't you have a postnatal check up in a formal health institution/personnel for this pregnancy?

RECORD UP TO 3 REASONS

TOO EXPENSIVE	01
TOO FAR	02
TOO BUSY (WORK, CHILDREN)	03
SELF-TREATED	04
DID NOT NEED	05
FACILITY HAS POOR STRUCTURE	06
FACILITY POORLY STOCKED	07
POOR STAFF ATTITUDE	08
POOR STAFF KNOWLEDGE	09
POOR QUALITY OF CARE	10
SERVICE NOT AVAILABLE	11
NO TRANSPORTATION	12
INCONVENIENT HOURS	13
LONG WAITING TIMES	14
PREFER HOME CARE	15
FAMILY DIDN'T WANT ME TO GO	16
Health provider did not come for home visit	97
OTHER (SPECIFY)	96

		NAME	CODE	FIRST	SECOND	THIRD
	1					
	2					
	3					
	1					
	2					
	3					
	1					
	2					
	3					
	1					
	2					
	3					
	1					
	2					
	3					

16 ANTENATAL AND POSTNATAL CARE

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERV
INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY
RESPONDENT: SELF

		IRON TABLETS/SYRUP				VITAMIN A	
(16.01)		(16.41)	(16.42)	(16.43)	(16.44)	(16.45)	(16.46)
INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	PREGNANCY NUMBER	After the birth/miscarriage, were you given or did you buy any iron tablets or iron syrup or folic acid? YES 1 NO 2 ► (16.45)	Who provided or prescribed you with the iron dose? FAMILY DOCTOR 01; FAMILY NURSE 02; FELDSHER 03; HOSPITAL DOCTOR 04; SPECIALIST AT PHC 05; OBSTETRICIAN/GYNECOL 06; MIDWIFE 07; TRADITIONAL BIRTH ATTENDANT 08; PRIVATE DOCTOR 09; TRADITIONAL HEALER 10; PHARMACIST 11; FAMILY MEMBER 12; FRIEND/NEIGHBOR 13; OTHER (SPECIFY) 96	How long after the birth/ miscarriage did you take the first iron dose? WRITE THE ANSWER IN DAYS — DAYS	For how many days after the birth/miscarriage did you take the iron tablets or iron syrup? NUMBER OF DAYS	In the first two months after the birth/miscarriage, did you receive a vitamin A dose (like this)? SHOW COMMON AMPULES / CAPSULES / SYRUPS. YES 1 NO 2 ► (16.47)	Who provided or prescribed you with the vitamin A dose? FAMILY DOCTOR 01; FAMILY NURSE 02; FELDSHER 03; HOSPITAL DOCTOR 04; SPECIALIST AT PHC 05; OBSTETRICIAN/GYNECOL 06; MIDWIFE 07; TRADITIONAL BIRTH ATTENDANT 08; PRIVATE DOCTOR 09; TRADITIONAL HEALER 10; PHARMACIST 11; FAMILY MEMBER 12; FRIEND/NEIGHBOR 13; OTHER (SPECIFY) 96
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16 ANTENATAL AND POSTNATAL CARE

'IEW
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FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW
INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
RESPONDENT: SELF

(16.01) INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	PREGNANCY NUMBER	INTERVIEWER: CHECK (16,18). IF STILL BIRTH, MISCARRIAGE, ABORTION: ► NEXT BIRTH IF LIVE BIRTH: ASK FOLLOWING QUESTIONS FOR AT LEAST FIRST CHILD, AND IF MULTIPLE BIRTHS, PROCEED TO SAME QUESTIONS FOR SECOND/THIRD CHILD IF APPLICABLE.	DEATH (16.47) Is the child still alive? YES 1 ► (16.49) NO 2			(16.48) How old was the child when he/she died? INTERVIEWER: WRITE THE ANSWER IN MONTHS IF LESS THAN ONE MONTH, WRITE ZERO ► NEXT BIRTH OR ► IF MULTIPLE BIRTH			PRESENCE IN HOUSEHOLD (16.49) Is the child still living with you? YES 1 NO 2 ► (16.51)			(16.50) INTERVIEWER: RECORD THE INDIVIDUAL ID CODE OF THE CHILD FROM ROSTER ► (16.52)			(16.51) INTERVIEWER: ONLY FOR CHILD THAT IS NOT HOUSEHOLD MEMBER How old was the child on his/her last birthday? INTERVIEWER: RECORD AGE IN MONTHS ► NEXT MODULE		
			A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD	A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD	A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD	A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD	A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD
						MONTHS	MONTHS	MONTHS				ID CODE	ID CODE	ID CODE	MONTHS	MONTHS	MONTHS
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16 ANTENATAL AND POSTNATAL CARE

FOR WOMEN WHO HAD ONE OR MORE LIVE BIRTH(S), STILL BIRTH(S), MISCARRIAGE(S) OR ABORTION(S) IN THE 24 MONTHS PRECEDING THE INTERVIEW
INTERVIEWER: MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
RESPONDENT: SELF

(16.01) INTERVIEWER: COPY ID CODE FOR WOMAN WHO RESPONDED YES TO (15.20) I.E. WOMAN WITH AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION IN LAST 24 MONTHS.	PREGNANCY NUMBER	INTERVIEWER: CHECK (16,25). IF STILL BIRTH, MISCARRIAGE, ABORTION: ► NEXT BIRTH IF LIVE BIRTH: ASK FOLLOWING QUESTIONS FOR AT LEAST FIRST CHILD, AND IF MULTIPLE BIRTHS, PROCEED TO SAME QUESTIONS FOR SECOND/THIRD CHILD IF APPLICABLE.	FEEDING IN LAST 24 HOURS (16.52) In the last 24 hours, have you given the child any of the following? YES 01 NO 02																														
			A. VITAMIN SUPPLEMENTS			B. PLAIN WATER			C. SWEET WATER/ FRUIT JUICE			D. ORAL REHYDRATION SOLUTION (ORS)			E. INFANT FORMULA			F. BREASTMILK			G. MILK OTHER THAN BREASTMILK			H. OTHER LIQUIDS			I. SOLID FOOD			J. MUSHY FOOD		
			1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD	1. FIRST CHILD	2. SECOND CHILD	3. THIRD CHILD
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17 REPRODUCTIVE HEALTH (FEMALE)

FOR ALL FEMALE HOUSEHOLD MEMBERS 15-49 YEARS OLD
RESPONDENT: SELF

ID CODE	(17.01) INTERVIEWER: CHECK QUESTION (15.02) IS THE WOMAN CURRENTLY PREGNANT?	(17.02) At the time you became pregnant, did you want to become pregnant then, did you want to be pregnant later, or did you not want to have any (more) children at all?	(17.03) If you could choose for yourself, how long would you wait from now until the birth of your next child?	(17.04) Do you approve or disapprove of couples using contraceptive methods to avoid getting pregnant?	(17.05) Are you currently doing something or using any method to delay or avoid getting pregnant?	(17.06) Why are you currently not using any method to delay or avoid getting pregnant?	(17.07) Have you ever used any method to delay or avoid getting pregnant?	(17.08) Which method are you currently using? IF MORE THAN ONE METHOD, INDICATE THE HIGHEST METHOD IN THE LIST
								FEMALE STERILIZATION 01 ► (17.13)
								MALE STERILIZATION 02 ► (17.13)
								IUD / SPIRAL 03
								INJECTABLES / DEPOPROVERA 04
								IMPLANTS / NORPLANT 05
								PILL 06
								MALE CONDOM 07
								FEMALE CONDOM 08
								DIAPHRAGM 09
								FOAM/JELLY 10
								LACTATIONAL AMENORRHEA METHOD 11 ► (17.13)
								RHYTHM / NATURAL METHOD 12 ► (17.13)
								WITHDRAWAL 13 ► (17.13)
								OTHER MODERN METHOD, SPECIFY 14
								OTHER TRADITIONAL METHOD, SPECIFY 15
	YES 1	THEN 1	HAVE NOT DECIDED YET 5	APPROVE 1	YES 1 ► (17.08)	WOULD LIKE TO GET PREGNANT 01	YES 1	
	NO 2 ► (17.03)	LATER 2	INFERTILE 6	DISAPPROVE 2	NO 2	DOES NOT APPROVE 02	NO 2	
		NOT AT ALL 3	► (17.13)			PARTNER DOES NOT APPROVE 03		
		► (17.04)	OTHER (SPECIFY) 96			FAMILY DOES NOT APPROVE 04	► (17.13)	
			WOULD NOT WAIT 1			NOT AVAILABLE 05		
			LESS THAN 2 YEARS 2			TOO EXPENSIVE 06		
			MORE THAN 2 YEARS 3			SCARED OF SIDE-EFFECTS 07		
			DOESN'T WANT MORE 4			DON'T KNOW OF ANY METHOD 08		
						LACTATIONAL AMENORRHEA 09		
						HAD HYSTERECTOMY 10 ► (17.13)		
						IS MENOPAUSAL 11 ► (17.13)		
						IS INFECUND 12 ► (17.13)		
						OTHER (SPECIFY) 96		
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17 REPRODUCTIVE HEALTH (FEMALE)

FOR ALL FEMALE HOUSEHOLD MEMBERS 15-49 YEARS OLD
RESPONDENT: SELF

ID CODE	(17.09) Where did you obtain the current method when you started using it (first time)?	(17.10) Where did you obtain the current method at your last refill?	(17.11) How long have you been using the current method?		(17.12) How much did you pay for your last refill?	(17.13) Have any of the following ever talked to you about family planning methods?		
	FAMILY DOCTOR 01	FAMILY DOCTOR 01						
	FAMILY NURSE 02	FAMILY NURSE 02				YES 1		
	FELDSHER 03	FELDSHER 03				NO 2		
	HOSPITAL DOCTOR 04	HOSPITAL DOCTOR 04						
	SPECIALIST AT PHC 05	SPECIALIST AT PHC 05						
	OBSTETRICIAN/GYNECOL 06	OBSTETRICIAN/GYNECOL 06	ENTER YEARS IF 12 MONTHS OR MORE, ENTER MONTHS IF LESS THAN 12 MONTHS.					
	MIDWIFE 07	MIDWIFE 07						
	TRADITIONAL BIRTH ATTENDANT 08	TRADITIONAL BIRTH ATTENDANT 08						
	PRIVATE DOCTOR 09	PRIVATE DOCTOR 09						
	TRADITIONAL HEALER 10	TRADITIONAL HEALER 10						
	PHARMACIST 11	PHARMACIST 11				A	C	D
	FAMILY MEMBER 12	FAMILY MEMBER 12				Health worker at health facility	Friends/Family	Other (Specify)
	FRIEND/NEIGHBOR 13	FRIEND/NEIGHBOR 13						
	NO ONE 14	NO ONE 14						
	OTHER (SPECIFY) 96	OTHER (SPECIFY) 96						
			YEARS	MONTHS	SOMONI			
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18 VACCINATION

FOR CHILDREN < 5 YEARS OLD
RESPONDENT: MOTHER OR PRIMARY CAREGIVER OF EACH CHILD < 5 YEARS

(18.01) CONFIRM TOTAL NUMBER OF LIVING CHILDREN 0-5 YEARS OLD:

Immunization Passport

ID CODE

(18.02) RECORD ID CODE OF PRIMARY CARE-GIVER

(18.03) Do you have a card where [NAME]'S vaccinations are written down? (For child under 5) IF YES, RECORD IF YOU SEE THE CARD OR NOT.

YES, SEEN 1

YES, NOT SEEN 2 ► (18.07)

NO 3 ► (18.06)

(18.04)

INTERVIEWER: COPY VACCINATION DATE FOR EACH VACCINE FROM CARD
* IF VACCINE WAS RECEIVED AND DATE WAS RECORDED, RECORD AS FOLLOWING:
RECORD DAY USING 2 DIGITS DD (RANGE 01-31)
RECORD MONTH USING 2 DIGITS MM (RANGE 01-12)
RECORD YEAR USING 2 DIGITS YY (RANGE XX-XX)
RECORD ANY MISSING ELEMENT OF THE DATE AS "DK" IF DATE DOES NOT INCLUDE DD OR MM OR YY.
* IF VACCINE WAS RECEIVED BUT NO DATE WAS RECORDED, RECORD "44" IN DAY COLUMN.
* IF VACCINE WAS NOT RECEIVED AT ALL, RECORD "00" IN DAY COLUMN.

ALL VACCINE COLUMNS SHOULD BE FILLED OUT.

			A. BCG			B. OPV0			C. OPV1			D. OPV2			E. OPV3			F. DPT1			G. DPT2			H. DPT3			I. HepB1			J. HepB2			K. HepB3		
	ID CODE		DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR
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18 VACCINATION

FOR CHILDREN < 5 YEARS OLD

RESPONDENT: MOTHER OR PRIMARY CAREGIVER OF EACH CHILD < 5 YEARS

ID CODE	Immunization Passport (18,04) continued INTERVIEWER: COPY VACCINATION DATE FOR EAC * IF VACCINE WAS RECEIVED AND DATE WAS RECO RECORD DAY USING 2 DIGITS DD (RANG RECORD MONTH USING 2 DIGITS MM (R RECORD YEAR USING 2 DIGITS YY (RAN RECORD ANY MISSING ELEMENT OF TH * IF VACCINE WAS RECEIVED BUT NO DATE WAS RE * IF VACCINE WAS NOT RECEIVED AT ALL, RECORD ALL VACCINE COLUMNS SHOULD BE FILLED OUT.									(18.05) Has [NAME] received any vaccinations or vitamin A, not recorded on this card, including vaccinations given on a national immunization day or child health week? YES 1 ► PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY IN (18,04). THEN ► NEXT CHILD NO 2 ► NEXT CHILD ► NEXT MODULE	(18.06) Did you ever have a vaccination (shedule) Card where [NAME]'s vaccinations are written down? YES 1 NO 2	(18.07) Did [NAME] ever receive any vaccinations to prevent him/her from getting diseases, including vaccines received on national immunization day or child health week? YES 1 NO 2 ► (18.16)	(18.08) Did [NAME] receive a BCG vaccination against tuberculosis, that is an injection in the forearm that usually causes a scar? YES 1 NO 2 DON'T KNOW 3	(18.09) Did [NAME] receive a polio vaccine, that is drops in the mouth? YES 1 NO 2 ► (18,12) DON'T KNOW 3 ► (18,12)	(18.10) When did [NAME] receive the polio vaccine the first time? JUST AFTER BIRTH 01 LATER 02 OTHER (SPECIFY) 96	(18.11) How many times was the polio vaccine given? # OF TIMES	(18.12) Did [NAME] receive a DPT vaccine, that is an injection in the thigh usually given at the same time as the polio vaccine? YES 1 NO 2 ► (18,14) DON'T KNOW 3 ► (18,14)	(18.13) How many times was the DPT vaccine given? # OF TIMES
	L. MEASLES			M. VITAMIN A first			N. VITAMIN A second								
	DAY	MONTH	YEAR	DAY	MONTH	YEAR	DAY	MONTH	YEAR							
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18 VACCINATION

FOR CHILDREN < 5 YEARS OLD

RESPONDENT: MOTHER OR PRIMARY CAREGIVER OF EACH CHILD < 5 YEARS

ID CODE	(18.14) Did [NAME] receive a measles injection or an MMR injection - that is, an injection in the arm at the age of 9 months or older - to prevent [HIM/HER] from gettings measles?	(18.15) Did [NAME] receive this measles vaccine before [HE/SHE] turned one year old, or after?	(18.16) Did [NAME] ever receive a vitamin A supplement during a national immunization campaign or child health week?	(18.17) How was the supplement provided? *DON'T READ*	(18.18) When was the last vitamin A supplement provided?	(18.19) In the last 6 months, how many vitamin A supplements has the child received?
	YES 1 NO 2 ► (18.16) DON'T KNOW 3 ► (18.16)	BEFORE 01 AFTER 02	YES 1 NO 2 ► NEXT CHILD DON'T KNOV 3 ► NEXT CHILD	BLUE/RED CAPSULE TAKEN WHOLE 01 CAPSULE CUT WITH SCISSORS 02 CAPSULE CUT WITH BLADE 03 CAPSULE PRICKED WITH NEEDLE 04 OTHER (SPECIFY) 96	6 MONTHS AGO OR LESS 01 MORE THAN 6 MONTHS AGO 02 ► NEXT MODULE OTHER (SPECIFY) 96 ► NEXT MODULE	NUMBER
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19 HEIGHT AND WEIGHT

FOR ALL CHILDREN <5 YEARS OLD AND ALL WOMEN 15-49 YEARS OLD
RESPONDENT: MOTHER OR PRIMARY CAREGIVER OF EACH CHILD < 5 YEARS, SELF FOR WOMEN 15-49 YEARS OLD

ID CODE	(19.01) RECORD INDIVIDUAL'S AGE FROM SECTION 1 IF WOMAN 15-49 SKIP TO (19.11) A. YEARS	B. MONTHS	(19.02) Did [NAME] sleep in the house last night? YES 1 NO 2	(19.03) In the last 6 months, was [NAME] measured to determine [NAME]'s nutritional status? YES 1 NO 2 ► (19.11)	(19.04) What was the date of the last measurement? MM	YYYY	(19.05) For the last measurement, which method was used to determine [NAME]'S nutritional status? Height only 1 Weight only 2 Height / Weight 3 Upper Arm Circumfe- 4	(19.06) For the last measurement, where was [NAME] measured? DISTRICT HOSPITAL 01 DISTRICT HEALTH CENTRE (DHC) 02 RURAL HEALTH CENTRE (RHC) 03 HEALTH HOUSE (HH) 04 PRIVATE CLINIC 05 HOME VISIT 06 OTHER, SPECIFY 96	(19.07) What was the result of the last measurement? GREEN 1 ► (19.11) YELLOW 2 RED 3	(19.08) Did you obtain any specialized care for [NAME]'s malnutrition after the last measurement? YES 1 NO 2 ► (19.11)	(19.09) Where was the care for [NAME]'s malnutrition obtained from? DISTRICT HOSPITAL 01 DISTRICT HEALTH CENTRE (DHC) 02 RURAL HEALTH CENTRE (RHC) 03 HEALTH HOUSE (HH) 04 PRIVATE CLINIC 05 HOME VISIT 06 OTHER, SPECIFY 96
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19 HEIGHT AND WEIGHT

FOR ALL CHILDREN <5 YEARS OLD AND ALL WOMEN 15-49 YEARS OLD
RESPONDENT: MOTHER OR PRIMARY CAREGIVER OF EACH CHILD < 5 YEARS, SELF FOR WOMEN 15-49 YEARS OLD

ID CODE	(19.10) Were any of the following given to take care of [NAME]'s malnutrition? READ EACH OPTION ALOUD AND RECORD YES OR NO (YES 1, NO 2): Vitamin A	Nutrition advise	Nutrition rehabilitation	Other vitamins and micronutrients	Referred to higher level	Other	(19.11) READ ALOUD THE ANTHROPOMETRIC CONSENT FORM TO ALL WOMEN 15-49 YEARS OLD, FOR CHILREN UNDER 5 AGE (MEASURED 01; NOT PRESENT 02; TOO ILL OR DISABLED 03; REFUSED 04; OTHER (SPECIFY) 96 ▶ NEXT PERSON)	(19.12) RECORD DATE OF MEASUREMENT: MM	DD	YYYY	(19.13) RECORD HEIGHT IN CENTIMETERS	(19.14) RECORD METHOD FOR MEASURING HEIGHT (STANDING 01; LYING 02)	(19.15) RECORD WEIGHT IN KILOGRAMS — WEIGHT OF WOMEN OR CARETAKER OF CHILD UNDER 5 YEARS RECORD WEIGHT IN KILOGRAMS — ONLY FOR WOMEN OR CARETAKER OF CHILD UNDER 5 YEARS	(19,16A) RECORD WEIGHT IN KILOGRAMS — ONLY FOR CHILREN UNDER 5 AGE — FIRST MEASUREMENT	(19,16B) RECORD WEIGHT IN KILOGRAMS — ONLY FOR CHILREN UNDER 5 AGE — SECOND MEASUREMENT	(19,16C) RECORD WEIGHT IN KILOGRAMS — ONLY FOR CHILREN UNDER 5 AGE — THIRD MEASUREMENT	(19.17) RECORD UPPER ARM CIRCUMFERENCE IN CENTIMETERS
								MM DD YYYY	CENTIMETERS		KILOGRAMS	KILOGRAMS	KILOGRAMS	KILOGRAMS	CENTIMETERS
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20 CHILD HEALTH

FOR ALL CHILDREN <5 YEARS OLD
RESPONDENT: MOTHER OR PRIMARY CAREGIVER OF EACH CHILD < 5 YEARS, SELF FOR WOMEN 15-49 YEARS OLD

ID CODE	(20.01) RECORD INDIVIDUAL'S AGE FROM MODULE 1		(20.02) In the last seven days, was (NAME) given iron pills, sprinkles with iron, or iron syrup like (this/any of these)?	(20.03) Was (NAME) given any drug for intestinal worms in the last six months?	(20.04) Did (NAME) have diarrhea in the last 2 weeks?	(20.05) Was there any blood in the stools?	(20.06) How much was YOU/[NAME] offered to drink during this illness? Was he/she offered more than usual, about the same, less than usual, or nothing at all?	(20.07) How much was YOU/[NAME] offered to eat during this illness? Was he/she offered more than usual, about the same, less than usual, or nothing at all?
			YES 1	YES 1	YES 1	YES 1	MORE THAN USUAL 1	MORE THAN USUAL 1
			NO 2	NO 2	NO 2 ► (20.17)	NO 2	ABOUT THE SAME 2	ABOUT THE SAME 2
							LESS THAN USUAL 3	LESS THAN USUAL 3
							NOTHING TO DRINK 4	NOTHING TO EAT 4
	A. YEARS	B. MONTHS						
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(20.08)	(20.09)		(20.10)		(20.11)
Did you seek advice or treatment for the diarrhea from any source?	Why didn't you go to a health facility for care?		Where did you seek advice or treatment?		IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE
	TOO EXPENSIVE	01			
	TOO FAR	02			
	TOO BUSY (WORK, CHILDREN)	03			
	WASN'T SICK ENOUGH	04			
	FACILITY HAS POOR STRUCTURE	05			
	FACILITY POORLY STOCKED	06			
	POOR STAFF ATTITUDE	07			
	POOR STAFF KNOWLEDGE	08			
	DON'T TRUST THE STAFF	09			
	STAFF USUALLY ABSENT	10			
	HEALTH FACILITY CLOSED	11			
	NO TRANSPORTATION	12			
	POOR QUALITY OF CARE	13			
	INCONVENIENT HOURS	14	DISTRICT HOSPITAL	01	
YES 1 ► (20.10)	LONG WAITING TIMES	15	DISTRICT HEALTH CENTRE (DHC)	02	
NO 2	PREFER HOME CARE	16	RURAL HEALTH CENTRE (RHC)	03	
	SHORTAGE OF HEALTH WORKERS	17	HEALTH HOUSE (HH)	04	
	OTHER (SPECIFY)	96	PRIVATE CLINIC	05	
	► (20.14)		Pharmacist	06	
	RECORD UP TO 3 ANSWERS		OTHER, SPECIFY	96	

	FIRST	SECOND	THIRD		NAME	CODE

20 CHILD HEALTH

FOR ALL CHILDREN <5 YEARS OLD
RESPONDENT: MOTHER OR PRIMARY CAREGIVER OF EACH CHILD < 5 YEARS, SELF FOR WOMEN 15-49 YEARS OLD

ID CODE	(20.12) INTERVIEWER PLEASE CHECK (20.10) : IF TWO OR MORE CODES CIRCLED SKIP (20.13) IF ONLY ONE CODE CIRCLED (20.14)	(20.13) Where did you first seek advice or treatment for the diarrhea?	(20.14) Was he/she given any of the following to drink at any time since he/she started having the diarrhea:		(20.15) Was anything (else) given to treat the diarrhea?	(20.16) What (else) was given to treat the diarrhea?	(20.17) Has (NAME) been ill with a fever at any time in the last 2 weeks?	(20.18) At any time during the ilness, did (NAME) have blood taken from his/her finger for testing?
		DISTRICT HOSPITAL 01	A	B	YES 1	PILL OR SYRUP:		
		DISTRICT HEALTH CENTRE (DHC) 02	A fluid made from a special packet called Regidron?	A homemade fluid?	NO 2 ► (20.17)	ANTIBIOTIC 01	YES 1	YES 1
		RURAL HEALTH CENTRE (RHC) 03				ANTIMOTILITY 02	NO 2 ► (20.19)	NO 2
		HEALTH HOUSE (HH) 04	YES 1			ZINC 03		
		PRIVATE CLINIC 05	NO 2			OTHER (NOT ANTI-IOTIC, ANTI-MOTILITY OR ZINC 04		
		Pharmacist 06				UNKNOWN PILL OR SYRUP 05		
		OTHER, SPECIFY 96				INJECTION:		
						ANTIBIOTIC 06		
						NON-ANTIBIOTIC 07		
						UNKNOWN INJECTION 08		
						(IV) INTRAVENOUS I 09		
						HOME REMEDY/HERBAL MEDICINE 10		
						OTHER, SPECIFY 96		
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20 CHILD HEALTH

FOR ALL CHILDREN <5 YEARS OLD
RESPONDENT: MOTHER OR PRIMARY CAREGIVER OF EACH CHILD < 5 YEARS, SELF FOR WOMEN 15-49 YEARS OLD

ID CODE	(20.19) Has (NAME) had an illness with a cough at any time in the last 2 weeks?	(20.20) When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, rapid breaths or have difficulty breathing?	(20.21) Was the fast or difficult breathing due to a problem in the chest or to a blocked or runny nose?	(20.22) INTERVIEWER PLEASE CHECK 20,17: Had fever?	(20.23) Now I would like to know how much (NAME) was given to drink (including breastmilk) during the illness with a (fever/cough). Was he/she given less than usual to drink, about the same amount, or more than usual to drink?	(20.24) When (NAME) had a (fever/cough), was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat?	(20.25) Did you seek advice or treatment for the illness from any source?	(20.26) Why didn't you go to a health facility for care?		
								TOO EXPENSIVE	01	
								TOO FAR	02	
								TOO BUSY (WORK, CHILDREN)	03	
								WASN'T SICK ENOUGH	04	
								FACILITY HAS POOR STRUCTURE	05	
								FACILITY POORLY STOCKED	06	
								POOR STAFF ATTITUDE	07	
								POOR STAFF KNOWLEDGE	08	
								DON'T TRUST THE STAFF	09	
								STAFF USUALLY ABSENT	10	
								HEALTH FACILITY CLOSED	11	
								NO TRANSPORTATION	12	
								POOR QUALITY OF CARE	13	
	YES 1	YES 1	CHEST ONLY 1 ► (20.23)	YES 1	MORE THAN USUAL 1	MORE THAN USUAL 1	YES 1 ► (20.27)	INCONVENIENT HOURS	14	
	NO 2 ► (20.22)	NO 2 ► (20.23)	NOSE ONLY 2 ► (20.23)	NO 2 ► (20.32)	ABOUT THE SAME 2	ABOUT THE SAME 2	NO 2	LONG WAITING TIMES	15	
			BOTH 3 ► (20.23)		LESS THAN USUAL 3	LESS THAN USUAL 3		PREFER HOME CARE	16	
			OTHER, SPECIFY 96 ► (20.23)		NOTHING TO DRINK 4	NOTHING TO EAT 4		SHORTAGE OF HEALTH WORKERS	17	
								OTHER (SPECIFY)	96	
								► (20.31)		
								RECORD UP TO 3 ANSWERS		
								FIRST	SECOND	THIRD
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20 CHILD HEALTH

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ID CODE	(20.27) Where did you seek advice or treatment?	(20.28) IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE		(20.29) INTERVIEWER PLEASE CHECK (20.28) IF TWO OR MORE CODES CIRCLED SKIP (20.30) IF ONLY ONE CODE CIRCLED (20.31)	(20.30) Where did you first seek advice or treatment?	(20.31) At any time during the illness, did (NAME) take any drugs for the illness?	(20.32) The last time (NAME) passed stools, what was done to dispose of the stools?
	DISTRICT HOSPITAL 01				DISTRICT HOSPITAL 01	ANTIMALARIAL DRUGS:	
	DISTRICT HEALTH CENTRE (DHC) 02				DISTRICT HEALTH CENTRE (DHC) 02	SP/FANSIDAR 1	
	RURAL HEALTH CENTRE (RHC) 03				RURAL HEALTH CENTRE (RHC) 03	CHLOROQUINE 2	
	HEALTH HOUSE (HH) 04				HEALTH HOUSE (HH) 04	PRIMAQUINE 3	
	PRIVATE CLINIC 05				PRIVATE CLINIC 05	QUININE 4	
	Pharmacist 06				Pharmacist 06	COMBINATION WITH ARTEMISININ/COARTEM 5	
	OTHER, SPECIFY 96				OTHER, SPECIFY 96	OTHER ANTI-MALARIAL (SPECIFY) 6	CHILD USED TOILET OR LATRINE 1
						ANTIBIOTIC DRUGS:	PUT/RINSED INTO TOILET OR LATRINE 2
						PILL/SYRUP 7	PUT/RINSED INTO DRAIN OR DITCH 3
						INJECTION 8	THROWN INTO GARBAGE 4
						OTHER DRUGS:	BURIED 5
						ASPIRIN 9	LEFT IN THE OPEN 6
						PARACETAMOL 10	OTHER (SPECIFY) 96
						IBUPROFEN 11	
						SALBUTAMOL 12	
						AMINOPHYLLIN 13	
						OTHER (SPECIFY) 96	
						DON'T KNOW 99	
		NAME	CODE				
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20 CHILD HEALTH

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ID CODE	(20.33) INTERVIEWER PLEASE CHECK 17,13 (a) ALL COLUMNS:	(20.34) Have you ever heard of a special product called Rehydron you can get for the treatment of diarrhea?	(20.35) Now I would like to ask you about liquids or foods that (NAME) 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) (drink/eat):																					
	NO CHILD RECEIVED FLUID FROM ORS 1 ► (20.34) / ANY CHILD RECEIVED FLUID FROM ORS 2 ► (20.35)	YES 1 / NO 2	a) Plain water?	b) Juice or juice drinks?	c) Clear broth?	d) Milk such as tinned, powdered, or fresh animal milk?	IF YES IN 17,35 (d): How many times did (NAME) drink milk?	e) Infant formula?	IF YES IN 17,35 (e): How many times did (NAME) drink infant formula?	f) Any other liquids?	g) Yogurt (churgot, kefir and similar)?	IF YES IN 17,35 (g): How many times did (NAME) eat yogurt?	h) Any commercially fortified baby food (e.g Nestle, Agusha, Winnie, Gerber, Gercules, Oats, Nutrilac 2-3)?	i) Bread, rice, noodles, porridge, or other foods made from grains (atala, garsu)?	j) Sweet red bell pepper, pumpkin or carrots that are yellow or orange inside?	k) Potatoes or any other foods made from roots (shalgan)?	l) Any dark green, leafy vegetables (spinach, dark green lettus)?	m) Ripe persimmons, or ripe fresh apricots, dried apricots or dried peaches?	n) Any other fruits or vegetables?	o) Liver, kidney, heart or other organ meats?	p) Any meat, such as beef, lamb, goat, chicken, or duck?
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ID CODE	(20.35) CONTINUE: Now I would like to ask you about liquids or foods that (NAME) 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) (drink/eat): YES 1 / NO 2 — q) Eggs?	r) Fresh, canned or dried fish-or any other seafood?	s) Any foods made from beans, peas, lentils, or nuts?	t) Cheese or other food made from milk?	u) Any other solid, semi-solid, or soft food?	(20.36) INTERVIEWER PLEASE (20.35) (CATEGORIES "g" THROUGH "u"): NOT A SINGLE "YES" 1 / AT LEAST ONE "YES" 2 ► (20.39)	(20.37) Did (NAME) eat any solid, semi-solid, or soft foods yesterday during the day or at night? YES 1 / NO 2 ► NEXT MODULE	(20.38) What kind of solid, semi-solid or soft foods did (NAME) eat? YES 1 / NO 2 ► NEXT MODULE	(20.39) How many times did (NAME) eat solid, semi-solid, or soft foods yesterday during the day or at night? NUMBER OF TIMES
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