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
01						
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13						
14						
15						

14 MENTAL HEALTH

FOR ALL FEMALE HOUSEHOLD MEMBERS 15-49 YEARS OLD

RESPONDENT: SELF

ID CODE	(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.					(14.02) In the last 12 months, did you ever seek any help from health workers because you felt sad, hopeless or anxious?	(14.03) Where did you seek help?	(14.04) Are you currently taking any medication to treat depression or anxiety?
	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	YES 1 NO 2 ► (14.04)		YES 1 NO 2
01								
02								
03								
04								
05								
06								
07								
08								
09								
10								
11								
12								
13								
14								
15								

(14.01)	
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

(14.03)	
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

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)? YES 1 / NO 2 ► NEXT MODULE / NO, I'M NOT MARRIED 3 ► NEXT MODULE	(15.02) Are you pregnant now? YES 1 / NO 2 ► (15.04) / NOT SURE 3 ► (15.04)	(15.03) How many months pregnant are you? MONTHS	(15.04) Do you have any children to whom you have given birth who are now living with you? YES 1 / NO 2 ► (15.06)	(15.05) A. How many sons live with you? SONS	(15.05) B. How many daughters live with you? DAUGHTERS	(15.06) Do you have any children to whom you have given birth who are still alive but do not live with you? YES 1 / NO 2 ► (15.08)	(15.07) A. How many sons live elsewhere? SONS	(15.07) B. How many daughters live elsewhere? DAUGHTERS
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									
15									

15 PREGNANCY HISTORY

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

ID CODE	(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? YES 1 / NO 2 ► (15.10)	(15.09) A. How many sons died? SONS	(15.09) B. How many daughters died? DAUGHTERS	(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)] YES 1 / NO 2 IF NOT CORRECT, PROBE AND CORRECT AS NECESSARY	(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)	(15.13) 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)
01									
02									
03									
04									
05									
06									
07									
08									
09									
10									
11									
12									
13									
14									
15									

15 PREGNANCY HISTORY

FOR ALL FEMALE HOUSEHOLD MEMBERS 15-49 YEARS OLD

RESPONDENT: SELF

ID CODE	(15.15) How many pregnancies have ended in a stillbirth?	(15.16) When was the last time you had a stillbirth?		(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?	(15.18) How many pregnancies have ended in a miscarriage or abortion?	(15.19) When was the last time you had a miscarriage or abortion?		(15.20) IN THE LAST 24 MONTHS, DID THE WOMAN HAVE AT LEAST ONE LIVE BIRTH, STILL BIRTH, MISCARRIAGE OR ABORTION?
				YES 1 NO 2 ► (15.20)				CHECK INFORMATION FROM CELLS (15.13) (15.16) (15.19) YES 1 NO 2 ► MODULE 17
	NUMBER	MONTH (MM)	YEAR (YYYY)		NUMBER	MONTH (MM)	YEAR (YYYY)	
01								
02								
03								
04								
05								
06								
07								
08								
09								
10								
11								
12								
13								
14								
15								

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 ► (16.18)			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 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; OTHER, SPECIFY 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) 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	(16.06) 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)*	(16.07) 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.*		(16.08) How many months pregnant were you when you **first** received antenatal care for this pregnancy?	(16.09) How many times did you receive antenatal care for this pregnancy?	(16.10) How many months pregnant were you when you **last** received antenatal care for this pregnancy?
		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	HEALTH CENTER COULD NOT BE IDENTIFIED BY INTERVIEWER 66666 HEALTH CENTER IS OUTSIDE THE STUDY AREA 99999 ADD NAMES OF RHCs / HHs		INTERVIEWER ROUND MONTHS	*IF ONCE, RECORD 1 AND ► (16.11)*	INTERVIEWER ROUND MONTHS
			NAME	CODE	NUMBER OF MONTHS	NUMBER OF TIMES	NUMBER OF MONTHS
	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
<u>INTERVIEWER:</u> MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
<u>RESPONDENT</u>: SELF

		ANTENATAL CARE												AIDS		
(16.01)		(16.11)												(16.12)	(16.13)	(16.14)
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	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												During this pregnancy, were you offered counseling and testing for the virus that causes AIDS? YES 1 1 NO 2 ► (16.15)	I will not ask you the result, but were you tested? YES 1 NO 2 ► (16.15)	I will not ask you the result, but did you receive the result? YES 1 NO 2
		A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	L.			
		Were you weighed?	Was your height measured?	Was your blood pressure measured?	Did you give a urine sample?	Did you give a blood sample?	Did you schedule your delivery in the facility?	Did the provider palpate your tummy?	Did the health worker estimate your due date?	Was your uterine height measured (this is when the provider measures your tummy using a measurement tape)?	Did the health worker ask for your blood type and Rhesus?	Did you receive advice on the diet during your pregnancy?	Did you receive advice on what to do in case of an emergency?			
	1															
	2															
	3															
	1															
	2															
	3															
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	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

		IRON			PREGNANCY RESULT				DELIVERY			
(16.01)		(16.15)	(16.16)	(16.17)	(16.18)			(16.19)	(16.20)	(16.21)	(16.22)	
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	During the pregnancy, were you prescribed or given any iron tablets or iron syrup?	During thre pregnancy did you take the iron tablets or iron syrup?	During the pregnancy, for how many days did you take the iron tablets or iron syrup?	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".			What was the result of this pregnancy?	Who assisted with the delivery for this pregnancy?	Where did you deliver?	IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE. ADD NAMES OF RHCs / HHs	
		YES, GIVEN 1 YES, PRESCRIBED 2 NO 3	YES 1 NO 2 ► (16.18)					BORN ALIVE, SINGLE BIRTH 1 BORN ALIVE, MULTIPLE BIRTH 2 STILL BIRTH 3 ► (16.36) MISCARRIAGE 4 ► (16.36) ABORTION 5 ► (16.36)	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 ► (16.24) OTHER, SPECIFY 96 ►	► (16.25)	
				NUMBER OF DAYS	DD	MM	YYYY				NAME	CODE
	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

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

<u>RESPONDENT</u>: 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

DELIVERY

(16.23) How many days after giving birth did you stay in [OPTION FROM Q16.21]?
► (16.25)

(16.24) 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

(16.25) Was the birth delivered by caesarean section, that is did they cut your belly open to take the baby out?

- YES 1
- NO 2

(16.26) Was the infant(s) a boy or a girl?

- MALE 01
- FEMALE 02

(16.27) Was the infant(s) weighed at birth?

- YES 1
- NO 2 ► (16.30)

(16.28) How much did the infant(s) weigh?

RECORD WEIGHT IN KILOGRAMS

maximum of 6kg

INFANT CHARACTERISTICS

(16.29) CONFIRM: IS THE SOURCE FOR WEIGHT RECALL OR HEALTH CARD?

- RECALL 1
- HEALTH CARD 2

(16.30) 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

(16.01)	PREGNANCY NUMBER	(16.23)	(16.24) FIRST	(16.24) SECOND	(16.24) THIRD	(16.25)	(16.26) A. FIRST CHILD	(16.26) B. SECOND CHILD	(16.26) C. THIRD CHILD	(16.27) A. FIRST CHILD	(16.27) B. SECOND CHILD	(16.27) C. THIRD CHILD	(16.28) A. FIRST CHILD KGS	(16.28) B. SECOND CHILD KGS	(16.28) C. THIRD CHILD KGS	(16.29) A. FIRST CHILD	(16.29) B. SECOND CHILD	(16.29) C. THIRD CHILD	(16.30) A. FIRST CHILD	(16.30) B. SECOND CHILD	(16.30) C. THIRD CHILD
	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

		FEEDING				FEEDING	FOR THOSE WHO DELIVERED AT MEDICAL FACILITY		
(16.01)		(16.31)	(16.32)	(16.33)	(16.34)	(16.35)	(16.36)	(16.37)	(16.38)
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	Did you ever breastfeed the infant? YES 1 NO 2 ▶ (16.36)	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 ▶ (16.35)	In the first 3 days after delivery, what was given to the infant other than breast milk? INTERVIEWER: RECORD UP TO 3 RESPONSES. MILK (OTHER THAN BREASTMILK) 01 PLAIN WATER 02 SUGA R/GLU 03 SUGA R 04 FRUIT JUICE 05 INFANT FORMULA 06 GRIP E 07 TEA/INFUSIONS 08 HONEY 09 COFFEE 10 OTH ER 96	For how many months did you breastfeed? RECORD IN MONTHS IF LESS THAN ONE MONTH 00 STILL BREASTFEEDIN 98	I would like to talk to you about checks on your health after delivery. Did anyone check on your health while you were still in the facility? YES 01 No 02	Did health professional check on your health after you left the facility? YES 01 No 02 ▶ (16.45)	After how many days from you left the facility the health professional checked on your health? ▶ (16.41) DAYS

(16.01)	PREGNANCY NUMBER	(16.31) A. FIRST CHILD	(16.31) B. SECOND CHILD	(16.31) C. THIRD CHILD	(16.32) A. FIRST CHILD HOURS	(16.32) B. SECOND CHILD HOURS	(16.32) C. THIRD CHILD HOURS	(16.33) A. FIRST CHILD	(16.33) B. SECOND CHILD	(16.33) C. THIRD CHILD	(16.34) A. FIRST CHILD 1	2	3	(16.34) B. SECOND CHILD 1	2	3	(16.34) C. THIRD CHILD 1	2	3	(16.35) A. FIRST CHILD MONTHS	(16.35) B. SECOND CHILD MONTHS	(16.35) C. THIRD CHILD MONTHS	(16.36)	(16.37)	(16.38) DAYS
	1																								
	2																								
	3																								
	1																								
	2																								
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	3																								
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	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

		FOR THOSE WHO DELIVERED OTHER THAN			POSTNATAL CARE				
(16.01)		(16.39)	(16.40)	(16.41)	(16.42)		(16.43)	(16.44)	
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	Did health professional check on your health after your delivery / misscarriage? YAS 01 No 02 ► (16.44)	After how many days from your delivery / misscarriage the health professional checked on your health? DAYS	Who checked on your health the first time? INSTRUCTIONS: FOR WOMEN WHO DELIVERED IN MEDICAL FACILITY, THE QUESTION ASKS ABOUT THE HEALTH CHECK AFTER THEY LEFT THE FACILITY. 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	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 ► (16.44) OTHER, SPECIFY 96	IF HOSPITAL, CLINIC OR CENTER, PROBE FOR NAME OF FACILITY AND RECORD CODE. ADD NAMES OF RHCs / ► (16.45)	Why didn't you have a postnatal check up in a formal health institution/personnel for this pregnancy? 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 INTERVIEW
<u>INTERVIEWER:</u> MUST LIST PREGNANCIES IN ORDER OF MOST RECENT IN THE LAST 24 MONTHS. MULTIPLE BIRTHS ARE LISTED AS ONE PREGNANCY.
<u>RESPONDENT</u>: SELF

		IRON TABLETS/SYRUP				VITAMIN A			DEATH					
(16.01)		(16.45)	(16.46)	(16.47)	(16.48)	(16.49)	(16.50)		(16.51)			(16.52)		
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 ► (16.49)	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	For how many days after the birth/miscarriage did you take the iron tablets or iron syrup?	In the first two months after the birth/miscarriage, did you receive a vitamin A dose (like this)? SHOW COMMON AMPULES / CAPSULES / SYRUPS. YES 1 NO 2 ► (16.51)	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	INTERVIEWER: CHECK (16.19). 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.	Is the child still alive? YES 1 ► (16.53) NO 2			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		
									A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD	A. FIRST CHILD	B. SECOND CHILD	C. THIRD CHILD
				DAYS	NUMBER OF DAYS							MONTHS	MONTHS	MONTHS
	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

		PRESENCE IN HOUSEHOLD								
(16.01)	PREGNANCY NUMBER	(16.53)			(16.54)			(16.55)		
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.		Is the child still living with you? YES 1; NO 2 ► (16.55)			INTERVIEWER: RECORD THE INDIVIDUAL ID CODE OF THE CHILD FROM ROSTER ► (16.56)			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.	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
					ID CODE	ID CODE	ID CODE	MONTHS	MONTHS	MONTHS
	1									
	2									
	3									
	1									
	2									
	3									
	1									
	2									
	3									
	1									
	2									
	3									
	1									
	2									
	3									

PREGNANCY NUMBER	FEEDING IN LAST 24 HOURS																													
	(16.56) 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			D. ORAL REHYDRATION			E. INFANT FORMULA			F. BREASTMILK			G. MILK OTHER THAN			H. OTHER LIQUIDS			I. SOLID FOOD			J. MUSHY FOOD		
	1.	2.	3.	1.	2.	3.	1.	2.	3.	1.	2.	3.	1.	2.	3.	1.	2.	3.	1.	2.	3.	1.	2.	3.	1.	2.	3.	1.	2.	3.
	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD	FIRST CHILD	SECOND CHILD	THIRD CHILD
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3																														

17 REPRODUCTIVE HEALTH (FEMALE)

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

ID CODE	(17.01)	(17.02)	(17.03)	(17.04)	(17.05)	(17.06)
	INTERVIEWER: CHECK QUESTION (15.02) IS THE WOMAN CURRENTLY PREGNANT?	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?	If you could choose for yourself, how long would you wait from now until the birth of your next child?	Do you approve or disapprove of couples using contraceptive methods to avoid getting pregnant?	Are you currently doing something or using any method to delay or avoid getting pregnant?	Why are you currently not using any method to delay or avoid getting pregnant?
			WOULD NOT WAIT 1			WOULD LIKE TO GET PREGNANT 01
						DOES NOT APPROVE 02
						PARTNER DOES NOT APPROVE 03
						FAMILY DOES NOT APPROVE 04
						NOT AVAILABLE 05
		► (17.04)	LESS THAN 2 YEARS 2			TOO EXPENSIVE 06
			MORE THAN 2 YEARS 3	APPROVE 1	YES 1 ► (17.08)	SCARED OF SIDE-EFFECTS 07
			DOESN'T WANT MORE 4	DISAPPROVE 2	NO 2	DON'T KNOW OF ANY METHOD 08
	YES 1	THEN 1	HAVE NOT DECIDED YET 5		HESITATE TO ANSWER 3 ► (17.13)	LACTATIONAL AMENORRHEA 09
	NO 2 ► (17.03)	LATER 2	INFERTILE 6			HAD HYSTERECTOMY 10 ► (17.13)
		NOT AT ALL 3	► (17.13)			IS MENOPAUSAL 11 ► (17.13)
			OTHER (SPECIFY) 96			IS INFECUND 12 ► (17.13)
			NOT MARRIED / HESITATE TO ANSWER 7			OTHER (SPECIFY) 96
01						
02						
03						
04						
05						
06						
07						
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11						
12						
13						
14						
15						

17 REPRODUCTIVE HEALTH (FEMALE)

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

(17.07) Have you ever used any method to delay or avoid getting pregnant?

YES 1
NO 2 ► (17.13)

(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	

(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?

FAMILY DOCTOR	01	FAMILY DOCTOR	01
FAMILY NURSE	02	FAMILY NURSE	02
FELDSHER	03	FELDSHER	03
HOSPITAL DOCTOR	04	HOSPITAL DOCTOR	04
SPECIALIST AT PHC	05	SPECIALIST AT PHC	05
OBSTETRICIAN/GYNECOL	06	OBSTETRICIAN/GYNECOL	06
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
FAMILY MEMBER	12	FAMILY MEMBER	12
FRIEND/NEIGHBOR	13	FRIEND/NEIGHBOR	13
NO ONE	14	NO ONE	14
OTHER (SPECIFY)	96	OTHER (SPECIFY)	96

(17.11) How long have you been using the current method?

ENTER YEARS IF 12 MONTHS OR MORE, ENTER MONTHS IF LESS THAN 12 MONTHS.

(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?

YES 1
NO 2

ID CODE	(17.07)	(17.08)	(17.09)	(17.10)	(17.11) YEARS	(17.11) MONTHS	(17.12) SOMONI	(17.13) A Health worker at health facility	(17.13) C Friends/ Family	(17.13) D Other (Specify)
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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:

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 (AT HOMR) 1

YES, NOT SEEN (NOT AT HOME) 2

► (18.08)

NO 3

► (18.06)

Immunization Passport

(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.

ID CODE			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
01																																			
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15																																			

18 VACCINATION

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

Immunization Passport

(18.04) continued

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 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.

ID CODE	L. MEASLES DAY	L. MEASLES MONTH	L. MEASLES YEAR	M. VITAMIN A first DAY	M. VITAMIN A first MONTH	M. VITAMIN A first YEAR	N. VITAMIN A second DAY	N. VITAMIN A second MONTH	N. VITAMIN A second YEAR	(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?	(18.06) Did you ever have a vaccination (shedule) Card where [NAME]'s vaccinations are written down?	(18.07) Where did your child receive vaccination?	(18.08) Did [NAME] ever receive any vaccinations to prevent him/her from getting diseases, including vaccines received on national immunization day or child health week?	(18.09) Did [NAME] receive a BCG vaccination against tuberculosis, that is an injection in the forearm that usually causes a scar?
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02														
03														
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06														
07														
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10														
11														
12														
13														
14														
15														

(18.05)
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)
YES 1
NO 2

(18.07)
HOSPITAL 01
DISTRICT HEALTH CENTRE (DHC) 02
RURAL HEALTH CENTRE (RHC) 03
HEALTH HOUSE (HH) 04
PRIVATE CLINIC 05
HOME 06
OTHER, SPECIFY 96

(18.08)
YES 1
NO 2
► (18.17)

(18.09)
YES 1
NO 2
DON'T KNOW 3

18 VACCINATION

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

ID CODE	(18.10) Did [NAME] receive a polio vaccine, that is drops in the mouth?	(18.11) When did [NAME] receive the polio vaccine the first time?	(18.12) How many times was the polio vaccine given?	(18.13) Did [NAME] receive a DPT vaccine, that is an injection in the thigh usually given at the same time as the polio vaccine?	(18.14) How many times was the DPT vaccine given?	(18.15) 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?	(18.16) Did [NAME] receive this measles vaccine before [HE/SHE] turned one year old, or after?	(18.17) Did [NAME] ever receive a vitamin A supplement during a national immunization campaign or child health week?	(18.18) How was the supplement provided? *DON'T READ*	(18.19) When was the last vitamin A supplement provided?	(18.20) In the last 6 months, how many vitamin A supplements has the child received?
	YES 1 NO 2 ► (18.13) DON'T KNOW 3 ► (18.13)	JUST AFTER BIRTH 01 LATER 02 OTHER (SPECIFY) 96	# OF TIMES	YES 1 NO 2 ► (18.15) DON'T KNOW 3 ► (18.15)	# OF TIMES	YES 1 NO 2 ► (18.17) DON'T KNOW 3 ► (18.17)	BEFORE 01 AFTER 02	YES 1 NO 2 ► NEXT CHILD DON'T KNOW 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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02											
03											
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19 HEIGHT AND WEIGHT

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

ID CODE	(19.01) RECORD INDIVIDUAL'S AGE FROM SECTION 1 — IF WOMAN 15-49 SKIP TO (19.13)		(19.02) Did [NAME] sleep in the house last night?	(19.03) In the last 6 months, was [NAME] measured to determine [NAME]'s nutritional status?	(19.04) What was the date of the last measurement?		(19.05) For the last measurement, which method was used to determine [NAME]'S nutritional status?	(19.06) For the last measurement, where was [NAME] measured?	(19.07) IF IT WAS IN DISTRICT HOSPITAL, HEALTH CENTER OR HEALTH HOUSE, PLEASE CHOOSE THE NAME OF THE FACILITY FROM THE LIST ADD NAMES OF RHCs / HHs FROM 16.07	(19.08) What was the result of the last measurement?	(19.09) How did the health professional evaluate nutrition of your child?	(19.10) Did you obtain any specialized care for [NAME]'s malnutrition after the last measurement?
	A. YEARS	B. MONTHS			MM	YYYY						
01												
02												
03												
04												
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15												

(19.02): YES 1 / NO 2

(19.03): YES 1 / NO 2 ► (19.13)

(19.05): Height only 1 / Weight only 2 / Height / Weight 3 / Upper Arm Circumfe- 4

(19.06): 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

(19.08): GREEN 1 ► (19.13) / YELLOW 2 / RED 3

(19.09): Good 01 ► (19.13) / Avergage 02 / REQUIRES SPECIAL ATTENTION 03

(19.10): YES 1 / YES 2 ► (19.13)

19 HEIGHT AND WEIGHT

FOR ALL CHILDREN <5 YEARS OLD

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

TO MEASURE THE WEIGHT THREE TIMES

(19.11) 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

(19.12) Were any of the following given to take care of [NAME]'s malnutrition?

READ EACH OPTION ALOUD AND RECORD YES OR NO

		Vitamin A	Nutrition advise	Nutrition rehabilitation	Other vitamins and micronutrients	Refered to higher level	Other
YES	1						
NO	2						

(19.13) READ ALOUD THE ANTHROPOMETRIC CONSENT FORM TO ALL WOMEN 15-49 YEARS OLD

MEASURED	01	
NOT PRESENT	02	▶ NEXT PERSON
TOO ILL OR DISABLED	03	▶ NEXT PERSON
REFUSED	04	▶ NEXT PERSON
OTHER (SPECIFY)	96	▶ NEXT PERSON

(19.14) RECORD DATE OF MEASUREMENT

(19.15) RECORD HEIGHT IN CENTIMETERS

(19.16) RECORD METHOD FOR MEASURING HEIGHT

STANDIN	01
LYING	02

(19.17) WRITE DOWN THE WEIGHT OF MOTHER OR PRIMARY CAREGIVER IN KILOGRAM

(19.18) WRITE DOWN THE WEIGHT OF CHILD <5 YEARS IN KILOGRAM - 1st MEASURE

(19.19) WRITE DOWN THE WEIGHT OF CHILD <5 YEARS IN KILOGRAM - 2nd MEASURE

(19.20) WRITE DOWN THE WEIGHT OF CHILD <5 YEARS IN KILOGRAM - 3rd MEASURE

ID CODE	(19.11)	(19.12) Vitamin A	Nutrition advise	Nutrition rehabilitation	Other vitamins and micronutrients	Refered to higher level	Other	(19.13)	(19.14) MM	DD	YYYY	(19.15) CENTIMETERS	(19.16)	(19.17) KILOGRAMS	(19.18) KILOGRAMS	(19.19) KILOGRAMS	(19.20) KILOGRAMS
01																	
02																	
03																	
04																	
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14																	
15																	

20 CHILD HEALTH

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

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?	(20.08) Did you seek advice or treatment for the diarrhea from any source?
	A. YEARS	B. MONTHS	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2 ► (20.17)	YES 1 NO 2	MORE THAN USUAL 1 ABOUT THE SAME 2 LESS THAN USUAL 3 NOTHING TO DRINK 4	MORE THAN USUAL 1 ABOUT THE SAME 2 LESS THAN USUAL 3 NOTHING TO EAT 4	YES 1 ► (20.10) NO 2
01									
02									
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20 CHILD HEALTH

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

(20.09) 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
INCONVENIENT HOURS	14
LONG WAITING TIMES	15
PREFER HOME CARE	16
SHORTAGE OF HEALTH WORKERS	17
OTHER (SPECIFY)	96

► (20.14)

RECORD UP TO 3 ANSWERS

(20.10) Where did you seek advice or treatment?

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

(20.11) IF IT WAS IN DISTRICT HOSPITAL, HEALTH CENTER OR HEALTH HOUSE, PLEASE CHOOSE THE NAME OF THE FACILITY FROM THE LIST ADD NAMES OF RHCs / HHs FROM 16.07

(20.12) INTERVIEWER PLEASE CHECK

(20.10) :

IF TWO OR MORE CODES CIRCLED SKIP (20.13)

IF ONLY ONE CODE CIRCLED SKIP (20.14)

(20.13) Where did you first seek advice or treatment for the diarrhea?

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

(20.14) Was he/she given any of the following to drink at any time since he/she started having the diarrhea:

YES	1
NO	2

ID CODE	(20.09) FIRST	(20.09) SECOND	(20.09) THIRD	(20.10)	(20.11) NAME	(20.11) CODE	(20.12)	(20.13)	(20.14) A: A fluid made from a special packet called Regidron?	(20.14) B: A homemade fluid?
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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	(20.15) 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?	(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?
		PILL OR SYRUP:				
		ANTIBIOTIC 01				
		ANTIMOTILITY 02				
		ZINC 03				
		OTHER (NOT ANTI-IOTIC, ANTI-MOTILITY OR ZINC 04				
		UNKNOWN PILL OR SYRUP 05				
		INJECTION:				
		ANTIBIOTIC 06				
	YES 1	NON-ANTIBIOTIC 07	YES 1	YES 1	YES 1	YES 1
	NO 2 ► (20.17)	UNKNOWN INJECTION 08	NO 2 ► (20.19)	NO 2	NO 2 ► (20.22)	NO 2 ► (20.23)
		(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	(20.21) 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?		
	CHEST ONLY 1 ► (20.23)	YES 1	MORE THAN USUAL 1	MORE THAN USUAL 1	YES 1 ► (20.27)	TOO EXPENSIVE 01		
	NOSE ONLY 2 ► (20.23)	NO 2 ► (20.32)	ABOUT THE SAME 2	ABOUT THE SAME 2	NO 2	TOO FAR 02		
	BOTH 3 ► (20.23)		LESS THAN USUAL 3	LESS THAN USUAL 3		TOO BUSY (WORK, CHILDREN) 03		
	OTHER, SPECIFY 96 ► (20.23)		NOTHING TO DRINK 4	NOTHING TO EAT 4		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		
						LONG WAITING TIMES 15		
						PREFER HOME CARE 16		
						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

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	(20.27) 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:	CHILD USED TOILET OR LATRINE 1
	DISTRICT HEALTH CENTRE (DHC) 02				DISTRICT HEALTH CENTRE (DHC) 02	SP/FANSIDAR 1	PUT/RINSED INTO TOILET OR LATRINE 2
	RURAL HEALTH CENTRE (RHC) 03				RURAL HEALTH CENTRE (RHC) 03	CHLOROQUINE 2	PUT/RINSED INTO DRAIN OR DITCH 3
	HEALTH HOUSE (HH) 04				HEALTH HOUSE (HH) 04	PRIMAQUINE 3	THROWN INTO GARBAGE 4
	PRIVATE CLINIC 05				PRIVATE CLINIC 05	QUININE 4	BURIED 5
	Pharmacist 06				Pharmacist 06	COMBINATION WITH ARTEMISININ/COARTEM 5	LEFT IN THE OPEN 6
	OTHER, SPECIFY 96				OTHER, SPECIFY 96	OTHER ANTI-MALARIAL (SPECIFY) 6	OTHER (SPECIFY) 96
						ANTIBIOTIC DRUGS:	
						PILL/SYRUP 7	
						INJECTION 8	
						OTHER DRUGS:	
						ASPIRIN 9	
						PARACETAMOL 10	
						IBUPROFEN 11	
						SALBUTAMOL 12	
						AMINOPHYLLIN 13	
						OTHER (SPECIFY) 96	
						DON'T KNOW 99	
		NAME	CODE				
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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	(20.33) 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)	YES 1	YES 1
	ANY CHILD RECEIVED FLUID FROM ORS 2 ► (20.35)	NO 2	NO 2

ID CODE	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, keifir 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-	i) Bread, rice, noodles, porridge, or other foods made from grains (atalla, garsus)?	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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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	(20.35) 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):					(20.36) INTERVIEWER PLEASE CHECK (20.35) (CATEGORIES "g" THROUGH "u"):	(20.37) Did (NAME) eat any solid, semi-solid, or soft foods yesterday during the day or at night?	(20.38) What kind of solid, semi-solid or soft foods did (NAME) eat?	(20.39) How many times did (NAME) eat solid, semi-solid, or soft foods yesterday during the day or at night?
	YES 1 / NO 2					NOT A SINGLE "YES" 1 / AT LEAST ONE "YES" 2 ► (20.39)	YES 1 / NO 2 ► NEXT MODULE	YES 1 ► GO BACK TO (20,35) TO RECORD FOOD EATEN YESTERDAY / NO 2 ► NEXT MODULE	
	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?				NUMBER OF TIMES
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26 HEALTH SERVICE

FOR ALL WOMEN FROM 15 TO 49 YEARS OLD
RESPONDENT: SELF

ID CODE	(26.01) Are you familiar with the RHC [Name] that serves this community? ADD NAMES OF RHCs / HHs	(26.02) I am going to read you a series of statements about RHC/HH "name". For each of these statements, please tell me whether you agree, disagree or neither agree or disagree: The staff at the facility is welcoming and	The staff at the facility is competent	The facility has the equipment needed to provide high quality health services	The is in good physical state to provide high quality health services	The facility staff works closely with the community on health matters	The facility staff listens to the opinions of the community	(26.03) In your opinion, during the last 3 years (2015-2018) did the facility infrastructure improve, deteriorate or remain the same?	(26.04) [IF IMPROVED>] During the last 3 years, has anyone in your community contributed money, materials or labor towards making these improvements in	(26.05) In your opinion, during the last 3 years (2015-2018) did the attitude of health staff at the facility improve, deteriorate or remain the same?	(26.06) In your opinion, during the last 3 years (2015) did the quality of health services at the facility improve, deteriorate or
	Yes 01 No 02	AGREE 01 DISAGREE 02 NEITHER 03 DK 04						IMPROVE 01 ▶ (26.04) DETERIORATE 02 ▶ (26.05) SAME 03 ▶ (26.05) DK 04 ▶ (26.05)	Yes 01 No 02 DK 03	IMPROVE 01 DETERIORATE 02 SAME 03 DK 04	IMPROVE 01 DETERIORATE 02 SAME 03 DK 04
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20B HEALTH SERVICE

FOR ALL WOMEN FROM 15 TO 49 YEARS OLD
RESPONDENT: SELF

ID CODE	(26.07) In your opinion, during the last 3 years (2015) did the collaboration between the staff at the facility and the community on health matters improve, deteriorate or remain the same?	(26.08) During the past 3 (2015-2018) years, have you heard any community member discuss the quality of service delivery at RHC/HH "X" or staff performance?	(26,08i) If yes: were the comments negative or positive?	(26.09) Do you use the services offered by the staff of the RHC/HH "Name"?	(26.10) Were you ever invited to attend a community meeting in which the RHC/HH "Name" was discussed?	(26.11) [if yes ->] Have you ever attended such a meeting?	(26.12) [if yes ->] Do you think the discussions in these meeting resulted in any action or change?
	IMPROVE 01	Yes 01	YES, POSITIVE FEEDBACK 01	Yes 01	Yes 01 ► (26.11)	Yes 01	Yes 01
	DETERIORATE 02	No 02 ► (26.09)	YES, NEGATIVE FEEDBACK 02	No 02	No 02 ► NEXT MODULE	No 02	No 02
	SAME 03	DK 03 ► (26.09)	YES, BOTH POSITIVE AND NEGATIVE 03	DK 03	DK 03 ► NEXT MODULE	DK 03	DK 03
	DK 04						
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