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Form. 2

**Lao Reproductive Health Survey 2005**  
**Woman questionnaire age 15 - 49 year old**

**Identification**

Province	District	Villages	EA	Household No	Woman ID get from hh questionnaire
<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>	<input style="width: 100px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 100px; height: 20px;" type="text"/>	<input style="width: 60px; height: 20px;" type="text"/>

**Interview visit**

First time	<input style="width: 60px; height: 20px;" type="text"/> Day	<input style="width: 60px; height: 20px;" type="text"/> Month	<input style="width: 30px; height: 20px;" type="text"/> Result
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Second time	<input style="width: 60px; height: 20px;" type="text"/> Day	<input style="width: 60px; height: 20px;" type="text"/> Month	<input style="width: 30px; height: 20px;" type="text"/> Result
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Final time	<input style="width: 60px; height: 20px;" type="text"/> Day	<input style="width: 60px; height: 20px;" type="text"/> Month	<input style="width: 30px; height: 20px;" type="text"/> Result
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Total number of visits:	<input type="checkbox"/> 1 Time	<input type="checkbox"/> 2 Time	<input type="checkbox"/> 3 Time
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Result code	1. Completed      2. No body stay at home      3. Postponed 4. Refused      5. Somepart completed      6. Vacant/Distoy dwelling 7. Other
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Respondent name	<input style="width: 95%; height: 25px;" type="text"/>
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Interviewer's name	<input style="width: 95%; height: 25px;" type="text"/>
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Supervisor's name	<input style="width: 95%; height: 25px;" type="text"/>
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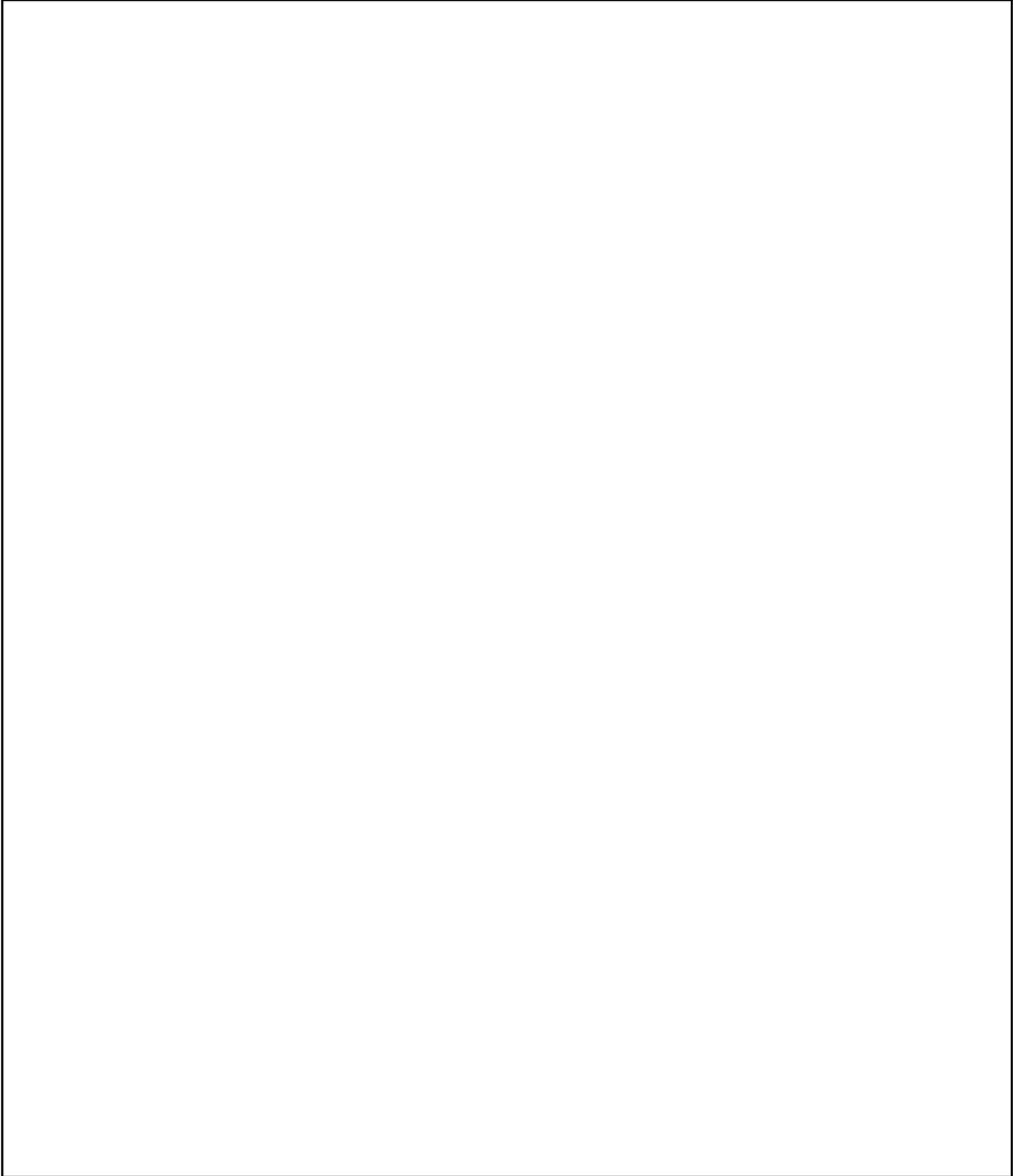
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<b>Section 1: Reproduction</b>	
Question	answer code
101. How old are you ?	<input type="text"/> Age
102. Have you ever given alive birth ?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No, go to Q. 106
103. How many sons and daughter living with you ?	<input type="text"/> Sons at home <input type="text"/> Daughter at home
104. How many sons and daughter living eslewher ?	<input type="text"/> Sons eslewhere <input type="text"/> Daughter eslewhere
105. Have you ever given birth who was born alive but later died ?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No,
106. How many sons and daughter died ?	<input type="text"/> Sons <input type="text"/> Daughter
107. Have you ever had miscarriage or abortion ?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No go to Q.109
108. How many miscarriages or abortions ?	<input type="text"/> Time
109. The period of space miscarriage or abortions ?	<input type="text"/> <input type="checkbox"/> 98.DK <input type="text"/> <input type="checkbox"/> 98.DK 1.Month      1.Year
110. How long ago did your last menstrual period start?	<input type="text"/> 1.Day <input type="text"/> 2.Month <input type="text"/> 3.Year <input type="checkbox"/> 98.DK <input type="checkbox"/> 98.DK <input type="checkbox"/> 1.98 DK <input type="checkbox"/> 1.Befor last birth <input type="checkbox"/> 2.Uterus removed <input type="checkbox"/> 3.Menopause <input type="checkbox"/> 4.Nevermenstruated <input type="checkbox"/> 5.DK
111. Total number given alive birth ? (If non, Record "00")	<input type="text"/> ( 102 + 103 + 105 )
<b>112: Checking Question 111:</b>	<b>* If, ever given birth 1 or more go to Q. 114</b> <b>* If, never given birth go to Q. 123</b>

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113. Ask about all of births, whether still alive or not, starting with the first one.

Record names of all the births in Q.114

( For twins and triplets on separate lines )

114	Q. 115	Q. 116	Q. 117	Q. 118	Q. 119	Q. 120	Q. 121
Name	Birth status	Sex	Month and year of birth	Is he / she still alive ?	How old is he/ she now ?	Is he/ she living with you now ?	How old he / she when he/ she died ?
01 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
02 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
03 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
04 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
05 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y

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114	Q. 115	Q. 116	Q. 117	Q. 118	Q. 119	Q. 120	Q. 121
Name	Birth status	Sex	Month and year of birth	Is he / she still alive ?	How old is he / she now ?	Is he/ she living with you now ?	How old he / she when he/ she died ?
06 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
07 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
08 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
09 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
10 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y
11 .....	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<input type="text"/> M <input type="text"/> Y	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<input type="text"/>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<input type="text"/> D <input type="text"/> M <input type="text"/> Y

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122 Compare number of birth Q111 and Q.114, correct it, if not the same number

\* Check Q. 117, for each birth did you record month and year of birth ?

\* Check Q. 119, for each living child did you record current age ?

\* Check Q. 121, for each deat child did you record age of deat ?

Question	answer code
123. Are you pregnant now ?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 3.Not sure ( If answer Q.2 or Q.3 skip to Q. 126 )
124. How many months pregnant are you ?	<input type="text"/> Month
125. At the time you become pregnant, did you want to become pregnant then, or did you want to become pregnant at all ?	<input type="checkbox"/> 1.Then <input type="checkbox"/> 2.Later <input type="checkbox"/> 3.Not at all
126. At what age did you first menstrual period start ?	<input type="text"/> Age <input type="checkbox"/> 98 Dontknow

## Section 2 : Pregnancy and breastfeeding ( for children birth since March/2000 )

**201Checking** - One or more birth since March 2000 → Go to Q 202  
**Question 116:** - No birth since March 2000 → Go to Q 301

202 Enter the line number, name and survival status of three last children birth since March 2000, begin with the last birth

203A: Line number from .Q 114	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Last birth	Next to last birth	Second from last birth
203B: Name from Q.114	<input type="text"/>	<input type="text"/>	<input type="text"/>
203C: Survival status from Q.118	<input type="checkbox"/> 1.Alive <input type="checkbox"/> 2.Dead	<input type="checkbox"/> 1.Alive <input type="checkbox"/> 2.Dead	<input type="checkbox"/> 1.Alive <input type="checkbox"/> 2.Dead

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Question	answer code		
204: At the time you become pregnant(name), did you want to become pregnant than or want to wait or did you not at all?	<input type="checkbox"/> 1.Then <input type="checkbox"/> 2.Later <input type="checkbox"/> 3.Not at all <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1.Then <input type="checkbox"/> 2.Later <input type="checkbox"/> 3.Not at all <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1.Then <input type="checkbox"/> 2.Later <input type="checkbox"/> 3.Not at all <input type="checkbox"/> 8.DK
205: When you were pregnant (name), did you see anyone for antenatal care for this pregnancy?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No, go to Q 209	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to Q.212	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No, go to Q. 212
206: Whom did you see ?  Multble answer	<input type="checkbox"/> 1.Doctor <input type="checkbox"/> 2.Nurse <input type="checkbox"/> 3.Midwife <input type="checkbox"/> 4.Health <input type="checkbox"/> 5.TBA <input type="checkbox"/> 7.Others	<input type="checkbox"/> 1.Doctor <input type="checkbox"/> 2.Nurse <input type="checkbox"/> 3.Midwife <input type="checkbox"/> 4.Health workers <input type="checkbox"/> 5.TBA <input type="checkbox"/> 7.Others	<input type="checkbox"/> 1.Doctor <input type="checkbox"/> 2.Nurse <input type="checkbox"/> 3.Midwife <input type="checkbox"/> 4.Health workers <input type="checkbox"/> 5.TBA <input type="checkbox"/> 7.Others
207: Where did you go for antenatal care for this pregnancy?  Multble answer	<input type="checkbox"/> 1.Central Hospital <input type="checkbox"/> 2.Prov/Dist hospit. <input type="checkbox"/> 3.Health Center <input type="checkbox"/> 4.Clicnic <input type="checkbox"/> 7.Others	<input type="checkbox"/> 1.Central Hospital <input type="checkbox"/> 2.Prov/Dist hospit. <input type="checkbox"/> 3.Health Center <input type="checkbox"/> 4.Clicnic <input type="checkbox"/> 7.Others	<input type="checkbox"/> 1.Central Hospital <input type="checkbox"/> 2.Prov/Dist hospit. <input type="checkbox"/> 3.Health Center <input type="checkbox"/> 4.Clicnic <input type="checkbox"/> 7.Others
208:How many months pregnant were you when you first recieved antenatal care?	<input type="text"/> Month <input type="checkbox"/> 8.DK	<input type="text"/> Month <input type="checkbox"/> 8.DK	<input type="text"/> Month <input type="checkbox"/> 8.DK
209: How many time did you have antenatal care?	<input type="text"/> Time	<input type="text"/> Time	<input type="text"/> Time
210: Did you get any treament for any difficuties?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. N o <input type="checkbox"/> 3.No difficuty	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. N o <input type="checkbox"/> 3.No difficuty	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. N o <input type="checkbox"/> 3.No difficuty

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Question	answer code		
211: Did you receive iron pills when you were pregnant with (name)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No go to Q. 212		
212: How many iron pills did you take during your pregnancy with (name)	<div style="border: 1px solid black; width: 100px; height: 20px; margin-bottom: 5px;"></div> Total pill <input type="checkbox"/> 8. DK		
213: Where did you give birth to (name)  Multiple answer	<input type="checkbox"/> 1. Central hospital <input type="checkbox"/> 2. Province <input type="checkbox"/> 3. District <input type="checkbox"/> 4. Health Center <input type="checkbox"/> 5. Clinic <input type="checkbox"/> 6. House, go to Q. 214 <input type="checkbox"/> 7. Others	<input type="checkbox"/> 1. Central hospital <input type="checkbox"/> 2. Province <input type="checkbox"/> 3. District <input type="checkbox"/> 4. Health Center <input type="checkbox"/> 5. Clinic <input type="checkbox"/> 6. House, go to Q. 214 <input type="checkbox"/> 7. Others	<input type="checkbox"/> 1. Central hospital <input type="checkbox"/> 2. Province <input type="checkbox"/> 3. District <input type="checkbox"/> 4. Health Center <input type="checkbox"/> 5. Clinic <input type="checkbox"/> 6. House, go to Q. 214 <input type="checkbox"/> 7. Others
214: Why did you not give birth in hospital?  Multiple answer	<input type="checkbox"/> 1. Cost <input type="checkbox"/> 2. Distance <input type="checkbox"/> 3. Health Services <input type="checkbox"/> 4. Not necessary <input type="checkbox"/> 7. Other	<input type="checkbox"/> 1. Cost <input type="checkbox"/> 2. Distance <input type="checkbox"/> 3. Health Services <input type="checkbox"/> 4. Not necessary <input type="checkbox"/> 7. Other	<input type="checkbox"/> 1. Cost <input type="checkbox"/> 2. Distance <input type="checkbox"/> 3. Health Services <input type="checkbox"/> 4. Not necessary <input type="checkbox"/> 7. Other
215: How much did your birth cost by health system? (Including cost of bedroom, medical equipment, medicine)	<div style="border: 1px solid black; width: 200px; height: 25px; margin-bottom: 5px;"></div> Unit kip	<div style="border: 1px solid black; width: 200px; height: 25px; margin-bottom: 5px;"></div> Unit kip	<div style="border: 1px solid black; width: 200px; height: 25px; margin-bottom: 5px;"></div> Unit kip
216: Who assisted with the delivery of (name)  Multiple answer	<input type="checkbox"/> 1. Doctor <input type="checkbox"/> 2. Nurse <input type="checkbox"/> 3. Midwife <input type="checkbox"/> 4. Health workers <input type="checkbox"/> 5. TAB <input type="checkbox"/> 6. Relative <input type="checkbox"/> 7. Other <input type="checkbox"/> 8. No one	<input type="checkbox"/> 1. Doctor <input type="checkbox"/> 2. Nurse <input type="checkbox"/> 3. Midwife <input type="checkbox"/> 4. Health workers <input type="checkbox"/> 5. TAB <input type="checkbox"/> 6. Relative <input type="checkbox"/> 7. Other <input type="checkbox"/> 8. No one	<input type="checkbox"/> 1. Doctor <input type="checkbox"/> 2. Nurse <input type="checkbox"/> 3. Midwife <input type="checkbox"/> 4. Health workers <input type="checkbox"/> 5. TAB <input type="checkbox"/> 6. Relative <input type="checkbox"/> 7. Other <input type="checkbox"/> 8. No one

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Question	answer code		
217 Was (name) born on time or prematurely	<input type="checkbox"/> 1.On time <input type="checkbox"/> 2.Premature <input type="checkbox"/> 3.later <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1.On time <input type="checkbox"/> 2.Premature/later <input type="checkbox"/> 3.later <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1.On time <input type="checkbox"/> 2.Premature/later <input type="checkbox"/> 3.later <input type="checkbox"/> 8.DK
218: When (name) was born, was he/she very large, larger than average, average, smaller than average, or very small?	<input type="checkbox"/> 1. Very large <input type="checkbox"/> 2.Larger than aver. <input type="checkbox"/> 3.Average <input type="checkbox"/> 4.Smaller than aver. <input type="checkbox"/> 5.Very small <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1. Very large <input type="checkbox"/> 2.Larger than aver. <input type="checkbox"/> 3.Average <input type="checkbox"/> 4.Smaller than aver. <input type="checkbox"/> 5.Very small <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1. Very large <input type="checkbox"/> 2.Larger than aver. <input type="checkbox"/> 3.Average <input type="checkbox"/> 4.Smaller than aver. <input type="checkbox"/> 5.Very small <input type="checkbox"/> 8.DK
219: How much did (name) weight?  (record weight from health card, if available)	<div style="border: 1px solid black; display: inline-block; padding: 2px;"> <input type="text"/> , <input type="text"/> </div> Kg <input type="checkbox"/> 8.DK <input type="checkbox"/> 1.Record from card <input type="checkbox"/> 2.Record from recall	<div style="border: 1px solid black; display: inline-block; padding: 2px;"> <input type="text"/> , <input type="text"/> </div> Kg <input type="checkbox"/> 8.DK <input type="checkbox"/> 1.Record from card <input type="checkbox"/> 2.Record from recall	<div style="border: 1px solid black; display: inline-block; padding: 2px;"> <input type="text"/> , <input type="text"/> </div> Kg <input type="checkbox"/> 8.DK <input type="checkbox"/> 1.Record from card <input type="checkbox"/> 2.Record from recall
220: For how many months after the birth of(name), did you not have sexual relation	<div style="border: 1px solid black; display: inline-block; padding: 2px;"> <input type="text"/> </div> Month <input type="checkbox"/> 8.DK	<div style="border: 1px solid black; display: inline-block; padding: 2px;"> <input type="text"/> </div> Month <input type="checkbox"/> 8.DK	<div style="border: 1px solid black; display: inline-block; padding: 2px;"> <input type="text"/> </div> Month <input type="checkbox"/> 8.DK
221: Did you ever breastfeed (name)	<input type="checkbox"/> 1.Yes Go to Q. 223 <input type="checkbox"/> 2.No	<input type="checkbox"/> 1.Yes Go to Q. 223 <input type="checkbox"/> 2.No	<input type="checkbox"/> 1.Yes Go to Q. 223 <input type="checkbox"/> 2.No
222: Why did you not breastfeed (name)?	<input type="checkbox"/> 1.Child died <input type="checkbox"/> 2.Child ill or weak <input type="checkbox"/> 3.Mother ill or weak <input type="checkbox"/> 4.Nipple/bre.problem <input type="checkbox"/> 5.No milk <input type="checkbox"/> 6.Moth. work <input type="checkbox"/> 7.Moth. stud <input type="checkbox"/> 8.Child refu. <input type="checkbox"/> 9.Keep brea. beat. <input type="checkbox"/> 10.Others	<input type="checkbox"/> 1.Child died <input type="checkbox"/> 2.Child ill or weak <input type="checkbox"/> 3.Mother ill or weak <input type="checkbox"/> 4.Nipple/bre.problem <input type="checkbox"/> 5.No milk <input type="checkbox"/> 6.Moth. work <input type="checkbox"/> 7.Moth. stud <input type="checkbox"/> 8.Child refu. <input type="checkbox"/> 9.Keep brea. beat. <input type="checkbox"/> 10.Others	<input type="checkbox"/> 1.Child died <input type="checkbox"/> 2.Child ill or weak <input type="checkbox"/> 3.Mother ill or weak <input type="checkbox"/> 4.Nipple/bre.problem <input type="checkbox"/> 5.No milk <input type="checkbox"/> 6.Moth. work <input type="checkbox"/> 7.Moth. stud <input type="checkbox"/> 8.Child refu. <input type="checkbox"/> 9.Keep brea. beat. <input type="checkbox"/> 10.Others

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Question	answer code																	
223: After 45 days of birth did meet a doctor?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No															
224. If yes, howmany time meet a doctor ?	<input type="text"/> Time	<input type="text"/> Time	<input type="text"/> Time															
225. Where did you go for take care ?	<input type="checkbox"/> 1. Central Hospital <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 4. Clicnic <input type="checkbox"/> 5. Midwife	<input type="checkbox"/> 1. Central Hospital <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 4. Clicnic <input type="checkbox"/> 5. Midwife	<input type="checkbox"/> 1. Central Hospital <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 4. Clicnic <input type="checkbox"/> 5. Midwife															
226. Have you given the yellow milk to a child at first delivery?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No															
227. Are you still breasfeeding (Name)	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No																	
228. How many months did you breastfeed (name)?	<input type="text"/> Month <input type="checkbox"/> 8. DK	<input type="text"/> Month <input type="checkbox"/> 8. DK	<input type="text"/> Month <input type="checkbox"/> 8. DK															
229. Why did you stop breastfeeding(name)?	<input type="checkbox"/> 1. Child died <input type="checkbox"/> 2. Mother ill/weak <input type="checkbox"/> 3. No milk <input type="checkbox"/> 4. Mother working <input type="checkbox"/> 5. Mother studying <input type="checkbox"/> 6. Child refused <input type="checkbox"/> 7. Become pregnant <input type="checkbox"/> 8. Weaning <input type="checkbox"/> 9. Other	<input type="checkbox"/> 1. Child died <input type="checkbox"/> 2. Mother ill/weak <input type="checkbox"/> 3. No milk <input type="checkbox"/> 4. Mother working <input type="checkbox"/> 5. Mother studying <input type="checkbox"/> 6. Child refused <input type="checkbox"/> 7. Become pregnant <input type="checkbox"/> 8. Weaning <input type="checkbox"/> 9. Other	<input type="checkbox"/> 1. Child died <input type="checkbox"/> 2. Mother ill/weak <input type="checkbox"/> 3. No milk <input type="checkbox"/> 4. Mother working <input type="checkbox"/> 5. Mother studying <input type="checkbox"/> 6. Child refused <input type="checkbox"/> 7. Become pregnant <input type="checkbox"/> 8. Weaning <input type="checkbox"/> 9. Other															
230. At any time yesterday was (name) given any of the following in addition to breastmilk.	<table border="0"> <thead> <tr> <th data-bbox="846 1667 894 1692">Yes</th> <th data-bbox="959 1667 1000 1692">No</th> <th data-bbox="1057 1667 1097 1692">DK</th> </tr> </thead> <tbody> <tr> <td data-bbox="846 1703 894 1728"><input type="checkbox"/></td> <td data-bbox="959 1703 1000 1728"><input type="checkbox"/></td> <td data-bbox="1057 1703 1097 1728"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="846 1745 894 1770"><input type="checkbox"/></td> <td data-bbox="959 1745 1000 1770"><input type="checkbox"/></td> <td data-bbox="1057 1745 1097 1770"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="846 1787 894 1812"><input type="checkbox"/></td> <td data-bbox="959 1787 1000 1812"><input type="checkbox"/></td> <td data-bbox="1057 1787 1097 1812"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="846 1829 894 1854"><input type="checkbox"/></td> <td data-bbox="959 1829 1000 1854"><input type="checkbox"/></td> <td data-bbox="1057 1829 1097 1854"><input type="checkbox"/></td> </tr> </tbody> </table>			Yes	No	DK	<input type="checkbox"/>											
Yes	No	DK																
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																

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<b>Section 3: Child Health ( For children birth since March 2000)</b>			
Question	answer code		
301 Name from Q.203 a	<input type="text"/>	<input type="text"/>	<input type="text"/>
302 From Q.203 B	<input type="checkbox"/> 1.Alive go to 301 <input type="checkbox"/> 2.Died go to next child	<input type="checkbox"/> 1.Alive go to 301 <input type="checkbox"/> 2.Died go to next child	<input type="checkbox"/> 1.Alive go to 301 <input type="checkbox"/> 2.Died go to Q. 401
303: Has (Name) been ill with a fever at any time in the last 2 weeks?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK
304: Has (Name) been ill with a cough at any time in the last 2 weeks?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8..DK } go to 306	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK } go to 306	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK } go to 306
305: When (name) was ill with a cough did he /she breaths more rapidly than usual with short rapid breaths?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK
306: Did you seek advice or treatment for the cough?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2. No, go to Q. 337	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No Go to337	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2. No Go to 337
307: Where did you seek advice or treatment?  Multible answer	<input type="checkbox"/> 1. Central hospital <input type="checkbox"/> 2. Prov./Dist.Hos. <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 5. Pramarcy <input type="checkbox"/> 6. Tradit. Doctor <input type="checkbox"/> 7. Others	<input type="checkbox"/> 1. Central hospital <input type="checkbox"/> 2. Prov./Dist.Hos. <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 5. Pramarcy <input type="checkbox"/> 6. Tradit. Doctor <input type="checkbox"/> 7. Others	<input type="checkbox"/> 1. Central hospital <input type="checkbox"/> 2. Prov./Dist.Hos. <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 5. Pramarcy <input type="checkbox"/> 6. Tradit. Doctor <input type="checkbox"/> 7. Others
308: Has (name) had diarrhea in the last 2 weeks?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 3DK → next child	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 3DK → next child	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 3DK → Go to Q. 401

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Question	answer code		
309: Was there any blood in the stools?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK
310: Did you seek advice or treatment for the diarrhea?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK > Go to next child	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK > Go to next child	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No <input type="checkbox"/> 8.DK > Go to Q 401
311: Where did you seek advice or treatment?	<input type="checkbox"/> 1. Central Hospital <input type="checkbox"/> 2.Prov./Dist.Hos. <input type="checkbox"/> 3.Health center <input type="checkbox"/> 4.Clinic <input type="checkbox"/> 5.Pharmacy <input type="checkbox"/> 6. Tradit. Doctor <input type="checkbox"/> 7. Others	<input type="checkbox"/> 1. Central Hospital <input type="checkbox"/> 2.Prov./Dist.Hos. <input type="checkbox"/> 3.Health center <input type="checkbox"/> 4.Clinic <input type="checkbox"/> 5.Pharmacy <input type="checkbox"/> 6. Tradit. Doctor <input type="checkbox"/> 7. Others	<input type="checkbox"/> 1. Central Hospital <input type="checkbox"/> 2.Prov./Dist.Hos. <input type="checkbox"/> 3.Health center <input type="checkbox"/> 4.Clinic <input type="checkbox"/> 5.Pharmacy <input type="checkbox"/> 6. Tradit. Doctor <input type="checkbox"/> 7. Others
312: What was given to treat the diarrhea?	<input type="checkbox"/> 1.Pill or syrup <input type="checkbox"/> 2. Injection <input type="checkbox"/> 3. Intravenous <input type="checkbox"/> 4.Drink oral <input type="checkbox"/> 5.Tradit.Medicine <input type="checkbox"/> 7.Others	<input type="checkbox"/> 1.Pill or syrup <input type="checkbox"/> 2. Injection <input type="checkbox"/> 3. Intravenous <input type="checkbox"/> 4.Drink oral <input type="checkbox"/> 5.Tradit.Medicine <input type="checkbox"/> 7.Others	<input type="checkbox"/> 1.Pill or syrup <input type="checkbox"/> 2. Injection <input type="checkbox"/> 3. Intravenous <input type="checkbox"/> 4.Drink oral <input type="checkbox"/> 5.Tradit.Medicine <input type="checkbox"/> 7.Others

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<b>Section 4: Contraceptive</b>			
<b>Contraceptive method</b>	<b>Q.401: Have you ever heard of this method ?</b>	<b>Q.402: Have you ever used of this method ?</b>	<b>Q.403: Where did you get it ?</b>
<b>A. Pill</b>	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy
<b>B. IUD</b>	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy
<b>C. Injection</b>	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy
<b>D. Diaphragm</b>	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy
<b>E. Condom</b>	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy

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Contraceptive method	Q.401: Have you ever heard of this method ?	Q.402: Have you ever used of this method ?	Q.403: Where did you get it ?
F. Female sterilization	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Parmacy
G. Female sterilization	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Parmacy
H. Rhythm/ periodic abstinence	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Parmacy
I. Withdrawal	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Parmacy
J. Norplant	<input type="checkbox"/> 1. Yes/ Spond <input type="checkbox"/> 2. Yes/ Probed <input type="checkbox"/> 3. No, go to next method	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to next method	<input type="checkbox"/> 1. Central/Prov. <input type="checkbox"/> 6. Moble outreach clinic <input type="checkbox"/> 2. Dist hospit. <input type="checkbox"/> 7. midwife on home visit <input type="checkbox"/> 3. Health Center <input type="checkbox"/> 8. VHV/TBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Parmacy

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Question	answer code		
420. What the main reason do you not intend to use a method ?	<input type="checkbox"/> 1. Husb and disapp <input type="checkbox"/> 2. Herad to get it <input type="checkbox"/> 3. Cost too much <input type="checkbox"/> 4. Incovenient to use	<input type="checkbox"/> 5. Wants children <input type="checkbox"/> 6. Health concerns <input type="checkbox"/> 7. Fatalistic <input type="checkbox"/> 8. Other pers. disapp.	<input type="checkbox"/> 9. Diff to get pregn. <input type="checkbox"/> 10. Menopausal <input type="checkbox"/> 11. Lack of knowled <input type="checkbox"/> 96. Other <input type="checkbox"/> 98. DK
<b>Section 5: Marriage</b>			
501: What is your marital status ?	<input type="checkbox"/> 1. Never married, go to q. 507 <input type="checkbox"/> 3. Divorced <input type="checkbox"/> 2. Married <input type="checkbox"/> 4. Widowed		
502: How many time are you married	<input type="checkbox"/> 1. Once <input type="checkbox"/> 2. More than once		
503: Are you and your husband currently living together or is he staying elaeewhere?	<input type="checkbox"/> 1. Yes, go to Q. 505 <input type="checkbox"/> 2. No		
504: How long is your husband staying elsewhere?	<input type="text"/> Month <input type="text"/> Year		
505: In what month and year did you first married ?	<input type="text"/> Month <input type="checkbox"/> 96. DK <input type="text"/> Year <input type="checkbox"/> 98. (DK year)		
506: How old were you at that time ?	<input type="text"/> Age		
507: Have you ever had sexual intercourse ?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to q. 601		
508: How old were you sexual intercourse ?	<input type="text"/> Age <input type="checkbox"/> 98. DK		
<b>Section 6: Fertility Preferences</b>			
<b>601 Check Q. 411:</b> - If, not sterilized go to q. 602 - If, sterilized go to q. 607			
602 : Check Q. 119	<input type="checkbox"/> <u>Not pregnant or unsure</u> Q.602A: Would you like more children ? <input type="checkbox"/> <u>Pregnant</u> Q. 602B: After this would you like more children ?	<input type="checkbox"/> 1. Yes, go to q. 603 <input type="checkbox"/> 2. No, go to q. 606 <input type="checkbox"/> 3. Can't pregnant, go to q. 607 <input type="checkbox"/> 4. Unsure / DK, go to q. 607	
Q. 603: How many children do you want ?	<input type="text"/> Chilh number		

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<b>Section 7: Husband's background</b>	
<b>701 Check Q. 501:</b>	<b>* If, married/ divorced/ widowed go to q. 702</b> <b>* If, never married go to q. 801</b>
702: How old was your ( last ) husband on his last birthday ?	<input type="text"/> Age <input type="checkbox"/> 98. Don't know
703: Did ( last ) your husband ever attend school ?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to q. 705
704: What was the highest level of school	Primery school
	Secondary school
	<input type="checkbox"/> 1.No class <input type="checkbox"/> 13.Third class <input type="checkbox"/> 21 Class <input type="checkbox"/> 31class <input type="checkbox"/> 11. First class <input type="checkbox"/> 14.Fourth class <input type="checkbox"/> 22 class <input type="checkbox"/> 32 class <input type="checkbox"/> 12.Second class <input type="checkbox"/> 15.Fifth class <input type="checkbox"/> 23 class <input type="checkbox"/> 33 class <input type="checkbox"/> 16.Second class
705: What kind of work does your ( last	<input type="text"/> <input type="text"/>
<b>Section 8: ( STIsSTDs ) and ( HIV/ AIDs )</b>	
801: Have you ever heard STIs/ STDs ?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to q. 807
802: From which sources of information have you heard about it ?	<input type="checkbox"/> 1. Radio <input type="checkbox"/> 5. Health workers <input type="checkbox"/> 9. Office <input type="checkbox"/> 2. TV <input type="checkbox"/> 6. School/ teachers <input type="checkbox"/> 96. Other <input type="checkbox"/> 3. Newsp./magaz. <input type="checkbox"/> 7. Community <input type="checkbox"/> 4. Posters <input type="checkbox"/> 8. Friend/ relative
803: What kind of STIs have you heard ?	<input type="checkbox"/> 1. Syphilis <input type="checkbox"/> 3. Warts <input type="checkbox"/> 8. DK <input type="checkbox"/> 2. Gonorrhoea <input type="checkbox"/> 4. Other
804: Have you had vaginal discharge in the last 12 month ?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to q. 807
805: What type of treatment did you take ?	<input type="checkbox"/> 1.Traditional medicine <input type="checkbox"/> 3. Injection antibiotic <input type="checkbox"/> 2.Oral antibiotic <input type="checkbox"/> 4.Cream/pessary in vaginal <input type="checkbox"/> 5.Other
806: Where did you get treatment?	<input type="checkbox"/> 1. Drug store <input type="checkbox"/> 4. Private clinic <input type="checkbox"/> 2. Hospital <input type="checkbox"/> 5. Midwife at home <input type="checkbox"/> 3. Health center <input type="checkbox"/> 6. Sell at home <input type="checkbox"/> 7. Other
807: Have you ever heard HIV/ AIDS ?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, the end interview

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Question	answer code
808: From which sources of information have you heard about it ?	<input type="checkbox"/> 1. Radio <input type="checkbox"/> 5. Health workers <input type="checkbox"/> 9. Office <input type="checkbox"/> 2. TV <input type="checkbox"/> 6. School/ teachers <input type="checkbox"/> 10. Other <input type="checkbox"/> 3. Newsp./magaz. <input type="checkbox"/> 7. Community <input type="checkbox"/> 4. Posters <input type="checkbox"/> 8. Friend/ relative
809: Is there anything a person can do to avoid getting HIV/ AIDS ?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 8. DK
810: Is it easy to recognize people infected with HIV/ AIDS ?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 8. DK <input type="checkbox"/> 2. No
811: How is HIV/ AIDS transmitted ?	<input type="checkbox"/> 1. Sexual intercourse <input type="checkbox"/> 3. Sharing syringe <input type="checkbox"/> 2. Blood trans. <input type="checkbox"/> 4. Mother to child transmission during pregnancy/birth <input type="checkbox"/> 5. Other
812: How to prevent infected STIs and HIVs ?	<input type="checkbox"/> 1. Have only one sex partner <input type="checkbox"/> 4. Using condom before have sex <input type="checkbox"/> 2. Using toilet carefully <input type="checkbox"/> 5. No answer <input type="checkbox"/> 3. Taking medicine before have sex <input type="checkbox"/> 7. Other <input type="checkbox"/> 8. DK
813: How to avoid getting HIV ? a. Avoid mosquitoes b. Not having sex c. Using condoms during sex d. Monogamy (having only one partner) e. Avoid sharing food with person with HIV f. Avoid sharing toilet with person with HIV g. Avoid sharing glass with person with HIV h. Avoid sharing needles/drugs i. No sex with CSWs	1. Yes                      2. No <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2

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