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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

Interview visit

First time

Day

Month

Result

Second time

Day

Month

Result

Final time

Day

Month

Result

Total number of visits:

☐ 1 Time☐ 2 Time☐ 3 Time

Result code

1. Completed

2. No body stay at home

3. Postponed

4. Refused

5. Somepart completed

6. Vacant/Disoy dwelling

7. Other

Respondent name

Interviewer's name

Supervisor's name

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Section 1: Reproduction	
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)
112: Checking Question 111: <div style="display: flex; justify-content: space-between;"> <div> <p>* If, ever given birth 1 or more go to Q. 114</p> <p>* If, never given birth go to Q. 123</p> </div> </div>	

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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	<div><div></div>M <div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D <div></div>M <div></div>Y</div>
02	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M <div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D <div></div>M <div></div>Y</div>
03	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M <div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D <div></div>M <div></div>Y</div>
04	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M <div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D <div></div>M <div></div>Y</div>
05	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M <div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ go to Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D <div></div>M <div></div>Y</div>

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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	<div><div></div>M</div> <div><div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D</div> <div><div></div>M</div> <div><div></div>Y</div>
07	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M</div> <div><div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D</div> <div><div></div>M</div> <div><div></div>Y</div>
08	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M</div> <div><div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D</div> <div><div></div>M</div> <div><div></div>Y</div>
09	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M</div> <div><div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D</div> <div><div></div>M</div> <div><div></div>Y</div>
10	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M</div> <div><div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D</div> <div><div></div>M</div> <div><div></div>Y</div>
11	<input type="checkbox"/> 1.sing <input type="checkbox"/> 2.Mult	<input type="checkbox"/> 1.Boy <input type="checkbox"/> 2.Girl	<div><div></div>M</div> <div><div></div>Y</div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ goto Q.121	<div><div></div></div>	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2.No ↓ net pers.	<div><div></div>D</div> <div><div></div>M</div> <div><div></div>Y</div>

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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 Question 116: - One or more birth since March 2000 → Go to Q 202
 - 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"/>
203B: Name from Q.114	Last birth <input type="text"/>	Next to last birth <input type="text"/>	Second from last birth <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?	<div><input type="text"/> <input type="text"/> Month</div> <input type="checkbox"/> 8.DK	<div><input type="text"/> <input type="text"/> Month</div> <input type="checkbox"/> 8.DK	<div><input type="text"/> <input type="text"/> Month</div> <input type="checkbox"/> 8.DK
209: How many time did you have antenatal care?	<div><input type="text"/> <input type="text"/> Time</div>	<div><input type="text"/> <input type="text"/> Time</div>	<div><input type="text"/> <input type="text"/> Time</div>
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: 60px; height: 20px; margin-bottom: 5px;"></div> Total pill <input type="checkbox"/> 8. DK		
213: Where did you give birth to (name) Multble 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 ? Multble 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: 180px; height: 20px; margin-bottom: 5px;"></div> Unit kip	<div style="border: 1px solid black; width: 180px; height: 20px; margin-bottom: 5px;"></div> Unit kip	<div style="border: 1px solid black; width: 180px; height: 20px; margin-bottom: 5px;"></div> Unit kip
216: Who assisted with the delivery of (name) Multble 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; padding: 2px; display: inline-block;"> <div style="border-bottom: 1px solid black; width: 20px; margin-bottom: 2px;"></div> <div style="display: inline-block; width: 10px; height: 10px; border: 1px solid black; margin: 0 5px;"></div> </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; padding: 2px; display: inline-block;"> <div style="border-bottom: 1px solid black; width: 20px; margin-bottom: 2px;"></div> <div style="display: inline-block; width: 10px; height: 10px; border: 1px solid black; margin: 0 5px;"></div> </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; padding: 2px; display: inline-block;"> <div style="border-bottom: 1px solid black; width: 20px; margin-bottom: 2px;"></div> <div style="display: inline-block; width: 10px; height: 10px; border: 1px solid black; margin: 0 5px;"></div> </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; padding: 2px; display: inline-block;"> <div style="border-bottom: 1px solid black; width: 20px; margin-bottom: 2px;"></div> </div> Month <input type="checkbox"/> 8.DK	<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border-bottom: 1px solid black; width: 20px; margin-bottom: 2px;"></div> </div> Month <input type="checkbox"/> 8.DK	<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border-bottom: 1px solid black; width: 20px; margin-bottom: 2px;"></div> </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 ?	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; border: 1px solid black;"></div> </div> Time	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; border: 1px solid black;"></div> </div> Time	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; border: 1px solid black;"></div> </div> 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)?	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; border: 1px solid black;"></div> </div> Month <input type="checkbox"/> 8. DK	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; border: 1px solid black;"></div> </div> Month <input type="checkbox"/> 8. DK	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; border: 1px solid black;"></div> </div> 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" style="width: 100%;"> <tr> <td style="width: 50%;"></td> <td style="width: 16.6%; text-align: center;">Yes</td> <td style="width: 16.6%; text-align: center;">No</td> <td style="width: 16.6%; text-align: center;">DK</td> </tr> <tr> <td>a. Pain water</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Tinned of fresh milk</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Any other liquids</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Any solid or mushy food</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>				Yes	No	DK	a. Pain water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Tinned of fresh milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Any other liquids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Any solid or mushy food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	DK																				
a. Pain water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
b. Tinned of fresh milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
c. Any other liquids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				
d. Any solid or mushy food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																				

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Section 3: Child Health (For children birth since March 2000)			
Question	answer code		
301 Name from Q.203 a	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div>
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? Multble 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"/> 2No <input type="checkbox"/> 3DK next child	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2No <input type="checkbox"/> 3DK next child	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2No <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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Section 4: Contraceptive			
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 ?
A. Pill	<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. Mobile 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. IUD	<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. Mobile 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
C. Injection	<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. Mobile 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
D. Diaphragm	<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. Mobile 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
E. Condom	<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. Mobile 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. Mobile 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. VHVTBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy
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. Mobile 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. VHVTBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy
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. Mobile 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. VHVTBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy
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. Mobile 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. VHVTBA <input type="checkbox"/> 4. Clinic <input type="checkbox"/> 9. Abroad <input type="checkbox"/> 5. Pharmacy
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. Mobile 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. VHVTBA <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 ?
K. Traditional medicine	<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. Mobile 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
L. Emergency contraception	<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. Mobile 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
M. Other	<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. Mobile 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
404. Check Q. 402: * Never use any contraceptive go to q. 409 * Ever use one or more contraceptive go to q. 405			
Question	answer code		
405: What was method at first time you used ?	<input type="checkbox"/> 1. Pill <input type="checkbox"/> 5. Condom <input type="checkbox"/> 9. Withdrawal <input type="checkbox"/> 2. IUD <input type="checkbox"/> 6. Female sterilization <input type="checkbox"/> 10. Norplant <input type="checkbox"/> 3. Injection <input type="checkbox"/> 7. Female sterilization <input type="checkbox"/> 11. Traditional medicine <input type="checkbox"/> 4. Diaphragm <input type="checkbox"/> 8. Rhythm/periodic abstinence <input type="checkbox"/> 13. Other		
406: How many living children do you have at that time ?	<div style="border: 1px solid black; width: 50px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; background-color: black;"></div> </div> number of living children		
407 What was your age when you first started using any method ?	<div style="border: 1px solid black; width: 50px; height: 20px; display: flex; align-items: center; justify-content: center;"> <div style="width: 10px; height: 10px; background-color: black;"></div> </div> Age <input type="checkbox"/> 98. Don't know		
408. Check Q. 123: *Not pregnant or unsure go to q. 410 *Currently pregnant go to q. 419			
409: Are you using any method now ?	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No, go to q. 418		

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Question	answer code
410: Which method are you using now ?	8.Rhythm/periodic abstinence
411: Who made the decision on type of reproductive to use ?	<input type="checkbox"/> 1.Self <input type="checkbox"/> 3.Partner <input type="checkbox"/> 5.Health worker <input type="checkbox"/> 2. Self with partner <input type="checkbox"/> 4.Relative
412: From where did you get this method ?	<input type="checkbox"/> 1.Central/Prov. <input type="checkbox"/> 6.Moble outreach clinic <input type="checkbox"/> 7.midwife on home visit <input type="checkbox"/> 2.Dist hospit. <input type="checkbox"/> 4.Clinic <input type="checkbox"/> 8.VHV/TBA <input type="checkbox"/> 3.Health Center <input type="checkbox"/> 5. Parmacy <input type="checkbox"/> 9.Abroad
413: For how many months have you been using this continuously ?	<div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block; margin-right: 10px;"></div> Month <input type="checkbox"/> 996. (11years or longer) (If, note one answer of them go to Q. 416) <input type="checkbox"/> 998. Don't know
414: In what month and year was you do sterilization ?	<div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block; margin-right: 10px;"></div> Month <input type="checkbox"/> 96. (DK month) <div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block; margin-right: 10px;"></div> Year <input type="checkbox"/> 98. (DK year)
415: Do you have any problem with the method you are using now ?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2. No, go to Q.501
416: What the main problem ?	<input type="checkbox"/> 1.Hunsb and disapp <input type="checkbox"/> 4.Incovenient to use <input type="checkbox"/> 96.Other <input type="checkbox"/> 2. Accessibility <input type="checkbox"/> 5.Wants children <input type="checkbox"/> 98.DK <input type="checkbox"/> 3.Cost too much <input type="checkbox"/> 6. Health concerns
417: Why have you not use contraceptive method ?	<input type="checkbox"/> 1.Hunsb and disapp <input type="checkbox"/> 5.Wants children <input type="checkbox"/> 9. Diff to get pregn. <input type="checkbox"/> 2. Herad to get it <input type="checkbox"/> 6. Health concerns <input type="checkbox"/> 10. Menopausal <input type="checkbox"/> 3. Cost too much <input type="checkbox"/> 7. Fatalistic <input type="checkbox"/> 11. Lack of knowled <input type="checkbox"/> 4.Incovenient to use <input type="checkbox"/> 8. Other pers. disapp. <input type="checkbox"/> 96. Other <input type="checkbox"/> 98. DK
418: Do you intend to use any method in the future ?	<input type="checkbox"/> 1.Yes <input type="checkbox"/> 2. No, go to q.420 <input type="checkbox"/> 8. Don't know, go to Q. 501
419 Which the method do you wish to use ?	<input type="checkbox"/> 1.Pill <input type="checkbox"/> 5.Condom <input type="checkbox"/> 9.Wthdrawal <input type="checkbox"/> 2.IUD <input type="checkbox"/> 6.Female sterilization <input type="checkbox"/> 10.Norplant <input type="checkbox"/> 3.Injection <input type="checkbox"/> 7.Female sterilization <input type="checkbox"/> 11.Tranditional medicine <input type="checkbox"/> 4.Diaphragm <input type="checkbox"/> 8.Rhythm/periodic abstinence <input type="checkbox"/> 13.Other

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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"/> 5. Wants children <input type="checkbox"/> 9. Diff to get pregn. <input type="checkbox"/> 2. Hard to get it <input type="checkbox"/> 6. Health concerns <input type="checkbox"/> 10. Menopausal <input type="checkbox"/> 3. Cost too much <input type="checkbox"/> 7. Fatalistic <input type="checkbox"/> 11. Lack of knowled <input type="checkbox"/> 4. Inconvenient to use <input type="checkbox"/> 8. Other pers. disapp. <input type="checkbox"/> 96. Other <input type="checkbox"/> 98. DK
Section 5: Marriage	
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 elsewhere?	<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
Section 6: Fertility Preferences	
601 Check Q. 411: - 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"/> Child number

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Question		answer code	
604: Why is the main reason you want more children ?		<input type="checkbox"/> 1. Don't have child <input type="checkbox"/> 2. Not enough child <input type="checkbox"/> 3. Have no son <input type="checkbox"/> 4. Have no daughter	<input type="checkbox"/> 5. Custom / religion <input type="checkbox"/> 6. Hunsband recom. <input type="checkbox"/> 7. Help fam. Econ <input type="checkbox"/> 8. Other
605: Check Q. 119	<input type="checkbox"/> <u>Not pregnant or unsure</u> → How long would you like to wait? <input type="checkbox"/> <u>Pregnant</u> → How long would you like to wait after this ?	<div> <input type="text"/> <input type="text"/> Month </div> <div> <input type="text"/> <input type="text"/> Year </div>	<input type="checkbox"/> 993. Soon/ now <input type="checkbox"/> 994. Can't pregnant <input type="checkbox"/> 995. After marriage <input type="checkbox"/> 996. Other <input type="checkbox"/> 998. Don't know
606: Why is the main reason you made like that?		<input type="checkbox"/> 1. Like to have a child <input type="checkbox"/> 2. Prefer no more children <input type="checkbox"/> 3. Undecided	
607: What is the main reason you don't want another child ?		<input type="checkbox"/> 1. Have enough <input type="checkbox"/> 3. Health <input type="checkbox"/> 5. Too busy <input type="checkbox"/> 2. Too old <input type="checkbox"/> 4. Poor <input type="checkbox"/> 6. Other	
608: Check Q. 215:			
<input type="checkbox"/> <u>Has living children</u> → If you could go back to the time when you han no children and could choose exactly the number of children how many would you like ? <input type="checkbox"/> <u>No living children</u> → If you could choose exactly the number of children to have in your whole life, how many would you like ?		<div> <input type="text"/> <input type="text"/> Chilh number </div> <input type="checkbox"/> 98. Don't know	
609. Chegk Q . 501		- If, married go to Q. 610 - If, never married / divorced/ widowed go toq. 612	
610: Have you and your husband discussed the number of children you would like to have ?		<input type="checkbox"/> 1. Yes, go to q. 603 <input type="checkbox"/> 2. No, go to q. 506	
611: Do you think your husband want the same number of children that you want, or does he want more or fewer than you want ?		<input type="checkbox"/> 1. Same number <input type="checkbox"/> 3. Fewer children <input type="checkbox"/> 2. More children <input type="checkbox"/> 8. DK	
612: What do think is the best number of year between the birth of one child and the birth of the next child ?		<div> <input type="text"/> <input type="text"/> Chilh number </div> <input type="checkbox"/> 98. Don't know	

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Section 7: Husband's background

701 Check Q. 501:

*** If, married/ divorced/ widowed go to q. 702**

*** If, never married go to q. 801**

702: How old was your (last) husband on his last birthday ?

Age

☐ 98. Don't know

703: Did (last) your husband ever attend school ?

☐ 1. Yes

☐ 2. No, go to q. 705

704: What was the highest level of school

Primery school

Secondary school

☐ 1.No class

☐ 13.Third class

☐ 21 Class

☐ 31class

☐ 11. First class

☐ 14.Fourth class

☐ 22 class

☐ 32 class

☐ 12.Second class

☐ 15.Fifth class

☐ 23 class

☐ 33 class

☐ 16.Second class

705: What kind of work does your (last

Section 8: (STIsSTDs) and (HIV/ AIDs)

801: Have you ever heard STIs/ STDs ?

☐ 1. Yes

☐ 2. No, go to q. 807

802: From which sources of information have you heard about it ?

☐ 1. Radio

☐ 5. Health workers

☐ 9. Office

☐ 2. TV

☐ 6. School/ teachers

☐ 96. Other

☐ 3. Newsp./magaz.

☐ 7. Community

☐ 4. Posters

☐ 8. Friend/ relative

803: What kind of STIs have you heard ?

☐ 1. Syphilis

☐ 3. Warts

☐ 8. DK

☐ 2. Gonorrheoea

☐ 4. Other

804: Have you had vaginal discharge in the last 12 month ?

☐ 1. Yes

☐ 2. No, go to q. 807

805: What type of treatment did you take ?

☐ 1.Traditional medicine

☐ 3. Injection antibiotic

☐ 2.Oral antibiotic

☐ 4.Cream/pessary in vaginal

☐ 5.Other

806: Where did you get treatment?

☐ 1.Drug store

☐ 4.Private clinic

☐ 2.Hospital

☐ 5. Midwife at home

☐ 3.Health center

☐ 6.Sell at home

☐ 7.Other

807: Have you ever heard HIV/ AIDS ?

☐ 1. Yes

☐ 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 ?	<div style="display: flex; justify-content: space-around;"> 1. Yes 2. No </div> <div style="display: flex; justify-content: space-around;"> <div style="width: 45%;"> 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 </div> <div style="width: 45%;"> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 </div> </div>

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