



INTRODUCTION AND CONSENT

Hello. My name is \_\_\_\_\_. I am working with the Ethiopian Public Health Institute. We are conducting a survey about health and other topics all over Ethiopia. The information we collect will help the government to plan health services. Your household was selected for the survey. The questions usually take about 30 to 60 minutes. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team. You don't have to be in the survey, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can stop the interview at any time.

In case you need more information about the survey, you may contact the person listed on the card that has already been given to your household.

Do you have any questions?  
May I begin the interview now?

SIGNATURE OF INTERVIEWER \_\_\_\_\_ DATE \_\_\_\_\_



| NO.  | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                                                                                               | CODING CATEGORIES                                                                                                                                                                                                      | SKIP  |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| 101  | RECORD THE TIME.                                                                                                                                                                                                                                                                                                                                    | HOURS .....<br>MINUTES.....                                                                                                                                                                                            |       |
| 101A | Before I begin the interview, could you please bring your and your children's Birth Certificate, Maternal and Child Immunisation Card, and any immunisation record from a private health provider, or any other document where the date of birth is officially registered for your self or your children? We will need to refer to those documents. |                                                                                                                                                                                                                        |       |
| 105  | In what month and year were you born?                                                                                                                                                                                                                                                                                                               | MONTH .....<br>DON'T KNOW MONTH ..... 98<br>YEAR .....<br>DON'T KNOW YEAR ..... 9998                                                                                                                                   |       |
| 106  | How old were you at your last birthday?<br>COMPARE AND CORRECT 105 AND/OR 106 IF INCONSISTENT.                                                                                                                                                                                                                                                      | AGE IN COMPLETED YEARS .....                                                                                                                                                                                           |       |
| 107  | Have you ever attended school?                                                                                                                                                                                                                                                                                                                      | YES ..... 1<br>NO ..... 2                                                                                                                                                                                              | → 111 |
| 108  | What is the highest level of school you attended: primary, secondary, or higher?                                                                                                                                                                                                                                                                    | PRIMARY ..... 1<br>SECONDARY ..... 2<br>TECHNICAL/VOCATIONAL ..... 3<br>HIGHER ..... 4                                                                                                                                 |       |
| 109  | What is the highest grade or number of years you completed at that level?<br>IF ATTENDED PRIMARY OR SECONDARY, RECORD COMPLETED GRADE COMPLETED AT THAT LEVEL.<br>IF ATTENDED TECHNICAL/VOCATIONAL OR IF COMPLETED LESS THAN ONE YEAR AT THAT LEVEL, RECORD '00'.                                                                                   | GRADE/NUMBER OF YEARS .....                                                                                                                                                                                            |       |
| 110  | CHECK 108:<br>PRIMARY OR <input type="checkbox"/> TECHNICAL/VOCATIONAL <input type="checkbox"/><br>SECONDARY ↓ OR HIGHER                                                                                                                                                                                                                            |                                                                                                                                                                                                                        | → 122 |
| 111  | Now I would like you to read this sentence to me.<br>SHOW CARD TO RESPONDENT.<br>IF RESPONDENT CANNOT READ WHOLE SENTENCE,<br>PROBE: Can you read any part of the sentence to me?                                                                                                                                                                   | CANNOT READ AT ALL ..... 1<br>ABLE TO READ ONLY PART OF THE SENTENCE ..... 2<br>ABLE TO READ WHOLE SENTENCE ..... 3<br>NO CARD WITH REQUIRED LANGUAGE ..... 4<br>(SPECIFY LANGUAGE)<br>BLIND/VISUALLY IMPAIRED ..... 5 |       |
| 122  | What is your religion?                                                                                                                                                                                                                                                                                                                              | ORTHODOX ..... 1<br>CATHOLIC ..... 2<br>PROTESTANT ..... 3<br>MUSLIM ..... 4<br>TRADITIONAL ..... 5<br>OTHER ..... 96<br>(SPECIFY)                                                                                     |       |

**SECTION 2. REPRODUCTION**

| NO. | QUESTIONS AND FILTERS                                                                                                                                                                                                                          | CODING CATEGORIES                                                                                                                                                                                                                                                                             | SKIP  |  |  |  |  |  |  |  |  |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|--|--|--|--|--|--|
| 201 | Now I would like to ask about all the births you have had during your life. Have you ever given birth?                                                                                                                                         | YES ..... 1<br>NO ..... 2                                                                                                                                                                                                                                                                     | → 206 |  |  |  |  |  |  |  |  |
| 202 | Do you have any sons or daughters to whom you have given birth who are now living with you?                                                                                                                                                    | YES ..... 1<br>NO ..... 2                                                                                                                                                                                                                                                                     | → 204 |  |  |  |  |  |  |  |  |
| 203 | a) How many sons live with you?<br>b) And how many daughters live with you?<br>IF NONE, RECORD '00'.                                                                                                                                           | a) SONS AT HOME ..... <table border="1" data-bbox="1209 344 1348 405"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table><br>b) DAUGHTERS AT HOME ..... <table border="1" data-bbox="1209 405 1348 465"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>     |       |  |  |  |  |  |  |  |  |
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|     |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                               |       |  |  |  |  |  |  |  |  |
| 204 | Do you have any sons or daughters to whom you have given birth who are alive but do not live with you?                                                                                                                                         | YES ..... 1<br>NO ..... 2                                                                                                                                                                                                                                                                     | → 206 |  |  |  |  |  |  |  |  |
| 205 | a) How many sons are alive but do not live with you?<br>b) And how many daughters are alive but do not live with you?<br>IF NONE, RECORD '00'.                                                                                                 | a) SONS ELSEWHERE ..... <table border="1" data-bbox="1209 589 1348 649"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table><br>b) DAUGHTERS ELSEWHERE ..... <table border="1" data-bbox="1209 649 1348 710"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> |       |  |  |  |  |  |  |  |  |
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|     |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                               |       |  |  |  |  |  |  |  |  |
| 206 | Have you ever given birth to a boy or girl who was born alive but later died?<br>IF NO, PROBE: Any baby who cried, who made any movement, sound, or effort to breathe, or who showed any other signs of life even if for a very short time?    | YES ..... 1<br>NO ..... 2                                                                                                                                                                                                                                                                     | → 208 |  |  |  |  |  |  |  |  |
| 207 | a) How many boys have died?<br>b) And how many girls have died?<br>IF NONE, RECORD '00'.                                                                                                                                                       | a) BOYS DEAD ..... <table border="1" data-bbox="1209 947 1348 1008"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table><br>b) GIRLS DEAD ..... <table border="1" data-bbox="1209 1008 1348 1068"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>            |       |  |  |  |  |  |  |  |  |
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|     |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                               |       |  |  |  |  |  |  |  |  |
| 208 | SUM ANSWERS TO 203, 205, AND 207, AND ENTER TOTAL. IF NONE, RECORD '00'.                                                                                                                                                                       | TOTAL BIRTHS ..... <table border="1" data-bbox="1209 1113 1348 1173"><tr><td> </td><td> </td></tr></table>                                                                                                                                                                                    |       |  |  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                               |       |  |  |  |  |  |  |  |  |
| 209 | CHECK 208:<br>Just to make sure that I have this right: you have had in TOTAL ____ births during your life. Is that correct?<br><br>YES <input type="checkbox"/> ↓<br>NO <input type="checkbox"/> ↑<br>PROBE AND CORRECT 201-208 AS NECESSARY. |                                                                                                                                                                                                                                                                                               |       |  |  |  |  |  |  |  |  |
| 210 | CHECK 208:<br>ONE OR MORE BIRTHS <input type="checkbox"/> ↓<br>NO BIRTHS <input type="checkbox"/> →                                                                                                                                            |                                                                                                                                                                                                                                                                                               | → 226 |  |  |  |  |  |  |  |  |

SECTION 2. REPRODUCTION

| 211 Now I would like to record the names of all your births, whether still alive or not, starting with the first one you had.<br>RECORD NAMES OF ALL THE BIRTHS IN 212. RECORD TWINS AND TRIPLETS ON SEPARATE ROWS. IF THERE ARE MORE THAN 10 BIRTHS, USE AN ADDITIONAL QUESTIONNAIRE, STARTING WITH THE SECOND ROW. |                            |                                 |                                                                                     |                                |                                               |                            |                                                                                      |                                                                                                                                                                                                                                                                 |                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------------|-------------------------------------------------------------------------------------|--------------------------------|-----------------------------------------------|----------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 212                                                                                                                                                                                                                                                                                                                  | 213                        | 214                             | 215                                                                                 | 216                            | 217                                           | 218                        | 219                                                                                  | 220                                                                                                                                                                                                                                                             | 221                                                                                                                        |
| What name was given to your (first/next) baby?                                                                                                                                                                                                                                                                       | Is (NAME) a boy or a girl? | Were any of these births twins? | On what day, month, and year was (NAME) born?                                       | Is (NAME) still alive?         | How old was (NAME) at (NAME)'s last birthday? | Is (NAME) living with you? | RECORD HOUSEHOLD LINE NUMBER OF CHILD. RECORD '00' IF CHILD NOT LISTED IN HOUSEHOLD. | How old was (NAME) when (he/she) died? IF '12 MONTHS' OR '1 YR'. ASK: Did (NAME) have (his/her) first birthday? THEN ASK: Exactly how many months old was (NAME) when (he/she) died? RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS. | Were there any other live births between (NAME OF PREVIOUS BIRTH) and (NAME), including any children who died after birth? |
| RECORD NAME.<br>BIRTH HISTORY NUMBER.                                                                                                                                                                                                                                                                                |                            |                                 |                                                                                     |                                | RECORD AGE IN COMPLETED YEARS.                |                            |                                                                                      |                                                                                                                                                                                                                                                                 |                                                                                                                            |
| 01                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(NEXT BIRTH)                           | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    |                                                                                                                            |
| 02                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |
| 03                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |
| 04                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |
| 05                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |
| 06                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |
| 07                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |
| 08                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |
| 09                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |
| 10                                                                                                                                                                                                                                                                                                                   | BOY 1<br>GIRL 2            | SING 1<br>MULT 2                | DAY <input type="text"/><br>MONTH <input type="text"/><br>YEAR <input type="text"/> | YES 1<br>NO 2<br>(SKIP TO 220) | AGE IN YEARS <input type="text"/>             | YES 1<br>NO 2              | HOUSEHOLD LINE NUMBER <input type="text"/><br>(SKIP TO 221)                          | DAYS 1 <input type="text"/><br>MONTHS 2 <input type="text"/><br>YEARS 3 <input type="text"/>                                                                                                                                                                    | YES (ADD BIRTH) 1<br>NO (NEXT BIRTH) 2                                                                                     |

SECTION 2. REPRODUCTION

| NO. | QUESTIONS AND FILTERS                                                                                       | CODING CATEGORIES                                                         | SKIP  |
|-----|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-------|
| 222 | Have you had any live births since the birth of (NAME OF LAST BIRTH)?                                       | YES ..... 1<br>(RECORD BIRTH(S) IN TABLE) ←<br>NO ..... 2                 |       |
| 223 | COMPARE 208 WITH NUMBER OF BIRTHS IN BIRTH HISTORY<br><br>NUMBERS ARE SAME<br><input type="checkbox"/><br>↓ | NUMBERS ARE DIFFERENT <input type="checkbox"/><br>(PROBE AND RECONCILE) ← |       |
| 224 | CHECK 215: ENTER THE NUMBER OF BIRTHS IN 2006-2011 E.C.                                                     | NUMBER OF BIRTHS ..... <input type="text"/><br>NONE ..... 0               |       |
| 226 | Are you pregnant now?                                                                                       | YES ..... 1<br>NO ..... 2<br>UNSURE ..... 8                               | → 301 |
| 227 | How many months pregnant are you?<br><br>RECORD NUMBER OF COMPLETED MONTHS.                                 | MONTHS ..... <input type="text"/> <input type="text"/>                    |       |

SECTION 3. CONTRACEPTION

|           |                                                                                                                                                                                                        |                                                                                                                     |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| 301       | Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy. Have you ever heard of (METHOD)?                                     |                                                                                                                     |
| 01        | Female Sterilization.<br>PROBE: Women can have an operation to avoid having any more children.                                                                                                         | YES ..... 1<br>NO ..... 2                                                                                           |
| 02        | Male Sterilization.<br>PROBE: Men can have an operation to avoid having any more children.                                                                                                             | YES ..... 1<br>NO ..... 2                                                                                           |
| 03        | IUD.<br>PROBE: Women can have a loop or coil placed inside them by a doctor or a nurse which can prevent pregnancy for one or more years.                                                              | YES ..... 1<br>NO ..... 2                                                                                           |
| 04        | Injectables.<br>PROBE: Women can have an injection by a health provider that stops them from becoming pregnant for three months.                                                                       | YES ..... 1<br>NO ..... 2                                                                                           |
| 05        | Implants.<br>PROBE: Women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.                                            | YES ..... 1<br>NO ..... 2                                                                                           |
| 06        | Pill.<br>PROBE: Women can take a pill every day to avoid becoming pregnant.                                                                                                                            | YES ..... 1<br>NO ..... 2                                                                                           |
| 07        | Male Condom.<br>PROBE: Men can put a rubber sheath on their penis before sexual intercourse.                                                                                                           | YES ..... 1<br>NO ..... 2                                                                                           |
| 08        | Female Condom.<br>PROBE: Women can place a sheath in their vagina before sexual intercourse.                                                                                                           | YES ..... 1<br>NO ..... 2                                                                                           |
| 09<br>(1) | Emergency Contraception.<br>PROBE: As an emergency measure, within three days after they have unprotected sexual intercourse, women can take special pills to prevent pregnancy.                       | YES ..... 1<br>NO ..... 2                                                                                           |
| 10<br>(2) | Standard Days Method.<br>PROBE: A woman uses a string of colored beads to know the days she can get pregnant. On the days she can get pregnant, she uses a condom or does not have sexual intercourse. | YES ..... 1<br>NO ..... 2                                                                                           |
| 11<br>(3) | Lactational Amenorrhea Method (LAM).<br>PROBE: Up to six months after childbirth, before the menstrual period has returned, women use a method requiring frequent breastfeeding day and night.         | YES ..... 1<br>NO ..... 2                                                                                           |
| 12        | Rhythm Method.<br>PROBE: To avoid pregnancy, women do not have sexual intercourse on the days of the month they think they can get pregnant.                                                           | YES ..... 1<br>NO ..... 2                                                                                           |
| 13        | Withdrawal.<br>PROBE: Men can be careful and pull out before climax.                                                                                                                                   | YES ..... 1<br>NO ..... 2                                                                                           |
| 14        | Have you heard of any other ways or methods that women or men can use to avoid pregnancy?                                                                                                              | YES, MODERN METHOD<br><br>_____ A<br>(SPECIFY)<br>YES, TRADITIONAL METHOD<br><br>_____ B<br>(SPECIFY)<br>NO ..... Y |

## SECTION 3. CONTRACEPTION

| NO.  | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                                                             | CODING CATEGORIES                                                                                                                                                                                                                                                                                                                                                                                                  | SKIP                                                                  |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| 302  | CHECK 226:<br><br>NOT PREGNANT <input type="checkbox"/><br>OR UNSURE ↓                                                                                                                                                                                                                                            | PREGNANT <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                  | → 305                                                                 |
| 303  | Are you or your partner currently doing something or using any method to delay or avoid getting pregnant?                                                                                                                                                                                                         | YES ..... 1<br>NO ..... 2                                                                                                                                                                                                                                                                                                                                                                                          | → 305                                                                 |
| 304  | Which method are you using?<br><br>RECORD ALL MENTIONED.<br><br>IF MORE THAN ONE METHOD MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD IN LIST.                                                                                                                                                            | FEMALE STERILIZATION ..... A<br>MALE STERILIZATION ..... B<br>IUD ..... C<br>INJECTABLES ..... D<br>IMPLANTS ..... E<br>PILL ..... F<br>MALE CONDOM ..... G<br>FEMALE CONDOM ..... H<br>EMERGENCY CONTRACEPTION ..... I<br>STANDARD DAYS METHOD ..... J<br>LACTATIONAL AMENORRHEA METHOD ..... K<br>RHYTHM METHOD ..... L<br>WITHDRAWAL ..... M<br>OTHER MODERN METHOD ..... X<br>OTHER TRADITIONAL METHOD ..... Y | → 304A<br><br><br><br><br><br><br><br><br><br>→ 304B<br><br><br>→ 305 |
| 304A | Where did you obtain (METHOD FROM Q.304) the last time?<br><br>IF MORE THAN ONE METHOD CIRCLED IN Q.304 ASK ABOUT THE METHOD THAT IS HIGHEST IN<br><br>PROBE TO IDENTIFY THE TYPE OF SOURCE.<br><br>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.<br><br>_____ (NAME OF PLACE) | <b>PUBLIC SECTOR</b><br>GOVERNMENT HOSPITAL ..... 11<br>GOVERNMENT HEALTH CENTER ..... 12<br>GOVERNMENT HEALTH POST ..... 13<br>PUBLIC PHARMACY ..... 14<br>OTHER PUBLIC SECTOR<br>_____ 16<br>(SPECIFY)<br><b>NGO</b><br>NGO HEALTH FACILITY ..... 21<br>OTHER NGO<br>_____ 26<br>(SPECIFY)                                                                                                                       |                                                                       |
| 304B | Where did you learn to use the (METHOD FROM Q.304)?                                                                                                                                                                                                                                                               | <b>PRIVATE MEDICAL SECTOR</b><br>PRIVATE HOSPITAL ..... 31<br>PRIVATE CLINIC ..... 32<br>PHARMACY ..... 33<br>OTHER PRIVATE MEDICAL SECTOR<br>_____ 36<br>(SPECIFY)<br><b>OTHER SOURCE</b><br>SHOP ..... 41<br>FRIEND/RELATIVE ..... 42<br><br>OTHER _____ 96<br>(SPECIFY)                                                                                                                                         |                                                                       |
| 305  | Are you currently married or living together with a man as if married?                                                                                                                                                                                                                                            | YES, CURRENTLY MARRIED ..... 1<br>YES, LIVING WITH A MAN ..... 2<br>NO, NOT IN UNION ..... 3                                                                                                                                                                                                                                                                                                                       | → 401                                                                 |
| 306  | Have you ever been married or lived together with a man as if married?                                                                                                                                                                                                                                            | YES, FORMERLY MARRIED ..... 1<br>YES, LIVED WITH A MAN ..... 2<br>NO ..... 3                                                                                                                                                                                                                                                                                                                                       | → 401                                                                 |
| 307  | What is your marital status now: are you widowed, divorced, or separated?                                                                                                                                                                                                                                         | WIDOWED ..... 1<br>DIVORCED ..... 2<br>SEPARATED ..... 3                                                                                                                                                                                                                                                                                                                                                           |                                                                       |

SECTION 4. PREGNANCY AND POSTNATAL CARE

|     |                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| 401 | CHECK 224:<br>ONE OR MORE BIRTHS IN <input type="checkbox"/> 2006-2011 E.C.      NO BIRTHS IN <input type="checkbox"/> 2006-2011 E.C. → 615                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |
| 402 | CHECK 215. RECORD THE BIRTH HISTORY NUMBER IN 403 AND THE NAME AND SURVIVAL STATUS IN 404 FOR EACH BIRTH IN 2006-2011 E.C. ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH. IF THERE ARE MORE THAN 2 BIRTHS, USE LAST COLUMN OF ADDITIONAL QUESTIONNAIRE(S).<br><br>Now I would like to ask some questions about your children born in the last five years. (We will talk about each separately.) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |
| 403 | BIRTH HISTORY NUMBER FROM 212 IN BIRTH HISTORY.                                                                                                                                                                                                                                                                                                                                                                          | LAST BIRTH<br>BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                 | NEXT-TO-LAST BIRTH<br>BIRTH HISTORY NUMBER ..... <input type="text"/> <input type="text"/> |
| 404 | FROM 212 AND 216:                                                                                                                                                                                                                                                                                                                                                                                                        | NAME _____<br>LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                        | NAME _____<br>LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>                |
| 408 | Did you see anyone for antenatal care for this pregnancy?                                                                                                                                                                                                                                                                                                                                                                | YES ..... 1<br>NO ..... 2<br>(SKIP TO 420) ←                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |
| 409 | Whom did you see?<br><br>Anyone else?<br><br><br>PROBE TO IDENTIFY EACH TYPE OF PERSON AND RECORD ALL MENTIONED.                                                                                                                                                                                                                                                                                                         | <b>HEALTH PERSONNEL</b><br>DOCTOR ..... A<br>NURSE ..... B<br>MIDWIFE ..... C<br>HEALTH OFFICER ..... D<br>HEALTH EXTENSION WORKER ..... E<br><br><b>OTHER PERSON</b><br>TRADITIONAL BIRTH ATTENDANT ..... F<br>OTHER _____ X<br>(SPECIFY)                                                                                                                                                                                                                                                         |                                                                                            |
| 410 | Where did you receive antenatal care for this pregnancy?<br><br>Anywhere else?<br><br>PROBE TO IDENTIFY THE TYPE OF SOURCE.<br><br>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.<br><br>_____<br>(NAME OF PLACE)                                                                                                                                                                      | <b>HOME</b><br>HER HOME ..... A<br>OTHER HOME ..... B<br><br><b>PUBLIC SECTOR</b><br>GOVERNMENT HOSPITAL... C<br>GOVERNMENT HEALTH CENTER ..... D<br>GOVERNMENT HEALTH POST ..... E<br>OTHER PUBLIC SECTOR _____ F<br>(SPECIFY)<br><b>NGO</b><br>HEALTH FACILITY ..... G<br>OTHER NGO HEALTH FACILITY _____ H<br>(SPECIFY)<br><b>PRIVATE MEDICAL SECTOR</b><br>PRIVATE HOSPITAL..... I<br>PRIVATE CLINIC..... J<br>OTHER PRIVATE MEDICAL SECTOR ..... K<br>(SPECIFY)<br>OTHER _____ X<br>(SPECIFY) |                                                                                            |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO.                       | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                      | LAST BIRTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | NEXT-TO-LAST BIRTH |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--|-----|----|-------------|---|---|----------------|---|---|----------------|---|---|---------------------------|---|---|
|                           |                                                                                                                                                                                                                                                                            | NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | NAME _____         |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| 411                       | How many months pregnant were you when you first received antenatal care for this pregnancy?                                                                                                                                                                               | MONTHS ..... <input type="text"/> <input type="text"/><br>DON'T KNOW ..... 98                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| 412                       | How many times did you receive antenatal care during this pregnancy?                                                                                                                                                                                                       | NUMBER OF TIMES ..... <input type="text"/> <input type="text"/><br>DON'T KNOW ..... 98                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| 413                       | As part of your antenatal care during this pregnancy, were any of the following done at least once:<br>a) Was your blood pressure measured?<br>b) Did you give a urine sample?<br>c) Did you give a blood sample?<br>d) Did any health worker counsel you about nutrition? | <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>a) BP .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>b) URINE .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>c) BLOOD .....</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>d) NUTRITIONAL COUNSELING</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table> |                    |  | YES | NO | a) BP ..... | 1 | 2 | b) URINE ..... | 1 | 2 | c) BLOOD ..... | 1 | 2 | d) NUTRITIONAL COUNSELING | 1 | 2 |
|                           | YES                                                                                                                                                                                                                                                                        | NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| a) BP .....               | 1                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| b) URINE .....            | 1                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| c) BLOOD .....            | 1                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| d) NUTRITIONAL COUNSELING | 1                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| 414                       | During (any of) your antenatal care visits(s), were you told about the signs of pregnancy complications?                                                                                                                                                                   | YES ..... 1<br>NO ..... 2<br>(SKIP TO 420) ←<br>DON'T KNOW ..... 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| 415                       | Which signs of pregnancy complications were you told about?                                                                                                                                                                                                                | VAGINAL BLEEDING ..... A<br>VAGINAL GUSH OF FLUID ..... B<br>SEVERE HEAD ACHE ..... C<br>BLURRED VISION ..... D<br>FEVER ..... E<br>ABDOMINAL PAIN ..... F<br>CONVULSION ..... G<br><br>OTHER _____ X<br>(SPECIFY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| 420                       | During this pregnancy, were you given or did you buy any iron tablets?<br><br>SHOW TABLETS.                                                                                                                                                                                | YES ..... 1<br>NO ..... 2<br>(SKIP TO 429) ←<br>DON'T KNOW ..... 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |
| 421                       | During the whole pregnancy, for how many days did you take the tablets?<br><br>IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.                                                                                                                             | DAYS ..... <input type="text"/> <input type="text"/> <input type="text"/><br>DON'T KNOW ..... 998                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                    |  |     |    |             |   |   |                |   |   |                |   |   |                           |   |   |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                                                                                                                                   | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | NEXT-TO-LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 429 | <p>Who assisted with the delivery of (NAME)?</p> <p>Anyone else?</p> <p>PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED.</p> <p>IF RESPONDENT SAYS NO ONE ASSISTED, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.</p> | <p><b>HEALTH PERSONNEL</b></p> <p>DOCTOR ..... A</p> <p>NURSE ..... B</p> <p>MIDWIFE ..... C</p> <p>HEALTH OFFICER ..... D</p> <p>HEALTH EXTENSION WORKER ..... E</p> <p><b>OTHER PERSON</b></p> <p>TRADITIONAL BIRTH ATTENDANT ..... F</p> <p>OTHER _____ X<br/>(SPECIFY)</p> <p>NO ONE ASSISTED ..... Y</p>                                                                                                                                                                                                                                                                                                              | <p><b>HEALTH PERSONNEL</b></p> <p>DOCTOR ..... A</p> <p>NURSE ..... B</p> <p>MIDWIFE ..... C</p> <p>HEALTH OFFICER ..... D</p> <p>HEALTH EXTENSION WORKER ..... E</p> <p><b>OTHER PERSON</b></p> <p>TRADITIONAL BIRTH ATTENDANT ..... F</p> <p>OTHER _____ X<br/>(SPECIFY)</p> <p>NO ONE ASSISTED ..... Y</p>                                                                                                                                                                                                                                                                                                              |
| 430 | <p>Where did you give birth to (NAME)?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____ (NAME OF PLACE)</p>                                            | <p><b>HOME</b></p> <p>HER HOME ..... 11<br/>(SKIP TO 449) ←</p> <p>OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL... 21</p> <p>GOVERNMENT HEALTH CENTER ..... 22</p> <p>GOVERNMENT HEALTH POST ..... 23</p> <p>OTHER PUBLIC SECTOR _____ 26<br/>(SPECIFY)</p> <p><b>NGO</b></p> <p>HEALTH FACILITY ..... 31</p> <p>OTHER NGO HEALTH FACILITY _____ 36<br/>(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL..... 41</p> <p>PRIVATE CLINIC ..... 42</p> <p>OTHER PRIVATE MEDICAL SECTOR _____ 46<br/>(SPECIFY)</p> <p>OTHER _____ 96<br/>(SPECIFY)<br/>(SKIP TO 449) ←</p> | <p><b>HOME</b></p> <p>HER HOME ..... 11<br/>(SKIP TO 464) ←</p> <p>OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b></p> <p>GOVERNMENT HOSPITAL... 21</p> <p>GOVERNMENT HEALTH CENTER ..... 22</p> <p>GOVERNMENT HEALTH POST ..... 23</p> <p>OTHER PUBLIC SECTOR _____ 26<br/>(SPECIFY)</p> <p><b>NGO</b></p> <p>HEALTH FACILITY ..... 31</p> <p>OTHER NGO HEALTH FACILITY _____ 36<br/>(SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b></p> <p>PRIVATE HOSPITAL..... 41</p> <p>PRIVATE CLINIC ..... 42</p> <p>OTHER PRIVATE MEDICAL SECTOR _____ 46<br/>(SPECIFY)</p> <p>OTHER _____ 96<br/>(SPECIFY)<br/>(SKIP TO 464) ←</p> |
| 432 | <p>Was (NAME) delivered by caesarean, that is, did they cut your belly open to take the baby out?</p>                                                                                                                                                   | <p>YES ..... 1</p> <p>NO ..... 2</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p>YES ..... 1</p> <p>NO ..... 2</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                                                                                                                           | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                    | NEXT-TO-LAST BIRTH<br>NAME _____ |  |  |  |  |  |  |
|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|--|--|--|--|--|
| 435 | I would like to talk to you about checks on your health after delivery, for example, someone asking you questions about your health or examining you. Did anyone check on your health while you were still in the facility?                     | YES ..... 1<br>NO ..... 2<br>(SKIP TO 438) ←                                                                                                                                                                                                                                                                                                |                                  |  |  |  |  |  |  |
| 436 | How long after delivery did the first check take place?<br><br>IF LESS THAN ONE DAY,<br>RECORD HOURS;<br>IF LESS THAN ONE WEEK,<br>RECORD DAYS.                                                                                                 | HOURS ..... 1 <table border="1" data-bbox="911 456 1050 510"><tr><td> </td><td> </td></tr></table><br>DAYS ..... 2 <table border="1" data-bbox="911 517 1050 571"><tr><td> </td><td> </td></tr></table><br>WEEKS ..... 3 <table border="1" data-bbox="911 577 1050 631"><tr><td> </td><td> </td></tr></table><br>DON'T KNOW ..... 998       |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                             |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                             |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                             |                                  |  |  |  |  |  |  |
| 437 | Who checked on your health at that time?<br><br>PROBE FOR MOST QUALIFIED PERSON.                                                                                                                                                                | <b>HEALTH PERSONNEL</b><br>DOCTOR ..... 11<br>NURSE ..... 12<br>MIDWIFE ..... 13<br>HEALTH OFFICER ..... 14<br>HEALTH EXTENSION WORKER ..... 15<br><br><b>OTHER PERSON</b><br>TRADITIONAL BIRTH ATTENDANT ..... 21<br>OTHER _____ 96<br>(SPECIFY)                                                                                           |                                  |  |  |  |  |  |  |
| 438 | Now I would like to talk to you about checks on (NAME)'s health after delivery – for example, someone examining (NAME), checking the cord, or seeing if (NAME) is OK. Did anyone check on (NAME)'s health while you were still in the facility? | YES ..... 1<br>NO ..... 2<br>(SKIP TO 441) ←<br>DON'T KNOW ..... 8                                                                                                                                                                                                                                                                          |                                  |  |  |  |  |  |  |
| 439 | How long after delivery was (NAME)'s health first checked?<br><br>IF LESS THAN ONE DAY,<br>RECORD HOURS;<br>IF LESS THAN ONE WEEK,<br>RECORD DAYS.                                                                                              | HOURS ..... 1 <table border="1" data-bbox="911 1359 1050 1413"><tr><td> </td><td> </td></tr></table><br>DAYS ..... 2 <table border="1" data-bbox="911 1420 1050 1473"><tr><td> </td><td> </td></tr></table><br>WEEKS ..... 3 <table border="1" data-bbox="911 1480 1050 1534"><tr><td> </td><td> </td></tr></table><br>DON'T KNOW ..... 998 |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                             |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                             |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                             |                                  |  |  |  |  |  |  |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                   | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                              | NEXT-TO-LAST BIRTH<br>NAME _____ |  |  |  |  |  |  |  |
|-----|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|--|--|--|--|--|--|
| 440 | Who checked on (NAME)'s health at that time?<br><br>PROBE FOR MOST QUALIFIED PERSON.                                                    | <b>HEALTH PERSONNEL</b><br>DOCTOR ..... 11<br>NURSE ..... 12<br>MIDWIFE ..... 13<br>HEALTH OFFICER ..... 14<br>HEALTH EXTENSION WORKER ..... 15<br><br><b>OTHER PERSON</b><br>TRADITIONAL BIRTH ATTENDANT ..... 21<br><br>OTHER _____ 96<br>(SPECIFY)                                                                                 |                                  |  |  |  |  |  |  |  |
| 441 | Now I want to talk to you about what happened after you left the facility. Did anyone check on your health after you left the facility? | YES ..... 1<br>NO ..... 2<br>(SKIP TO 445) ←                                                                                                                                                                                                                                                                                          |                                  |  |  |  |  |  |  |  |
| 442 | How long after delivery did that check take place?<br><br>IF LESS THAN ONE DAY, RECORD HOURS;<br>IF LESS THAN ONE WEEK, RECORD DAYS.    | HOURS ..... 1 <table border="1" data-bbox="911 808 1050 864"><tr><td> </td><td> </td></tr></table><br>DAYS ..... 2 <table border="1" data-bbox="911 864 1050 920"><tr><td> </td><td> </td></tr></table><br>WEEKS ..... 3 <table border="1" data-bbox="911 920 1050 976"><tr><td> </td><td> </td></tr></table><br>DON'T KNOW ..... 998 |                                  |  |  |  |  |  |  |  |
|     |                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |  |  |
|     |                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |  |  |
|     |                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |  |  |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                                                                                                   | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NEXT-TO-LAST BIRTH<br>NAME _____ |
|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 443 | <p>Who checked on your health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>                                                                                                                                 | <p><b>HEALTH PERSONNEL</b><br/>           DOCTOR ..... 11<br/>           NURSE ..... 12<br/>           MIDWIFE ..... 13<br/>           HEALTH OFFICER ..... 14<br/>           HEALTH EXTENSION<br/>           WORKER ..... 15</p> <p><b>OTHER PERSON</b><br/>           TRADITIONAL BIRTH<br/>           ATTENDANT ..... 21</p> <p>OTHER _____ 96<br/>           (SPECIFY)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                  |
| 444 | <p>Where did the check take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____<br/>           (NAME OF PLACE)</p> | <p><b>HOME</b><br/>           HER HOME ..... 11<br/>           OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b><br/>           GOVERNMENT HOSPITAL... 21<br/>           GOVERNMENT HEALTH<br/>           CENTER ..... 22<br/>           GOVERNMENT HEALTH<br/>           POST ..... 23<br/>           OTHER PUBLIC SECTOR<br/>           _____ 26<br/>           (SPECIFY)</p> <p><b>NGO</b><br/>           HEALTH FACILITY ..... 31<br/>           OTHER NGO HEALTH<br/>           FACILITY<br/>           _____ 36<br/>           (SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b><br/>           PRIVATE HOSPITAL..... 41<br/>           PRIVATE CLINIC ..... 42<br/>           OTHER PRIVATE<br/>           MEDICAL SECTOR<br/>           _____ 46<br/>           (SPECIFY)</p> <p>OTHER _____ 96<br/>           (SPECIFY)</p> |                                  |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                                                                                                                    | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                              | NEXT-TO-LAST BIRTH<br>NAME _____ |  |  |  |  |  |  |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|--|--|--|--|--|
| 445 | I would like to talk to you about checks on (NAME)'s health after you left (FACILITY IN 430). Did any health care provider or a traditional birth attendant check on (NAME)'s health in the two months after you left (FACILITY IN 430)? | YES ..... 1<br>NO ..... 2<br>(SKIP TO 457) ←<br>DON'T KNOW ..... 8                                                                                                                                                                                                                                                                    |                                  |  |  |  |  |  |  |
| 446 | How many hours, days or weeks after the birth of (NAME) did that check take place?<br><br>IF LESS THAN ONE DAY, RECORD HOURS;<br>IF LESS THAN ONE WEEK, RECORD DAYS.                                                                     | HOURS ..... 1 <table border="1" data-bbox="911 443 1050 501"><tr><td> </td><td> </td></tr></table><br>DAYS ..... 2 <table border="1" data-bbox="911 501 1050 560"><tr><td> </td><td> </td></tr></table><br>WEEKS ..... 3 <table border="1" data-bbox="911 560 1050 618"><tr><td> </td><td> </td></tr></table><br>DON'T KNOW ..... 998 |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |  |
| 447 | Who checked on (NAME)'s health at that time?<br><br>PROBE FOR MOST QUALIFIED PERSON.                                                                                                                                                     | <b>HEALTH PERSONNEL</b><br>DOCTOR ..... 11<br>NURSE ..... 12<br>MIDWIFE ..... 13<br>HEALTH OFFICER ..... 14<br>HEALTH EXTENSION WORKER ..... 15<br><br><b>OTHER PERSON</b><br>TRADITIONAL BIRTH ATTENDANT ..... 21<br><br>OTHER _____ 96<br>(SPECIFY)                                                                                 |                                  |  |  |  |  |  |  |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                                                                                                        | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | NEXT-TO-LAST BIRTH<br>NAME _____ |  |  |  |  |  |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|--|--|--|--|
| 448 | <p>Where did this check of (NAME) take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____ (NAME OF PLACE)</p>          | <p><b>HOME</b><br/> HER HOME ..... 11<br/> OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b><br/> GOVERNMENT HOSPITAL... 21<br/> GOVERNMENT HEALTH CENTER ..... 22<br/> GOVERNMENT HEALTH POST ..... 23<br/> OTHER PUBLIC SECTOR<br/> _____ 26<br/> (SPECIFY)</p> <p><b>NGO</b><br/> HEALTH FACILITY ..... 31<br/> OTHER NGO HEALTH FACILITY<br/> _____ 36<br/> (SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b><br/> PRIVATE HOSPITAL..... 41<br/> PRIVATE CLINIC..... 42<br/> OTHER PRIVATE MEDICAL SECTOR<br/> _____ 46<br/> (SPECIFY)</p> <p>OTHER _____ 96<br/> (SPECIFY)</p> <p>(SKIP TO 457) ←</p> |                                  |  |  |  |  |  |
| 449 | <p>I would like to talk to you about checks on your health after delivery, for example, someone asking you questions about your health or examining you. Did anyone check on your health after you gave birth to (NAME)?</p> | <p>YES ..... 1<br/> NO ..... 2<br/> (SKIP TO 453) ←</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                  |  |  |  |  |  |
| 450 | <p>How long after delivery did the first check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS;<br/> IF LESS THAN ONE WEEK, RECORD DAYS.</p>                                                                           | <p>HOURS ..... 1 <table border="1" data-bbox="911 1406 1050 1473"><tr><td></td><td></td></tr></table></p> <p>DAYS ..... 2 <table border="1" data-bbox="911 1473 1050 1541"><tr><td></td><td></td></tr></table></p> <p>WEEKS ..... 3 <table border="1" data-bbox="911 1541 1050 1608"><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW ..... 998</p>                                                                                                                                                                                                                                              |                                  |  |  |  |  |  |
|     |                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |
|     |                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |
|     |                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |  |  |  |  |  |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                                                                                                  | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | NEXT-TO-LAST BIRTH<br>NAME _____ |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| 451 | <p>Who checked on your health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>                                                                                                                                | <p><b>HEALTH PERSONNEL</b><br/>           DOCTOR ..... 11<br/>           NURSE ..... 12<br/>           MIDWIFE ..... 13<br/>           HEALTH OFFICER ..... 14<br/>           HEALTH EXTENSION<br/>           WORKER ..... 15</p> <p><b>OTHER PERSON</b><br/>           TRADITIONAL BIRTH<br/>           ATTENDANT ..... 21</p> <p>OTHER _____ 96<br/>           (SPECIFY)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                  |
| 452 | <p>Where did this first check take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p>(NAME OF PLACE)</p> | <p><b>HOME</b><br/>           HER HOME ..... 11<br/>           OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b><br/>           GOVERNMENT HOSPITAL . . 21<br/>           GOVERNMENT HEALTH<br/>           CENTER ..... 22<br/>           GOVERNMENT HEALTH<br/>           POST ..... 23<br/>           OTHER PUBLIC SECTOR<br/>           _____ 26<br/>           (SPECIFY)</p> <p><b>NGO</b><br/>           HEALTH FACILITY ..... 31<br/>           OTHER NGO HEALTH<br/>           FACILITY<br/>           _____ 36<br/>           (SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b><br/>           PRIVATE HOSPITAL ..... 41<br/>           PRIVATE CLINIC ..... 42<br/>           OTHER PRIVATE<br/>           MEDICAL SECTOR<br/>           _____ 46<br/>           (SPECIFY)</p> <p>OTHER _____ 96<br/>           (SPECIFY)</p> |                                  |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                                              | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                | NEXT-TO-LAST BIRTH<br>NAME _____ |  |  |  |  |  |  |  |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|--|--|--|--|--|--|
| 453 | I would like to talk to you about checks on (NAME)'s health after delivery – for example, someone examining (NAME), checking the cord, or seeing if (NAME) is OK. In the two months after (NAME) was born, did any health care provider or a traditional birth attendant check on (NAME)'s health? | YES ..... 1<br>NO ..... 2<br>(SKIP TO 457) ←<br>DON'T KNOW ..... 8                                                                                                                                                                                                                                                                                                                                                                                      |                                  |  |  |  |  |  |  |  |
| 454 | How many hours, days or weeks after the birth of (NAME) did the first check take place?<br><br>IF LESS THAN ONE DAY,<br>RECORD HOURS;<br>IF LESS THAN ONE WEEK,<br>RECORD DAYS.                                                                                                                    | HOURS AFTER BIRTH ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table><br>DAYS AFTER BIRTH ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table><br>WEEKS AFTER BIRTH ..... 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table><br>DON'T KNOW ..... 998 |                                  |  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  |  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  |  |  |  |  |  |  |  |
|     |                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                  |  |  |  |  |  |  |  |
| 455 | Who checked on (NAME)'s health at that time?<br><br>PROBE FOR MOST QUALIFIED PERSON.                                                                                                                                                                                                               | <b>HEALTH PERSONNEL</b><br>DOCTOR ..... 11<br>NURSE ..... 12<br>MIDWIFE ..... 13<br>HEALTH OFFICER ..... 14<br>HEALTH EXTENSION WORKER ..... 15<br><br><b>OTHER PERSON</b><br>TRADITIONAL BIRTH ATTENDANT ..... 21<br><br>OTHER _____ 96<br>(SPECIFY)                                                                                                                                                                                                   |                                  |  |  |  |  |  |  |  |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO.                    | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                                                 | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NEXT-TO-LAST BIRTH<br>NAME _____     |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----|----|----|--------------|---|---|---|---------------|---|---|---|---------------|---|---|---|------------------------|---|---|---|------------------------|---|---|---|--|
| 456                    | <p>Where did this first check of (NAME) take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____ (NAME OF PLACE)</p>                                                                             | <p><b>HOME</b><br/> HER HOME ..... 11<br/> OTHER HOME ..... 12</p> <p><b>PUBLIC SECTOR</b><br/> GOVERNMENT HOSPITAL... 21<br/> GOVERNMENT HEALTH CENTER ..... 22<br/> GOVERNMENT HEALTH POST ..... 23<br/> OTHER PUBLIC SECTOR<br/> _____ 26<br/> (SPECIFY)</p> <p><b>NGO</b><br/> HEALTH FACILITY ..... 31<br/> OTHER NGO HEALTH FACILITY<br/> _____ 36<br/> (SPECIFY)</p> <p><b>PRIVATE MEDICAL SECTOR</b><br/> PRIVATE HOSPITAL..... 41<br/> PRIVATE CLINIC ..... 42<br/> OTHER PRIVATE MEDICAL SECTOR<br/> _____ 46<br/> (SPECIFY)</p> <p>OTHER _____ 96<br/> (SPECIFY)</p> |                                      |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |
| 457                    | <p>During the first two days after (NAME)'s birth, did any health care provider do the following:</p> <p>a) Examine the cord?<br/> b) Measure (NAME)'s temperature?<br/> c) Counsel you on danger signs for newborns?<br/> d) Counsel you on breastfeeding?<br/> e) Observe (NAME) breastfeeding?</p> | <table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>a) CORD.....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) TEMP. ....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>c) SIGNS ....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>d) COUNSEL BREAST-FEED</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>e) OBSERVE BREAST-FEED</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>                                                                                         |                                      | YES | NO | DK | a) CORD..... | 1 | 2 | 8 | b) TEMP. .... | 1 | 2 | 8 | c) SIGNS .... | 1 | 2 | 8 | d) COUNSEL BREAST-FEED | 1 | 2 | 8 | e) OBSERVE BREAST-FEED | 1 | 2 | 8 |  |
|                        | YES                                                                                                                                                                                                                                                                                                   | NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DK                                   |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |
| a) CORD.....           | 1                                                                                                                                                                                                                                                                                                     | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8                                    |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |
| b) TEMP. ....          | 1                                                                                                                                                                                                                                                                                                     | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8                                    |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |
| c) SIGNS ....          | 1                                                                                                                                                                                                                                                                                                     | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8                                    |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |
| d) COUNSEL BREAST-FEED | 1                                                                                                                                                                                                                                                                                                     | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8                                    |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |
| e) OBSERVE BREAST-FEED | 1                                                                                                                                                                                                                                                                                                     | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 8                                    |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |
| 464                    | <p>Did you ever breastfeed (NAME)?</p>                                                                                                                                                                                                                                                                | <p>YES ..... 1<br/> (SKIP TO 466) ←</p> <p>NO ..... 2</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p>YES ..... 1</p> <p>NO ..... 2</p> |     |    |    |              |   |   |   |               |   |   |   |               |   |   |   |                        |   |   |   |                        |   |   |   |  |

SECTION 4. PREGNANCY AND POSTNATAL CARE

| NO. | QUESTIONS AND FILTERS                                                                                                                                                          | LAST BIRTH<br>NAME _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | NEXT-TO-LAST BIRTH<br>NAME _____                                                              |                                                                                         |  |  |  |  |  |  |  |  |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|
| 465 | CHECK 404: IS CHILD LIVING?                                                                                                                                                    | LIVING <input type="checkbox"/> DEAD <input type="checkbox"/><br>(SKIP TO 470) ←      (SKIP TO 471) ←                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |                                                                                         |  |  |  |  |  |  |  |  |
| 466 | How long after birth did you first put (NAME) to the breast?<br><br>IF LESS THAN 1 HOUR, RECORD '00' HOURS;<br>IF LESS THAN 24 HOURS, RECORD HOURS;<br>OTHERWISE, RECORD DAYS. | IMMEDIATELY ..... 000<br><br>HOURS ..... 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table><br><br>DAYS ..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> |                                                                                               |                                                                                         |  |  |  |  |  |  |  |  |
|     |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                         |  |  |  |  |  |  |  |  |
|     |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                         |  |  |  |  |  |  |  |  |
|     |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                         |  |  |  |  |  |  |  |  |
|     |                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                         |  |  |  |  |  |  |  |  |
| 467 | In the first three days after delivery, was (NAME) given anything to drink other than breast milk?                                                                             | YES ..... 1<br>NO ..... 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                         |  |  |  |  |  |  |  |  |
| 468 | CHECK 404: IS CHILD LIVING?                                                                                                                                                    | LIVING <input type="checkbox"/> DEAD <input type="checkbox"/><br>↓      (SKIP TO 471) ←                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               | LIVING <input type="checkbox"/> DEAD <input type="checkbox"/><br>↓      (SKIP TO 471) ← |  |  |  |  |  |  |  |  |
| 469 | Are you still breastfeeding (NAME)?                                                                                                                                            | YES ..... 1<br>NO ..... 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |                                                                                         |  |  |  |  |  |  |  |  |
| 470 | Did (NAME) drink anything from a bottle with a nipple yesterday or last night?                                                                                                 | YES ..... 1<br>NO ..... 2<br>DON'T KNOW ..... 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | YES ..... 1<br>NO ..... 2<br>DON'T KNOW ..... 8                                               |                                                                                         |  |  |  |  |  |  |  |  |
| 471 |                                                                                                                                                                                | GO BACK TO 429 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 479.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | GO BACK TO 429 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 479. |                                                                                         |  |  |  |  |  |  |  |  |

SECTION 4. CHILD NUTRITION

| NO.      | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | CODING CATEGORIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | SKIP |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
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| 479      | <p>CHECK 215 AND 218, ALL ROWS: NUMBER OF CHILDREN BORN IN 2009-2011 E.C. LIVING WITH THE RESPONDENT</p> <p>ONE OR MORE <input type="checkbox"/>      NONE <input type="checkbox"/></p> <p>(NAME OF YOUNGEST CHILD LIVING WITH HER)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 501A |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| 480      | <p>Now I would like to ask you about liquids or foods that (NAME FROM 479) had yesterday during the day or at night. I am interested in whether your child had the item I mention even if it was combined with other foods. Did (NAME FROM 479) drink or eat:</p> <p>a) Plain water?</p> <p>b) Juice or juice drinks?</p> <p>c) Clear broth?</p> <p>d) Milk such as tinned, powdered, or fresh animal milk?<br/>IF YES: How many times did (NAME) drink milk? IF 7 OR MORE TIMES, RECORD '7'.</p> <p>e) Infant formula such as Plan, S-26?<br/>IF YES: How many times did (NAME) drink infant formula? IF 7 OR MORE TIMES, RECORD '7'.</p> <p>f) Any other liquids?</p> <p>g) Yogurt?<br/>IF YES: How many times did (NAME) eat yogurt? IF 7 OR MORE TIMES, RECORD '7'.</p> <p>h) Any commercially fortified baby food such as Fafa, Hilina, Cerilak, Cerifam, Mother Choice?</p> <p>i) Injera, bread, rice, noodles, porridge, or other foods made from grains such as tef, oats, maize, barley,</p> <p>j) Pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside?</p> <p>k) White potatoes, white yams, manioc, cassava, or any other foods made from roots?</p> <p>l) Any dark green, leafy vegetables?</p> <p>m) Ripe mangoes or papayas?</p> <p>n) Any other fruits or vegetables?</p> <p>o) Liver, kidney, heart, or other organ meats?</p> <p>p) Any meat, such as beef, pork, lamb, goat, chicken, or duck?</p> <p>q) Eggs?</p> <p>r) Fresh or dried fish or shellfish?</p> <p>s) Any foods made from beans, peas, lentils, or nuts?</p> <p>t) Cheese or other food made from milk?</p> <p>u) Any other solid, semi-solid, or soft food?</p> | <table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>a) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>c) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>d) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td></td> <td colspan="3">NUMBER OF TIMES DRANK <input type="checkbox"/></td> </tr> <tr> <td>e) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td></td> <td colspan="3">NUMBER OF TIMES DRANK <input type="checkbox"/></td> </tr> <tr> <td>f) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>g) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td></td> <td colspan="3">NUMBER OF TIMES ATE <input type="checkbox"/></td> </tr> <tr> <td>h) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>i) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>j) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>k) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>l) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>m) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>n) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>o) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>p) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>q) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>r) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>s) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>t) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>u) .....</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table> |      | YES | NO | DK | a) ..... | 1 | 2 | 8 | b) ..... | 1 | 2 | 8 | c) ..... | 1 | 2 | 8 | d) ..... | 1 | 2 | 8 |  | NUMBER OF TIMES DRANK <input type="checkbox"/> |  |  | e) ..... | 1 | 2 | 8 |  | NUMBER OF TIMES DRANK <input type="checkbox"/> |  |  | f) ..... | 1 | 2 | 8 | g) ..... | 1 | 2 | 8 |  | NUMBER OF TIMES ATE <input type="checkbox"/> |  |  | h) ..... | 1 | 2 | 8 | i) ..... | 1 | 2 | 8 | j) ..... | 1 | 2 | 8 | k) ..... | 1 | 2 | 8 | l) ..... | 1 | 2 | 8 | m) ..... | 1 | 2 | 8 | n) ..... | 1 | 2 | 8 | o) ..... | 1 | 2 | 8 | p) ..... | 1 | 2 | 8 | q) ..... | 1 | 2 | 8 | r) ..... | 1 | 2 | 8 | s) ..... | 1 | 2 | 8 | t) ..... | 1 | 2 | 8 | u) ..... | 1 | 2 | 8 |  |
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| a) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| b) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| c) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| d) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
|          | NUMBER OF TIMES DRANK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| e) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
|          | NUMBER OF TIMES DRANK <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| f) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| g) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
|          | NUMBER OF TIMES ATE <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| h) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| i) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| j) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| k) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| l) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| m) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| n) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| o) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| p) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| q) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| r) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| s) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| t) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| u) ..... | 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 8    |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| 481      | <p>CHECK 480 (CATEGORIES 'g' THROUGH 'u'):</p> <p>NOT A SINGLE 'YES' <input type="checkbox"/>      AT LEAST ONE 'YES' <input type="checkbox"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 483  |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| 482      | <p>Did (NAME FROM 479) eat any solid, semi-solid, or soft foods yesterday during the day or at night?</p> <p>IF 'YES' PROBE: What kind of solid, semi-solid or soft foods did (NAME) eat?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p>YES ..... 1</p> <p>(GO BACK TO 480 TO RECORD FOOD EATEN YESTERDAY)</p> <p>(THEN CONTINUE TO 483)</p> <p>NO ..... 2</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 501A |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |
| 483      | <p>How many times did (NAME FROM 479) eat solid, semi-solid, or soft foods yesterday during the day or at night?</p> <p>IF 7 OR MORE TIMES, RECORD '7'.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <p>NUMBER OF TIMES ..... <input type="checkbox"/></p> <p>DON'T KNOW ..... 8</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |      |     |    |    |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |                                                |  |  |          |   |   |   |  |                                                |  |  |          |   |   |   |          |   |   |   |  |                                              |  |  |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |          |   |   |   |  |

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

| NO.  | QUESTIONS AND FILTERS                                                                                                                                                                       | CODING CATEGORIES                                                                                                                                                | SKIP             |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| 501A | CHECK 215 IN THE BIRTH HISTORY: ANY BIRTHS IN 2008-2011 E.C.?<br>ONE OR MORE BIRTHS <input type="checkbox"/> IN 2008-2011 E.C. ↓ NO BIRTHS IN 2008-2011 E.C. <input type="checkbox"/>       |                                                                                                                                                                  | → 616            |
| 502A | RECORD THE NAME AND BIRTH HISTORY NUMBER FROM 212 OF THE LAST CHILD BORN IN 2008-2011 E.C.<br>NAME OF LAST BIRTH _____ BIRTH HISTORY NUMBER. .... <input type="text"/> <input type="text"/> |                                                                                                                                                                  |                  |
| 503A | CHECK 216 FOR CHILD:<br>LIVING <input type="checkbox"/> ↓ DEAD <input type="checkbox"/>                                                                                                     |                                                                                                                                                                  | → 501B           |
| 504A | Do you have a card, mother and child book, or other document where (NAME)'s vaccinations are written down?                                                                                  | YES, HAS ONLY A CARD ..... 1<br>YES, HAS ONLY AN OTHER DOCUMENT ..... 2<br>YES, HAS CARD AND OTHER DOCUMENT ..... 3<br>NO, NO CARD AND NO OTHER DOCUMENT ..... 4 | → 507A<br>→ 507A |
| 505A | Did you ever have a vaccination card or mother and child book for (NAME)?                                                                                                                   | YES ..... 1<br>NO ..... 2                                                                                                                                        |                  |
| 506A | CHECK 504A:<br>CODE '2' CIRCLED <input type="checkbox"/> ↓ CODE '4' CIRCLED <input type="checkbox"/>                                                                                        |                                                                                                                                                                  | → 511A           |
| 507A | May I see the card, mother and child book or other document where (NAME)'s vaccinations are written down?                                                                                   | YES, ONLY CARD SEEN ..... 1<br>YES, ONLY OTHER DOCUMENT SEEN ..... 2<br>YES, CARD AND OTHER DOCUMENT SEEN ..... 3<br>NO CARD AND NO OTHER DOCUMENT SEEN ..... 4  | → 511A           |

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

| NO.                                     | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | CODING CATEGORIES                                                                                                                                                                                                                                                                                               | SKIP   |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
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|                                         | NAME OF LAST BIRTH _____ BIRTH HISTORY NUMBER. .... <input type="text"/> <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 508A                                    | COPY DATES FROM THE CARD.<br>WRITE '44' IN 'DAY' COLUMN IF CARD SHOWS THAT A DOSE WAS GIVEN, BUT NO DATE IS RECORDED.<br><br><table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>DAY</th> <th>MONTH</th> <th>YEAR</th> </tr> </thead> <tbody> <tr><td>BCG</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 1</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 2</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 3</td><td></td><td></td><td></td></tr> <tr><td>INACTIVATED POLIO VACCINE (IPV)</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP.B-HIB/Pentavalent 1</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP.B-HIB/Pentavalent 2</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP.B-HIB/Pentavalent 3</td><td></td><td></td><td></td></tr> <tr><td>PCV/Pneumoccal 1</td><td></td><td></td><td></td></tr> <tr><td>PCV/Pneumoccal 2</td><td></td><td></td><td></td></tr> <tr><td>PCV/Pneumoccal 3</td><td></td><td></td><td></td></tr> <tr><td>ROTAVIRUS 1</td><td></td><td></td><td></td></tr> <tr><td>ROTAVIRUS 2</td><td></td><td></td><td></td></tr> <tr><td>MEASLES 1</td><td></td><td></td><td></td></tr> <tr><td>MEASLES 2</td><td></td><td></td><td></td></tr> <tr><td>VITAMIN A (MOST RECENT)</td><td></td><td></td><td></td></tr> </tbody> </table> |                                                                                                                                                                                                                                                                                                                 | DAY    | MONTH | YEAR | BCG |  |  |  | ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE) |  |  |  | ORAL POLIO VACCINE (OPV) 1 |  |  |  | ORAL POLIO VACCINE (OPV) 2 |  |  |  | ORAL POLIO VACCINE (OPV) 3 |  |  |  | INACTIVATED POLIO VACCINE (IPV) |  |  |  | DPT-HEP.B-HIB/Pentavalent 1 |  |  |  | DPT-HEP.B-HIB/Pentavalent 2 |  |  |  | DPT-HEP.B-HIB/Pentavalent 3 |  |  |  | PCV/Pneumoccal 1 |  |  |  | PCV/Pneumoccal 2 |  |  |  | PCV/Pneumoccal 3 |  |  |  | ROTAVIRUS 1 |  |  |  | ROTAVIRUS 2 |  |  |  | MEASLES 1 |  |  |  | MEASLES 2 |  |  |  | VITAMIN A (MOST RECENT) |  |  |  |  |  |
|                                         | DAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MONTH                                                                                                                                                                                                                                                                                                           | YEAR   |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| BCG                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ORAL POLIO VACCINE (OPV) 1              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ORAL POLIO VACCINE (OPV) 2              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ORAL POLIO VACCINE (OPV) 3              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| INACTIVATED POLIO VACCINE (IPV)         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| DPT-HEP.B-HIB/Pentavalent 1             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| DPT-HEP.B-HIB/Pentavalent 2             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| DPT-HEP.B-HIB/Pentavalent 3             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| PCV/Pneumoccal 1                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| PCV/Pneumoccal 2                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| PCV/Pneumoccal 3                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ROTAVIRUS 1                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ROTAVIRUS 2                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| MEASLES 1                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| MEASLES 2                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| VITAMIN A (MOST RECENT)                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 509A                                    | CHECK 508A: 'BCG' TO 'MEASLES 2' ALL RECORDED?<br>NO <input type="checkbox"/> ↓ YES <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                 | → 525A |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 510A                                    | In addition to what is recorded on (this document/these documents), did (NAME) receive any other vaccinations, including vaccinations received in campaigns or immunization days or child health days?<br><br>RECORD 'YES' ONLY IF THE RESPONDENT MENTIONS AT LEAST ONE OF THE VACCINATIONS IN 508A THAT ARE NOT RECORDED AS HAVING BEEN GIVEN.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | YES ..... 1<br>(PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 508A THEN WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL (THEN SKIP TO 525A)<br>NO ..... 2<br>DONT KNOW ..... 8<br>(WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN) (THEN SKIP TO 525A) | → 525A |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 511A                                    | Did (NAME) ever receive any vaccinations to prevent (NAME) from getting diseases, including vaccinations received in campaigns or immunization days or child health days?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  | → 525A |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 512A                                    | Has (NAME) ever received a BCG vaccination against tuberculosis, that is, an injection in the right arm or shoulder that usually causes a scar?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 514A                                    | Has (NAME) ever received oral polio vaccine, that is, about two drops in the mouth to prevent polio?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  | → 517A |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 515A                                    | Did (NAME) receive the first oral polio vaccine in the first two weeks after birth or later?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | FIRST TWO WEEKS ..... 1<br>LATER ..... 2                                                                                                                                                                                                                                                                        |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 516A                                    | How many times did (NAME) receive the oral polio vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | NUMBER OF TIMES ..... <input type="text"/>                                                                                                                                                                                                                                                                      |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 516A1                                   | The last time (NAME) received the polio drops, did (NAME) also get an IPV injection in the right thigh to protect against polio?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 517A                                    | Has (NAME) ever received a DPT-HEP.B-HIB/Pentavalent vaccination, that is, an injection given in the left thigh sometimes at the same time as polio?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  | → 519A |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 518A                                    | How many times did (NAME) receive the DPT-HEP.B-HIB/Pentavalent vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | NUMBER OF TIMES ..... <input type="text"/>                                                                                                                                                                                                                                                                      |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 519A                                    | Has (NAME) ever received a PCV/Pneumoccal vaccination, that is, an injection in the right thigh to prevent pneumonia?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  | → 521A |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 520A                                    | How many times did (NAME) receive the PCV/Pneumoccal vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | NUMBER OF TIMES ..... <input type="text"/>                                                                                                                                                                                                                                                                      |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 521A                                    | Has (NAME) ever received a rotavirus vaccination, that is, liquid in the mouth to prevent diarrhea?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  | → 523A |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 522A                                    | How many times did (NAME) receive the rotavirus vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | NUMBER OF TIMES ..... <input type="text"/>                                                                                                                                                                                                                                                                      |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 523A                                    | Has (NAME) ever received a measles vaccination, that is, an injection in the left arm to prevent measles?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  | → 525A |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 524A                                    | How many times did (NAME) receive the measles vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NUMBER OF TIMES ..... <input type="text"/>                                                                                                                                                                                                                                                                      |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 525A                                    | In the last six months, was (NAME) given a vitamin A dose like [this/any of these]?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                                                  |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 526A                                    | CONTINUE WITH 501B.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                 |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                  |  |  |  |                  |  |  |  |                  |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |

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

| NO.  | QUESTIONS AND FILTERS                                                                                                                                                                  | CODING CATEGORIES                                                                                                                                                | SKIP             |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| 501B | CHECK 215 IN THE BIRTH HISTORY: ANY MORE BIRTHS IN 2008-2011 E.C.?<br>MORE BIRTHS IN 2008-2011 E.C. <input type="checkbox"/> NO MORE BIRTHS IN 2008-2011 E.C. <input type="checkbox"/> |                                                                                                                                                                  | → 600            |
| 502B | RECORD THE NAME AND BIRTH HISTORY NUMBER FROM 212 OF THE NEXT-TO-LAST CHILD BORN IN 2008-2011 E.C.<br>NAME OF NEXT-TO-LAST BIRTH _____ BIRTH HISTORY NUMBER..... <input type="text"/>  |                                                                                                                                                                  |                  |
| 503B | CHECK 216 FOR CHILD:<br>LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>                                                                                                  |                                                                                                                                                                  | → 526B           |
| 504B | Do you have a card, mother and child book, or other document where (NAME)'s vaccinations are written down?                                                                             | YES, HAS ONLY A CARD ..... 1<br>YES, HAS ONLY AN OTHER DOCUMENT ..... 2<br>YES, HAS CARD AND OTHER DOCUMENT ..... 3<br>NO, NO CARD AND NO OTHER DOCUMENT ..... 4 | → 507B<br>→ 507B |
| 505B | Did you ever have a vaccination card or mother and child book for (NAME)?                                                                                                              | YES ..... 1<br>NO ..... 2                                                                                                                                        |                  |
| 506B | CHECK 504B:<br>CODE '2' CIRCLED <input type="checkbox"/> CODE '4' CIRCLED <input type="checkbox"/>                                                                                     |                                                                                                                                                                  | → 511B           |
| 507B | May I see the card, mother and child book, or other document where (NAME)'s vaccinations are written down?                                                                             | YES, ONLY CARD SEEN ..... 1<br>YES, ONLY OTHER DOCUMENT SEEN ..... 2<br>YES, CARD AND OTHER DOCUMENT SEEN ..... 3<br>NO CARD AND NO OTHER DOCUMENT SEEN ..... 4  | → 511B           |

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

| NO.                                     | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CODING CATEGORIES                                                                                                                                                                                                                                                                            | SKIP   |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------|------|-----|--|--|--|-----------------------------------------|--|--|--|----------------------------|--|--|--|----------------------------|--|--|--|----------------------------|--|--|--|---------------------------------|--|--|--|-----------------------------|--|--|--|-----------------------------|--|--|--|-----------------------------|--|--|--|--------------------|--|--|--|--------------------|--|--|--|--------------------|--|--|--|-------------|--|--|--|-------------|--|--|--|-----------|--|--|--|-----------|--|--|--|-------------------------|--|--|--|--|--|
|                                         | NAME OF NEXT-TO-LAST BIRTH _____ BIRTH HISTORY NUMBER..... <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 508B                                    | COPY DATES FROM THE CARD.<br>WRITE '44' IN 'DAY' COLUMN IF CARD SHOWS THAT A DOSE WAS GIVEN, BUT NO DATE IS RECORDED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
|                                         | <table border="1"> <thead> <tr> <th></th> <th>DAY</th> <th>MONTH</th> <th>YEAR</th> </tr> </thead> <tbody> <tr><td>BCG</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 1</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 2</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 3</td><td></td><td></td><td></td></tr> <tr><td>INACTIVATED POLIO VACCINE (IPV)</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP-B-HIB/Pentavalent 1</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP-B-HIB/Pentavalent 2</td><td></td><td></td><td></td></tr> <tr><td>DPT-HEP-B-HIB/Pentavalent 3</td><td></td><td></td><td></td></tr> <tr><td>PCV/Pneumococcal 1</td><td></td><td></td><td></td></tr> <tr><td>PCV/Pneumococcal 2</td><td></td><td></td><td></td></tr> <tr><td>PCV/Pneumococcal 3</td><td></td><td></td><td></td></tr> <tr><td>ROTAVIRUS 1</td><td></td><td></td><td></td></tr> <tr><td>ROTAVIRUS 2</td><td></td><td></td><td></td></tr> <tr><td>MEASLES 1</td><td></td><td></td><td></td></tr> <tr><td>MEASLES 2</td><td></td><td></td><td></td></tr> <tr><td>VITAMIN A (MOST RECENT)</td><td></td><td></td><td></td></tr> </tbody> </table> |                                                                                                                                                                                                                                                                                              | DAY    | MONTH | YEAR | BCG |  |  |  | ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE) |  |  |  | ORAL POLIO VACCINE (OPV) 1 |  |  |  | ORAL POLIO VACCINE (OPV) 2 |  |  |  | ORAL POLIO VACCINE (OPV) 3 |  |  |  | INACTIVATED POLIO VACCINE (IPV) |  |  |  | DPT-HEP-B-HIB/Pentavalent 1 |  |  |  | DPT-HEP-B-HIB/Pentavalent 2 |  |  |  | DPT-HEP-B-HIB/Pentavalent 3 |  |  |  | PCV/Pneumococcal 1 |  |  |  | PCV/Pneumococcal 2 |  |  |  | PCV/Pneumococcal 3 |  |  |  | ROTAVIRUS 1 |  |  |  | ROTAVIRUS 2 |  |  |  | MEASLES 1 |  |  |  | MEASLES 2 |  |  |  | VITAMIN A (MOST RECENT) |  |  |  |  |  |
|                                         | DAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | MONTH                                                                                                                                                                                                                                                                                        | YEAR   |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| BCG                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ORAL POLIO VACCINE (OPV) 1              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ORAL POLIO VACCINE (OPV) 2              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ORAL POLIO VACCINE (OPV) 3              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| INACTIVATED POLIO VACCINE (IPV)         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| DPT-HEP-B-HIB/Pentavalent 1             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| DPT-HEP-B-HIB/Pentavalent 2             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| DPT-HEP-B-HIB/Pentavalent 3             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| PCV/Pneumococcal 1                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| PCV/Pneumococcal 2                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| PCV/Pneumococcal 3                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ROTAVIRUS 1                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| ROTAVIRUS 2                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| MEASLES 1                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| MEASLES 2                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| VITAMIN A (MOST RECENT)                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                              |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 509B                                    | CHECK 508B: 'BCG' TO 'MEASLES 2' ALL RECORDED?<br>NO <input type="checkbox"/> YES <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                              | → 525B |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 510B                                    | In addition to what is recorded on (this document/these documents), did (NAME) receive any other vaccinations, including vaccinations received in campaigns or immunization days or child health days?<br><br>RECORD 'YES' ONLY IF THE RESPONDENT MENTIONS AT LEAST ONE OF THE VACCINATIONS IN 508B THAT ARE NOT RECORDED AS HAVING BEEN GIVEN.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | YES ..... 1<br>(PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 508B THEN WRITE '00' IN THE CORRESPONDING (THEN SKIP TO 525B)<br>NO ..... 2<br>DONT KNOW ..... 8<br>(WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN) (THEN SKIP TO 525B) | → 525B |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 511B                                    | Did (NAME) ever receive any vaccinations to prevent (NAME) from getting diseases, including vaccinations received in campaigns or immunization days or child health days?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               | → 525B |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 512B                                    | Has (NAME) ever received a BCG vaccination against tuberculosis, that is, an injection in the right arm or shoulder that usually causes a scar?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 514B                                    | Has (NAME) ever received oral polio vaccine, that is, about two drops in the mouth to prevent polio?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               | → 517B |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 515B                                    | Did (NAME) receive the first oral polio vaccine in the first two weeks after birth or later?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | FIRST TWO WEEKS ..... 1<br>LATER ..... 2                                                                                                                                                                                                                                                     |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 516B                                    | How many times did (NAME) receive the oral polio vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | NUMBER OF TIMES <input type="text"/>                                                                                                                                                                                                                                                         |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 516B1                                   | The last time (NAME) received the polio drops, did (NAME) also get an IPV injection in the right thigh to protect against polio?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 517B                                    | Has (NAME) ever received a DPT-HEP-B-HIB/Pentavalent vaccination, that is, an injection given in the left thigh sometimes at the same time as polio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               | → 519B |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 518B                                    | How many times did (NAME) receive the DPT-HEP-B-HIB/Pentavalent vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NUMBER OF TIMES <input type="text"/>                                                                                                                                                                                                                                                         |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 519B                                    | Has (NAME) ever received a PCV/Pneumococcal vaccination, that is, an injection in the right thigh to prevent pneumonia?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               | → 521B |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 520B                                    | How many times did (NAME) receive the PCV/Pneumococcal vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | NUMBER OF TIMES <input type="text"/>                                                                                                                                                                                                                                                         |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 521B                                    | Has (NAME) ever received a rotavirus vaccination, that is, liquid in the mouth to prevent diarrhea?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               | → 523B |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 522B                                    | How many times did (NAME) receive the rotavirus vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | NUMBER OF TIMES <input type="text"/>                                                                                                                                                                                                                                                         |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 523B                                    | Has (NAME) ever received a measles vaccination, that is, an injection in the left arm to prevent measles?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               | → 525B |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 524B                                    | How many times did (NAME) receive the measles vaccine?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | NUMBER OF TIMES <input type="text"/>                                                                                                                                                                                                                                                         |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 525B                                    | In the last six months, was (NAME) given a vitamin A dose like (this/any of these)?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | YES ..... 1<br>NO ..... 2<br>DONT KNOW ..... 8                                                                                                                                                                                                                                               |        |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |
| 526B                                    | CHECK 215 IN BIRTH HISTORY: ANY MORE BIRTHS IN 2008-2011 E.C.?<br>MORE BIRTHS IN 2008-2011 E.C. <input type="checkbox"/> NO MORE BIRTHS IN 2008-2011 E.C. <input type="checkbox"/><br>(GO TO 502B IN AN ADDITIONAL QUESTIONNAIRE)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                              | → 600  |       |      |     |  |  |  |                                         |  |  |  |                            |  |  |  |                            |  |  |  |                            |  |  |  |                                 |  |  |  |                             |  |  |  |                             |  |  |  |                             |  |  |  |                    |  |  |  |                    |  |  |  |                    |  |  |  |             |  |  |  |             |  |  |  |           |  |  |  |           |  |  |  |                         |  |  |  |  |  |

SECTION 6. INFORMATION ABOUT HEALTH FACILITY WHERE VACCINATION CARDS ARE KEPT

| NO.                                                                                                                                                                                                                                                   | QUESTIONS AND FILTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | CODING CATEGORIES                                                                                     |                                                                                                       | SKIP |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------|
| 600                                                                                                                                                                                                                                                   | CHECK 504A, 507A, 504B AND 507B: VACCINATION CARD SEEN?<br>NO CARD AND NO OTHER DOCUMENT SEEN <input type="checkbox"/><br>CARD OR OTHER DOCUMENT SEEN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                       |                                                                                                       | 616  |
| 601                                                                                                                                                                                                                                                   | Did any of your children born in 2008 E.C. or later ever receive any vaccination at a health facility (including government hospitals, health centers/posts, NGO facilities, or private hospitals/clinics)?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | YES ..... 1<br>NO ..... 2<br>DON'T KNOW ..... 8                                                       |                                                                                                       | 616  |
| 602                                                                                                                                                                                                                                                   | <p><b>ASK RESPONDENT FOR CONSENT TO COPY VACCINATION DATES FROM THE CHILDREN'S HEALTH CARDS OR FAMILY FOLDER OR IMMUNISATION REGISTRATION BOOK KEPT IN A HEALTH FACILITY</b></p> <p>As part of this survey, we would like to visit the health facility in which your children got vaccinated. With your permission, our health facility team will visit the health center and copy the vaccination records from the health cards, family folder or immunisation registration book directly to the same questionnaire I am using right now for our interview. The information will be kept confidential and will not be shared with anyone other than members of our survey team. We hope you will allow access to the health card, family folder or immunisation registration book because information about your children's vaccinations is very important. The information will complement the information that we obtained from you in this interview. Many dangerous childhood illnesses such as measles or tetanus can be prevented through timely and effective vaccination. The information from the cards will assist the government to develop programs to protect children from vaccine preventable diseases and reduce childhood mortality and morbidity in Ethiopia.</p> <p>Do you have any questions?</p> <p>Will you allow (NAME OF CHILD) to have his/her vaccination records copied from his/her health card, family folder or immunisation registration book kept at the health facility?</p> |                                                                                                       |                                                                                                       |      |
| 603                                                                                                                                                                                                                                                   | CIRCLE THE CODE AND SIGN YOUR NAME.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (LAST BIRTH)<br>GRANTED ..... 1<br>(SIGN) .....<br>REFUSED (THEN SKIP TO 615) ..... 2                 | (NEXT-TO-LAST BIRTH)<br>GRANTED ..... 1<br>(SIGN) .....<br>REFUSED (THEN SKIP TO 615) ..... 2         |      |
| RECORD CHILD'S FULL NAME, MOTHER'S FULL NAME, FATHER'S FULL NAME, CHILD'S KEBELE, TOWN, AND REGION, AND NAME OF HEALTH FACILITY WHERE CHILD'S LAST VACCINATION WAS ADMINISTERED. BE SURE TO TAKE ADDRESS AND LOCATION DESCRIPTION OF HEALTH FACILITY. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                       |                                                                                                       |      |
| 604                                                                                                                                                                                                                                                   | BIRTH HISTORY NUMBER OF EACH CHILD BORN IN 2008 E.C. OR LATER FROM 212 IN BIRTH HISTORY.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | BIRTH HISTORY NUMBER <input type="text"/>                                                             | BIRTH HISTORY NUMBER <input type="text"/>                                                             |      |
| 605                                                                                                                                                                                                                                                   | CHILD'S FULL NAME FROM 212                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | _____                                                                                                 | _____                                                                                                 |      |
| 606                                                                                                                                                                                                                                                   | CHILD'S DATE OF BIRTH FROM 215                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DAY ..... <input type="text"/><br>MONTH ..... <input type="text"/><br>YEAR ..... <input type="text"/> | DAY ..... <input type="text"/><br>MONTH ..... <input type="text"/><br>YEAR ..... <input type="text"/> |      |
| 607                                                                                                                                                                                                                                                   | CHILD'S AGE FROM 217                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | AGE ..... <input type="text"/>                                                                        | AGE ..... <input type="text"/>                                                                        |      |
| 607A                                                                                                                                                                                                                                                  | Insert health card number for (NAME OF CHILD)<br>IF UNAVAILABLE WRITE '00'                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | _____                                                                                                 | _____                                                                                                 |      |
| 608                                                                                                                                                                                                                                                   | What name was used at the health facility where (NAME) was last vaccinated?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | _____                                                                                                 | _____                                                                                                 |      |
| 609                                                                                                                                                                                                                                                   | What is your first and last name?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | _____                                                                                                 | _____                                                                                                 |      |
| 610                                                                                                                                                                                                                                                   | What is the first and last name of (NAME's) father?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | _____                                                                                                 | _____                                                                                                 |      |
| 611                                                                                                                                                                                                                                                   | What is the name of the health facility where (NAME's) last vaccination was administered?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | _____                                                                                                 | _____                                                                                                 |      |
| 612                                                                                                                                                                                                                                                   | What is the location (Kebele, Town, Woreda), where (NAME's) last vaccination was administered?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | KEBELE ..... <input type="text"/><br>TOWN .....<br>WOREDA .....                                       | KEBELE ..... <input type="text"/><br>TOWN .....<br>WOREDA .....                                       |      |
| 613                                                                                                                                                                                                                                                   | Can you describe the location of the health facility?<br>ADD TO THE DESCRIPTION ALL LANDMARKS (SUCH AS A PARK), PUBLIC STRUCTURES (SUCH AS SCHOOL OR CHURCH), AND STREETS OR ROADS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | _____                                                                                                 | _____                                                                                                 |      |
| 614                                                                                                                                                                                                                                                   | What is the name of the Doctor/health officer that vaccinated (NAME) at the health facility?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | _____                                                                                                 | _____                                                                                                 |      |
| 615                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | GO BACK TO 604 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, GO TO 616.                                      | GO TO 604 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE, OR, IF NO MORE CHILD GO TO 616.                |      |
| 616                                                                                                                                                                                                                                                   | RECORD THE TIME.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | HOURS ..... <input type="text"/><br>MINUTES ..... <input type="text"/>                                | <input type="text"/>                                                                                  |      |

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT INTERVIEW:

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COMMENTS ON SPECIFIC QUESTIONS:

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ANY OTHER COMMENTS:

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SUPERVISOR'S OBSERVATIONS

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EDITOR'S OBSERVATIONS

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