

NATIONAL INSTITUTE OF POPULATION STUDIES
PAKISTAN DEMOGRAPHIC AND HEALTH SURVEY 2006

COMMUNITY QUESTIONNAIRE
(FOR RURAL SAMPLE POINTS ONLY)

(IF MORE THAN ONE VILLAGE IN THE SAMPLE POINT, GET INFORMATION FROM THE LARGEST)

IDENTIFICATION														
PROVINCE (PUNJAB=1; SINDH=2; NWFP=3; BALOCHISTAN=4; FATA=5) _____ DISTRICT _____ TEHSIL _____ CLUSTER NUMBER	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin: 2px;"></div> </div>													
INFORMATION ABOUT THE PARTICIPANTS	DATE / RESULT													
PEOPLE WHO PARTICIPATED TO PROVIDE INFORMATION (WRITE NAME AND POSITION, E.G., VILLAGE LEADER, NAZIM, COUNCILLOR, RELIGIOUS LEADER, CHOWKIDAR, LOCAL FEMALE OR MALE TEACHER, LHV OR LHW) 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____	DAY <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> MONTH <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> YEAR <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td></tr></table> INT. NUMBER <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> RESULT * <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>					2	0	0						
2	0	0												
*RESULT CODES: 1 COMPLETED 2 UNABLE TO FIND SUITABLE RESPONDENTS 9 OTHER _____ <div style="text-align: right; margin-left: 150px;">(SPECIFY)</div>														
LANGUAGE OF QUESTIONNAIRE: ENGLISH														
INTERVIEWER/SUPERVISOR NAME _____ DATE _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: center;">OFFICE EDITOR</th> <th style="text-align: center;">KEYED BY</th> </tr> <tr> <td style="text-align: center;"> <table border="1" style="border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> </td> <td style="text-align: center;"> <table border="1" style="border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> </td> </tr> </table>	OFFICE EDITOR	KEYED BY	<table border="1" style="border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>			<table border="1" style="border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>							
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1. GENERAL DESCRIPTION

NO.	QUESTIONS	CODING CATEGORIES	SKIP
101	How far is the district headquarters from this village? ASK FROM THE CENTER OF THE LARGEST VILLAGE	KILOMETERS <input type="text"/> <input type="text"/> 95 KMS. OR MORE 95	
102	Is the road to the district headquarters mainly a katcha road or a pukka road?	MAINLY KATCHA 1 MAINLY PUKKA 2	
103	How far is it from this village to the road that goes to the district headquarters? ASK FROM THE CENTER OF THE LARGEST VILLAGE	LESS THAN 1 KM. 00 KILOMETERS <input type="text"/> <input type="text"/> 95 KMS. OR MORE 95	
104	How do most people get from here to the road?	WALK 01 RICKSHAW 02 BICYCLE 03 MOTORBIKE 04 PRIVATE CAR / TAXI / SUZUKI VAN TRACTOR TROLLY 05 TONGA/CATTLE CART 06 BUS / TRUCK 07 OTHER 96 (SPECIFY)	
105	If a woman in this village has a serious problem with her pregnancy, where would she go for treatment? _____ (NAME OF PLACE)	DHQ HOSPITAL 01 THQ HOSPITAL 02 MCH CENTRE 03 RHC 04 BHU 05 PRIVATE CLINIC / HOSPITAL 06 DAI / BIRTH ATTENDANT 07 LADY HEALTH WORKER 08	
106	How would she reach (NAME OF PLACE IN 105)?	WALK 01 RICKSHAW 02 BICYCLE 03 MOTORBIKE 04 PRIVATE CAR / TAXI / SUZUKI VAN TRACTOR TROLLY 05 TONGA/CATTLE CART 06 BUS / TRUCK 07 OTHER 96 (SPECIFY)	→ 108
107	Is transport available during the night time?	YES 1 NO 2 DOES NOT KNOW/NOT SURE 8	
108	How long would it take to reach the facility using this means? GIVE TIME IN MINUTES ONLY.	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> DOES NOT KNOW 998	
109	Is there a Lady Health Worker in this village?	YES 1 NO 2 DOES NOT KNOW/NOT SURE 8	↳ 201

NO.	QUESTIONS	CODING CATEGORIES	SKIP
110	What services does she provide? CIRCLE ALL MENTIONED.	ANTENATAL CARE A DELIVERY B CHILD IMMUNIZATIONS C CHILD CARE SERVICE D FAMILY PLANNING E GENERAL AILMENTS F OTHER _____ X (SPECIFY)	
111	Does the LHW make house visits on a regular basis?	YES 1 NO 2 DOES NOT KNOW/NOT SURE 8	

2. AVAILABILITY OF FACILITIES AND SERVICES

Now I would like to ask you about facilities and other services that may be in this village or at some distance.

	Type of facility/service	201 Is the (FACILITY / SERVICE) in this village?	202 How far away is (FACILITY/ SERVICE) from this village? IF >95 KMS, WRITE 95.
a.	Medical store?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
b.	General store or shop?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
c.	Motorized public transport?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
d.	Non-motorized public transport?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
e.	Post office?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
f.	Bank?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
g.	Primary school for boys ?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
h.	Primary school for girls ?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
i.	Secondary school for boys ?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
j.	Secondary school for girls ?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
k.	Any ambulance service?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
l.	Ultrasound services for pregnant women?	YES . 1 NO 2 →	KMS. <input type="text"/> <input type="text"/>
m.	A waste water drainage scheme?	YES . 1 NO 2	
n.	A drinking water scheme?	YES . 1 NO 2	
o.	Television service?	YES . 1 NO 2	
p.	Cable television connections	YES . 1 NO 2	
q.	Any land-line telephone service?	YES . 1 NO 2	
r.	Mobile telephone coverage?	YES . 1 NO 2	
s.	Any public call office (PCO)?	YES . 1 NO 2	

3. AVAILABILITY OF HEALTH FACILITIES

NO.	QUESTIONS	CODING CATEGORIES	SKIP
301	Please tell me how far away each of the following facilities are from here? ASK FROM THE CENTER OF THE (LARGEST) VILLAGE a. Dai? b. A functioning* basic health unit (BHU)? c. A rural health center (RHC)? d. A government dispensary. e. A functioning* MCH Centre. f. A private doctor. g. A dispenser or a compounder. h. A family welfare center (FWC) or somewhere else to get family planning. i. A hakeem or homeopath. j. A hospital.	<p align="center">IF LESS THAN 1 KM PUT 00 IF 95 KMS. OR MORE PUT 95</p> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/> KILOMETERS <input type="text"/> <input type="text"/>	
302	Think back over the last 3 years, has any woman in this village died because of a problem of pregnancy or died during childbirth or within 6 weeks of childbirth?	YES 1 NO 2 DOES NOT KNOW/NOT SURE 8	<input type="checkbox"/> GPS
303	Please tell me about the death(s). WHO IT WAS, WHEN IT OCCURRED.	WHO WAS IT - NAME / WIFE OF: _____ _____ WHEN DID IT OCCUR: _____ _____ END OF INTERVIEW - NOTE GPS READING	

* **Funtioning** facility: Presence of LHV to provide required services on regular basis.

Pakistan Demographic and Health Survey 2006

GPS Cluster Position Form

Before recording, did you...

- ✓ Check that the estimated accuracy shown in the opening screen is **15 meters or less?**
- ✓ Mark the point in the GPS unit?
- ✓ Rename the point to the cluster number ?

After recording the coordinates on this sheet, don't forget to ...

- ✓ Save the waypoint in the GPS unit's memory

CLUSTER AND OPERATOR IDENTIFICATION:	
Place name:	
Cluster:	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
Region:	<input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/>
Date:	Day <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> Month <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> Year <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
Operator name:	Code <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
POSITION INFORMATION:	
Waypoint ID <small>(as enter in GPS unit)</small>	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
Altitude	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> feet
Latitude	<div style="display: flex; justify-content: space-between; font-size: small;"> (Circle one) Degree Decimal degrees </div> N S <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> . <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>
Longitude	<div style="display: flex; justify-content: space-between; font-size: small;"> (Circle one) Degree Decimal degrees </div> E W <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> . <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>

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PAKISTAN DEMOGRAPHIC AND HEALTH SURVEY 2006

SHORT HOUSEHOLD QUESTIONNAIRE

IDENTIFICATION				
PROVINCE (PUNJAB=1; SINDH=2; NWFP=3; BALOCHISTAN=4; FATA=5) _____ <input type="checkbox"/>			
DISTRICT _____ <input type="checkbox"/>			
TEHSIL _____ <input type="checkbox"/>			
CLUSTER NUMBER <input type="checkbox"/>			
HOUSEHOLD NUMBER <input type="checkbox"/>			
IS HOUSEHOLD SELECTED FOR: (SHORT=1; WOMAN=2; VERBAL AUTOPSY=3; WOMAN AND VERBAL AUTOPSY= 4) <input type="checkbox"/>			
NAME OF HOUSEHOLD HEAD _____ <input type="checkbox"/>			
INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY <input type="checkbox"/> MONTH <input type="checkbox"/> YEAR <input type="checkbox"/> 2 <input type="checkbox"/> 0 <input type="checkbox"/> 0
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER <input type="checkbox"/>
RESULT*	_____	_____	_____	RESULT <input type="checkbox"/>
NEXT VISIT: DATE TIME	_____ _____	_____ _____		TOTAL NUMBER OF VISITS <input type="checkbox"/>
*RESULT CODES: 1 COMPLETED 2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME 3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME 4 POSTPONED 5 REFUSED 6 DWELLING VACANT OR ADDRESS NOT A DWELLING 7 DWELLING DESTROYED 8 DWELLING NOT FOUND 9 OTHER _____ (SPECIFY)			TOTAL PERSONS IN HOUSEHOLD <input type="checkbox"/>	
			DEATHS UNDER 5/ SBs FROM Q. 38 <input type="checkbox"/>	
			FEMALE DEATHS AGE 12-49 FROM Q. 39 <input type="checkbox"/>	
LANGUAGE OF QUESTIONNAIRE: URDU			LINE NO. OF RESPONDENT <input type="checkbox"/>	
SUPERVISOR		FIELD EDITOR		OFFICE EDITOR
NAME _____	<input type="checkbox"/>	NAME _____	<input type="checkbox"/>	<input type="checkbox"/>
DATE _____	<input type="checkbox"/>	DATE _____	<input type="checkbox"/>	<input type="checkbox"/>
Signature of interviewer: _____ Date: _____ RESPONDENT AGREES TO BE INTERVIEWED 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 → END				

HOUSEHOLD SCHEDULE

Now we would like some information about the people who usually live in your household or who are staying with you now.

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	IF AGE 12 OR OLDER	IF AGE 5 YEARS OR OLDER		
							MARITAL STATUS	EDUCATION		
	Please give me the names of the persons who usually live in your household and guest of the household who stayed here last night, starting with the head of the household AFTER LISTING NAMES, RELATIONSHIP AND SEX FOR EACH PERSON, ASK Qs. 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK QUESTIONS IN COLUMNS 5-11 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household? (SEE CODES BELOW)	Is (NAME) male or female?	Does (NAME) usually live here?	Did (NAME) stay here last night?	How old is (NAME)? IF LESS THAN 1 YEAR, WRITE '00'. IF AGE 96 YEARS OR MORE, WRITE '96'. (SEE CODES BELOW)	What is (NAME'S) current marital status? (SEE CODES BELOW)	Has (NAME) ever attended school?	What is the highest class of school (NAME) completed? (SEE CODES BELOW)	
(1)									(2)	(3)
			M F	YES NO	YES NO	IN YEARS	M W D/S N	YES NO	CLASS	
01		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
02		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
03		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
04		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
05		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
06		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
07		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
08		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
09		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
10		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	

CODES FOR Q. 3
RELATIONSHIP TO HEAD OF HOUSEHOLD:
01 = HEAD
02 = WIFE OR HUSBAND
03 = SON OR DAUGHTER
04 = SON-IN-LAW OR DAUGHTER-IN-LAW
05 = GRANDCHILD
06 = PARENT
07 = PARENT-IN-LAW
08 = BROTHER OR SISTER

09 = BROTHER/SISTER IN LAW
10 = NIECE/NEPHEW
11 = GRAND PARENTS
12 = AUNTS/UNCLE
13 = OTHER RELATIVE
14 = ADOPTED/FOSTER/STEPCHILD
15 = NOT RELATED
16 = DOMESTIC SERVANT
98 = DONT KNOW

CODES FOR Q. 8
MARITAL STATUS
1 = MARRIED
2 = WIDOWED
3 = DIVORCED/SEPARATED
4 = NEVER MARRIED

CODES FOR Q. 11
EDUCATION CLASS:
00 = LESS THAN 1 YEAR COMPLETED
01 = CLASS 1;
02 = CLASS 2
...
10 = MATRIC, CLASS 10
11 = CLASS 11
...
16 = MASTER'S DEGREE OR MBBS, PH.D, MPHIL, BSc (4 YEARS)
98 = DONT KNOW

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	IF AGE 12 OR OLDER	IF AGE 5 YEARS OR OLDER		
				MARITAL STATUS	EDUCATION					
	Please give me the names of the persons who usually live in your household and guest of the household who stayed here last night, starting with the head of the household AFTER LISTING NAMES, RELATIONSHIP AND SEX FOR EACH PERSON, ASK Qs. 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK QUESTIONS IN COLUMNS 5-11 FOR EACH PERSON.	What is the relationship of (NAME) to the head of the household? (SEE CODES BELOW)	Is (NAME) male or female?	Does (NAME) usually live here?	Did (NAME) stay here last night?	How old is (NAME)? IF LESS THAN 1 YEAR, WRITE '00'. IF AGE 96 YEARS OR MORE, WRITE '96'.	What is (NAME'S) current marital status? (SEE CODES BELOW)	Has (NAME) ever attended school?	What is the highest class of school (NAME) completed? (SEE CODES BELOW)	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(10)	(11)	
			M F	YES NO	YES NO	IN YEARS	M W D/S N	YES NO	CLASS	
11		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
12		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
13		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
14		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
15		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
16		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
17		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
18		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
19		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	
20		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	1 2 ↓ NEXT	<input type="text"/>	

TICK HERE IF CONTINUATION SHEET USED

Just to make sure that I have a complete household listing:

2A) Are there any other persons such as small children or infants that we have not listed?

YES ADD TO TABLE NO

2B) Are there any other people who may not be members of your family, such as domestic servants, lodgers or friends who usually live here?

YES ADD TO TABLE NO

2C) Are there any guests or temporary visitors staying here, or anyone else who slept here last night, who have not been listed?

YES ADD TO TABLE NO

IF NO MORE MEMBERS, GO TO COLUMN 5.

CODES FOR Q. 11

EDUCATION CLASS:
 00 = LESS THAN 1 YEAR COMPLETED
 01 = CLASS 1;
 02 = CLASS 2
 ...
 10 = MATRIC, CLASS 10
 11 = CLASS 11
 ...
 16 = MASTER'S DEGREE OR MBBS,
 PHD, MPHIL, BSc (4 YEARS)
 98 = DON'T KNOW

INFORMATION ABOUT BIRTHS AND DEATHS IN THE HOUSEHOLD IN THE PREVIOUS 3 YEARS

18 Now I would like to ask you about all the births that occurred in this household in the last 3 years, whether they were born alive or dead. Since January 2003, did any woman who was a usual resident of this household at that time give birth? I am interested in any birth, even stillbirths and children who did not survive.

YES . . . 1
NO . . . 2 → 27

19 How many births occurred in this household in the last 3 years?

NO.	What are the names of the babies born in the last 3 years? IF STILL BORN, WRITE 'BABY'.	Is (NAME) a boy or a girl?	In what month and year was (NAME) born? IF MONTH DON'T KNOW RECORD '98'	Was (NAME) born alive?	Is (NAME) still alive?	LINE NUMBER FROM HOUSEHOLD ROSTER (RECORD '00' IF CHILD NOT LISTED IN HH ROSTER)
20	21	22	23	24	25	26
01	_____	BOY . 1 GIRL . 2	MONTH <input type="text"/> <input type="text"/> YR <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/>	YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<input type="text"/> <input type="text"/> NEXT ←
02	_____	BOY . 1 GIRL . 2	MONTH <input type="text"/> <input type="text"/> YR <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/>	YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<input type="text"/> <input type="text"/> NEXT ←
03	_____	BOY . 1 GIRL . 2	MONTH <input type="text"/> <input type="text"/> YR <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/>	YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<input type="text"/> <input type="text"/> NEXT ←
04	_____	BOY . 1 GIRL . 2	MONTH <input type="text"/> <input type="text"/> YR <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/>	YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<input type="text"/> <input type="text"/> NEXT ←
05	_____	BOY . 1 GIRL . 2	MONTH <input type="text"/> <input type="text"/> YR <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/>	YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<input type="text"/> <input type="text"/> NEXT ←
06	_____	BOY . 1 GIRL . 2	MONTH <input type="text"/> <input type="text"/> YR <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/>	YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<input type="text"/> <input type="text"/> NEXT ←
07	_____	BOY . 1 GIRL . 2	MONTH <input type="text"/> <input type="text"/> YR <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/>	YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<input type="text"/> <input type="text"/> NEXT ←
08	_____	BOY . 1 GIRL . 2	MONTH <input type="text"/> <input type="text"/> YR <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> 0 <input type="text"/>	YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<input type="text"/> <input type="text"/> NEXT ←

CONTINUED (Additional Sheet)

27 Now I would like to ask you about any deaths that occurred in this household in the last 3 years. YES . 1
NO . 2 → 38
 Since January 2003, God forbid, has any usual member of this household died?

28 How many deaths occurred to usual residents in this household in the last 3 years?

NO.	What were the names of the people who died in the last 3 years?	Was (NAME) male or female?	In what month and year did (NAME) die? IF MONTH DON'T KNOW RECORD '98'	How old was (NAME) when he/she died? RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN 2 YEARS; OR YEARS.	CHECK 31 AND 33: WAS THIS A WOMAN AGE 12-49 WHEN SHE DIED?	Female, 12-49 years old		
						Was (NAME) pregnant when she died?	Did (NAME) die during childbirth?	Did (NAME) die within 6 weeks after delivery?
29	30	31	32	33	34	35	36	37
01	_____	MALE 1 FEMALE 2	MONTH YR 2 0 0	DAYS . 1 MONTH . 2 YEARS . 3	YES . 1 NO . 2 NEXT ↙	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2 NEXT ↙
02	_____	MALE 1 FEMALE 2	MONTH YR 2 0 0	DAYS . 1 MONTH . 2 YEARS . 3	YES . 1 NO . 2 NEXT ↙	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2 NEXT ↙
03	_____	MALE 1 FEMALE 2	MONTH YR 2 0 0	DAYS . 1 MONTH . 2 YEARS . 3	YES . 1 NO . 2 NEXT ↙	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2 NEXT ↙
04	_____	MALE 1 FEMALE 2	MONTH YR 2 0 0	DAYS . 1 MONTH . 2 YEARS . 3	YES . 1 NO . 2 NEXT ↙	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2 NEXT ↙

38. CHECK COLS. 32, 33 AND 24/23: NUMBER OF DEATHS TO CHILDREN UNDER 5 YEARS AND STILLBIRTHS IN 2005 OR AFTER

39. CHECK COLUMN 34 AND 32: NUMBER OF DEATHS TO WOMEN AGE 12-49 YEARS OLD IN 2003 OR AFTER

NATIONAL INSTITUTE OF POPULATION STUDIES
PAKISTAN DEMOGRAPHIC AND HEALTH SURVEY 2006

LONG HOUSEHOLD QUESTIONNAIRE

IDENTIFICATION				
PROVINCE (PUNJAB=1; SINDH=2; NWFP=3; BALOCHISTAN=4; FATA=5) _____ <input style="width: 20px; height: 15px;" type="text"/>			
DISTRICT _____ <input style="width: 20px; height: 15px;" type="text"/>			
TEHSIL _____ <input style="width: 20px; height: 15px;" type="text"/>			
CLUSTER NUMBER <input style="width: 20px; height: 15px;" type="text"/>			
HOUSEHOLD NUMBER <input style="width: 20px; height: 15px;" type="text"/>			
IS HOUSEHOLD SELECTED FOR ? (SHORT=1; WOMAN=2; VERBAL AUTOPSY=3; WOMAN AND VERBAL AUTOPSY= 4) <input style="width: 20px; height: 15px;" type="text"/>			
NAME OF HOUSEHOLD HEAD _____ <input style="width: 20px; height: 15px;" type="text"/>			
INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
DATE	_____	_____	_____	DAY <input style="width: 20px; height: 15px;" type="text"/> MONTH <input style="width: 20px; height: 15px;" type="text"/> YEAR <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/> <input style="width: 20px; height: 15px;" type="text"/>
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER <input style="width: 20px; height: 15px;" type="text"/>
RESULT*	_____	_____	_____	RESULT <input style="width: 20px; height: 15px;" type="text"/>
NEXT VISIT: DATE TIME	_____ _____	_____ _____		TOTAL NUMBER OF VISITS <input style="width: 20px; height: 15px;" type="text"/>
*RESULT CODES: 1 COMPLETED 2 NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME 3 ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME 4 POSTPONED 5 REFUSED 6 DWELLING VACANT OR ADDRESS NOT A DWELLING 7 DWELLING DESTROYED 8 DWELLING NOT FOUND 9 OTHER _____ <div style="text-align: right;">(SPECIFY)</div>				TOTAL PERSONS IN HOUSEHOLD <input style="width: 20px; height: 15px;" type="text"/> TOTAL ELIGIBLE WOMEN <input style="width: 20px; height: 15px;" type="text"/> DEATHS UNDER 5 /SBs FROM Q. 38 <input style="width: 20px; height: 15px;" type="text"/> FEMALE DEATHS AGE 12-49 FROM Q. 39 <input style="width: 20px; height: 15px;" type="text"/>
LANGUAGE OF QUESTIONNAIRE: URDU				LINE NO. OF RESPONDENT <input style="width: 20px; height: 15px;" type="text"/>
SUPERVISOR NAME _____ <input style="width: 20px; height: 15px;" type="text"/> DATE _____ <input style="width: 20px; height: 15px;" type="text"/>		FIELD EDITOR NAME _____ <input style="width: 20px; height: 15px;" type="text"/> DATE _____ <input style="width: 20px; height: 15px;" type="text"/>		OFFICE EDITOR <input style="width: 20px; height: 15px;" type="text"/> KEYED BY <input style="width: 20px; height: 15px;" type="text"/>
Signature of interviewer: _____ Date: _____ RESPONDENT AGREES TO BE INTERVIEWED 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 → END				

HOUSEHOLD SCHEDULE

Now we would like some information about the people who usually live in your household or who are staying with you now.

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX		RESIDENCE		AGE	IF AGE 12 OR OLDER
			Is (NAME) male or female?	Does (NAME) usually live here?	Did (NAME) stay here last night?	How old is (NAME)?		
	<p>Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.</p> <p>AFTER LISTING NAMES, RELATIONSHIP AND SEX FOR EACH PERSON, ASK Qs. 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK QUESTIONS IN COLUMNS 5-17 FOR EACH PERSON.</p>	<p>What is the relationship of (NAME) to the head of the household?</p> <p>(SEE CODES BELOW)</p>					<p>IF LESS THAN 1 YEAR, WRITE '00'.</p> <p>IF AGE 96 YEARS OR MORE, WRITE '96'.</p>	<p>MARITAL STATUS</p> <p>What is (NAME'S) current marital status?</p> <p>(SEE CODES BELOW)</p>
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	
01		<input type="text"/>	M F 1 2	YES NO 1 2	YES NO 1 2	IN YEARS <input type="text"/>	M W D/S N 1 2 3 4	
02		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	
03		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	
04		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	
05		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	
06		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	
07		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	
08		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	
09		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	
10		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4	

CODES FOR Q. 3
 RELATIONSHIP TO HEAD OF HOUSEHOLD:
 01 = HEAD
 02 = WIFE OR HUSBAND
 03 = SON OR DAUGHTER
 04 = SON-IN-LAW OR DAUGHTER-IN-LAW
 05 = GRANDCHILD
 06 = PARENT
 07 = PARENT-IN-LAW
 08 = BROTHER OR SISTER

09 = BROTHER/SISTER IN LAW
 10 = NIECE/NEPHEW
 11 = GRAND PARENTS
 12 = AUNTS/UNCLE
 13 = OTHER RELATIVE
 14 = ADOPTED/FOSTER/STEPCHILD
 15 = NOT RELATED
 16 = DOMESTIC SERVANT
 98 = DON'T KNOW

CODES FOR Q. 8
 MARITAL STATUS
 1 = MARRIED
 2 = WIDOWED
 3 = DIVORCED/SEPARATED
 4 = NEVER MARRIED

ELIGIBILITY	IF AGE 5 YEARS OR OLDER		IF AGE 5-24 YEARS			IF AGE 0-17 YEARS SURVIVORSHIP OF BIOLOGICAL PARENTS			FOR ALL AGES REGISTRATION WITH NADRA
	EDUCATION		CURRENT SCHOOLING		SCHOOLING DURING LAST YEAR				
CIRCLE LINE NUMBER OF ALL WOMEN AGE 12-49 WHO ARE MARRIED, WIDOWED OR DIVORCED OR SEPARATED	Has (NAME) ever attended school?	What is the highest class of school (NAME) completed?	Did (NAME) attend school at any time during the 2006 year?	During this school year, what class/grade [is/was] NAME attending?	Did (NAME) attend school at any time during the previous year 2005?	Is (NAME)'s natural mother alive?	Is (NAME)'s natural father alive?	Has (NAME) been registered with NADRA?	
		(SEE CODES BELOW)		(SEE CODES BELOW)				IF YES - PROBE: Does (NAME) have NIC card or name entered onto a 'bay' form, or nothing at all? (SEE CODES BELOW)	
(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	
	YES NO	CLASS	YES NO	CLASS	YES NO	Y N DK	Y N DK	NIC BF NONE DK	
01	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
02	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
03	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
04	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
05	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
06	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
07	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
08	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
09	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
10	1 2 ↓ GO TO 15	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	

CODES FOR Q. 11 AND 13
EDUCATION CLASS:
00 = LESS THAN 1 YEAR COMPLETED
01 = CLASS 1;
02 = CLASS 2
...
10 = MATRIC, CLASS 10
11 = CLASS 11
...
16 = MASTER'S DEGREE OR MBBS, PhD, MPHIL, BSc (4 YEARS);
98 = DON'T KNOW

CODES FOR Q. 17
(1) HAS NIC
(2) NAME ON 'BAY' FORM
(3) NEITHER OF THE ABOVE
(8) DOES NOT KNOW

LINE NO.	USUAL RESIDENTS AND VISITORS	RELATIONSHIP TO HEAD OF HOUSEHOLD	SEX	RESIDENCE		AGE	IF AGE 12 OR OLDER
				Does (NAME) usually live here?	Did (NAME) stay here last night?		MARITAL STATUS
	<p>Please give me the names of the persons who usually live in your household and guests of the household who stayed here last night, starting with the head of the household.</p> <p>AFTER LISTING NAMES, RELATIONSHIP AND SEX FOR EACH PERSON, ASK Qs. 2A-2C TO BE SURE THAT THE LISTING IS COMPLETE. THEN ASK QUESTIONS IN COLUMNS 5-17 FOR EACH PERSON.</p>	<p>What is the relationship of (NAME) to the head of the household?</p> <p>(SEE CODES BELOW)</p>	<p>Is (NAME) male or female?</p>			<p>How old is (NAME)?</p> <p>IF LESS THAN 1 YEAR, WRITE '00'.</p> <p>IF AGE 96 YEARS OR MORE, WRITE '96'.</p>	<p>What is (NAME'S) current marital status?</p> <p>(SEE CODES BELOW)</p>
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
			M F	YES NO	YES NO	IN YEARS	M W D/S N
11		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
12		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
13		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
14		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
15		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
16		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
17		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
18		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
19		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
20		<input type="text"/>	1 2	1 2	1 2	<input type="text"/>	1 2 3 4
TICK HERE IF CONTINUATION SHEET USED			<input type="checkbox"/>				
<p>Just to make sure that I have a complete household listing:</p> <p>2A) Are there any other persons such as small children or infants that we have not listed? YES <input type="checkbox"/> ADD TO TABLE NO <input type="checkbox"/></p> <p>2B) Are there any other people who may not be members of your family such as domestic servants, lodgers or friends who usually live here? YES <input type="checkbox"/> ADD TO TABLE NO <input type="checkbox"/></p> <p>2C) Are there any guests or temporary visitors staying here, or anyone else who slept here last night, who have not been listed? YES <input type="checkbox"/> ADD TO TABLE NO <input type="checkbox"/></p> <p>IF NO MORE MEMBERS, GO TO COLUMN 5.</p>							

ELIGIBILITY	IF AGE 5 YEARS OR OLDER		IF AGE 5-24 YEARS			IF AGE 0-17 YEARS SURVIVORSHIP OF BIOLOGICAL PARENTS			FOR ALL AGES REGISTRATION WITH NADRA
	EDUCATION		CURRENT SCHOOLING		SCHOOLING DURING LAST YEAR				
CIRCLE LINE NUMBER OF ALL WOMEN AGE 12-49 WHO ARE MARRIED, WIDOWED OR DIVORCED OR SEPARATED	Has (NAME) ever attended school?	What is the highest class of school (NAME) completed? (SEE CODES BELOW)	Did (NAME) attend school at any time during the 2006 year?	During this school year, what class/grade [is/was] NAME attending? (SEE CODES BELOW)	Did (NAME) attend school at any time during the previous year 2005?	Is (NAME)'s natural mother alive?	Is (NAME)'s natural father alive?	Has (NAME) been registered with NADRA? IF YES - PROBE: Does (NAME) have NIC card or name entered onto a 'bay' form, or nothing at all? (SEE CODES BELOW)	
(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	
	YES NO	CLASS	YES NO	CLASS	YES NO	Y N DK	Y N DK	NIC BF NONE DK	
11	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
12	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
13	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
14	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
15	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
16	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
17	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
18	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
19	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	
20	1 2 ↓ NEXT	<input type="text"/> <input type="text"/>	1 2 ↓ GO TO 14	<input type="text"/> <input type="text"/>	1 2	1 2 8	1 2 8	1 2 3 8	

CODES FOR Q. 11 AND 13
EDUCATION CLASS:

- 00 = LESS THAN 1 YEAR COMPLETED
- 01 = CLASS 1;
- 02 = CLASS 2
- ...
- 10 = MATRIC, CLASS 10
- 11 = CLASS 11
-
- 16 = MASTER'S DEGREE OR MBBS, PhD, MPHIL, BSc (4 YEARS)
- 98 = DON'T KNOW

CODES FOR Q. 17

- (1) HAS NIC
- (2) NAME ON 'BAY' FORM
- (3) NEITHER OF THE ABOVE
- (8) DOES NOT KNOW

INFORMATION ABOUT BIRTHS AND DEATHS IN THE HOUSEHOLD IN THE PREVIOUS 3 YEARS

18 Now I would like to ask you about all the births that occurred in this household in the last 3 years, whether they were born alive or dead. Since January 2003, did any woman who was a usual resident of this household at that time give birth? I am interested in any birth, even stillbirths and children who did not survive.

YES . . . 1
NO . . . 2 → 27

19 How many births occurred in this household in the last 3 years?

NO.	What are the names of the babies born in the last 3 years? IF STILL BORN, WRITE 'BABY'.	Is (NAME) a boy or a girl?	In what month and year was (NAME) born?	Was (NAME) born alive?	Is (NAME) still alive?	LINE NUMBER FROM HOUSEHOLD ROSTER (RECORD '00' IF CHILD NOT LISTED IN HH ROSTER)							
			IF MONTH DON'T KNOW RECORD '98'										
20	21	22	23	24	25	26							
01	_____	BOY . 1 GIRL . 2	MONTH YR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0			YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NEXT ←		
2	0	0											
02	_____	BOY . 1 GIRL . 2	MONTH YR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0			YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NEXT ←		
2	0	0											
03	_____	BOY . 1 GIRL . 2	MONTH YR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0			YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NEXT ←		
2	0	0											
04	_____	BOY . 1 GIRL . 2	MONTH YR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0			YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NEXT ←		
2	0	0											
05	_____	BOY . 1 GIRL . 2	MONTH YR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0			YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NEXT ←		
2	0	0											
06	_____	BOY . 1 GIRL . 2	MONTH YR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0			YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NEXT ←		
2	0	0											
07	_____	BOY . 1 GIRL . 2	MONTH YR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0			YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NEXT ←		
2	0	0											
08	_____	BOY . 1 GIRL . 2	MONTH YR <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0			YES 1 NO 2 NEXT ←	YES 1 NO 2 NEXT ←	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> NEXT ←		
2	0	0											

CONTINUED (Additional Sheet)

27 Now I would like to ask you about any deaths that occurred in this household in the last 3 years. Since January 2003, God forbid, has any usual member of this household died? YES . 1
NO . 2 → 38

28 How many deaths occurred to usual residents in this household in the last 3 years?

NO.	What were the names of the people who died in the last 3 years?	Was (NAME) male or female?	In what month and year did (NAME) die? IF MONTH DON'T KNOW RECORD '98'	How old was (NAME) when he/she died? RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN 2 YEARS; OR YEARS.	CHECK 31 AND 33: WAS THIS A WOMAN AGE 12-49 WHEN SHE DIED?	Female, 12-49 years old		
						Was (NAME) pregnant when she died?	Did (NAME) die during childbirth?	Did (NAME) die within 6 weeks after delivery?
29	30	31	32	33	34	35	36	37
01	_____	MALE 1 FEMALE 2	MONTH YR 2 0 0	DAYS . 1 MONTH. 2 YEARS . 3	YES . 1 NO . 2 NEXT ↙	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2 NEXT ↙
02	_____	MALE 1 FEMALE 2	MONTH YR 2 0 0	DAYS . 1 MONTH. 2 YEARS . 3	YES . 1 NO . 2 NEXT ↙	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2 NEXT ↙
03	_____	MALE 1 FEMALE 2	MONTH YR 2 0 0	DAYS . 1 MONTH. 2 YEARS . 3	YES . 1 NO . 2 NEXT ↙	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2 NEXT ↙
04	_____	MALE 1 FEMALE 2	MONTH YR 2 0 0	DAYS . 1 MONTH. 2 YEARS . 3	YES . 1 NO . 2 NEXT ↙	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2	YES . 1 NEXT ↙ NO . 2 NEXT ↙

38. CHECK COLS. 32, 33 AND 24/23: NUMBER OF DEATHS TO CHILDREN UNDER 5 YEARS AND STILLBIRTHS IN 2005 OR AFTER

39. CHECK COLUMN 34 AND 32: NUMBER OF DEATHS TO WOMEN AGE 12-49 YEARS OLD IN 2003 OR AFTER

HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	What is the main source of drinking water for members of your household?	PIPED WATER PIPED INTO DWELLING 11 PIPED TO YARD/PLOT 12 PUBLIC TAP/STAND PIPE ... 13 TUBE WELL OR BOREHOLE 21 HAND PUMP 22 DUG WELL PROTECTED WELL 31 UNPROTECTED WELL 32 WATER FROM SPRING PROTECTED SPRING/KAREZ ... 41 UNPROTECTED SPRING 42 RAINWATER 51 TANKER TRUCK 61 CART WITH SMALL TANK 71 SURFACE WATER (RIVER/DAM/LAKE/ POND/STREAM/CANAL 81 BOTTLED WATER 91 OTHER _____ 96 (SPECIFY)	→ 103
102	How long does it take to go there, get water, and come back?	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> ON PREMISES 996 DON'T KNOW 998	
103	Do you treat your water in any way to make it safer to drink?	YES 1 NO 2 DON'T KNOW 8	→ 105
104	What do you usually do to the water to make it safer to drink? Anything else? RECORD ALL MENTIONED.	BOIL A ADD BLEACH/CHLORINE B STRAIN THROUGH A CLOTH C USE WATER FILTER (CERAMIC/ SAND/COMPOSITE/ETC.) D SOLAR DISINFECTION E LET IT STAND AND SETTLE F OTHER _____ X (SPECIFY) DON'T KNOW Z	
105	What kind of toilet facility do members of your household usually use?	FLUSH OR POUR FLUSH TOILET FLUSH TO SEWER SYSTEM ... 11 FLUSH TO SEPTIC TANK 12 FLUSH TO SOMEWHERE ELSE ... 13 FLUSH, DON'T KNOW WHERE ... 14 PIT LATRINE VENTILATED IMPROVED PIT LATRINE (VIP) 21 PIT LATRINE WITH SLAB 22 PIT LATRINE WITHOUT SLAB/ OPEN PIT 23 BUCKET TOILET 41 HANGING TOILET/HANGING LATRINE 51 NO FACILITY/BUSH/FIELD 61 OTHER _____ 96 (SPECIFY)	→ 107

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																			
106	Do you share this toilet facility with other households?	YES 1 NO 2																																																				
107	Does your household have: Electricity? Radio? Television? Refrigerator? Mobile telephone or land line telephone? Room cooler, air conditioner? Washing machine? Water pump? Bed? Chairs? Almira / cabinet? Clock? Sofa? Sewing machine? Camera? Personal computer?	<table border="0"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>ELECTRICITY</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>RADIO</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>TELEVISION</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>REFRIGERATOR</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>ANY TELEPHONE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>ROOM COOLER, AIR COND. . .</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>WASHING MACHINE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>WATER PUMP</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>BED</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>CHAIRS</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>ALMIRAH/CABINET</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>CLOCK</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>SOFA</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>SEWING MACHINE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>CAMERA</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>PERSONAL COMPUTER ...</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		YES	NO	ELECTRICITY	1	2	RADIO	1	2	TELEVISION	1	2	REFRIGERATOR	1	2	ANY TELEPHONE	1	2	ROOM COOLER, AIR COND. . .	1	2	WASHING MACHINE	1	2	WATER PUMP	1	2	BED	1	2	CHAIRS	1	2	ALMIRAH/CABINET	1	2	CLOCK	1	2	SOFA	1	2	SEWING MACHINE	1	2	CAMERA	1	2	PERSONAL COMPUTER ...	1	2	
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PERSONAL COMPUTER ...	1	2																																																				
108	What type of fuel does your household mainly use for cooking?	ELECTRICITY 01 CYLINDER GAS 02 NATURAL GAS 03 BIOGAS 04 KEROSENE 05 CHARCOAL 06 WOOD 07 STRAW/SHRUBS/GRASS 08 AGRICULTURAL CROP 09 ANIMAL DUNG 10 NO FOOD COOKED IN HOUSEHOLD 95 OTHER _____ 96 (SPECIFY)																																																				
109	MAIN MATERIAL OF THE FLOOR: RECORD OBSERVATION	NATURAL FLOOR EARTH / SAND / MUD 11 FINISHED FLOOR CHIPS / TERRAZZO 31 CERAMIC TILES 32 MARBLE 33 CEMENT 34 CARPET 35 BRICKS 36 MATS 37 OTHER _____ 96 (SPECIFY)																																																				

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
110	<p>MAIN MATERIAL OF THE ROOF:</p> <p>RECORD OBSERVATION</p>	<p>NATURAL ROOFING THATCH / BAMBOO / WOOD / MUD 12</p> <p>RUDIMENTARY ROOFING CARDBOARD / PLASTIC 21</p> <p>FINISHED ROOFING IRON SHEETS / ASBESTOS 31 T-IRON / WOOD / BRICK 32 REINFORCED BRICK CEMENT/RCC 33</p> <p>OTHER _____ 96 (SPECIFY)</p>	
111	<p>MAIN MATERIAL OF THE WALLS:</p> <p>RECORD OBSERVATION</p>	<p>NATURAL WALLS MUD / STONES 11 BAMBOO / STICKS / MUD 12</p> <p>RUDIMENTARY WALLS UNBAKED BRICKS / MUD 21 PLYWOOD SHEETS 22 CARTON / PLASTIC 23</p> <p>FINISHED WALLS STONE BLOCKS 31 BAKED BRICKS 32 CEMENT BLOCKS/ CEMENT ... 33 TENT 34</p> <p>OTHER _____ 96 (SPECIFY)</p>	
112	How many rooms in this household are used for sleeping?	ROOMS <input type="text"/> <input type="text"/>	
113	Is this house rented, rent-free, mortgaged, or owned by a member of the household?	<p>RENTED 1</p> <p>RENT-FREE 2</p> <p>MORTGAGED 3</p> <p>OWNED 4</p> <p>OTHER 6</p>	
114	Does any member of this household own:	<p style="text-align: right;">YES NO</p> <p>A watch? WATCH 1 2</p> <p>A bicycle? BICYCLE 1 2</p> <p>A motorcycle or motor scooter? MOTORCYCLE/SCOOTER ... 1 2</p> <p>An animal-drawn cart? ANIMAL-DRAWN CART 1 2</p> <p>A car or truck or Tractor? CAR/TRUCK 1 2</p> <p>A boat with a motor? BOAT WITH MOTOR 1 2</p>	
115	Does any member of this household own any land that can be used for agriculture?	<p>YES 1</p> <p>NO 2</p>	
116	Does this household own any livestock, herds, other farm animals, or poultry?	<p>YES 1</p> <p>NO 2</p>	→ 118

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP														
117	<p>How many of the following animals does this household own?</p> <p>Buffalo</p> <p>Milk cows or bulls?</p> <p>Camels?</p> <p>Donkeys, or mules or horses?</p> <p>Goats?</p> <p>Sheep?</p> <p>Chickens?</p> <p>IF NONE, WRITE '00'. IF > 95, WRITE '95'. IF UNKNOWN, WRITE '98'</p>	<p>BUFFALO</p> <p>COWS/BULLS</p> <p>CAMELS</p> <p>DONKEYS/MULES/HORSES .</p> <p>GOATS</p> <p>SHEEP</p> <p>CHICKENS</p> <table border="1" data-bbox="1230 285 1321 617"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>															
118	<p>Does your household have any mosquito nets that can be used while sleeping?</p>	<p>YES 1</p> <p>NO 2</p>	→ 126														
119	<p>How many mosquito nets does your household have?</p>	<p>NUMBER OF NETS <input type="text"/></p>															

	ASK THESE QUESTIONS FOR TWO BEDNETS ONLY	NET #1	NET #2	
120	When you got the net, was it already treated with an insecticide to kill or repel mosquitos?	YES 1 SKIP to 123 ← NO 2 NOT SURE 8	YES 1 (SKIP TO 123) ← NO 2 NOT SURE 8	
121	Since you got the mosquito net, was it ever soaked or dipped in a liquid to kill or repel mosquitos?	YES 1 NO 2 (SKIP TO 123) ← NOT SURE 8	YES 1 NO 2 (SKIP TO 123) ← NOT SURE 8	
122	How many months ago was the net last soaked or dipped? IF LESS THAN ONE MONTH, RECORD '00'.	MONTH AGO <input type="text"/> 25 OR MORE MONTHS AGO ... 95 NOT SURE 98	MONTH AGO <input type="text"/> 25 OR MORE MONTHS AGO ... 95 NOT SURE 98	
123	Did anyone sleep under this mosquito net last night?	YES 1 NO 2 (SKIP TO 125) ← NOT SURE 8	YES 1 NO 2 (SKIP TO 125) ← NOT SURE 8	
124	Who slept under this mosquito net last night? RECORD THE PERSON'S LINE NUMBER FROM THE HOUSEHOLD SCHEDULE.	NAME _____ LINE NO. <input type="text"/> NAME _____ LINE NO. <input type="text"/> NAME _____ LINE NO. <input type="text"/>	NAME _____ LINE NO. <input type="text"/> NAME _____ LINE NO. <input type="text"/> NAME _____ LINE NO. <input type="text"/>	
125		GO BACK TO 120 FOR NEXT NET; OR, IF NO MORE NETS, GO TO 126.	GO TO 126.	
126	Does your household do anything (else) to avoid mosquitos?		YES 1 NO 2	→128
127	What do you do? CIRCLE ALL MENTIONED.		COIL A MATS B SPRAY C ELECTRIC SPRAY REPELLANT D INSECT REPELLANT E OTHER _____ X (SPECIFY)	
128	Do you have any medicines for treating malaria in your house now?		YES 1 NO 2 DOES NOT KNOW 8	

**NATIONAL INSTITUTE OF POPULATION STUDIES
PAKISTAN DEMOGRAPHIC AND HEALTH SURVEY
EVER-MARRIED WOMAN'S QUESTIONNAIRE**

IDENTIFICATION																				
PROVINCE (PUNJAB=1; SINDH=2; NWFP=3; BALOCHISTAN=4; FATA=5) _____ DISTRICT _____ TEHSIL _____ CLUSTER NUMBER HOUSEHOLD NUMBER LARGE CITY=1; SMALL CITY=2; TOWN=3; RURAL=4 NAME OF HOUSEHOLD HEAD _____ NAME AND LINE NUMBER OF WOMAN _____	<table border="1" style="margin:auto; border-collapse: collapse;"> <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> <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> <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> <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>																			
INTERVIEWER VISITS																				
	1	2	3	FINAL VISIT																
DATE	_____	_____	_____	DAY MONTH YEAR <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; height:20px; text-align:center;">2</td><td style="width:20px; height:20px; text-align:center;">0</td><td style="width:20px; height:20px; text-align:center;">0</td></tr></table>	2	0	0													
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INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td></tr></table>																
RESULT*	_____	_____	_____	RESULT <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td></tr></table>																
NEXT VISIT: DATE TIME	_____	_____		TOTAL NUMBER OF VISITS <table border="1" style="display:inline-table; border-collapse: collapse;"><tr><td style="width:20px; height:20px;"></td></tr></table>																
*RESULT CODES: 1 COMPLETED 4 REFUSED 2 NOT AT HOME 5 PARTLY COMPLETED 7 OTHER _____ 3 POSTPONED 6 INCAPACITATED (SPECIFY)																				
LANGUAGE OF QUESTIONNAIRE: URDU LANGUAGE OF INTERVIEW* LANGUAGE WOMAN SPEAKS AT HOME* * URDU = 1 SINDHI= 3 BALUCHI=5 SARAIKI=7 OTHER=9 PUNJABI=2 PUSHTO=4 ENGLISH=6 POTOHARI=8				<table border="1" style="border-collapse: collapse;"> <tr><td style="width:20px; height:20px; text-align:center;">1</td></tr> <tr><td style="width:20px; height:20px;"></td></tr> <tr><td style="width:20px; height:20px;"></td></tr> </table>	1															
1																				
SUPERVISOR NAME _____ DATE _____	FIELD EDITOR NAME _____ DATE _____	OFFICE EDITOR <table border="1" style="width:100%; border-collapse: collapse;"><tr><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td></tr></table>			KEYED BY <table border="1" style="width:100%; border-collapse: collapse;"><tr><td style="width:20px; height:20px;"></td><td style="width:20px; height:20px;"></td></tr></table>															
Signature of interviewer: _____ Date: _____ RESPONDENT AGREES TO BE INTERVIEWED 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 → END																				

SECTION 1. RESPONDENT'S BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	RECORD THE TIME.	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>	
102	In what month and year were you born?	MONTH <input type="text"/> <input type="text"/> DON'T KNOW MONTH 98 YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW YEAR 9998	
103	How old are you? COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT	AGE IN COMPLETED YEARS <input type="text"/> <input type="text"/>	
104	What is your current marital status? Are you married, Godforbid widowed, divorced, or separated?	MARRIED 1 WIDOWED 2 DIVORCED 3 SEPARATED 4 NEVER MARRIED 5	} → 107 } → END
105	Is your husband usually living with you now or is he staying elsewhere?	LIVING WITH HER 1 STAYING ELSEWHERE 2	
106	Does your husband have other wives?	YES 1 NO 2 DON'T KNOW 8	
107	Is/was there a blood relationship between you and your husband?	YES 1 NO 2	→ 109
108	What type of relationship (is/was) it?	FIRST COUSIN ON FATHER'S SIDE . 1 FIRST COUSIN ON MOTHER'S SIDE . 2 SECOND COUSIN 3 OTHER RELATIONSHIP 6	
109	Have you been married only once or more than once?	ONLY ONCE 1 MORE THAN ONCE 2	
110	CHECK 109: <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <input type="checkbox"/> MARRIED/ ONLY ONCE ↓ In what month and year did you start living with your husband? 4 </div> <div style="text-align: center;"> <input type="checkbox"/> MARRIED/ MORE THAN ONCE ↓ Now I would like to ask about when you started living with your first husband. In what month and year was that? </div> </div>	MONTH <input type="text"/> <input type="text"/> DON'T KNOW MONTH 98 YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW YEAR 9998	→ 112

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
111	How old were you when you first started living with him?	AGE <input type="text"/> <input type="text"/>	
112	Have you ever attended school?	YES 1 NO 2	→ 115
113	What is the highest class you completed? WRITE '00' IF LESS THAN CLASS ONE; WRITE '16' = IF MA, MPHIL, PHD, MBBS, BSC/4YEARS	CLASS <input type="text"/> <input type="text"/>	
114	CHECK 113 CLASS 00 - 08 <input type="checkbox"/> ↓ CLASS 09 <input type="checkbox"/> OR HIGHER		→ 116
115	Now I would like you to read this sentence to me. SHOW CARD TO RESPONDENT. IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE: Can you read any part of the sentence to me?	CANNOT READ AT ALL 1 CAN READ ONLY PARTS OF SENTENCE 2 CAN READ WHOLE SENTENCE..... 3 NO CARD WITH REQUIRED LANGUAGE 4 (SPECIFY LANGUAGE) BLIND/VISUALLY IMPAIRED 5	
116	What is your mother tongue?	URDU 01 PUNJABI 02 SINDHI 03 PUSHTO 04 BALOCHI 05 ENGLISH 06 BARAUHI 07 SIRAIKI 08 HINDKO 09 KASHMIRI 10 PAHARI 11 POTOWARI 12 MARWARI 13 FARSI 14 OTHER 96	

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 live birth?	YES 1 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 NO 2	→ 204								
203	How many sons live with you? And how many daughters live with you? IF NONE, RECORD '00'.	SONS AT HOME <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAUGHTERS AT HOME <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>									
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 NO 2	→ 206								
205	How many sons are alive but do not live with you? And how many daughters are alive but do not live with you? IF NONE, RECORD '00'.	SONS ELSEWHERE <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAUGHTERS ELSEWHERE <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>									
206	Have you ever given birth to a boy or girl who was born alive but later died? IF NO, PROBE: Any baby who cried or showed signs of life but did not survive?	YES 1 NO 2	→ 208								
207	How many boys have died? And how many girls have died? IF NONE, RECORD '00'.	BOYS DEAD <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> GIRLS DEAD <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>									
208	SUM ANSWERS TO 203, 205, 207. ENTER TOTAL. IF NONE, RECORD '00'.	TOTAL <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table>									
209	CHECK 208: Just to make sure that I have this right: you have had in TOTAL _____ births during your life. Is that correct? YES <input type="checkbox"/> NO <input type="checkbox"/> → PROBE AND CORRECT 201-208 AS NECESSARY.										
210	CHECK 208: ONE OR MORE BIRTHS <input type="checkbox"/> NO BIRTHS <input type="checkbox"/> →		→ 226								

211 Now I would like to record the names of all your births, whether still alive or not, starting with the last one you had.

**RECORD NAMES OF ALL THE BIRTHS IN 212. RECORD TWINS AND TRIPLETS ON SEPARATE LINES.
(IF THERE ARE MORE THAN 12 BIRTHS, USE AN ADDITIONAL QUESTIONNAIRE, STARTING WITH THE FIRST ROW)**

212	213	214	215	216	217	218	219	220	221	222
What name was given to your last (next-to-last) baby? (NAME)	Were any of these births twins?	Is (NAME) a boy or a girl?	In what month and year was (NAME) born? PROBE: What is his/her birthday? RECORD MONTHS 1 THROUGH 12 OR SEASONS WINTER = 21 SPRING = 22 SUMMER = 23 MONSOON = 24 AUTUMN = 25 DON'T KNOW = 98	Is (NAME) still alive?	IF ALIVE: How old is (NAME)? WRITE AGE IN COMPLETED YEARS. WRITE '00' IF UNDER 1	IF ALIVE: Is (NAME) living with you?	IF ALIVE: RECORD HOUSE-HOLD LINE NUMBER OF CHILD (RECORD '00' IF CHILD NOT LISTED IN HOUSE-HOLD).	IF DEAD: How old was (NAME) when he/she died? IF '1 YR', PROBE: How many months old was (NAME)? RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.	IF DEAD: Where did (NAME) die?	Were there any other livebirths between (NAME) and (NAME OF PREVIOUS BIRTH), including any children who died after birth?*
01	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/ SEASON YEAR [][] [][] [][][][] DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS [][]	YES ... 1 NO ... 2	LINE NUMBER [][] (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD BIRTH NO ... 2 NEXT BIRTH
02	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/ SEASON YEAR [][] [][] [][][][] DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS [][]	YES ... 1 NO ... 2	LINE NUMBER [][] (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD BIRTH NO ... 2 NEXT BIRTH
03	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/ SEASON YEAR [][] [][] [][][][] DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS [][]	YES ... 1 NO ... 2	LINE NUMBER [][] (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD BIRTH NO ... 2 NEXT BIRTH
04	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/ SEASON YEAR [][] [][] [][][][] DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS [][]	YES ... 1 NO ... 2	LINE NUMBER [][] (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD BIRTH NO ... 2 NEXT BIRTH
05	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/ SEASON YEAR [][] [][] [][][][] DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS [][]	YES ... 1 NO ... 2	LINE NUMBER [][] (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD BIRTH NO ... 2 NEXT BIRTH
06	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/ SEASON YEAR [][] [][] [][][][] DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS [][]	YES ... 1 NO ... 2	LINE NUMBER [][] (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD BIRTH NO ... 2 NEXT BIRTH
07	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/ SEASON YEAR [][] [][] [][][][] DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS [][]	YES ... 1 NO ... 2	LINE NUMBER [][] (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD BIRTH NO ... 2 NEXT BIRTH
08	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/ SEASON YEAR [][] [][] [][][][] DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS [][]	YES ... 1 NO ... 2	LINE NUMBER [][] (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD BIRTH NO ... 2 NEXT BIRTH

* NOTE: FOR FIRST BIRTH ALWAYS ASK - " WERE THERE ANY OTHER LIVEBIRTHS BETWEEN (NAME) AND YOUR (FIRST) MARRIAGE?"

212	213	214	215	216	217	218	219	220	221	222
What name was given to your last (next-to-last) baby? (NAME)	Were any of these births twins?	Is (NAME) a boy or a girl?	In what month and year was (NAME) born? PROBE: What is his/her birthday? RECORD MONTHS 1 THROUGH 12 OR SEASONS WINTER = 21 SPRING = 22 SUMMER = 23 MONSOON = 24 AUTUMN = 25 DON'T KNOW = 98	Is (NAME) still alive?	IF ALIVE: How old is (NAME)? WRITE AGE IN COMPLETED YEARS. WRITE '00' IF UNDER 1	IF ALIVE: Is (NAME) living with you?	IF ALIVE: RECORD HOUSE-HOLD LINE NUMBER OF CHILD (RECORD '00' IF CHILD NOT LISTED IN HOUSE-HOLD).	IF DEAD: How old was (NAME) when he/she died? IF '1 YR', PROBE: How many months old was (NAME)? RECORD DAYS IF LESS THAN 1 MONTH; MONTHS IF LESS THAN TWO YEARS; OR YEARS.	IF DEAD: Where did (NAME) die?	Were there any other livebirths between (NAME) and (NAME OF PREVIOUS BIRTH), including any children who died after birth?*
09	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS <input type="text"/> <input type="text"/>	YES ... 1 NO ... 2	LINE NUMBER <input type="text"/> (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD ↙ BIRTH NO ... 2 NEXT ↖ BIRTH
10	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS <input type="text"/> <input type="text"/>	YES ... 1 NO ... 2	LINE NUMBER <input type="text"/> (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD ↙ BIRTH NO ... 2 NEXT ↖ BIRTH
11	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS <input type="text"/> <input type="text"/>	YES ... 1 NO ... 2	LINE NUMBER <input type="text"/> (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD ↙ BIRTH NO ... 2 NEXT ↖ BIRTH
12	SING 1 MULT 2	BOY 1 GIRL 2	MONTH/SEASON YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	YES ... 1 NO ... 2 220	AGE IN YEARS <input type="text"/> <input type="text"/>	YES ... 1 NO ... 2	LINE NUMBER <input type="text"/> (GO TO 222)	DAYS ... 1 MONTHS 2 YEARS ... 3	HOME 1 HOSP 2 OTHER 6	YES ... 1 ADD ↙ BIRTH NO ... 2 NEXT ↖ BIRTH

* NOTE: FOR FIRST BIRTH ALWAYS ASK : " WERE THERE ANY OTHER LIVEBIRTHS BETWEEN (NAME) AND YOUR (FIRST) MARRIAGE?"

223	Have you had any live births since the birth of (NAME OF LAST BIRTH)? IF YES, WRITE BIRTH(S) IN TABLE	YES 1 NO 2
224	COMPARE 208 WITH NUMBER OF BIRTHS IN HISTORY ABOVE AND MARK: NUMBERS ARE SAME <input type="checkbox"/> NUMBERS ARE DIFFERENT <input type="checkbox"/> (PROBE AND RECONCILE) CHECK: 215 FOR EACH BIRTH SINCE JANUARY 2001: MONTH AND YEAR OF BIRTH ARE RECORDED CHECK: 217 FOR EACH LIVING CHILD: CURRENT AGE IS RECORDED. CHECK: 220 FOR EACH DEAD CHILD: AGE AT DEATH IS RECORDED. CHECK: 220 FOR AGE AT DEATH 12 MONTHS OR 1 YEAR: PROBE TO DETERMINE EXACT NUMBER OF MONTHS.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
225	CHECK 215 AND ENTER THE NUMBER OF BIRTHS IN 2001 OR LATER. IF NONE, RECORD '0' AND SKIP TO 226.	<input type="text"/>

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
226	Are you pregnant now?	YES 1 NO 2 UNSURE 8	<input type="checkbox"/> → 229
227	How many months pregnant are you?	MONTHS <input type="text"/>	
228	At the time you became pregnant did you want to become pregnant <u>then</u> , did you want to wait until <u>later</u> , or did you <u>not want</u> to have any (more) children at all?	THEN 1 LATER 2 NOT AT ALL 3	
229	Have you ever had a pregnancy that miscarried, was aborted, or ended in a stillbirth?	YES 1 NO 2	→ 234
230	When did the <u>last</u> such pregnancy end? PROBE TO ASK BETWEEN WHICH BIRTHS, ETC.	MONTH <input type="text"/> YEAR <input type="text"/>	
231	CHECK 230: LAST PREGNANCY ENDED IN JAN. 2001 OR LATER <input type="checkbox"/> LAST PREGNANCY ENDED BEFORE JAN. 2001 <input type="checkbox"/>		→ 234
232	How many months pregnant were you when the <u>last</u> such pregnancy ended?	MONTHS <input type="text"/>	
233	Since January 2001, how many pregnancies have you had that did not result in a live birth. How many of these pregnancies were miscarried, aborted or ended in a still birth? IF 7 OR MORE, RECORD '7'.	NUMBER OF MISCARRIAGES <input type="text"/> NUMBER OF ABORTIONS <input type="text"/> NUMBER OF STILLBIRTHS <input type="text"/>	
234	When did your last menstrual period start? _____ (DATE, IF GIVEN) IF LESS THAN A WEEK, RECORD DAYS, IF ONE WEEK AND LESS THAN ONE MONTH RECORD WEEKS. IF ONE MONTH AND LESS THAN A YEAR RECORD MONTHS, IF YEAR OR MORE RECORD YEARS.	DAYS AGO 1 <input type="text"/> WEEKS AGO 2 <input type="text"/> MONTHS AGO 3 <input type="text"/> YEARS AGO 4 <input type="text"/> IN MENOPAUSE/ HAS HAD HYSTERECTOMY 994 BEFORE LAST BIRTH 995 NEVER MENSTRUATED 996	
235	Do you know about any problems or complications a woman can have during pregnancy or delivery or after delivery?	YES 1 NO 2	→ 301
236	What complications or problems do you know about? _____ _____ _____ (SPECIFY)	<input type="text"/>	

SECTION 3. CONTRACEPTION

301	<p>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.</p> <p>Which ways or methods have you heard about?</p> <p>FOR METHODS NOT MENTIONED SPONTANEOUSLY, ASK: Have you ever heard of (METHOD)?</p> <p>CIRCLE CODE 1 IN 301 FOR EACH METHOD MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN COLUMN 301, READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 1 IF METHOD IS RECOGNIZED, AND CODE 2 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 1 CIRCLED IN 301, ASK 302.</p>	302 Have you ever used (METHOD)?	
01	<p>FEMALE STERILISATION Women can have an operation to avoid having any more pregnancies.</p>	<p>YES 1</p> <p>NO 2 ↙</p>	<p>Have you ever had an operation to avoid having any more pregnancies?</p> <p>YES 1</p> <p>NO 2</p>
02	<p>MALE STERILISATION Men can have an operation to avoid having any more pregnancies.</p>	<p>YES 1</p> <p>NO 2 ↙</p>	<p>Has your husband ever had an operation to avoid having any more pregnancies?</p> <p>YES 1</p> <p>NO 2</p>
03	<p>PILL Women can take a pill every day to avoid becoming pregnant.</p>	<p>YES 1</p> <p>NO 2 ↙</p>	<p>YES 1</p> <p>NO 2</p>
04	<p>IUD Women can have a loop or coil placed inside them by a doctor or a trained health worker.</p>	<p>YES 1</p> <p>NO 2 ↙</p>	<p>YES 1</p> <p>NO 2</p>
05	<p>INJECTABLES Women can have an injection by a health provider that stops them from becoming pregnant for one or more months.</p>	<p>YES 1</p> <p>NO 2 ↙</p>	<p>YES 1</p> <p>NO 2</p>
06	<p>IMPLANTS Women can have several small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years.</p>	<p>YES 1</p> <p>NO 2 ↙</p>	<p>YES 1</p> <p>NO 2</p>
07	<p>CONDOM Men can put a rubber sheath on their organ before sexual intercourse.</p>	<p>YES 1</p> <p>NO 2 ↙</p>	<p>YES 1</p> <p>NO 2</p>

08	RHYTHM METHOD Every month that a woman is sexually active she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	YES 1 NO 2 ↴	YES 1 NO 2
09	WITHDRAWAL, AZAL Men can be careful and pull out before ejaculation.	YES 1 NO 2 ↴	YES 1 NO 2
10	EMERGENCY CONTRACEPTION Women can take pills up to five days after sexual intercourse to avoid becoming pregnant.	YES 1 NO 2 ↴	YES 1 NO 2
11	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	YES 1 _____ (SPECIFY) _____ (SPECIFY) NO 2 ↴	YES 1 NO 2 YES 1 NO 2
303	CHECK 302: NOT A SINGLE "YES" (NEVER USED) <input type="checkbox"/> ↴ AT LEAST ONE "YES" (EVER USED) <input type="checkbox"/> → 306		
304	Have you ever used anything or tried in any way to delay or avoid getting pregnant?	YES 1 NO 2	→ 322
305	What have you used or done? CORRECT 302 AND 303 (AND 301 IF NECESSARY).		
306	CHECK 104: CURRENTLY MARRIED <input type="checkbox"/> ↴ WIDOWED, DIVORCED OR SEPARATED <input type="checkbox"/> → 322		
307	CHECK 302 (01): WOMAN NOT STERILISED <input type="checkbox"/> ↴ WOMAN STERILISED <input type="checkbox"/> → 310		
308	CHECK 226: NOT PREGNANT OR UNSURE <input type="checkbox"/> ↴ PREGNANT <input type="checkbox"/> → 322		
309	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES 1 NO 2	→ 322

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
310	<p>Which method are you using?</p> <p>CIRCLE ALL MENTIONED.</p> <p>IF MORE THAN ONE METHOD MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD ON LIST.</p> <p>CIRCLE 'A' FOR FEMALE STERILISATION.</p>	FEMALE STERILISATION A MALE STERILISATION B PILL C IUD D INJECTABLES E IMPLANTS F CONDOM G RHYTHM H WITHDRAWAL I OTHER _____ X (SPECIFY)	→ 316 → 316 → 314 → 316 → 321
311	<p>May I see the package of pills/condoms you are now using?</p> <p>RECORD NAME OF BRAND IF PACKAGE SEEN.</p>	PACKAGE SEEN 1 BRAND NAME _____ <input type="text"/> <input type="text"/> (SPECIFY) PACKAGE NOT SEEN 2	→ 313
312	<p>Do you know the brand name of the (pills/condoms) you are using?</p> <p>RECORD NAME OF BRAND.</p>	BRAND NAME _____ <input type="text"/> <input type="text"/> (SPECIFY) DON'T KNOW 98	
313	<p>How many (pill cycles/condoms) did you or your husband get the last time?</p>	NUMBER OF PILL CYCLES/CONDOMS ... <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	→ 316
314	<p>Can you tell me the name of the injection you are using?</p>	BRAND NAME _____ <input type="text"/> (SPECIFY) DON'T KNOW 8	
315	<p>Please tell me for how many weeks one injection is effective?</p>	NUMBER OF WEEKS <input type="text"/> <input type="text"/> DON'T KNOW 98	
316	<p>The last time you obtained (CURRENT METHOD), how much did you pay in total, including the cost of the method and any consultation you may have had?</p> <p>IF STERILISED: How much did you or your husband pay for the sterilisation, including any consultation?</p>	NOTHING, FREE 0000 Rs. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Rs. 10000+ . . . 9995 DON'T KNOW . . . 9998	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
317	<p>Where did you obtain (CURRENT METHOD) the last time?</p> <p>IF STERILISED: Where did the sterilisation take place?</p> <p>IF SOURCE IS HOSPITAL, HEALTH CENTER, OR FWC, WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE.</p> <p>_____</p> <p>(NAME OF PLACE)</p> <p>ONLY FOR MODERN METHOD</p>	<p>PUBLIC SECTOR</p> <p>GOVT. HOSPITAL/RHSC 11</p> <p>RURAL HEALTH CENTRE, MCH .. 12</p> <p>FAMILY WELFARE CENTRE..... 13</p> <p>MOBILE SERVICE CAMP 14</p> <p>LADY HEALTH WORKER..... 15</p> <p>LH VISITOR 16</p> <p>BASIC HEALTH UNIT 17</p> <p>MALE MOBILIZEF..... 18</p> <p>OTHER PUBLIC 19</p> <p>(SPECIFY)</p> <p>PRIVATE/NGO MEDICAL SECTOR</p> <p>PRIVATE/NGO HOSPITAL/CLINIC 21</p> <p>PHARMACY, CHEMISTS 22</p> <p>PRIVATE DOCTOR 23</p> <p>HOMEOPATH 24</p> <p>DISPENSER/COMPOUNDER 25</p> <p>OTHER PRIVATE</p> <p>MEDICAL..... 26</p> <p>(SPECIFY)</p> <p>OTHER SOURCE</p> <p>SHOP (NOT PHARMACY/CHEMI!.. 31</p> <p>FRIEND/RELATIVE 32</p> <p>HAKIM 33</p> <p>DAI, TRAD. BIRTH ATTENDANT . 34</p> <p>PUSHCART 35</p> <p>OTHER 96</p> <p>(SPECIFY)</p> <p>DON'T KNOW 98</p>									
318	<p>At the time you obtained (CURRENT METHOD) from the above source, were you told about side effects or problems you might have with the method?</p>	<p>YES 1</p> <p>NO 2</p>	→ 320								
319	<p>Were you told what to do if you experienced side effects or problems?</p>	<p>YES 1</p> <p>NO 2</p>									
320	<p>Were you ever told about other methods of family planning that you could use?</p>	<p>YES 1</p> <p>NO 2</p>									
321	<p>Since what month and year have you been using (CURRENT METHOD) without stopping?</p> <p>IF STERILISED: In what month and year was the sterilisation performed?</p> <p>PROBE: For how long have you been using (CURRENT METHOD) now without stopping?</p>	<p>MONTH <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><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p> <p>YEAR <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><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table></p>									→ 324

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
322	Do you know of a place where you can obtain a method of family planning?	YES 1 NO 2	→ 324
323	Where is that? IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. _____ (NAME OF PLACE) Any other place? RECORD ALL PLACES MENTIONED.	PUBLIC SECTOR GOVT. HOSPITAL/RHSC A RURAL HEALTH CENTRE, MCH B FAMILY WELFARE CENTRE C MOBILE SERVICE CAMP D LADY HEALTH WORKER (LHW) E LADY HEALTH VISITOR (LHV) ... F BASIC HEALTH UNIT G MALE MOBILIZER H OTHER PUBLIC I (SPECIFY) PRIVATE/NGO MEDICAL SECTOR PRIVATE, NGO HOSPITAL/CLINIC J PHARMACY, CHEMISTS K PRIVATE DOCTOR L HOMEOPATH M DISPENSER/COMPOUNDER N OTHER PRIVATE O MEDICAL O (SPECIFY) OTHER SOURCE SHOP (NOT PHARMACY) P FRIEND/RELATIVE Q HAKIM R DAI, TRAD. BIRTH ATTENDANT . S PUSH CART T OTHER X (SPECIFY)	
324	In the last 12 months, were you visited by a fieldworker or a Lady Health Worker who talked to you about family planning?	YES 1 NO 2	→ 327
325	Did you receive any care and help from this woman?	YES 1 NO 2	→ 327
326	What type of help did you receive? CIRCLE ALL MENTIONED.	INFORMATION A CONTRACEPTIVE SUPPLIES B REFERRED TO HEALTH / FP FACILITY C TREATMENT OF SIDE EFFECTS D OTHER X (SPECIFY)	
327	In the last month, have you heard a message about family planning on:	YES NO RADIO 1 2 TELEVISION 1 2	
328	CHECK 327: HEARD MESSAGE <input type="checkbox"/> (ANY YES IN 327) NOT HEARD MESSAGE <input type="checkbox"/>		→ 401

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
329	What messages did it convey to you? RECORD ALL MENTIONED	LIMITING THE FAMILY A HIGHER AGE AT MARRIAGE B SPACING OF CHILDREN C USE OF CONTRACEPTIVES D WELFARE OF FAMILY E MATERNAL AND CHILD HEALTH . . . F LESS CHILDREN MEAN PROSPEROUS LIFE G MORE CHILDREN MEAN POVERTY AND STARVATION H IMPORTANCE OF BREASTFEEDING . . I OTHER-1 _____ . . . X (SPECIFY) OTHER-2 _____ . . . Y (SPECIFY) DON'T KNOW/NOT REMEMBER Z	
330	Do you think that the message you heard was effective or not effective in persuading couples to use family planning?	EFFECTIVE 1 NOT EFFECTIVE 2 DK 8	

SECTION 4. PREGNANCY, LABOUR/DELIVERY AND POSTNATAL CARE

401	CHECK 225: ONE OR MORE LIVE BIRTHS IN 2001 OR LATER <input type="checkbox"/> NO LIVE BIRTHS IN 2001 OR LATER <input type="checkbox"/> → 601			
402	ENTER IN THE TABLE THE BIRTH NUMBER, NAME, AND SURVIVAL STATUS OF EACH BIRTH IN 2001 OR LATER. ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH. (IF THERE ARE MORE THAN 3 BIRTHS, USE LAST 2 COLUMNS OF ADDITIONAL QUESTIONNAIRES). Now I would like to ask you some questions about the health of all your children born since January 2001. (We will talk about each separately.)			
403	BIRTH NUMBER FROM 212	LAST BIRTH BIRTH NO. <input type="text"/> <input type="text"/>	NEXT-TO-LAST BIRTH BIRTH NO. <input type="text"/> <input type="text"/>	SECOND-FROM-LAST BIRTH BIRTH NO. <input type="text"/> <input type="text"/>
404	FROM 212 AND 216	NAME _____ LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>	NAME _____ LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>	NAME _____ LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>
405	At the time you became pregnant with (NAME), did you want to become pregnant <u>then</u> , did you want to wait until <u>later</u> , or did you <u>not want</u> to have any (more) children at all?	THEN 1 (SKIP TO 407) ← LATER 2 NOT AT ALL 3 (SKIP TO 407) ←	THEN 1 (SKIP TO 444) ← LATER 2 NOT AT ALL 3 (SKIP TO 444) ←	THEN 1 (SKIP TO 444) ← LATER 2 NOT AT ALL 3 (SKIP TO 444) ←
406	How much longer would you have liked to wait?	MONTHS ..1 <input type="text"/> <input type="text"/> YEARS ..2 <input type="text"/> <input type="text"/> DON'T KNOW ... 998	MONTHS ..1 <input type="text"/> <input type="text"/> YEARS ..2 <input type="text"/> <input type="text"/> DON'T KNOW ... 998	MONTHS ..1 <input type="text"/> <input type="text"/> YEARS ..2 <input type="text"/> <input type="text"/> DON'T KNOW ... 998
407	Did you see anyone for antenatal care for this pregnancy? IF YES: Whom did you see? Anyone else? PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD THE ALL MENTIONED.	HEALTH PERSON DOCTOR A NURSE/MIDWIFE/ LHV B OTHER PERSON DAI-TBA C LADY H. WORKER D HOMEOPATH ... E HAKIM F DISPENSER / COMPOUNDER .. G OTHER _____ X (SPECIFY) NO ONE Y (SKIP TO 417) ←		

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
408	<p>Where did you receive antenatal care for this pregnancy?</p> <p>Anywhere else?</p> <p>FOR ANY HOSPITAL, HEALTH CENTRE, OR CLINIC, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p>(NAME OF PLACE(S))</p> <p>PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.</p>	<p>HOME YOUR HOME ... A OTHER HOME ... B</p> <p>PUBLIC SECTOR GOVT. HOSPITAL.. C RHC/MCH D BHU/FWC E OTHER PUBLIC _____ F (SPECIFY)</p> <p>PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC H PVT. DOCTOR . . I HOMEOPATH . . J DISPENSER / COMPOUNDER . . K OTHER PRIVATE MED. _____ L (SPECIFY) HAKIM M OTHER _____ X (SPECIFY)</p>		
409	<p>The <u>first time</u> you went for antenatal care did you go because you had a problem or did you go just for a check-up?</p>	<p>FOR PROBLEM 1</p> <p>FOR CHECK-UP ONLY 2</p>		
410	<p>How many months pregnant were you when you first received antenatal care for <u>this</u> pregnancy?</p>	<p>MONTHS ... <input type="text"/> <input type="text"/></p> <p>DON'T KNOW 98</p>		
411	<p>How much did you pay for the first antenatal visit?</p>	<p>NOTHING / FREE .. 0000</p> <p>Rs. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Rs. 10000+ 9995</p> <p>DON'T KNOW 9998</p>		
412	<p>How many times did you receive antenatal care during this pregnancy?</p>	<p>NUMBER OF TIMES .. <input type="text"/> <input type="text"/></p> <p>DON'T KNOW 98</p>		

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
413	<p>As part of your antenatal care during this pregnancy, were any of the following measures taken at least once?</p> <p>Were you weighed?</p> <p>Was your blood pressure measured?</p> <p>Did you get a urine test?</p> <p>Did you get a blood test?</p> <p>Did you have an ultra sound exam?</p>	<p style="text-align: center;">YES NO</p> <p>WEIGHT . . . 1 2</p> <p>B.PRESSURE 1 2</p> <p>URINE 1 2</p> <p>BLOOD . . . 1 2</p> <p>U/S EXAM . 1 2</p>		
414	Do you know your blood group?	<p>YES 1</p> <p>NO 2</p>		
415	During any antenatal care visit, were you told about the <u>signs</u> of pregnancy complications?	<p>YES 1</p> <p>NO 2</p> <p style="text-align: center;">(SKIP TO 418) ←</p> <p>DON'T KNOW 8</p>		
416	During any antenatal care visit, were you told where to go if you had any of these complications?	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p> <p style="text-align: center;">(SKIP TO 418) ←</p>		
417	Why didn't you see anyone for an antenatal check-up?	<p>NOT NECESSARY .. A</p> <p>COSTS TOO MUCH .. B</p> <p>TOO FAR C</p> <p>NO TRANSPORT ... D</p> <p>NO ONE TO GO WITH E</p> <p>SERVICE NOT GOOD F</p> <p>NO TIME TO GO ... G</p> <p>DID NOT KNOW</p> <p>WHERE TO GO .. H</p> <p>DID NOT WANT TO SEE A MALE DOCTOR.. I</p> <p>LONG WAITING TIME J</p> <p>NOT ALLOWED TO GO. K</p> <p>OTHER _____ X</p> <p>_____ X</p>		

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
418	When you were pregnant with (NAME), did <u>anyone</u> talk to you about how to have a safe delivery? I mean things like using a safe delivery kit or a clean blade to cut the baby's cord or asking the person who helps you to wash their hands?	YES 1 NO 2 DON'T KNOW 8		
419	During this pregnancy, were you given an injection in the buttocks or your arm to prevent the baby from getting tetanus, that is, convulsions after birth?	YES 1 NO 2 (SKIP TO 422) ← DON'T KNOW 8		
420	During this pregnancy, how many times did you get this tetanus injection?	TIMES <input type="checkbox"/> DON'T KNOW 8		
421	CHECK 420	2 OR MORE TIMES <input type="checkbox"/> OTHER <input type="checkbox"/> (SKIP TO 426) ↓		
422	At any time <u>before this pregnancy</u> , did you receive any tetanus injections, either to protect yourself or another baby?	YES 1 NO 2 (SKIP TO 426) ← DON'T KNOW 8		
423	<u>Before this pregnancy</u> , how many other times did you receive a tetanus injection? IF 7 OR MORE TIMES, RECORD '7'.	TIMES <input type="checkbox"/> DON'T KNOW 8		

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
424	<p>In what month and year did you receive the last tetanus injection before this pregnancy?</p> <p>ASK TO SEE THE CHILD HEALTH/IMMUNISATION CARD. CHECK FOR TETANUS INJECTIONS FOR MOTHER.</p>	<p>MONTH ... <input type="text"/> <input type="text"/></p> <p>DK MONTH 98</p> <p>YEAR</p> <p><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>(SKIP TO 426) ←</p> <p>DK YEAR 9998</p>		
425	<p>How many years ago did you receive that tetanus injection?</p>	<p>YEARS AGO <input type="text"/> <input type="text"/></p>		
426	<p>During this pregnancy, were you given or did you buy any iron tablets or iron syrup?</p> <p>SHOW TABLETS/SYRUP.</p>	<p>YES 1</p> <p>NO 2</p> <p>(SKIP TO 428) ←</p> <p>DON'T KNOW 8</p>		
427	<p>During the whole pregnancy, for how many days did you take the tablets or syrup?</p> <p>IF ANSWER NOT NUMERIC, ASK FOR APPROXIMATE NUMBER.</p>	<p>DAYS .. <input type="text"/> <input type="text"/> <input type="text"/></p> <p>DIDN'T TAKE ... 997</p> <p>DON'T KNOW ... 998</p>		
428	<p>During this pregnancy, were you given or did you take calcium tablets?</p>	<p>YES 1</p> <p>NO 2</p> <p>(SKIP TO 430) ←</p> <p>DON'T KNOW 8</p>		
429	<p>During the whole pregnancy for how many days did you take the tablets?</p>	<p>DAYS .. <input type="text"/> <input type="text"/> <input type="text"/></p> <p>DIDN'T TAKE ... 997</p> <p>DON'T KNOW ... 998</p>		
430	<p>During this pregnancy, did you have difficulty with your vision during daylight?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>		
431	<p>During this pregnancy, did you suffer from night blindness <i>[Punjabi=andirata]</i></p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>		

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
432	During this pregnancy, did you suffer from malaria?	YES 1 NO 2 (SKIP TO 435) ← DON'T KNOW 8		
433	Did you receive treatment for the malaria during the pregnancy?	YES 1 NO 2 (SKIP TO 435) ←		
434	Where did you receive treatment for the malaria during this pregnancy? IF MORE THAN ONE PLACE, ASK FOR THE MAIN ONE.	HOME YOUR HOME ... 11 OTHER HOME ... 12 PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 BHU/FWC 23 LH WORKER ... 24 OTHER PUBLIC _____ 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC 31 PVT. DOCTOR .. 32 HOMEOPATH .. 33 DISPENSER / COMPOUNDER .. 34 HAKIM 35 OTHER PRIVATE MED. _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY)		
435	When you were pregnant with (NAME), did you have any of the following problems?: <div style="display: flex; justify-content: space-around;"> YES NO </div> Severe headaches? 1 2 Blurred vision? 1 2 Swelling of your hands? 1 2 Swelling of your face? 1 2 Vaginal bleeding /spotting 1 2 Fits or convulsions? 1 2 Epigastric pains? 1 2			

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____		
436	CHECK 435:	ANY YES ALL NO <input type="checkbox"/> <input type="checkbox"/> ↓ ↓ (SKIP TO 442)				
437	Were any of these problems so severe that you were afraid you might die?	YES 1 NO 2 DO NOT REMEMBER 8				
438	Did you seek advice or treatment for the problem(s)? IF YES: Whom did you see? Anyone else? PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED.	HEALTH PERSON DOCTOR A NURSE/MIDWIFE/ LHV B OTHER PERSON DAI-TBA C LADY H. WORKER D HOMEOPATH ... E HAKIM F DISPENSER / COMPOUNDER ... G OTHER _____ X (SPECIFY) NO ONE Y (SKIP TO 441) ←				
439	Where did you seek treatment for the problem(s)? Anywhere else? PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.	HOME YOUR HOME ... A OTHER HOME ... B PUBLIC SECTOR GOVT. HOSPITAL C RHC/MCH D BHU/FWC E OTHER PUBLIC _____ F (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC H PVT. DOCTOR .. I HOMEOPATH .. J DISPENSER / COMPOUNDER .. K HAKIM L OTHER PRIVATE MED. _____ M (SPECIFY) OTHER _____ X (SPECIFY)				

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
440	<p>How long after you first started having the (first) problem did you seek advice or treatment?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS IF LESS THAN ONE WEEK, RECORD DAYS. IF MORE THAN ONE WEEK, RECORD WEEKS.</p>	<p>HOURS .. .1 <input type="text"/></p> <p>DAYS2 <input type="text"/></p> <p>WEEKS3 <input type="text"/></p> <p>DON'T REMEMBER 998 (SKIP TO 442) ←</p>		
441	<p>Why didn't you see anyone for the problem(s)?</p> <p>RECORD ALL MENTIONED.</p>	<p>NOT NECESSARY .. A COSTS TOO MUCH .. B TOO FAR C NO TRANSPORT ... D NO ONE TO GO WITH E SERVICE NOT GOOD F NO TIME TO GO ... G DID NOT KNOW WHERE TO GO .. H DID NOT WANT TO SEE A MALE DOCTOR I LONG WAITING TIME J NOT ALLOWED TO GO. K OTHER _____ X (SPECIFY)</p>		
442	<p>During this pregnancy, did you and your husband discuss where you would deliver?</p>	<p>YES 1 NO 2 CANNOT REMEMBER 8</p>		
443	<p>During this pregnancy, did you set aside any money in case of an emergency?</p>	<p>YES 1 NO 2 CANNOT REMEMBER 8</p>		
444	<p>When (NAME) was born, was he/she very large, larger than average, average, smaller than average, or very small?</p>	<p>VERY LARGE 1 LARGER THAN AVERAGE 2 AVERAGE 3 SMALLER THAN AVERAGE 4 VERY SMALL 5 DON'T KNOW 8</p>		
445	<p>Was (NAME) weighed at birth?</p>	<p>YES 1 NO 2 (SKIP TO 447) ← DON'T KNOW 8</p>	<p>YES 1 NO 2 (SKIP TO 447) ← DON'T KNOW 8</p>	<p>YES 1 NO 2 (SKIP TO 447) ← DON'T KNOW 8</p>

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
446	How much did (NAME) weigh? RECORD WEIGHT IN KILOGRAMS FROM HEALTH CARD, IF AVAILABLE.	KG FROM CARD 1 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> KG FROM RECALL 2 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW .. 99.998	KG FROM CARD 1 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> KG FROM RECALL 2 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW .. 99.998	KG FROM CARD 1 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> KG FROM RECALL 2 <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW .. 99.998
447	Who assisted with the delivery of (NAME)? Anyone else? PROBE FOR THE TYPE OF PERSON AND RECORD ALL MENTIONED. IF RESPONDENT SAYS NO ONE ASSISTED, ASK IF ANY ADULTS WERE PRESENT AT THE DELIVERY.	HEALTH PERSON DOCTOR A NURSE/MIDWIFE/ LHV B OTHER PERSON DAI-TBA C LADY H. WORKER D HOMEOPATH ... E HAKIM F RELATIVE/FRIEND (NOT A DAI) ... G OTHER _____ X (SPECIFY) NO ONE Y	HEALTH PERSON DOCTOR A NURSE/MIDWIFE/ LHV B OTHER PERSON DAI-TBA C LADY H. WORKER D HOMEOPATH ... E HAKIM F RELATIVE/FRIEND (NOT A DAI) ... G OTHER _____ X (SPECIFY) NO ONE Y	HEALTH PERSON DOCTOR A NURSE/MIDWIFE/ LHV B OTHER PERSON DAI-TBA C LADY H. WORKER D HOMEOPATH ... E HAKIM F RELATIVE/FRIEND (NOT A DAI) ... G OTHER _____ X (SPECIFY) NO ONE Y
448	Were you given an injection to induce labour to deliver (NAME) ?	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8
449	Where did you give birth to (NAME)? IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. _____ (NAME OF PLACE - Last birth) _____ (NAME OF PLACE - next to last birth) _____ (NAME OF PLACE - 2nd from last birth)	HOME YOUR HOME ... 11 (SKIP TO 458) ← OTHER HOME ... 12 PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 OTHER PUBLIC _____ 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC 31 OTHER PRIVATE MED. _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY) (SKIP TO 458) ←	HOME YOUR HOME ... 11 (SKIP TO 464) ← OTHER HOME ... 12 PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 OTHER PUBLIC _____ 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC 31 OTHER PRIVATE MED. _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY) (SKIP TO 464) ←	HOME YOUR HOME ... 11 (SKIP TO 464) ← OTHER HOME ... 12 PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 OTHER PUBLIC _____ 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC 31 OTHER PRIVATE MED. _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY) (SKIP TO 464) ←
450	Why did you deliver at the hospital/health centre?	<input type="text"/> <input type="text"/> _____ _____ _____	<input type="text"/> <input type="text"/> _____ _____ _____	<input type="text"/> <input type="text"/> _____ _____ _____

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
451	<p>How long after (NAME) was delivered did you stay there?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS. IF ONE WEEK OR MORE, RECORD WEEKS.</p>	<p>HOURS.. 1 <input type="text"/><input type="text"/></p> <p>DAYS .. 2 <input type="text"/><input type="text"/></p> <p>WEEKS.. 3 <input type="text"/><input type="text"/></p> <p>DON'T KNOW .. 998</p>	<p>HOURS.. 1 <input type="text"/><input type="text"/></p> <p>DAYS .. 2 <input type="text"/><input type="text"/></p> <p>WEEKS.. 3 <input type="text"/><input type="text"/></p> <p>DON'T KNOW ... 998</p>	<p>HOURS.. 1 <input type="text"/><input type="text"/></p> <p>DAYS .. 2 <input type="text"/><input type="text"/></p> <p>WEEKS.. 3 <input type="text"/><input type="text"/></p> <p>DON'T KNOW 998</p>
452	Was (NAME) delivered by caesarean section?	<p>YES 1</p> <p>NO 2</p>	<p>YES 1</p> <p>NO 2</p>	<p>YES 1</p> <p>NO 2</p>
453	In total, how much did you pay for the delivery, including doctors' fees, facility costs and medicines?	<p>NOTHING, FREE 0000</p> <p>Rs. <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Rs. 10000+ . . . 9995</p> <p>DON'T KNOW . . . 9998</p>		
454	Before you were discharged after (NAME) was born, did any health personnel check on your health?	<p>YES 1</p> <p>NO 2 (SKIP TO 457) ←</p>	<p>YES 1 (SKIP TO 482) ←</p> <p>NO 2</p>	<p>YES 1 (SKIP TO 482) ←</p> <p>NO 2</p>
455	<p>How many hours, days or weeks after delivery did the first check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS. IF MORE THAN ONE WEEK, RECORD WEEKS.</p>	<p>HOURS 1 <input type="text"/><input type="text"/></p> <p>DAYS 2 <input type="text"/><input type="text"/></p> <p>WEEKS 3 <input type="text"/><input type="text"/></p> <p>DON'T KNOW ... 998</p>		
456	<p>Who checked on your health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p>HEALTH PERSONNEL</p> <p>DOCTOR 11 ←</p> <p>NURSE/MIDWIFE</p> <p>LHV 12 ←</p> <p>OTHER PERSON</p> <p>DAI- TBA 21 ←</p> <p>LADY H.WORKER 22</p> <p>HOMEOPATH ... 23 ←</p> <p>HAKIM 24 ←</p> <p>OTHER _____ 96 ← (SPECIFY) (SKIP TO 472) ←</p>		

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____						
457	After you were discharged, did any health care provider or a traditional birth attendant check on your health?	YES 1 (SKIP TO 465) ← NO 2 (SKIP TO 472) ←	YES 1 (SKIP TO 482) ← NO 2	YES 1 (SKIP TO 482) ← NO 2						
458	Why didn't you deliver in a health facility? PROBE: Any other reason? RECORD ALL MENTIONED.	COST TOO MUCH . . . A FACILITY NOT OPEN . B TOO FAR/ NO TRANS- PORTATION C DON'T TRUST FACILITY/POOR QUALITY SERVICE D NO FEMALE PROVID- ER AT FACILITY .. E HUSBAND/FAMILY DID NOT ALLOW .. F NOT NECESSARY .. G NOT CUSTOMARY .. H NO TIME/ BABY CAME TOO FAST .. I OTHER _____ (SPECIFY) X								
459	In total, how much did you pay for the delivery?	NOTHING, FREE 0000 Rs. <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><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table> Rs. 10000+ 9995 DON'T KNOW ... 9998								
460	Was a safe delivery kit used during this delivery?	YES 1 NO 2 DOES NOT KNOW .. 8								
461	What was used to TIE the umbilical cord?	UNBOILED THREAD 1 BOILED THREAD ... 2 WASHED CLAMPS .. 3 UNWASHED CLAMPS 4 HAIR 5 OTHER _____ 6								
462	What was used to CUT the umbilical cord?	NEW RAZOR BLADE 1 OLD RAZOR BLADE 2 SCISSORS 3 KNIFE 4 TOKA, CHOPPER ... 5 OTHER _____ 6								
463	Was the instrument boiled before using or not boiled?	BOILED 1 NOT BOILED 2 DON'T KNOW 8								

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____						
464	After (NAME) was born, did any health care provider or a traditional birth attendant check on your health?	YES 1 NO 2 (SKIP TO 468) ←	YES 1 NO 2	YES 1 NO 2						
465	How many hours, days or weeks after delivery did the first check take place? IF LESS THAN 1 DAY, RECORD HOURS. IF LESS THAN 1 WEEK, RECORD DAYS; IF ONE WEEK OR MORE, RECORD WEEKS.	HOURS... 1 <table border="1" data-bbox="812 520 899 667"><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table> DAYS ... 2 WEEKS... 3 DON'T KNOW ... 998								
466	Who checked on your health at that time? PROBE FOR MOST QUALIFIED PERSON.	HEALTH PERSONNEL DOCTOR 11 NURSE/MIDWIFE LHV 12 OTHER PERSON DAI- TBA 21 LADY H.WORKER 22 HOMEOPATH ... 23 HAKIM 24 DISPENSER / COMPOUNDER .. 25 OTHER _____ 96 (SPECIFY)								
467	Where did this first check take place? IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, RECORD THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. _____ (NAME OF PLACE)	HOME YOUR HOME ... 11 OTHER HOME ... 12 PUBLIC SECTOR GOVT. HOSPITAL.. 21 RHC/MCH 22 BHU/FWC 23 OTHER PUBLIC _____ 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC 31 OTHER PRIVATE MED. _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY)								
468	In the two months after (NAME) was born, did any health care provider or dai or a LHW or hakim check on <u>his/her</u> health?	YES 1 NO 2 (SKIP TO 472) ← DON'T KNOW 8								

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____						
469	<p>How many hours, days or weeks after the birth of (NAME) did the first check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS. IF LESS THAN ONE WEEK, RECORD DAYS. IF ONE WEEK OR MORE, RECORD WEEKS.</p>	<p>HOURS.. 1 <table border="1" data-bbox="813 285 899 323"><tr><td></td><td></td></tr></table></p> <p>DAYS .. 2 <table border="1" data-bbox="813 327 899 365"><tr><td></td><td></td></tr></table></p> <p>WEEKS.. 3 <table border="1" data-bbox="813 369 899 407"><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW ... 998</p>								
470	<p>Who checked on (NAME)'s health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p>HEALTH PERSONNEL DOCTOR 11 NURSE/MIDWIFE LHV 12 OTHER PERSON DAI- TBA 21 LADY H.WORKER 22 HOMEOPATH ... 23 HAKIM 24 OTHER _____ 96 (SPECIFY)</p>								
471	<p>Where did this first check of (NAME) take place?</p> <p>IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, RECORD THE NAME OF THE PLACE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE.</p> <p>_____ (NAME OF PLACE)</p>	<p>HOME YOUR HOME ... 11 OTHER HOME ... 12 PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 BHU/FWC 23 OTHER PUBLIC _____ 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC 31 OTHER PRIVATE MED. _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY)</p>								
472	<p>How long after birth was (NAME) first bathed?</p> <p>IF LESS THAN 1 HOUR, RECORD '00' HOURS. IF LESS THAN 24 HOURS, RECORD HOURS. IF ONE DAY OR MORE RECORD DAYS.</p>	<p>IMMEDIATELY ... 000</p> <p>HOURS.. 1 <table border="1" data-bbox="813 1398 899 1436"><tr><td></td><td></td></tr></table></p> <p>DAYS .. 2 <table border="1" data-bbox="813 1440 899 1478"><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW ... 998</p>								

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
473	<p>During the delivery or in the 40-day period after the delivery of (NAME), did you experience any of the following problems?</p> <p style="text-align: center;">YES NO</p> <p>Severe headaches? 1 2</p> <p>Blurred vision? 1 2</p> <p>Swelling of your hands? 1 2</p> <p>Swelling of your face? 1 2</p> <p>High fever? 1 2</p> <p>Fits or convulsions? 1 2</p> <p>Labor for more than 12 hours? 1 2</p> <p>Baby's feet came first? 1 2</p> <p>Placenta came first? 1 2</p> <p>Continuous dribbling of urine even during sleep 1 2</p> <p>Bad-smelling vaginal discharge? 1 2</p> <p>Inability to control motions. 1 2</p> <p>Heavy vaginal bleeding? 1 2</p> <p style="text-align: center;">(SKIP TO 474) ←</p> <p>IF YES: When did you experience this:</p> <p style="padding-left: 40px;">Immediately after birth of baby 0</p> <p style="padding-left: 40px;">In the first 24 hours 1</p> <p style="padding-left: 40px;">Later 2</p>			
474	<p>CHECK 473: ANY YES <input type="checkbox"/></p>	<p>ALL NO <input type="checkbox"/> → (SKIP TO 480)</p>		
475	<p>Were any of these problems so severe that you were afraid you might die?</p>	<p>YES 1</p> <p>NO 2</p> <p>CANNOT REMEMBER 8</p>		

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____														
476	<p>Did you seek advice or treatment for the problem(s)?</p> <p>IF YES: Whom did you see?</p> <p>Anyone else?</p> <p>PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD THE ALL MENTIONED.</p>	<p>HEALTH PERSON DOCTOR A NURSE/MIDWIFE/ LHV B OTHER PERSON DAI-TBA C LADY H. WORKER D HOMEOPATH ... E HAKIM F OTHER _____ X (SPECIFY) NO ONE Y (SKIP TO 479) ←</p>																
477	<p>Where did you seek treatment for the problem(s)?</p> <p>Anywhere else?</p> <p>PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.</p>	<p>HOME YOUR HOME ... A OTHER HOME ... B PUBLIC SECTOR GOVT. HOSPITAL C RHC/MCH D BHU/FWC E OTHER PUBLIC _____ F (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC H PVT. DOCTOR .. I HOMEOPATH .. J DISPENSER / COMPOUNDER ... K HAKIM L OTHER PRIVATE MED. _____ M (SPECIFY) OTHER _____ X (SPECIFY)</p>																
478	<p>How long after you first started having the problem did you seek advice or treatment?</p> <p>IF LESS THAN 1 HOUR, RECORD '00' HOURS. IF LESS THAN 24 HOURS, RECORD HOURS. IF LESS THAN 7 DAYS, RECORD DAYS. OTHERWISE WEEKS.</p>	<p>HOURS.. ..1 <table border="1" data-bbox="812 1186 901 1249"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DAYS2 <table border="1" data-bbox="812 1249 901 1312"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>WEEKS... ..3 <table border="1" data-bbox="812 1312 901 1375"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW ... 998 (SKIP TO 480) ←</p>																

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____		
479	Why didn't you see anyone for the problem(s)? CIRCLE ALL MENTIONED.	NOT NECESSARY A COSTS TOO MUCH B FACILITY TOO FAR AWAY ... C NO TRANSPORT ... D NO ONE TO GO WITH E SERVICE NOT GOOD F NO TIME TO GO ... G DID NOT KNOW WHERE TO GO H DID NOT WANT TO SEE A MALE DOCTOR I LONG WAITING TIME J NOT ALLOWED TO GO. K OTHER _____ X				
480	In the first two months after delivery, did you receive a vitamin A dose like this? SHOW AMPULES/CAPSULE/SYRUP.	YES 1 NO 2				
481	Has your menstrual period returned since the birth of (NAME)?	YES 1 (SKIP TO 483) ← NO 2 (SKIP TO 484) ←				
482	Did your period return between the birth of (NAME) and your next pregnancy?				YES 1 NO 2 (SKIP TO 486) ←	YES 1 NO 2 (SKIP TO 486) ←
483	For how many months after the birth of (NAME) did you <u>not</u> have a period?	MONTHS ... <input type="text"/> <input type="text"/> DON'T KNOW 98	MONTHS ... <input type="text"/> <input type="text"/> DON'T KNOW 98	MONTHS ... <input type="text"/> <input type="text"/> DON'T KNOW 98		
484	CHECK 226: IS RESPONDENT PREGNANT?	NOT <input type="checkbox"/> PREGNANT PREG- OR <input type="checkbox"/> NANT UNSURE ↓ (SKIP TO 486) ←				
485	Have you resumed sexual relations since the birth of (NAME)?	YES 1 NO 2 (SKIP TO 487) ←				

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____						
486	For how many months after the birth of (NAME) did you <u>not</u> have sexual relations?	MONTHS ... <input type="text"/> <input type="text"/> DON'T KNOW 98	MONTHS ... <input type="text"/> <input type="text"/> DON'T KNOW 98	MONTHS ... <input type="text"/> <input type="text"/> DON'T KNOW 98						
487	Did you ever breastfeed (NAME)?	YES 1 NO 2 (SKIP TO 495) ←	YES 1 NO 2 (SKIP TO 495) ←	YES 1 NO 2 (SKIP TO 495) ←						
488	How long after birth did you first put (NAME) to the breast? IF LESS THAN 1 HOUR, RECORD '00' HOURS. IF LESS THAN 24 HOURS, RECORD HOURS. OTHERWISE, RECORD DAYS.	IMMEDIATELY ... 000 HOURS 1 <input type="text"/> <input type="text"/> DAYS 2 <input type="text"/> <input type="text"/>								
489	Did you give the (NAME) the thick milk (colostrum) that comes first or did you discard it?	GAVE COLOSTRUM 1 DISCARDED IT ... 2 DO NOT REMEMBER 8								
490	In the first three days after delivery, was (NAME) given anything to drink other than breast milk?	YES 1 NO 2 (SKIP TO 492) ←								
491	What was (NAME) given to drink? Anything else? RECORD ALL LIQUIDS MENTIONED.	MILK (OTHER THAN BREAST MILK) . . A PLAIN WATER ... B HONEY OR SUGAR WATER ... C GHEE, BUTTER ... D FRUIT JUICE E INFANT FORMULA . F GHUTEE G GREEN TEA H OTHER _____ X (SPECIFY)								
492	CHECK 404: IS CHILD LIVING?	LIVING DEAD <input type="checkbox"/> <input type="checkbox"/> (SKIP TO 494) ←								
493	Are you still breastfeeding (NAME)?	YES 1 (SKIP TO 496) ← NO 2								

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____																		
494	For how many months did you breastfeed (NAME)? IF LESS THAN ONE MONTH, RECORD '00'	MONTHS ... <input type="text"/> <input type="text"/> DON'T KNOW ... 98	MONTHS ... <input type="text"/> <input type="text"/> STILL BF 95 DON'T KNOW ... 98	MONTHS ... <input type="text"/> <input type="text"/> STILL BF 95 DON'T KNOW ... 98																		
495	CHECK 404: IS CHILD LIVING?	LIVING <input type="checkbox"/> DEAD <input type="checkbox"/> (GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501) (SKIP TO 498)	LIVING <input type="checkbox"/> DEAD <input type="checkbox"/> (GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501) (SKIP TO 499)	LIVING <input type="checkbox"/> DEAD <input type="checkbox"/> (GO BACK TO 405 IN NEXT COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 501) (SKIP TO 499)																		
496	How many times did you breastfeed last night between sunset and sunrise? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER.	NUMBER OF NIGHTTIME FEEDINGS .. <input type="text"/> <input type="text"/>																				
497	How many times did you breastfeed yesterday during the daylight hours? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER.	NUMBER OF DAYLIGHT FEEDINGS .. <input type="text"/> <input type="text"/>																				
498	Yesterday or last night, did (NAME) drink or eat: Plain water? Baby formula or other milk? Juice, soda, tea, rice water? Any mushy or solid food?	<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td>DK</td> </tr> <tr> <td>WATER ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>MILK ...</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>JUICE/SODA</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>FOOD ...</td> <td>1</td> <td>2</td> <td>8</td> </tr> </table>				YES	NO	DK	WATER ..	1	2	8	MILK ...	1	2	8	JUICE/SODA	1	2	8	FOOD ...	1
	YES	NO	DK																			
WATER ..	1	2	8																			
MILK ...	1	2	8																			
JUICE/SODA	1	2	8																			
FOOD ...	1	2	8																			
499	Did (NAME) drink anything from a bottle with a nipple yesterday or last night?	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8																		
499A		GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501.	GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501.	GO BACK TO 405 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 501.																		

SECTION 5. CHILD VACCINATION, HEALTH AND NUTRITION

501	ENTER IN THE TABLE THE BIRTH NUMBER, NAME, AND SURVIVAL STATUS OF EACH LIVE BIRTH IN 2001 OR LATER. ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH. (IF THERE ARE MORE THAN 3 BIRTHS, USE LAST 2 COLUMNS OF ADDITIONAL QUESTIONNAIRES).																																																																																																																																																							
502	BIRTH NUMBER FROM 212	LAST BIRTH BIRTH NUMBER <input type="text"/> <input type="text"/>	NEXT-TO-LAST BIRTH BIRTH NUMBER <input type="text"/> <input type="text"/>																																																																																																																																																					
503	FROM 212 AND 216	NAME _____ LIVING <input type="checkbox"/> DEAD <input type="checkbox"/> <input type="checkbox"/> (GO TO 503 IN NEXT COLUMN OR, IF NO MORE BIRTHS, GO TO 601)	NAME _____ LIVING <input type="checkbox"/> DEAD <input type="checkbox"/> <input type="checkbox"/> (GO TO 503 IN NEXT COLUMN OR, IF NO MORE BIRTHS, GO TO 601)																																																																																																																																																					
504	Do you have a card where (NAME'S) vaccinations are written down? IF YES: May I see it please?	YES, SEEN 1 (SKIP TO 506) ← YES, NOT SEEN 2 (SKIP TO 508) ← NO CARD 3	YES, SEEN 1 (SKIP TO 506) ← YES, NOT SEEN 2 (SKIP TO 508) ← NO CARD 3																																																																																																																																																					
505	Did you ever have a vaccination card for (NAME)?	YES 1 (SKIP TO 508) ← NO 2	YES 1 (SKIP TO 508) ← NO 2																																																																																																																																																					
506	<p>(1) COPY DATE OF BIRTH IF GIVEN. IF NOT ON CARD, LEAVE IT BLANK. (2) COPY VACCINATION DATE FOR EACH VACCINE FROM THE CARD. (3) WRITE '44' IN 'DAY' COLUMN IF CARD SHOWS THAT A VACCINATION WAS GIVEN, BUT NO DATE IS RECORDED.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">LAST BIRTH</th> <th colspan="3">NEXT-TO-LAST BIRTH</th> <th colspan="3">SECOND-FROM-LAST BIRTH</th> </tr> <tr> <th>DAY</th> <th>MONTH</th> <th>YEAR</th> <th>DAY</th> <th>MONTH</th> <th>YEAR</th> <th>DAY</th> <th>MONTH</th> <th>YEAR</th> </tr> </thead> <tbody> <tr> <td>BIRTH</td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> <tr> <td>BCG</td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td><input 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NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
507	Has (NAME) received any vaccinations that are not recorded on this card, including vaccinations received in a national immunization day campaign? RECORD 'YES' ONLY IF RESPONDENT MENTIONS BCG, POLIO 0-3, DPT 1-3, HBV, OR MEASLES VACCINES.	YES 1 (PROBE FOR ← VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 506) (SKIP TO 510) ← NO 2 (SKIP TO 510) ← DON'T KNOW 8	YES 1 (PROBE FOR ← VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 506) (SKIP TO 510) ← NO 2 (SKIP TO 510) ← DON'T KNOW 8	YES 1 (PROBE FOR ← VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 506) (SKIP TO 510) ← NO 2 (SKIP TO 510) ← DON'T KNOW 8
508	Did (NAME) ever receive any vaccinations to prevent him/her from getting diseases, including vaccinations received in a national immunisation campaign?	YES 1 NO 2 (SKIP TO 511) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 511) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 511) ← DON'T KNOW 8
509	Please tell me if (NAME) received any of the following vaccinations:			
509A	A BCG vaccination against tuberculosis, that is, an injection in the arm or shoulder that usually causes a scar?	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8
509B	Polio vaccine, that is, drops in the mouth?	YES 1 NO 2 (SKIP TO 509E) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 509E) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 509E) ← DON'T KNOW 8
509C	Was the first time polio drops were received in the first 2 weeks after birth or later?	FIRST 2 WEEKS ... 1 LATER 2	FIRST 2 WEEKS ... 1 LATER 2	FIRST 2 WEEKS ... 1 LATER 2
509D	How many times was the polio vaccine received? IF 7 OR MORE TIMES RECORD 7	NUMBER OF TIMES <input type="text"/>	NUMBER OF TIMES <input type="text"/>	NUMBER OF TIMES <input type="text"/>

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
509E	A DPT vaccination, that is, an injection given in the thigh or buttocks,(sometimes at the same time as polio drops)?	YES 1 NO 2 (SKIP TO 509G) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 509G) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 509G) ← DON'T KNOW 8
509F	How many times was a DPT vaccination received?	NUMBER OF TIMES <input type="text"/>	NUMBER OF TIMES <input type="text"/>	NUMBER OF TIMES <input type="text"/>
509G	A hepatitis HBV vaccination, that is an injection given in the thigh or buttocks, sometimes at the same time as polio drops?	YES 1 NO 2 (SKIP TO 509I) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 509I) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 509I) ← DON'T KNOW 8
509H	How many times was an HBV vaccination received?	NUMBER OF TIMES <input type="text"/>	NUMBER OF TIMES <input type="text"/>	NUMBER OF TIMES <input type="text"/>
509I	An injection to prevent measles?	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8
510	Did (NAME) ever receive a polio vaccine (drops in the mouth) during a national immunisation day campaign? IF YES, CHECK 506 OR 509D IS 1 OR MORE.	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2
511	Has (NAME) ever received a vitamin A dose like this? SHOW VIT.A CAPSULES.	YES 1 NO 2 (SKIP TO 513) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 513) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 513) ← DON'T KNOW 8
512	How many months ago did (NAME) take the last dose? PUT "00" IF LESS THAN 1 MONTH	MONTHS AGO <input type="text"/> <input type="text"/> DON'T KNOW 98	MONTHS AGO <input type="text"/> <input type="text"/> DON'T KNOW 98	MONTHS AGO <input type="text"/> <input type="text"/> DON'T KNOW 98

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
513	Has (NAME) had diarrhea in the last 2 weeks?	YES 1 NO 2 (SKIP TO 525) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 525) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 525) ← DON'T KNOW 8
514	Was there any blood in the stools?	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8
515	Has (NAME) had diarrhea in the <u>last 24 hours</u> ?	YES 1 NO 2 (SKIP TO 517) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 517) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 517) ← DON'T KNOW 8
516	How many times did (NAME) pass stool in the <u>last 24 hours</u> ?	NUMBER OF STOOLS .. <input type="text"/> <input type="text"/>	NUMBER OF STOOLS .. <input type="text"/> <input type="text"/>	NUMBER OF STOOLS .. <input type="text"/> <input type="text"/>
517	Now I would like to know how much (NAME) was given to drink during the diarrhea. Was he/she given less than usual to drink, about the same amount, or more than usual to drink? IF LESS, PROBE: Was he/she given much less than usual to drink or somewhat less?	MUCH LESS 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8
518	When (NAME) had diarrhea, was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? IF LESS, PROBE: Was he/she given much less than usual to eat or somewhat less?	MUCH LESS 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . . 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . . 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS . 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . . 5 NEVER GAVE FOOD 6 DON'T KNOW 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
519	Did you seek advice or treatment for the diarrhea from any source?	YES 1 NO 2 (SKIP TO 522) ←	YES 1 NO 2 (SKIP TO 522) ←	YES 1 NO 2 (SKIP TO 522) ←
520	Where did you seek advice or treatment? Anywhere else? FOR ANY HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE) _____ (NAME OF PLACE) _____ (NAME OF PLACE) PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.	PUBLIC SECTOR GOVT. HOSPITAL A RHC/MCH B BHU/FWC C LADY H.WORKER D OTHER PUBLIC _____ E (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC F CHEMIST G PVT. DOCTOR ... H HOMEOPATH ... I DISPENSER / COMPOUNDER .. J OTHER PRIVATE MED. _____ K (SPECIFY) OTHER SOURCE SHOP L HAKIM M DAI, TBA N OTHER _____ X (SPECIFY)	PUBLIC SECTOR GOVT. HOSPITAL A RHC/MCH B BHU/FWC C LADY H.WORKER D OTHER PUBLIC _____ E (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC F CHEMIST G PVT. DOCTOR ... H HOMEOPATH ... I DISPENSER / COMPOUNDER .. J OTHER PRIVATE MED. _____ K (SPECIFY) OTHER SOURCE SHOP L HAKIM M DAI, TBA N OTHER _____ X (SPECIFY)	PUBLIC SECTOR GOVT. HOSPITAL A RHC/MCH B BHU/FWC C LADY H.WORKER D OTHER PUBLIC _____ E (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/ CLINIC F CHEMIST G PVT. DOCTOR ... H HOMEOPATH ... I DISPENSER / COMPOUNDER .. J OTHER PRIVATE MED. _____ K (SPECIFY) OTHER SOURCE SHOP L HAKIM M DAI, TBA N OTHER _____ X (SPECIFY)
521	How many days after the illness began did you first seek advice or treatment for (NAME) IF THE SAME DAY RECORD '00'	Days <input type="text"/> <input type="text"/>	Days <input type="text"/> <input type="text"/>	Days <input type="text"/> <input type="text"/>
522	Was he/she given any of the following to drink at any time since he/she started having the diarrhea:			
522A	A fluid made from a special packet called ORS or Nimkol?	YES NO DK FLUID FROM ORS PKT .. 1 2 8	YES NO DK FLUID FROM ORS PKT .. 1 2 8	YES NO DK FLUID FROM ORS PKT .. 1 2 8
522B	A drink made at home with sugar, salt and water?	HOMEMADE FLUID ... 1 2 8	HOMEMADE FLUID ... 1 2 8	HOMEMADE FLUID ... 1 2 8
523	Was anything (else) given to treat the diarrhea?	YES 1 NO 2 (SKIP TO 525) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 525) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 525) ← DON'T KNOW 8

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
524	<p>What (else) was given to treat the diarrhea?</p> <p>Anything else?</p> <p>RECORD ALL TREATMENTS GIVEN.</p>	PILLS/SYRUP A INJECTION B I V DRIP C HOME REMEDY/ HERBAL MEDICINE / ISPAGHOL D OTHER _____ X (SPECIFY)	PILLS/SYRUP A INJECTION B I V DRIP C HOME REMEDY/ HERBAL MEDICINE / ISPAGHOL D OTHER _____ X (SPECIFY)	PILLS/SYRUP A INJECTION B I V DRIP C HOME REMEDY/ HERBAL MEDICINE / ISPAGHOL D OTHER _____ X (SPECIFY)
525	<p>Has (NAME) been ill with a fever at any time in the last 2 weeks?</p>	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8
526	<p>Has (NAME) had an illness with a cough at any time in the last 2 weeks?</p>	YES 1 NO 2 (SKIP TO 529) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 529) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 529) ← DON'T KNOW 8
527	<p>When (NAME) had an illness with a cough, did he/she breathe faster than usual with short, rapid breaths or have difficulty breathing?</p>	YES 1 NO 2 (SKIP TO 530) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 530) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 530) ← DON'T KNOW 8
528	<p>Were these breathing symptoms due to a problem in the chest or to a blocked or runny nose?</p>	CHEST ONLY ... 1 NOSE ONLY 2 BOTH 3 OTHER 6 (SPECIFY) DON'T KNOW 8 (SKIP TO 530) ←	CHEST ONLY ... 1 NOSE ONLY 2 BOTH 3 OTHER 6 (SPECIFY) DON'T KNOW 8 (SKIP TO 530) ←	CHEST ONLY ... 1 NOSE ONLY 2 BOTH 3 OTHER 6 (SPECIFY) DON'T KNOW 8 (SKIP TO 530) ←

NO.	QUESTIONS AND FILTERS	LAST BIRTH		NEXT-TO-LAST BIRTH		SECOND-FROM-LAST BIRTH	
		NAME _____	NAME _____	NAME _____	NAME _____	NAME _____	NAME _____
529	CHECK 525: HAD FEVER?	YES <input type="checkbox"/> ↓ (GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)	NO OR DK <input type="checkbox"/> ↓ (GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)	YES <input type="checkbox"/> ↓ (GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)	NO OR DK <input type="checkbox"/> ↓ (GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)	YES <input type="checkbox"/> ↓ (GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)	NO OR DK <input type="checkbox"/> ↓ (GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)
530	Now I would like to know how much (NAME) was given to drink during the illness with a (fever/cough). Was he/she given less than usual to drink, about the same amount, or more than usual to drink? IF LESS, PROBE: Was he/she given much less than usual to drink or somewhat less?	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 NOTHING TO DRINK.. 5 DON'T KNOW 8
531	When (NAME) had a (fever/cough), was he/she given less than usual to eat, about the same amount, more than usual, or nothing to eat? IF LESS, PROBE: Was he/she given much less than usual to eat or somewhat less?	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . 5 NEVER GAVE FOOD 6 DON'T KNOW 8	MUCH LESS 1 SOMEWHAT LESS .. 2 ABOUT THE SAME . 3 MORE 4 STOPPED FOOD . 5 NEVER GAVE FOOD 6 DON'T KNOW 8
532	Did you seek advice or treatment for the illness from any source?	YES 1 NO 2 (SKIP TO 535) →	YES 1 NO 2 (SKIP TO 535) →	YES 1 NO 2 (SKIP TO 535) →	YES 1 NO 2 (SKIP TO 535) →	YES 1 NO 2 (SKIP TO 535) →	YES 1 NO 2 (SKIP TO 535) →

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
533	<p>Where did you seek advice or treatment?</p> <p>Anywhere else?</p> <p>FOR ANY HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p>(NAME OF PLACE(S))</p> <p>PROBE TO IDENTIFY TYPE(S) OF SOURCE(S) AND RECORD ALL MENTIONED.</p>	<p>PUBLIC SECTOR</p> <p>GOVT. HOSPITAL A</p> <p>RHC/MCH B</p> <p>BHU/FWC C</p> <p>LADY H.WORKER D</p> <p>OTHER PUBLIC _____ E</p> <p>(SPECIFY)</p> <p>PRIVATE MED. SECTOR</p> <p>PVT. HOSPITAL/CLINIC F</p> <p>PHARMACY G</p> <p>PVT. DOCTOR ... H</p> <p>HOMEOPATH ... I</p> <p>DISPENSER / COMPOUNDER ... J</p> <p>OTHER PRIVATE MED. _____ K</p> <p>(SPECIFY)</p> <p>OTHER SOURCE</p> <p>SHOP L</p> <p>HAKIM M</p> <p>DAI, TBA N</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p>	<p>PUBLIC SECTOR</p> <p>GOVT. HOSPITAL A</p> <p>RHC/MCH B</p> <p>BHU/FWC C</p> <p>LADY H.WORKER D</p> <p>OTHER PUBLIC _____ E</p> <p>(SPECIFY)</p> <p>PRIVATE MED. SECTOR</p> <p>PVT. HOSPITAL/CLINIC F</p> <p>PHARMACY G</p> <p>PVT. DOCTOR ... H</p> <p>HOMEOPATH ... I</p> <p>DISPENSER / COMPOUNDER ... J</p> <p>OTHER PRIVATE MED. _____ K</p> <p>(SPECIFY)</p> <p>OTHER SOURCE</p> <p>SHOP L</p> <p>HAKIM M</p> <p>DAI, TBA N</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p>	<p>PUBLIC SECTOR</p> <p>GOVT. HOSPITAL A</p> <p>RHC/MCH B</p> <p>BHU/FWC C</p> <p>LADY H.WORKER D</p> <p>OTHER PUBLIC _____ E</p> <p>(SPECIFY)</p> <p>PRIVATE MED. SECTOR</p> <p>PVT. HOSPITAL/CLINIC F</p> <p>PHARMACY G</p> <p>PVT. DOCTOR ... H</p> <p>HOMEOPATH ... I</p> <p>DISPENSER / COMPOUNDER ... J</p> <p>OTHER PRIVATE MED. _____ K</p> <p>(SPECIFY)</p> <p>OTHER SOURCE</p> <p>SHOP L</p> <p>HAKIM M</p> <p>DAI, TBA N</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p>
534	<p>How many days after the illness began did you first seek advice or treatment for (NAME)?</p> <p>IF THE SAME DAY, RECORD '00'.</p>	<p>DAYS <input type="text"/> <input type="text"/></p>	<p>DAYS <input type="text"/> <input type="text"/></p>	<p>DAYS <input type="text"/> <input type="text"/></p>
535	<p>Is (NAME) still sick with a (fever/ cough)?</p>	<p>FEVER ONLY 1</p> <p>COUGH ONLY ... 2</p> <p>BOTH FEVER AND COUGH 3</p> <p>NO, NEITHER 4</p> <p>DON'T KNOW ... 8</p>	<p>FEVER ONLY 1</p> <p>COUGH ONLY ... 2</p> <p>BOTH FEVER AND COUGH 3</p> <p>NO, NEITHER 4</p> <p>DON'T KNOW ... 8</p>	<p>FEVER ONLY 1</p> <p>COUGH ONLY ... 2</p> <p>BOTH FEVER AND COUGH 3</p> <p>NO, NEITHER 4</p> <p>DON'T KNOW ... 8</p>
536	<p>At any time during the illness, did (NAME) take any medicine for the illness?</p>	<p>YES 1</p> <p>NO 2</p> <p>(GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, TO 601)</p> <p>DON'T KNOW 8</p>	<p>YES 1</p> <p>NO 2</p> <p>(GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, TO 601)</p> <p>DON'T KNOW 8</p>	<p>YES 1</p> <p>NO 2</p> <p>(GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, TO 601)</p> <p>DON'T KNOW 8</p>

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____	SECOND-FROM-LAST BIRTH NAME _____
537	<p>What medicine did (NAME) take?</p> <p>Any other medicine?</p> <p>RECORD ALL MENTIONED.</p>	<p>ANTIMALARIAL DRUGS QUININE A CHLOROQUINE . B FANSIDAR/SP . . . C OTHER ANTI-MALARIAL _____ D (SPECIFY)</p> <p>ANTIBIOTIC PILL/SYRUP . . . E INJECTION . . . F</p> <p>OTHER DRUGS ASPIRIN G PARACETEMOL/ CALPOL H BRUFEN I</p> <p>COUGH DRUGS PILL/SYRUP . . . J OTHER _____ X (SPECIFY)</p> <p>DON'T KNOW Z</p>	<p>ANTIMALARIAL DRUGS QUININE A CHLOROQUINE . B FANSIDAR/SP . . . C OTHER ANTI-MALARIAL _____ D (SPECIFY)</p> <p>ANTIBIOTIC PILL/SYRUP . . . E INJECTION . . . F</p> <p>OTHER DRUGS ASPIRIN G PARACETEMOL/ CALPOL H BRUFEN I</p> <p>COUGH DRUGS PILL/SYRUP . . . J OTHER _____ X (SPECIFY)</p> <p>DON'T KNOW Z</p>	<p>ANTIMALARIAL DRUGS QUININE A CHLOROQUINE . B FANSIDAR/SP . . . C OTHER ANTI-MALARIAL _____ D (SPECIFY)</p> <p>ANTIBIOTIC PILL/SYRUP . . . E INJECTION . . . F</p> <p>OTHER DRUGS ASPIRIN G PARACETEMOL/ CALPOL H BRUFEN I</p> <p>COUGH DRUGS PILL/SYRUP . . . J OTHER _____ X (SPECIFY)</p> <p>DON'T KNOW Z</p>
538	<p>Was any medicine prescribed by a doctor, nurse, pharmacist, or other health practitioner?</p>	<p>YES 1</p> <p>NO 2</p>	<p>YES 1</p> <p>NO 2</p>	<p>YES 1</p> <p>NO 2</p>
539	<p>CHECK 537:</p> <p>ANY CODE A-D CIRCLED?</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>(GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>(GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)</p>	<p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>(GO TO 503 IN NEXT COLUMN, OR, IF NO MORE BIRTHS, TO 601)</p>
540	<p>How long after the fever started did (NAME) first take the medicine?</p>	<p>SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE DAYS AFTER FEVER 3 FOUR OR MORE DAYS AFTER FEVER . . 4 DON'T KNOW 8</p>	<p>SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE DAYS AFTER FEVER 3 FOUR OR MORE DAYS AFTER FEVER . . 4 DON'T KNOW 8</p>	<p>SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE DAYS AFTER FEVER 3 FOUR OR MORE DAYS AFTER FEVER . . 4 DON'T KNOW 8</p>
541	<p>For how many days did (NAME) take the medicine?</p> <p>IF 7 DAYS OR MORE, RECORD 7.</p>	<p>DAYS <input type="checkbox"/></p> <p>DON'T KNOW 8</p>	<p>DAYS <input type="checkbox"/></p> <p>DON'T KNOW 8</p>	<p>DAYS <input type="checkbox"/></p> <p>DON'T KNOW 8</p>
542		<p>GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 601.</p>	<p>GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 601.</p>	<p>GO TO 503 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 601.</p>

SECTION 6. FERTILITY PREFERENCES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																				
601	<p>CHECK 104: CURRENTLY MARRIED <input type="checkbox"/> ↓</p>	<p>WIDOWED, DIVORCED, SEPARATED <input type="checkbox"/></p>	<p>612</p>																				
602	<p>CHECK 310: NEITHER STERILISED <input type="checkbox"/> ↓</p>	<p>HE OR SHE STERILISED <input type="checkbox"/></p>	<p>612</p>																				
602	<p>CHECK 104: CURRENTLY MARRIED <input type="checkbox"/> ↓</p>	<p>WIDOWED, DIVORCED, SEPARATED <input type="checkbox"/></p>	<p>612</p>																				
603	<p>CHECK 226:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>NOT PREGNANT OR UNSURE <input type="checkbox"/> ↓</p> <p>Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?</p> </td> <td style="width: 50%;"> <p>PREGNANT <input type="checkbox"/> ↓</p> <p>Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?</p> </td> </tr> </table>	<p>NOT PREGNANT OR UNSURE <input type="checkbox"/> ↓</p> <p>Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?</p>	<p>PREGNANT <input type="checkbox"/> ↓</p> <p>Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?</p>	<table border="0"> <tr> <td>HAVE (A/ANOTHER) CHILD</td> <td>1</td> <td></td> </tr> <tr> <td>NO MORE/NONE</td> <td>2</td> <td>→ 605</td> </tr> <tr> <td>SAYS SHE CAN'T GET PREGNANT ..</td> <td>3</td> <td>→ 612</td> </tr> <tr> <td>UNDECIDED/DON'T KNOW AND PREGNANT</td> <td>4</td> <td>→ 610</td> </tr> <tr> <td>UNDECIDED/DON'T KNOW AND NOT PREGNANT</td> <td>5</td> <td>→ 609</td> </tr> </table>	HAVE (A/ANOTHER) CHILD	1		NO MORE/NONE	2	→ 605	SAYS SHE CAN'T GET PREGNANT ..	3	→ 612	UNDECIDED/DON'T KNOW AND PREGNANT	4	→ 610	UNDECIDED/DON'T KNOW AND NOT PREGNANT	5	→ 609				
<p>NOT PREGNANT OR UNSURE <input type="checkbox"/> ↓</p> <p>Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?</p>	<p>PREGNANT <input type="checkbox"/> ↓</p> <p>Now I have some questions about the future. After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?</p>																						
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UNDECIDED/DON'T KNOW AND PREGNANT	4	→ 610																					
UNDECIDED/DON'T KNOW AND NOT PREGNANT	5	→ 609																					
604	<p>CHECK 226:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>NOT PREGNANT OR UNSURE <input type="checkbox"/> ↓</p> <p>How long would you like to wait from now before the birth of (a/another) child?</p> </td> <td style="width: 50%;"> <p>PREGNANT <input type="checkbox"/> ↓</p> <p>After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?</p> </td> </tr> </table>	<p>NOT PREGNANT OR UNSURE <input type="checkbox"/> ↓</p> <p>How long would you like to wait from now before the birth of (a/another) child?</p>	<p>PREGNANT <input type="checkbox"/> ↓</p> <p>After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?</p>	<table border="0"> <tr> <td>MONTHS</td> <td>1</td> <td><input type="checkbox"/></td> </tr> <tr> <td>YEARS</td> <td>2</td> <td><input type="checkbox"/></td> </tr> <tr> <td>SOON/NOW</td> <td>993</td> <td>→ 609</td> </tr> <tr> <td>SAYS SHE CAN'T GET PREGNANT ..</td> <td>994</td> <td>→ 612</td> </tr> <tr> <td>OTHER _____ (SPECIFY)</td> <td>996</td> <td>→ 609</td> </tr> <tr> <td>DON'T KNOW</td> <td>998</td> <td>→ 609</td> </tr> </table>	MONTHS	1	<input type="checkbox"/>	YEARS	2	<input type="checkbox"/>	SOON/NOW	993	→ 609	SAYS SHE CAN'T GET PREGNANT ..	994	→ 612	OTHER _____ (SPECIFY)	996	→ 609	DON'T KNOW	998	→ 609	
<p>NOT PREGNANT OR UNSURE <input type="checkbox"/> ↓</p> <p>How long would you like to wait from now before the birth of (a/another) child?</p>	<p>PREGNANT <input type="checkbox"/> ↓</p> <p>After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?</p>																						
MONTHS	1	<input type="checkbox"/>																					
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SAYS SHE CAN'T GET PREGNANT ..	994	→ 612																					
OTHER _____ (SPECIFY)	996	→ 609																					
DON'T KNOW	998	→ 609																					
605	<p>CHECK 226: NOT PREGNANT OR UNSURE <input type="checkbox"/> ↓</p>	<p>PREGNANT <input type="checkbox"/></p>	<p>610</p>																				
606	<p>CHECK 309: NOT ASKED <input type="checkbox"/> ↓</p>	<p>NOT CURRENTLY USING <input type="checkbox"/> ↓</p> <p>CURRENTLY USING <input type="checkbox"/></p>	<p>612</p>																				
607	<p>CHECK 604: NOT ASKED <input type="checkbox"/> ↓</p>	<p>24 OR MORE MONTHS OR 02 OR MORE YEARS <input type="checkbox"/> ↓</p> <p>00-23 MONTHS OR 00-01 YEAR <input type="checkbox"/></p>	<p>610</p>																				

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
608	<p>CHECK 603:</p> <p>WANTS TO HAVE A/ANOTHER CHILD (CODE 1) <input type="checkbox"/> ↓</p> <p>WANTS NO MORE/NONE (CODE 2) <input type="checkbox"/> ↓</p> <p>You have said that you do not want (a/another) child soon, but you are not using any method to avoid pregnancy.</p> <p>You have said that you do not want any (more) children, but you are not using any method to avoid pregnancy.</p> <p>Can you tell me why you are not using a method? <input type="checkbox"/></p> <p>Can you tell me why you are not using a method? <input type="checkbox"/></p> <p>Any other reason? <input type="checkbox"/></p> <p>Any other reason? <input type="checkbox"/></p> <p>RECORD ALL REASONS MENTIONED.</p>	<p>FERTILITY-RELATED REASONS</p> <p>INFREQUENT SEX/NO SEX A</p> <p>MENOPAUSAL/HYSTERECTOMY B</p> <p>INFERTILE/CAN'T GET PREGNANT C</p> <p>NO MENSTRUATION AFTER BIRTH D</p> <p>BREASTFEEDING E</p> <p>UP TO GOD, CAN'T CONTROL F</p> <p>OPPOSITION TO USE</p> <p>RESPONDENT OPPOSED G</p> <p>HUSBAND OPPOSED H</p> <p>OTHERS OPPOSED I</p> <p>AGAINST RELIGION J</p> <p>LACK OF KNOWLEDGE</p> <p>KNOWS NO METHOD K</p> <p>KNOWS NO SOURCE L</p> <p>METHOD-RELATED REASONS</p> <p>HEALTH CONCERNS M</p> <p>FEAR OF SIDE EFFECTS N</p> <p>LACK OF ACCESS/TOO FAR O</p> <p>COSTS TOO MUCH P</p> <p>INCONVENIENT TO USE Q</p> <p>INTERFERES WITH BODY'S NORMAL PROCESSES R</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p> <p>DON'T KNOW Z</p>	
609	<p>CHECK 309:</p> <p>NOT ASKED <input type="checkbox"/> ↓ NO, NOT CURRENTLY USING <input type="checkbox"/> ↓ YES, CURRENTLY USING <input type="checkbox"/> → 612</p>		
610	<p>Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	→ 612
611	<p>What is the main reason that you think you will not use a contraceptive method at any time in the future?</p>	<p>FERTILITY-RELATED REASONS</p> <p>INFREQUENT SEX/NO SEX 11</p> <p>MENOPAUSAL/HYSTERECTOMY 12</p> <p>INFERTILE/CAN'T GET PREGNANT 13</p> <p>NO MENSTRUATION AFTER BIRTH 14</p> <p>BREASTFEEDING 15</p> <p>UP TO GOD, CAN'T CONTROL 16</p> <p>OPPOSITION TO USE</p> <p>RESPONDENT OPPOSED 21</p> <p>HUSBAND OPPOSED 22</p> <p>OTHERS OPPOSED 23</p> <p>AGAINST RELIGION 24</p> <p>LACK OF KNOWLEDGE</p> <p>KNOWS NO METHOD 31</p> <p>KNOWS NO SOURCE 32</p> <p>METHOD-RELATED REASONS</p> <p>HEALTH CONCERNS 41</p> <p>FEAR OF SIDE EFFECTS 42</p> <p>LACK OF ACCESS/TOO FAR 43</p> <p>COSTS TOO MUCH 44</p> <p>INCONVENIENT TO USE 45</p> <p>INTERFERES WITH BODY'S NORMAL PROCESSES 46</p> <p>OTHER _____ 96</p> <p>DON'T KNOW 98</p>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																		
612	<p>CHECK 216:</p> <p>HAS LIVING CHILDREN <input type="checkbox"/> NO LIVING CHILDREN <input type="checkbox"/></p> <p>If you could go back to the time you did not have any children and could choose exactly the number of children to have in your whole life, how many would that be?</p> <p>If you could choose exactly the number of children to have in your whole life, how many would that be?</p> <p>PROBE FOR A NUMERIC RESPONSE.</p>	<p>NONE 00</p> <p>NUMBER <input type="text"/> <input type="text"/></p> <p>OTHER _____ 96 (SPECIFY)</p>	<p>→ 614</p> <p>→ 614</p>																		
613	<p>How many of these children would you like to be boys, how many would you like to be girls and for how many would the sex not matter?</p>	<p>BOYS GIRLS EITHER</p> <p>NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>OTHER _____ 96 (SPECIFY)</p>																			
614	<p>CHECK 104:</p> <p>CURRENTLY MARRIED <input type="checkbox"/></p>	<p>WIDOWED, DIVORCED, SEPARATED <input type="checkbox"/></p>	<p>→ 617</p>																		
615	<p>CHECK 310:</p> <p>NEITHER STERILISED <input type="checkbox"/></p>	<p>HE OR SHE STERILISED <input type="checkbox"/></p>	<p>→ 617</p>																		
616	<p>Do you think your husband wants the same number of children that you want, or does he want more or fewer than you want?</p>	<p>SAME NUMBER 1</p> <p>MORE CHILDREN 2</p> <p>FEWER CHILDREN 3</p> <p>DON'T KNOW 8</p>																			
617	<p>PRESENCE OF OTHERS AT THIS POINT.</p>	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>CHILDREN UNDER 10</td> <td>1</td> <td>2</td> </tr> <tr> <td>HUSBAND</td> <td>1</td> <td>2</td> </tr> <tr> <td>MOTHER IN LAW</td> <td>1</td> <td>2</td> </tr> <tr> <td>OTHER MALE(S)</td> <td>1</td> <td>2</td> </tr> <tr> <td>OTHER FEMALE(S)</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	CHILDREN UNDER 10	1	2	HUSBAND	1	2	MOTHER IN LAW	1	2	OTHER MALE(S)	1	2	OTHER FEMALE(S)	1	2	
	YES	NO																			
CHILDREN UNDER 10	1	2																			
HUSBAND	1	2																			
MOTHER IN LAW	1	2																			
OTHER MALE(S)	1	2																			
OTHER FEMALE(S)	1	2																			

SECTION 7. HUSBAND'S BACKGROUND AND WOMAN'S WORK

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	<p>CHECK 104:</p> <p>CURRENTLY MARRIED <input type="checkbox"/> ↓</p> <p>WIDOWED, DIVORCED, SEPARATED <input type="checkbox"/> →</p>		→ 703
702	How old is your husband?	AGE IN COMPLETED YEARS <input type="text"/> <input type="text"/>	
703	Did your (last) husband ever attend school?	YES 1 NO 2	→ 705
704	What was the highest class he completed? WRITE '00' IF LESS THAN CLASS ONE; WRITE '16' = IF MA,MPHIL,PHD, MBBS, BSC(4 YEARS)	CLASS <input type="text"/> <input type="text"/> DON'T KNOW 98	
705	<p>CHECK 701:</p> <p>CURRENTLY MARRIED <input type="checkbox"/> ↓ WIDOWED, DIVORCED OR SEPARATED <input type="checkbox"/> ↓</p> <p>What is your husband's occupation? What was your (last) husband's occupation? That is, what kind of work does he mainly do? That is, what kind of work did he mainly do?</p>	<p>_____ <input type="text"/> <input type="text"/></p> <p>_____</p> <p>_____</p>	
706	Aside from your own housework, have you done any work in the last seven days?	YES 1 NO 2	→ 709
707	As you know, some women take up jobs for which they are paid in cash or kind. Others sell things, have a small business or work on the family farm or in the family business. In the last seven days, have you done any of these things or any other work?	YES 1 NO 2	→ 709
708	Although you did not work in the last seven days, do you have any job or business from which you were absent for leave, illness, vacation, maternity leave or any other such reason?	YES 1 NO 2	→ 710
709	Do you receive money for the work you do?	YES 1 NO 2	→ 712
710	If you could find a suitable job, would you like to work?	YES 1 NO 2	
711	Have you done any work in the last 12 months?	YES 1 NO 2	→ 713

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
712	What is your occupation, that is, what kind of work do you mainly do?	<div style="border-bottom: 1px solid black; width: 150px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; width: 150px; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; width: 150px; margin-bottom: 5px;"></div> <div style="float: right; border: 1px solid black; width: 40px; height: 20px; margin-top: 10px; margin-right: 10px;"></div>	
713	Did you work at any time before you (first) got married?	YES 1 NO 2	
714	Did you work after you (first) got married?	YES 1 NO 2	

SECTION 8. HIV/AIDS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	Now I would like to talk about something else. Have you ever heard of an illness called AIDS?	YES 1 NO 2	→ 814
802	Can people reduce their chance of getting the AIDS virus by staying faithful to just one partner?	YES 1 NO 2 DON'T KNOW 8	
803	Can people get the AIDS virus from mosquito bites?	YES 1 NO 2 DON'T KNOW 8	
804	Can people reduce their chance of getting the AIDS virus by using a condom every time they have sex?	YES 1 NO 2 DON'T KNOW 8	
805	Can people get the AIDS virus by sharing food with a person who has AIDS?	YES 1 NO 2 DON'T KNOW 8	
806	Can people reduce their chance of getting the AIDS virus by not having sexual intercourse at all?	YES 1 NO 2 DON'T KNOW 8	
807	Can people get the AIDS virus because of witchcraft or other supernatural means?	YES 1 NO 2 DON'T KNOW 8	
808	Is it possible for a healthy-looking person to have the AIDS virus?	YES 1 NO 2 DON'T KNOW 8	
809	Do you know someone personally who has the virus that causes AIDS or someone who died from AIDS?	YES 1 NO 2	
810	Can the virus that causes AIDS be transmitted from a mother to a child: During pregnancy? During delivery? By breastfeeding?	YES NO DK DURING PREGNANCY? .. 1 2 8 DURING DELIVERY? 1 2 8 BY BREASTFEEDING? 1 2 8	
811	Have you ever talked about ways to prevent getting the virus that causes AIDS with your (former) husband?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
812	God forbid If a member of your family got infected with the virus that causes AIDS, would you want it to remain a secret or not?	YES, REMAIN A SECRET 1 NO 2 DON'T KNOW / NOT SURE 8	
813	God forbid If a relative of yours became sick with the virus that causes AIDS, would you be willing to care for her or him in your own household?	YES 1 NO 2 DON'T KNOW / NOT SURE 8	
814	Apart from AIDS, have you heard about other infections that can be transmitted through sexual contact?	YES 1 NO 2	→ 901
815	Could you kindly tell me some signs of these infections that you know about? RECORD ALL MENTIONED.	WOUND WITHOUT PAIN A WOUND WITH PAIN B WOUND, PAIN WITH LOTS C OF PIMPLES PUS LIKE DISCHARGE D DARK PUS LIKE DISCHARGE E SOUR MILK LIKE THICK F DISCHARGE SPONGE LIKE DISCHARGE G DISCHARGE WITH BAD H ODOUR/DIRTY WATER OTHER-1 _____ X (SPECIFY) OTHER-2 _____ Y (SPECIFY)	

SECTION 9. OTHER HEALTH RELATED ISSUES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
901	Have you ever heard of an illness called tuberculosis or TB?	YES 1 NO 2	→ 906
902	How does tuberculosis spread from one person to another? PROBE: Any other ways? RECORD ALL MENTIONED.	THROUGH THE AIR WHEN COUGHING OR SNEEZING A BY SHARING UTENSILS B BY TOUCHING A PERSON WITH TB . . . C THROUGH SHARING FOOD D THROUGH SEXUAL CONTACT E THROUGH MOSQUITO BITES F OTHER _____ X (SPECIFY) DON'T KNOW Z	
903	Can tuberculosis be cured?	YES 1 NO 2 DON'T KNOW 8	→ 905
904	What is the duration of treatment of TB now a days? IF MORE THAN 7 MONTHS, RECORD 7	MONTHS <input style="width: 40px; height: 20px;" type="text"/> DON'T KNOW 8	
905	Have you ever been told by a doctor or nurse or LHV that God forbid you have/had tuberculosis?	YES 1 NO 2 DON'T KNOW 8	
906	CHECK 212: ONE OR MORE <input style="width: 20px; height: 15px;" type="checkbox"/> LIVE BIRTH	NO LIVE BIRTHS <input style="width: 20px; height: 15px;" type="checkbox"/>	→ 911
907	Sometimes a woman can have a problem, usually after a difficult childbirth, such that she continuously dribbles urine even during sleep that wets her clothes too and/or leaks stool from her vagina. Have you ever experienced this problem?	YES, DRIBBLING OF URINE 1 YES, STOOL COMING FROM VAGINA 2 YES, BOTH 3 NO 4 DON'T KNOW 8	→ 911
908	Do you still have this problem?	YES 1 NO 2	
909	Please tell me how did this problem start:	AFTER A DIFFICULT CHILDBIRTH 1 AFTER A RAPE/SEXUAL ASSAULT 2 OTHER _____ 6 (SPECIFY)	
910	What happened to baby?	LIVE BIRTH: DIED IN SEVEN DAYS 1 DIED AFTER SEVEN DAYS 2 STILL LIVING 3 STILL BIRTH 4	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
911	<p>Now I would like to ask you some questions relating to other health matters. Have you had an injection for any reason in the <u>last 12 months</u>?</p> <p>IF YES: How many injections have you had?</p> <p>IF NUMBER OF INJECTIONS IS GREATER THAN 90, OR DAILY FOR 3 MONTHS OR MORE, RECORD '90'. IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE.</p>	<p>NUMBER OF INJECTIONS ... <input type="text"/> <input type="text"/></p> <p>NONE 00 → 915</p>	
912	<p>Among these injections, how many were given by a doctor, nurse, pharmacist, dentist, LHV or any other health worker?</p> <p>IF NUMBER OF INJECTIONS IS GREATER THAN 90, OR DAILY FOR 3 MONTHS OR MORE, RECORD '90'. IF NON-NUMERIC ANSWER, PROBE TO GET AN ESTIMATE.</p>	<p>NUMBER OF INJECTIONS ... <input type="text"/> <input type="text"/></p> <p>NONE 00 → 915</p>	
913	<p>The last time you had an injection from where did you obtain the syringe?</p> <p>IF SOURCE IS HOSPITAL, HEALTH CENTER, OR CLINIC, WRITE THE NAME OF THE SOURCE. PROBE TO IDENTIFY THE TYPE OF SOURCE AND CIRCLE THE APPROPRIATE CODE. IF SYRINGE WAS PURCHASED FROM A CHEMIST CODE "23".</p> <p>_____</p> <p>(NAME OF PLACE)</p>	<p>PUBLIC SECTOR</p> <p>GOVT. HOSPITAL/RHSC 11</p> <p>RHC/MCH 12</p> <p>BHU/FWC 13</p> <p>MOBILE SERVICE CAMP 14</p> <p>LADY HEALTH WORKER (LHW)</p> <p>HEALTH HOUSE 15</p> <p>OTHER PUBLIC _____ 16</p> <p>(SPECIFY)</p> <p>PRIVATE MED. SECTOR</p> <p>PRIVATE HOSPITAL/CLINIC/ PRIVATE DOCTOR 21</p> <p>DENTAL CLINIC/OFFICE 22</p> <p>CHEMIST... 23</p> <p>OFFICE OR HOME OF NURSE/ HEALTH WORKER 24</p> <p>DISPENSER / COMPOUNDER 25</p> <p>OTHER PRIVATE MEDICAL _____ 26</p> <p>(SPECIFY)</p> <p>OTHER PLACE AT HOME 31</p> <p>OTHER _____ 96</p> <p>(SPECIFY)</p>	
914	<p>Did the person who gave you that injection take the syringe and needle from a new, unopened package?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
915	Do you think that one can protect herself/himself from getting Hepatitis B,C, and HIV AIDS if:										
915A	A syringe and needle from a new unopened packet is used while giving an injection?	YES 1 NO 2 DON'T KNOW 8									
915B	If need be , blood tested for Hepatitis B,C and HIV AIDS virus is transfused?	YES 1 NO 2 DON'T KNOW 8									
916	RECORD THE TIME.	HOUR <table border="1" data-bbox="1214 594 1304 642"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table> MINUTES <table border="1" data-bbox="1214 642 1304 690"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>									

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: _____ DATE: _____

EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____

NATIONAL INSTITUTE OF POPULATION STUDIES
PAKISTAN DEMOGRAPHIC AND HEALTH SURVEY

DECEASED CHILD'S IDENTIFICATION

IDENTIFICATION													
PROVINCE (PUNJAB=1; SINDH=2; NWFP=3; BALOCHISTAN=4; FATA=5) _____ <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>												
DISTRICT _____ <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></table>												
TEHSIL/TALUKA _____													
CLUSTER NUMBER <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><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><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>												
HOUSEHOLD NUMBER <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><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>												
NAME OF HOUSEHOLD HEAD _____													
NAME OF CHILD WHO DIED _____ (IF NO NAME GIVEN OR STILL BIRTH WRITE BABY)	<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></table>												
INTERVIEWER VISITS													
	1	2	3	FINAL VISIT									
DATE	_____	_____	_____	DAY MONTH YEAR <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><td style="width: 20px; height: 20px;"></td></tr><tr><td style="width: 20px; height: 20px;">2</td><td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">0</td></tr></table>				2	0	0			
2	0	0											
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER <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><td style="width: 20px; height: 20px;"></td></tr></table>									
RESULT*	_____	_____	_____	RESULT <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></table>									
NEXT VISIT: DATE TIME	_____ _____	_____ _____		TOTAL NUMBER OF VISITS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td></tr></table>									
*RESULT CODES: 1 COMPLETED 4 REFUSED 2 NOT AT HOME 5 PARTLY COMPLETED 7 OTHER _____ 3 POSTPONED 6 INCAPACITATED (SPECIFY)													
LANGUAGE OF QUESTIONNAIRE: URDU													
SUPERVISOR NAME _____ DATE _____ <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><td style="width: 20px; height: 20px;"></td></tr></table>				FIELD EDITOR NAME _____ DATE _____ <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><td style="width: 20px; height: 20px;"></td></tr></table>				OFFICE EDITOR <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></table>			KEYED BY <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></table>		
Introduction and Consent Assalamo Alaikum. My name is _____ and I am working with (NIPS, Islamabad). We are conducting a national survey about various he issues. We would very much appreciate your participation in this survey. As part of this survey, we are interested in the illness that le death. All of the answers you give will be confidential. Participation in the survey is completely voluntary. If I ask any question you do not to answer just let me know and I will go to the next question; or you can stop the interview at any time. However, we hope you will particip the survey since your views are important At this time, do you want to ask me anything about the survey? May I begin the interview now? Signature of interviewer: _____ Date: _____ RESPONDENT AGREES TO BE INTERVIEWED 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 → END													

SECTION 1. INFORMATION ABOUT RESPONDENTS

INTERVIEWER: ASK TO TALK TO THOSE WHO KNOW THE MOST ABOUT THE CHILD'S LAST ILLNESS AND DEATH, IF A NEIGHBOR, FRIEND, OR DAI WAS PRESENT DURING HIS/HER ILLNESS OR DEATH, ASK THEM TO COME AND JOIN IN FOR INTERVIEW GET ALL THE RESPONDENTS TOGETHER FOR THE INTERVIEW AND FILL THE TABLE BELOW.

First, I have a few questions about each of you. Please tell me:

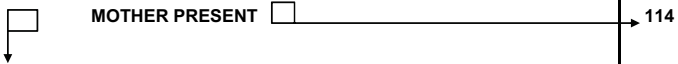
101	102	103	104	105	106	107	108	109	110
NO.	What is your name?	Sex of respondent ?	How old are you? COMPLETED YEARS	What was your relationship to (NAME) i.e deceased child? RELATION	What is your education? SEE CODES BELOW (CLASSES PASSED)	Were you present at the delivery of (NAME)?	Were you present when (NAME) was ill?	Were you present when (NAME) died?	CIRCLE LINE NO. OF MAIN RESPONDENT
1		MALE. ... 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES .. 1 NO ... 2	YES 1 NO 2	YES .. 1 NO ... 2	1
2		MALE. ... 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES .. 1 NO ... 2	YES 1 NO 2	YES .. 1 NO ... 2	2
3		MALE. ... 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES .. 1 NO ... 2	YES 1 NO 2	YES .. 1 NO ... 2	3
4		MALE. ... 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES .. 1 NO ... 2	YES 1 NO 2	YES .. 1 NO ... 2	4
5		MALE. ... 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES .. 1 NO ... 2	YES 1 NO 2	YES .. 1 NO ... 2	5
6		MALE. ... 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES .. 1 NO ... 2	YES 1 NO 2	YES .. 1 NO ... 2	6

RELATIONSHIP TO DECEASED CHILD:

- 01 = PARENT
- 02 = BROTHER / SISTER
- 03 = GRAND PARENTS
- 04 = GRAND MATERNAL PARENTS
- 05 = ANTS / UNCLE
- 06 = OTHERRELATIVE
- 07 = STEP PARENTS
- 08 = NOT RELATED
- 09 = DOMESTIC SERVANT

EDUCATION CLASS:

- 00 = LESS THAN 1 YEAR COMPLETED
- 01 = CLASS 1;
- 02 = CLASS 2
- ...
- 10 = MATRIC, CLASS 10
- 11 = CLASS 11
- ...
- 16 = MASTER'S DEGREE OR MBBS, PhD, MPhil, BSc (4 YEARS)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
111	RECORD THE TIME AT BEGINNING OF INTERVIEW	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>	
112	CHECK 105: MOTHER NOT PRESENT <input type="checkbox"/> MOTHER PRESENT <input type="checkbox"/>		114
113	Is (NAME)'s mother still alive? IF YES: Where is she living now?	ALIVE AND IN THE HOUSEHOLD 1 ALIVE BUT LIVING ELSEWHERE . 2 DEAD 3	
114	Name of the mother of deceased child: _____ (WRITE THE LINE NO. OF THE MOTHER FROM HOUSEHOLD SCHEDULE OR '00' IF NOT IN THE HOUSEHOLD)	LINE NUMBER <input type="text"/> <input type="text"/>	
115	Name of the father of deceased child: _____ (WRITE THE LINE NO. OF THE FATHER FROM HOUSEHOLD SCHEDULE OR '00' IF NOT IN THE HOUSEHOLD)	LINE NUMBER <input type="text"/> <input type="text"/>	
116	In what month and year did you/mother was born?	MONTH <input type="text"/> <input type="text"/> DON'T KNOW 98 YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	
117	In what month and year did you/mother start living with your/her (first) husband?	MONTH <input type="text"/> <input type="text"/> DON'T KNOW 98 YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
118	How many times have you/mother been pregnant ?	TIMES <input type="text"/> <input type="text"/> DON'T KNOW 98	
119	What was the date of delivery or birth of the deceased child?	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	
120	Was the child born alive or dead ?	ALIVE 1 DEAD 2	→ 124
121	Did the baby ever cry, even a little ?	YES 1 NO 2 DON'T KNOW 8	→ 124
122	Did the baby ever show movement, even a little bit ?	YES 1 NO 2 DON'T KNOW 8	→ 124
123	Did the baby ever breathe, even for a short while ?	YES 1 NO 2 DON'T KNOW 8	
124	When did (NAME) die ? IF NOT IN THE YEARS 2005 OR 2006, END INTERVIEW. CHANGE DATE ON THE HOUSEHOLD QUESTIONNAIRE	DAY <input type="text"/> <input type="text"/> MONTH <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ H101
125	How old was (NAME) when he/she died ? IF < 1 HOUR, WRITE MINUTES IF < 1 DAY, WRITE HOURS IF < 1 MONTH, WRITE DAYS IF < 2 YEARS, WRITE MONTHS IF > = 2 YEARS, WRITE YEARS	STILLBIRTH 000 MINUTES 1 <input type="text"/> <input type="text"/> HOURS 2 <input type="text"/> <input type="text"/> DAY 3 <input type="text"/> <input type="text"/> MONTH 4 <input type="text"/> <input type="text"/> YEAR 5 <input type="text"/> <input type="text"/>	
126	Was (NAME) a boy or girl ?	BOY 1 GIRL 2 UNCERTAIN 3	

SECTION 2. OPEN HISTORY

OPEN HISTORY

INSTRUCTIONS TO INTERVIEWER: ALLOW THE RESPONDENT TO TELL YOU ABOUT THE PREGNANCY, DELIVERY AND THE BABY'S ILLNESS IN HER OWN WORDS. WRITE DOWN WHAT THE RESPONDENT TELLS YOU IN HER OWN WORDS. DO NOT PROMPT EXCEPT FOR ASKING WHETHER THERE WAS ANYTHING ELSE

FOR STILLBIRTHS (I.E., NO CRY, NO BREATHING, NO MOVEMENT AT BIRTH), ASK: COULD YOU TELL ME ABOUT THE PREGNANCY FOR THIS BABY, LABOUR AND DELIVERY, WHAT THE BABY WAS LIKE AT BIRTH AND WHAT HAPPENED AFTER THE DELIVERY?

FOR NEONATAL DEATHS (LIVE BIRTH THAT DIED AT LESS THAN 28 DAYS OLD). ASK: COULD YOU TELL ME ABOUT THE PREGNANCY FOR THIS BABY, LABOUR AND BIRTH, WHAT HAPPENED IMMEDIATELY AFTER BIRTH AND ABOUT THE BABY'S ILLNESS THAT LED TO DEATH?

FOR POST NEONATAL AND CHILD DEATHS (LIVE BIRTH THAT DIED AT MORE THAN 28 DAYS OLD), PLEASE DESCRIBE THE SYMPTOMS IN ORDER OF APPEARANCE, CARE PROVIDER CONSULTED OR HOSPITALIZATION, HISTORY OF SIMILAR EPISODES, ENTER THE RESULTS FROM REPORTS OF INVESTIGATION

INTERVIEWER: USE THE FOLLOWING CHECKLIST TO MARK ALL COMPLICATIONS REPORTED SPONTANEOUSLY IN THE WRITTEN OPEN HISTORY. IF NOT MENTIONED IN OPEN HISTORY, ASK ABOUT EACH ONE. ALL MORBIDITIES TO BE MARKED.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	What were the complications/ problems that occurred during pregnancy but before labor and delivery ?	<p>COMPLICATIONS</p> <p>VAGINAL BLEEDING? 1 2 8</p> <p>HIGH BLOOD PRESSURE? . 1 2 8</p> <p>CRAMPS AND</p> <p>ABDOMINAL PAIN..... 1 2 8</p> <p>CONVULSIONS/ FITS? ... 1 2 8</p> <p>SEVERE HEADACHE?..... 1 2 8</p> <p>HAND, FEET AND</p> <p>FACIAL SWELLING?..... 1 2 8</p> <p>ANEMIA? 1 2 8</p> <p>SEVERE ANEMIA? 1 2 8</p> <p>DIABETES? 1 2 8</p> <p>URINARY COMPLAINTS? . 1 2 8</p> <p>GENITAL ULCER? 1 2 8</p> <p>BABY STOPPED MOVING? . 1 2 8</p> <p>OTHER (SPECIFY) 1 2 8</p>	
	Did you/ the mother have:		
202	What were the complications/ problems that occurred during labour and/ or delivery ?	<p>COMPLICATIONS</p> <p>HAND, FEET AND</p> <p>FACIAL SWELLING 1 2 8</p> <p>HIGH BLOOD PRESSURE ... 1 2 8</p> <p>ANEMIA 1 2 8</p> <p>SEVERE ANEMIA 1 2 8</p> <p>CONVULSIONS 1 2 8</p> <p>BABY STOPPED MOVING . 1 2 8</p> <p>VAGINAL BLEEDING LIKE</p> <p>A PERIOD..... 1 2 8</p> <p>WATER BAG BROKE</p> <p>MORE THAN ONE DAY</p> <p>BEFORE LABOR BEGAN ... 1 2 8</p> <p>LIQUOR (WATER) WAS</p> <p>YELLOW MECONIUM</p> <p>STAINED 1 2 8</p> <p>LIQUOR (WATER) WAS</p> <p>GREEN 1 2 8</p> <p>VERY SMELLY</p> <p>LIQUOR (WATER) 1 2 8</p> <p>MULTIPLE PREGNANCY ... 1 2 8</p> <p>BABY VERY SMALL AT</p> <p>BIRTH 1 2 8</p> <p>BORN EARLY 1 2 8</p> <p>BREECH DELIVERY 1 2 8</p> <p>PROLONGED/ DIFFICULT</p> <p>LABOR 1 2 8</p> <p>INSTRUMENTAL DELIVERY</p> <p>(FORCEPS AND VACUUM) 1 2 8</p> <p>C – SECTION (OPERATIVE</p> <p>DELIVERY) 1 2 8</p> <p>OTHERS 1 2 8</p> <p>(SPECIFY)</p>	
	Did you/ the mother have:		
203	CHECK 126:		
	LIVE BIRTH <input type="checkbox"/>	STILL BIRTH <input type="checkbox"/>	301

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
204	What were the complications that occurred to the baby, during the illness that led to death?	<p>COMPLICATIONS YES NO DK</p> <p>BABY WAS VERY SMALL 1 2 8</p> <p>PREMATURE (BABY WAS BORN BEFORE 38 WEEKS OF GESTATIONAL AGE) ... 1 2 8</p> <p>BRUISES OR MARKS OF INJURY ON HEAD/BODY 1 2 8</p> <p>HAD A PHYSICAL MALFORMATION 1 2 8</p> <p>DID NOT HAVE STRONG SUCK 1 2 8</p> <p>COULD NOT GET FEED . 1 2 8</p> <p>HAD A STRONG SUCK, BUT THEN STOPPED SUCKING WELL 1 2 8</p> <p>DID NOT HAVE STRONG CRY 1 2 8</p> <p>HAD A STRONG CRY BUT THEN STOPPED CRYING 1 2 8</p> <p>HAD A SPASM OR CONVULSION 1 2 8</p> <p>HAD TETANUS 1 2 8</p> <p>AREAS OF SKIN THAT WERE RED AND HOT ... 1 2 8</p> <p>HAD A BULGING FONTANEL 1 2 8</p> <p>BECOME UNRESPONSIVE/ UNCONSCIOUS..... 1 2 8</p> <p>HANDS OR FEET WERE COLD 1 2 8</p> <p>HAD FEVER 1 2 8</p> <p>HAD REDNESS OR DRAINAGE FROM UMBILICAL STUMP ... 1 2 8</p> <p>BABY WAS VERY PALE . 1 2 8</p> <p>HAD YELLOW EYES AND BODY 1 2 8</p> <p>HAD CYANOSIS (BLUE COLOR) 1 2 8</p> <p>HAD DIFFICULTY BREATHING 1 2 8</p> <p>BABY WAS NOT ABLE TO BREATHE 1 2 8</p> <p>HAD CHEST IN-DRAWING 1 2 8 WAS BREATHING VERY FAST 1 2 8</p> <p>COUGH 1 2 8</p> <p>HAD PERSISTENT VOMITING..... 1 2 8</p> <p>FREQUENT, LIQUID OR WATERY STOOLS ... 1 2 8</p> <p>ABDOMINAL DISTENSION 1 2 8</p> <p>OTHER _____ 1 2 8 (SPECIFY)</p>	

SECTION 3. DETAILS OF THE LAST (DECEASED CHILD) PREGNANCY LABOUR AND DELIVERY
(FOR ALL DEATHS)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																
301	<p>Did any of illness (problem) occur to the child's mother during pregnancy ?</p> <p align="center">(CIRCLE ALL MENTIONED)</p> <p align="center">* (GESTATIONAL AGE) IN MONTHS WHEN DISEASE STARTED)</p>	<table border="1"> <thead> <tr> <th></th> <th>Duration of illness (Weeks)</th> <th>Stage of pregnancy *</th> </tr> </thead> <tbody> <tr> <td>BLEEDING FROM THE VAGINA A</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>SMELLY OR EXCESSIVE VAGINAL DISCHARGE B</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>SEVERE OR PERSISTENT ABDOMINAL OR BACK PAIN THAT WAS NOT LABOUR PAIN C</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HAND OR FACE SWELLING OR RAPID LEG SWELLING D</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>BLURRING OF VISION AND SEVERE HEADACHE E</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>CONVULSIONS F</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HIGH BLOOD PRESSURE G</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>LESS BLOOD OR WAS ANEMIC H</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>MALARIA I</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>DIABETES J</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>JAUNDICE K</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>POSITIVE HIV TEST L</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>OTHER _____ X</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td align="center">(SPECIFY)</td> <td></td> <td></td> </tr> <tr> <td>DON'T KNOW Z</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Duration of illness (Weeks)	Stage of pregnancy *	BLEEDING FROM THE VAGINA A	<input type="checkbox"/>	<input type="checkbox"/>	SMELLY OR EXCESSIVE VAGINAL DISCHARGE B	<input type="checkbox"/>	<input type="checkbox"/>	SEVERE OR PERSISTENT ABDOMINAL OR BACK PAIN THAT WAS NOT LABOUR PAIN C	<input type="checkbox"/>	<input type="checkbox"/>	HAND OR FACE SWELLING OR RAPID LEG SWELLING D	<input type="checkbox"/>	<input type="checkbox"/>	BLURRING OF VISION AND SEVERE HEADACHE E	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS F	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE G	<input type="checkbox"/>	<input type="checkbox"/>	LESS BLOOD OR WAS ANEMIC H	<input type="checkbox"/>	<input type="checkbox"/>	MALARIA I	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES J	<input type="checkbox"/>	<input type="checkbox"/>	JAUNDICE K	<input type="checkbox"/>	<input type="checkbox"/>	POSITIVE HIV TEST L	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____ X	<input type="checkbox"/>	<input type="checkbox"/>	(SPECIFY)			DON'T KNOW Z	<input type="checkbox"/>	<input type="checkbox"/>	
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302	<p>CHECK 301:</p> <p>AT LEAST ONE ILLNESS <input type="checkbox"/> NOT A SINGLE ILLNESS <input type="checkbox"/></p>		<p align="right">→ 305</p>																																																
303	<p>In case of illness or problem, was health care sought from a health care provider/ facility for any illness (problem)?</p>	<p>YES 1</p> <p>NO 2</p>	<p align="right">→ 305</p>																																																
304	<p>From where the care was sought ?</p> <p align="center">CIRCLE ALL MENTIONED</p>	<p>GOVERNMENT SECTOR</p> <p>GOVT. DHQ/THQ/CIVIL HOSPITAL. A</p> <p>RURAL HEALTH CENTER B</p> <p>BASIC HEALTH UNIT C</p> <p>DISPENSARY D</p> <p>LADY HEALTH WORKER E</p> <p>OTHER GOV'T _____ F</p> <p align="center">(SPECIFY)</p> <p>PRIVATE SECTOR</p> <p>HOSPITAL /NURSING HOME G</p> <p>LADY HEALTH VISITER H</p> <p>MIDWIFE I</p> <p>COMPOUNDER/ DISPENSEL J</p> <p>DAI K</p> <p>HAKEEM/ HOMEOPATH L</p> <p>OTHER PRIVATE _____ M</p> <p align="center">(SPECIFY)</p>																																																	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP		
305	Did you/ mother have vaginal bleeding before delivery for any previous pregnancy (APH)?	YES 1 NO 2	→ 308		
306	Was healthcare sought during this problem?	YES 1 NO 2	→ 308		
307	From where did you/ mother seek care CIRCLE ALL MENTIONED	GOVERNMENT SECTOR GOVT. DHQ/THQ/CIVIL HOSPITAL A RURAL HEALTH CENTER..... B BASIC HEALTH UNIT C DISPENSARY D LADY HEALTH WORKER E OTHER GOV'T F (SPECIFY) PRIVATE SECTOR HOSPITAL /NURSING HOME..... G LADY HEALTH VISITER H MIDWIFE I COMPOUNDER/ DISPENSEL..... J DAI K HAKEEM/ HOMEOPATH L OTHER PRIVATE X (SPECIFY)			
308	Was this child a single or multiple birth ?	SINGLE BIRTH 1 FIRST OF TWINS 2 SECOND OF TWINS 3 OTHERS 4 (SPECIFY) DON'T KNOW 8			
309	Was he/ she born after full term or pre-term or after term ?	FULL TERM 1 PRE-TERM 2 AFTER-TERM 3 DON'T KNOW 8			
310	How many months of pregnancy were completed ?	MONTHS <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></table>			
311	Where was he/she born ?	AT HOME 1 GOVT. HEALTH FACILITY 2 PRIVATE HEALTH FACILITY ... 3 ON THE WAY TO HEALTH FACILITY 4 OTHER GOV'T 5 (SPECIFY)			
312	Who attended the delivery ? (CIRCLE ALL MENTIONED)	DOCTOR A MIDWIFE / NURSE / LHV B TRAINED TBA C DAI D LADY HEALTH WORKER E HOMEOPATH F HAKEEM G FAMILY ELDER WOMAN H HERSELF I OTHERS X (SPECIFY) NO ONE Y			

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
313	How long did the labor take, from the time contractions began and before the baby came out ? IF < 1 HOUR WRITE '00'	HOURS <input type="text"/> <input type="text"/> DON'T KNOW 98	
314	Was any intervention or procedure done during the labor / delivery ?	YES 1 NO 2	→ 316
315	Which types of interventions or procedure were done ? (CIRCLE ALL MENTIONED)	MANIPULATION WITH HANDS ... A AUGMENTATION B FORCEP ASSISTED C VACUUM D C-SECTION E DON'T KNOW Z	
316	How much time did the delivery take ? IF < 1 HOUR WRITE MINUTES IF ≥ 1 HOUR WRITE HOURS	MINUTES 1 <input type="text"/> <input type="text"/> HOURS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
317	CHECK 126: LIVE BIRTH <input type="checkbox"/> STILL BIRTH <input type="checkbox"/>		→ 321
318	What was the weight of the baby at birth ?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Kg. Gm. DON'T KNOW 98 998	→ 320
319	What was the size of the baby at birth ? (SHOW PHOTOS AND RECORD ITS NUMBER)	PHOTO NO. <input type="text"/>	
320	Did child receive any vaccinations to prevent him/ her from getting diseases, including vaccinations received in a national immunization campaign ?	VACCINATION YES NO DK BCG 1 2 8 POLIO 0 1 2 8 POLIO 1 1 2 8 POLIO 2 1 2 8 POLIO 3 1 2 8 DPT 1 1 2 8 DPT 2 1 2 8 DPT 3 1 2 8 HBV 1 1 2 8 HBV 2 1 2 8 HBV 3 1 2 8 MEASLES 1 2 8	
321	During this pregnancy, were you/mother given an injection in the buttocks or arm to prevent you/mother and the baby from getting tetanus ?	YES 1 NO 2 DON'T KNOW 8	→ 323
322	How many times did you/ mother get this tetanus injection ?	NO. OF DOSES <input type="text"/> DON'T KNOW 98	
323	CHECK 124: CHILD WAS BORN DEAD CHILD HAD DIED AT AGE LESS THAN 28 DAYS CHILD HAD DIED AFTER 28 COMPLETED DAYS OF BIRTH	STILL BIRTH 1 NEONATAL DEATH 2 POST NEONATAL & CHILD DEATH 3	→ 401 → 501

SECTION 4. STILL BIRTH (BORN DEAD)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP						
401	Was the baby moving in the last few days before the delivery?	YES 1 NO 2 DON'T KNOW 8							
402	When did you/ mother last feel the movements of the baby before the delivery ? IF < 1 HOUR WRITE MINUTES IF < 1 DAY WRITE HOURS IF > = 1 DAY WRITE DAYS	MINUTES 1 HOURS 2 DAYS 3 DON'T KNOW 998	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>						
403	Was you/ mother having excess fluid in the womb (Ployhydramnios) ?	YES 1 NO 2 DON'T KNOW 8							
404	What was the color of liquor (water) during delivery ?	GREENISH 1 BROWNISH 2 NORMAL 3 DON'T KNOW 8							
405	Was the liquor foul smelling ?	YES 1 NO 2 DON'T KNOW 8							
406	Which part of the baby came out first	HEAD 1 BOTTOM 2 FEET 3 HANDS AND ARMS 4 C-SECTION 5 DON'T KNOW 8							
407	Was the cord around the neck of the dead baby ?	YES 1 NO 2 DON'T KNOW 8							
408	Was there any gross physical deformity in the dead baby ?	YES 1 NO 2 DON'T KNOW 8							
409	Was the head not properly formed or skull vault and forebrain absent at the time to birth (Anencephaly) ? (SHOW PHOTO)	YES 1 NO 2 DON'T KNOW 8							
410	Was there a mass or defect on the back (Meningomyelocele) ? (SHOW PHOTO)	YES 1 NO 2 DON'T KNOW 8							
411	Was there any cleft lip or cleft palate in the dead baby ? (SHOW PHOTO)	YES 1 NO 2 DON'T KNOW 8							
412	Was dead baby macerated (skin and tissue was pulpy)? (SHOW PHOTO)	YES 1 NO 2 DON'T KNOW 8	→ H101						

SECTION 5. DEATH FROM INJURY OR ACCIDENT
 (For Neonatal, Post Neonatal child deaths)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	Did he/she die from an injury or accident ?	YES 1 NO 2	→ 503
502	IF YES: What kind of injury or accident ?	ROAD TRAFFICE ACCIDENT 01 FALL DOWN 02 SOMETHING FELL ON THE CHILD ... 03 BURN 04 DROWNING 05 POISONING 06 BITE/STING 07 NATURAL DISASTER 08 HOMICIDE/ ASSAULT 09 OTHERS 10 (SPECIFY) DON'T KNOW 98	→ H101
503	CHECK 126: CIRCLE THE APPROPRIATE CODE FOR TYPE OF DEATH.	NEONATAL DEATH 1 POST NEONATAL DEATH 2	→ 601 → 701

SECTION 6. NEONATAL DEATHS (INFANT DIED WITH IN 28 DAYS AFTER BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601	Did the water bag rupture before or after start of labor pains or water bag never broke ?	BEFORE 1 AFTER 2 WATER BAG NEVER BROKE 3 DON'T KNOW 8	→ 603
602	How much time before labor started did the water bag rupture ? IF < 1 DAY WRITE HOURS IF >= 1 DAY WRITE DAYS	HOURS 1 DAYS 2 DON'T KNOW 998	
603	What was the color of liquor (amniotic fluid) ?	GREENISH 1 BROWNISH 2 NORMAL 3 DON'T KNOW 8	
604	What was the color of child at birth ?	PINK 1 PALE 2 BLUE 3 DON'T KNOW 8	
605	What was the color of child after 5 minutes of birth ?	PINK 1 PALE 2 BLUE 3 DON'T KNOW 8	
606	Did the baby breathe immediately after birth ? (THIS DOES NOT INCLUDE GASPS OR VERY BRIEF EFFORTS TO BREATHE)	YES 1 NO 2 DON'T KNOW 8	
607	Did the child cry after birth ?	YES 1 NO 2 DON'T KNOW 8	→ 609
608	Was the cry feeble or strong ?	FEEBLE 1 STRONG 2 DON'T KNOW 8	
609	Were there any green marks of meconium on the child's body ?	YES 1 NO 2 DON'T KNOW 8	
610	Were there any bruises or marks of injury on the child's body ?	YES 1 NO 2 DON'T KNOW 8	
611	Did the newborn have swelling(s) over the skull ?	YES 1 NO 2 DON'T KNOW 8	
612	Was there any physical deformity in the baby ?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
613	Was the head size not properly formed or skull vault and forebrain absent, very small, small, normal or very large? (Anencephaly, Microcephaly, Hydrocephaly) (SHOW PHOTO)	NOT PROPERLY FORMED 1 SMALL 2 NORMAL 3 LARGE 4 VERY LARGE 5 DON'T KNOW 8	
614	Was there a mass or defect on the back of head or spine? (Meningomyelocele) (SHOW PHOTO)	YES 1 NO 2 DON'T KNOW 8	
615	Was there any cleft lip or cleft palate ? (SHOW PHOTO)	YES 1 NO 2 DON'T KNOW 8	
616	Was there any limp defect ? (SHOW PHOTO)	YES 1 NO 2 DON'T KNOW 8	
617	Was the child limp/ flaccid during first 72 hours ?	YES 1 NO 2 DON'T KNOW 8	
618	When did the child start sucking on the breast or feed bottle after birth ? IF < 1 HOUR WRITE MINUTES IF > 1 HOUR BUT > 1 DAY WRITE HOURS IF >= 1 DAY WRITE DAYS	IMMEDIATELY 000 MINUTES 1 HOURS 2 DAYS 3 NEVER FED 995 DON'T KNOW 998	621
619	When did child stop sucking or bottle-feeding before death ? IF < 1 DAY WRITE HOURS IF >= 1 DAY WRITE DAYS	HOURS 1 DAYS 2 DON'T KNOW 998	
620	How long before death, did the infant stop crying? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 MINUTES 2 DON'T KNOW 998	
621	Did body of the child become stiff with the back arched?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
622	Did the newborn have convulsions (Fits/seizure) during first 24 hours after birth ?	YES 1 NO 2 DON'T KNOW 8	
623	Was a safe delivery kit used during this delivery ?	YES 1 NO 2 DON'T KNOW 8	
624	What was used to TIE the umbilical cord ?	UNBOILED THREAD 1 BOILED THREAD 2 WASHED CLAMPS 3 UNWASHED CLAMPS 4 HAIR 5 OTHER 6 (SPECIFY) DON'T KNOW 8	
625	What was used to cut the umbilical cord ?	NEW RAZOR BLADE 1 OLD RAZOR BLADE 2 SCISSOR 3 KNIFE 4 TOKA / CHOPPER 5 OTHER 6 (SPECIFY) DON'T KNOW 8	→ 627
626	Were the instruments boiled before using or not boiled ?	BOILED 1 NOT BOILED 2 DON'T KNOW 8	
627	Did child have "Tetanus" (local words)? (EXPLAIN DESCRIPTION OF DISEASE)	YES 1 NO 2 DON'T KNOW 8	
628	Did child become unresponsive / unconscious during the illness ?	YES 1 NO 2 DON'T KNOW 8	
629	Did child have a bulging fontanelle during the illness ?	YES 1 NO 2 DON'T KNOW 8	
630	Did child have jaundice or yellow discoloration of skin ?	YES 1 NO 2 DON'T KNOW 8	
631	Did child have redness or pus oozing from the umbilical cord ?	YES 1 NO 2 DON'T KNOW 8	
632	Did child have areas of skin that were red and hot ?	YES 1 NO 2 DON'T KNOW 8	
633	Did child have skin rash with pus ?	YES 1 NO 2 DON'T KNOW 8	→ 635

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
634	Did the skin peel off after the rash started ?	YES 1 NO 2 DON'T KNOW 8									
635	Did child have ear discharge ?	YES 1 NO 2 DON'T KNOW 8									
636	Did Child become lethargic at any stage of the illness ?	YES 1 NO 2 DON'T KNOW 8									
637	Did the child have a fever at any stage of the illness ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 639								
638	For how long did fever last ? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
639	Did child have frequent loose or watery stools / diarrhea ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 645								
640	For how long did the diarrhea last ? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
641	Was there visible blood in the stools at any stage of diarrhea ?	YES 1 NO 2 DON'T KNOW 8									
642	Did child have abdominal distension at any stage of diarrhea ?	YES 1 NO 2 DON'T KNOW 8									
643	Did the child take any liquids during loose or watery stools ?	YES 1 NO 2 DON'T KNOW 8									
644	Did the child take ORS during loose or watery stools ?	YES 1 NO 2 DON'T KNOW 8									
645	Did child have cough ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 647								
646	For how long did cough last ? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
647	Did child have difficult breathing ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 649								

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP				
648	For how long did difficult breathing last ? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 DON'T KNOW 998					
649	Did child have fast breathing ?	YES 1 NO 2 DON'T KNOW 8	→ 651				
650	For how long did fast breathing last ? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 DON'T KNOW 998					
651	Did child ever stop breathing for a long time, and start again ?	YES 1 NO 2 DON'T KNOW 8					
652	Did child have chest in-drawing ?	YES 1 NO 2 DON'T KNOW 8					
653	Did child have noisy breathing (Stridor)? (DEMONSTRATE SOUND)	YES 1 NO 2 DON'T KNOW 8					
654	Did child have noisy breathing (Grunting) ? (DEMONSTRATE SOUND)	YES 1 NO 2 DON'T KNOW 8					
655	Did child have noisy breathing (Wheezing) > (DEMONSTRATE SOUND)	YES 1 NO 2 DON'T KNOW 8					
656	Did child's nostrils flare with breathing ?	YES 1 NO 2 DON'T KNOW 8					
657	Did child have pneumonia (local term) ?	YES 1 NO 2 DON'T KNOW 8					
658	Did child become cold at the beginning/ during of illness ?	YES 1 NO 2 DON'T KNOW 8	→ 801				

SECTION 7. POST NEONATAL AND CHILD DEATHS (CHILD DIED AFTER 28 DAYS UP TO 5 YEARS)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP				
701	Did child have a fever ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 703				
702	For how long did fever last ? IF < 1 DAY WRITE HOURS IF >= 1 DAY WRITE DAYS	HOURS 1 DAYS 2 DON'T KNOW 998	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>				
703	Did child become unresponsive / unconscious ?	YES 1 NO 2 DON'T KNOW 8					
704	Did child have "Tetanus" (local words) ? (EXPLAIN DESCRIPTION OF DISEASE)	YES 1 NO 2 DON'T KNOW 8					
705	Did child have a bulging fontanelle ?	YES 1 NO 2 DON'T KNOW 8					
706	Did the child have a stiff neck ? (DEMONSTRATE)	YES 1 NO 2 DON'T KNOW 8					
707	Did the child have convulsions (Fits/ seizure) ?	YES 1 NO 2 DON'T KNOW 8					
708	Did child have frequent loose or watery stools / diarrhea ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 713				
709	For how long did diarrhea last ? IF < 1 DAY WRITE HOURS IF >= 1 DAY WRITE DAYS	HOURS 1 DAYS 2 DON'T KNOW 998	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>				
710	Was there visible blood in stools during diarrhea ?	YES 1 NO 2 DON'T KNOW 8					
711	Did child have abdominal distention during diarrhea ?	YES 1 NO 2 DON'T KNOW 8					
712	Did the child drink anything during loose or watery stools ?	YES 1 NO 2 DON'T KNOW 8					
712A	Did the child take ORS during loose or watery stools ?	YES 1 NO 2 DON'T KNOW 8					

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
713	Did child have a cough ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 716
714	For how long did cough last ? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 <input type="text"/> <input type="text"/> DAYS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
715	How severe was the cough ?	MILD 1 SEVERE 2 VERY SEVERE 3	
716	Did child have difficult breathing ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 718
717	For how long did difficult breathing last ? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 <input type="text"/> <input type="text"/> DAYS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
718	Did child have fast breathing ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 720
719	For how long did fast breathing last ? IF < 1 DAY RECORD HOURS IF >= 1 DAY RECORD DAYS	HOURS 1 <input type="text"/> <input type="text"/> DAYS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
720	Did child ever stop breathing for a long time and start again ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 720
721	Did child have chest indrawing ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 720
722	Did child have noisy breathing (Stridor)? (DEMONSTRATE SOUND)	YES 1 NO 2 DON'T KNOW 8	
723	Did child have noisy breathing (Grunting) ? (DEMONSTRATE SOUND)	YES 1 NO 2 DON'T KNOW 8	
724	Did child have noisy breathing (Wheezing) > (DEMONSTRATE SOUND)	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
725	Did child's nostrils flare with breathing ?	YES 1 NO 2 DON'T KNOW 8	
726	Did child have pneumonia (local term) ?	YES 1 NO 2 DON'T KNOW 8	
727	Did child become cold at the beginning of illness ?	YES 1 NO 2 DON'T KNOW 8	
728	Did child become cold during the illness ?	YES 1 NO 2 DON'T KNOW 8	
729	Did child have yellow eyes ?	YES 1 NO 2 DON'T KNOW 8	
730	Did child have jaundice or yellow coloured skin ?	YES 1 NO 2 DON'T KNOW 8	
731	Did the child have skin rash ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 737
732	Was the rash all over child's body ?	YES 1 NO 2 DON'T KNOW 8	
733	Was the rash also on child's face ?	YES 1 NO 2 DON'T KNOW 8	
734	For how many days did the rash last ? IF < 1 DAY RECORD '00'	DAYS <input type="text"/> <input type="text"/> DON'T KNOW 98	
735	Did rash contain clear fluid ?	YES 1 NO 2 DON'T KNOW 8	
736	Did the skin crack or peel off after the rash started ?	YES 1 NO 2 DON'T KNOW 8	
737	Did the child have "measles" ?	YES 1 NO 2 DON'T KNOW 8	
738	Did child become very thin ?	YES 1 NO 2 DON'T KNOW 8	
739	Did child become very weak ?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
740	Did child have swelling on legs or feet ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 742
741	For how long did the swelling last ? IF < 1 DAY RECORD '00'	DAYS <input type="text"/> <input type="text"/> DON'T KNOW 98	
742	Did child's skin flake off in patches ?	YES 1 NO 2 DON'T KNOW 8	
743	Did Child's hair colour change to reddish (or yellowish) ?	YES 1 NO 2 DON'T KNOW 8	
744	Did child have "kwashiorkor" ?	YES 1 NO 2 DON'T KNOW 8	
745	Did child have "marasmus" ?	YES 1 NO 2 DON'T KNOW 8	
746	Did child suffer from "lack of blood" or "pallor" ?	YES 1 NO 2 DON'T KNOW 8	
747	Did child have pale palms ?	YES 1 NO 2 DON'T KNOW 8	
748	Did child have white nails ?	YES 1 NO 2 DON'T KNOW 8	
749	Did child have swellings in the armpits ?	YES 1 NO 2 DON'T KNOW 8	
750	Did child have swellings in the groin ?	YES 1 NO 2 DON'T KNOW 8	
751	Did child have a whitish rash inside the mouth or on the tongue ?	YES 1 NO 2 DON'T KNOW 8	

SECTION 8. TREATMENT AND RECORDS (FOR NEONATAL AND POST NEONATAL DEATH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																														
801	<p>I would like to ask a few questions about any medicines/ drugs child might have received during the illness. Did child receive any of the following medicine/ drugs during illness? (PROMPT ALL BELOW)</p> <p>Antibiotics</p> <p>Antimalarial medicines</p> <p>Fever medicines</p> <p>Diarrhea medicines</p> <p>Other medicines _____ (SPECIFY)</p>	<p style="text-align: right;">YES NO DK</p> <p>ANTIBIOTICS 1 2 8</p> <p>ANTI-MALARIAL 1 2 8</p> <p>FEVER..... 1 2 8</p> <p>DIARRHEA 1 2 8</p> <p>OTHER MEDICINES..... 1 2 8</p>																															
802	Do you have any health records that belong to your child ?	YES 1 NO 2	→ 804																														
803	Are these records available at this time ?	YES 1 NO 2																															
804	<p>RECORD THE MOST RECENT TWO WEIGHTS OF THE CHILD (IF AVAILABLE)</p> <p>RECORD THE DATES OF THE MOST RECENT WEIGHTS RECORD MOST RECENT IN WEIGHT 1</p> <p>IF CARD IS NOT AVAILABLE THEN SKIP TO 805</p>	<p>WEIGHTS 1</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Kg.</td> <td colspan="2" style="text-align: center;">Gm.</td> </tr> </table> <p>DATE</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> <p>WEIGHTS 2</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Kg.</td> <td colspan="2" style="text-align: center;">Gm.</td> </tr> </table> <p>DATE</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> <p>DON'T KNOW 8</p>					Kg.		Gm.				-			-						Kg.		Gm.				-			-		
Kg.		Gm.																															
		-			-																												
Kg.		Gm.																															
		-			-																												
805	Was a death certificate sought for the deceased child ?	YES 1 NO 2 DON'T KNOW 8	→ 901																														
806	RECORD THE IMMEDIATE CAUSE OF DEATH FROM THE CERTIFICATE (IF AVAILABLE)	_____ _____ _____ _____																															

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
807	RECORD THE OTHER CAUSES FROM DEATH CERTIFICATE RECOR THE FIRST UNDERLYING CAUSE OF DEATH FROM THE CERTIFICATE	<hr/> <hr/> <hr/> <hr/>	
	RECORD THE SECOND UNDERLYING CAUSES OF DEATH FROM THE CERTIFICATE	<hr/> <hr/> <hr/> <hr/>	
	RECORD THE CONTRIBUTING CAUSES OF DEATH FROM THE CERTIFICATE	<hr/> <hr/> <hr/> <hr/>	

SECTION 9. SOCIAL AUDIT AND OTHER ASPECTS

Please ask about any maternal complication during the last trimester of pregnancy and response of family/provider to the complication.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
901	Did you/mother have any complaints or problems during the last trimester (last 3 months) of pregnancy?	YES 1 NO 2	→ 906
902	Please describe the nature of illness which you/mother faced during the last 3-months of pregnancy? <input type="text"/> _____ _____ _____	
903	Did you/mother seek advice or treatment for the problem(s)?	YES 1 NO 2	→ 905
904	Whom did you/mother see?	DOCTOR A HAKIM B HOMEOPATH C PHARMACY D GOVERNMENT HOSPITAL E PRIVATE HOSPITAL F NGO CLINIC G OTHERS _____ ... X (SPECIFY) DON'T KNOW Z	→ 906
905	Why did'nt you/mother see anyone for this problem?	DISEASE WAS TOO SERIOUS BUT NO USE OF SEEKING CARE . 1 DISEASE WAS NOT TOO SERIOUS TOO SEEK CARE 2 HAD NO MONEY TO SEEK CARE . 3 TRANSPORT WAS NOT AVAILABLE 4 HAD NO PERMISSION TO GO OUT ON MY OWN 5 MALE MEMBER/ HUSBAND WAS NOT AVAILABLE AT HOME TO ACCOMPANY ME TO HOSPITAL 6 OTHER _____ ... 7 (SPECIFY)	→ 914
906	Where was the baby delivered?	GOVT HEALTH FACILITY 1 PRIVATE HEALTH FACILITY 2 ON ROUTE TO THE HEALTH FACILITY 3 AT HOME 4 OTHERS _____ ... 6 (SPECIFY)	→ 908

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																
907	Why did'nt you/mother deliver baby in a health facility?	COST TOO MUCH A FACILITY NOT OPENED B POOR SERVICES AT FACILITY ... C NO PERMISSION FROM FAMILY ... D FACILITY TOO FAR E NO TRANSPORTATION F ALWAYS A DAI ASSIST IN FAMILY G OTHERS _____ ... X (SPECIFY) DON'T KNOW Z																	
908	What was the age of the baby/child when you/ mother first noticed that he/ she is not well ? IF < 1 DAY WRITE HOURS IF > = 1 DAY BUT < 1 MONTH WRITE DAYS IF > 1 MONTH BUT < 1 YEAR WRITE MONTHS IF >= 1 YEAR WRITE YEARS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTH!..... 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> YEARS 4 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW998																	
909	What signs and symptoms did you/ mother notice ?	_____ _____ _____																	
DAY ONE OF ILLNESS																			
910	What did you/ mother/ family do first day of illness ?	NOTHING 1 HOME CARE 2 SOUGHT CARE OUTSIDE 3	→ 912 → 913																
911	Why did you do nothing ?	DISEASE WAS TOO SERIOUS BUT NO USE OF SEEKING CARE . 1 DISEASE WAS NOT TOO SERIOUS TO SEEK CARE 2 HAD NO MONEY TO SEEK CARE . 3 TRANSPORT WAS NOT AVAILABLE 4 HAD NO PERMISSION TO GO OUT ON MY OWN 5 MALE MEMBER/ HUSBAND WAS NOT AVAILABLE AT HOME TO ACCOMPANY ME TO HOSPITAL 6 OTHER _____ ... 7 (SPECIFY) BABY DIED SAME DAY 8	→ 915 → 933																
912	Why did you seek home care ?	FAMILY ADVISED FOR HOME CARE 1 ILLNESS WAS NOT SERIOUS 2 OTHERS _____ ... 3 (SPECIFY)	→ 915																

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
913	From whom did you seek care ? CIRCLE ALL MENTIONED	DOCTOR A HAKIM B HOMEOPATH C PHARMACY D GOVERNMENT HOSPITAL E PRIVATE HOSPITAL F NGO CLINIC G OTHERS _____ ... X (SPECIFY) NO ANSWER Y	→ 918
914	What did care provider do ? CIRCLE ALL MENTIONED	GAVE MEDICINE A REFERRED TO ANOTHER HOSPITAL B ADMITTED IN HOSPITAL C OTHERS _____ ... X (SPECIFY)	
DAY TWO AND THREE OF ILLNESS			
915	How was child on second and third day of illness?	WITH SAME CONDITION 1 WORSENERD 2 IMPROVED 3 WAS HOSPITALIZED 4 OTHERS _____ ... 6 (SPECIFY) HAD DIED DURING THIS PERIOD 5	→ 933
916	What did you/ family do ?	NOTHING 1 HOME CARE 2 SOUGHT CARE OUTSIDE 3	→ 918 → 919
917	Why did you do nothing ?	DISEASE WAS TOO SERIOUS BUT NO USE OF SEEKING CARE 1 DISEASE WAS NOT TOO SERIOUS TOO SEEK CARE ... 2 HAD NO MONEY TO SEEK CARE . 3 TRANSPORT WAS NOT AVAILABLE 4 HAD NO PERMISSION TO GO OUT ON MY OWN 5 MALE MEMBER/ HUSBAND WAS NOT AVAILABLE AT HOME TO ACCOMPANY ME TO HOSPITAL 6 OTHER _____ ... 7 (SPECIFY)	→ 921
918	Why was home care sought ?	FAMILY ADVISED FOR HOME CARE 1 ILLNESS WAS NOT SERIOUS ... 2 OTHERS _____ ... 3 (SPECIFY)	→ 921

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
919	From whom did you/ mother seek care ? CIRCLE ALL MENTIONED	DOCTOR A HAKIM B HOMEOPATH C PHARMACY D GOVERNMENT HOSPITAL E PRIVATE HOSPITAL F NGO CLINIC G OTHERS _____ ... X (SPECIFY) DON'T KNOW Z	→ 921
920	What did the care provider do ? CIRCLE ALL MENTIONED	GAVE MEDICINE A REFERRED TO ANOTHER HOSPITAL B ADMITTED IN HOSPITAL C OTHERS _____ ... X (SPECIFY) DON'T KNOW Z	
DAY 4 -8 OF ILLNESS			
921	How was (NAME) baby/ child between days 4-8 of illness?	WITH SAME CONDITION 1 WORSENERD 2 IMPROVED 3 WAS HOSPITALIZED 4 OTHERS _____ ... 6 (SPECIFY) HAD DIED DURING THIS PERIOD 5	→ 933
922	What did you/ mother/ family do ?	NOTHING 1 HOME CARE 2 SOUGHT CARE OUTSIDE 3	→ 924 → 925
923	Why did you/ mother/family do nothing ?	DISEASE WAS TOO SERIOUS BUT NO USE OF SEEKING CARE . 1 DISEASE WAS NOT TOO SERIOUS TOO SEEK CARE ... 2 HAD NO MONEY TO SEEK CARE . 3 TRANSPORT WAS NOT AVAILABLE 4 HAD NO PERMISSION TO GO OUT ON MY OWN 5 MALE MEMBER/ HUSBAND WAS NOT AVAILABLE AT HOME TO ACCOMPANY ME TO HOSPITAL 6 OTHER _____ ... 7 (SPECIFY)	→ 927
924	Why did you seek home care ?	FAMILY ADVISED FOR HOME CARE 1 ILLNESS WAS NOT SERIOUS 2 OTHERS _____ ... 3 (SPECIFY)	→ 927

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
925	From whom did you/ mother seek care ? (CIRCLE ALL MENTIONED)	DOCTOR A HAKIM B HOMEOPATH C PHARMACY D GOVERNMENT HOSPITAL E PRIVATE HOSPITAL F NGO CLINIC G OTHERS _____ ... X (SPECIFY) DON'T KNOW Z	→ 927
926	What did the care provider do ? (CIRCLE ALL MENTIONED)	GAVE MEDICINE A REFERRED TO ANOTHER HOSPITAL B ADMITTED IN HOSPITAL C OTHERS _____ ... X (SPECIFY)	
LAST DAY OF ILLNESS			
927	How was (NAME) baby/ child on last day of illness ?	WITH SAME CONDITION 1 WORSENERD 2 IMPROVED 3 WAS HOSPITALIZED 4 OTHERS _____ 6 (SPECIFY) HAD DIED DURING THIS PERIOD 5	→ 933
928	What did you/mother/family do ?	NOTHING 1 HOME CARE 2 SOUGHT CARE OUTSIDE 3	→ 930 → 931
929	Why did you do nothing ?	DISEASE WAS TOO SERIOUS BUT NO USE OF SEEKING CARE . 1 DISEASE WAS NOT TOO SERIOUS TOO SEEK CARE ... 2 HAD NO MONEY TO SEEK CARE . 3 TRANSPORT WAS NOT AVAILABLE 4 HAD NO PERMISSION TO GO OUT ON MY OWN 5 MALE MEMBER/ HUSBAND WAS NOT AVAILABLE AT HOME TO ACCOMPANY ME TO HOSPITAL 6 OTHER _____ 7 (SPECIFY)	→ 933
930	Why did you/ mother seek home care ?	FAMILY ADVISED FOR HOME CARE 1 ILLNESS WAS NOT SERIOUS 2 OTHERS _____ 3 (SPECIFY)	→ 933

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
931	From whom did you seek care ? (CIRCLE ALL MENTIONED)	DOCTOR A HAKIM B HOMEOPATH C PHARMACY D GOVERNMENT HOSPITAL E PRIVATE HOSPITAL F NGO CLINIC G OTHERS _____ ... X (SPECIFY) DON'T KNOW Z	→ 933
932	What did care provider do ? (CIRCLE ALL MENTIONED)	GAVE MEDICINE A REFERRED TO ANOTHER HOSPITAL B ADMITTED IN HOSPITAL C OTHERS _____ X (SPECIFY)	
DECISION MAKING MECHANISM AND HELP SEEKING			
933	When did you/ mother tell your spouse about the illness of baby ?	AT THE START OF THE ILLNESS . 1 DURING THE ILLNESS 2 TOWARDS THE END OF THE ILLNESS(WHEN IT BECAME SEVERE) 3 OTHER _____ ... 6 (SPECIFY) DON'T KNOW 8	→ 935
934	What was the reaction of your spouse ?	_____	
935	Who mainly takes the care seeking (& other) decisions in the household ?	HUSBAND 1 MOTHER/MOTHER IN LAW 2 FATHER/FATHER IN LAW 3 GRANDMOTHER 4 GRANDFATHER 5 UNCLE 6 OTHER _____ ... 7 (SPECIFY) DON'T KNOW 8	→ 937
936	Why does he/ she take the decisions ?	_____	
937	Who took the child for seeking care ?	MOTHER A FATHER B GRANDMOTHER C GRANDFATHER D UNCLE E OTHER _____ ... X (SPECIFY) DON'T KNOW Z	→ 939
938	Why did the above mentioned person go ?	_____	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
939	Who decided the care should be sought outside home ?	MOTHER 1 FATHER 2 GRANDMOTHER 3 GRANDFATHER 4 UNCLE 5 OTHER _____ ... 6 (SPECIFY) DON'T KNOW 8	
940	In your opinion, what was the illness; (PLEASE READ THE RESPONSES)	MILD/ DID NOT REQUIRE IMMEDIATE ATTENTION/ TREATABLE WITH HOME REMEDIES 1 MODERATE/ ILLNESS PERSISTING YET TREATABLE/ NOT SEVERE ENOUGH TO CAUSE DEATH ... 2 SEVERE/ DEATH WAS POSSIBLE 3 DON'T KNOW 8	
SOURCES OF CARE			
941	Where did you usually go to receive health care ?	HAKIM/ MATAB 1 HOMEOPATH CLINIC/ HOSPITAL . . 2 PHARMACY 3 GOVERNMENT HOSPITAL 4 PRIVATE HOSPITAL 5 NGO CLINIC 6 OTHERS _____ ... 7 (SPECIFY) DON'T KNOW 8	
942	How far is the nearest health facility from your house ?	KILOMETER: <input type="text"/> <input type="text"/> DON'T KNOW 98	
943	How do you commute to the nearest health facility ? (CIRCLE ALL MENTIONED)	TAXI A BUS B RICKSHAW C MOTORBIKE D WALKING E OTHER _____ X (SPECIFY) DON'T KNOW Z	
944	How much is the transportation cost to reach the nearest health facility?	RUPEES <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
945	When did you or your household member last time visit a health care facility ? IF < 1 MONTH WRITE DAYS IF < 1 YEAR, WRITE MONTHS IF >= 1 YEAR WRITE YEARS	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> DON'T KNOW 998	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
946	CHECK 916, 922, 928: HEALTH CARE <input type="checkbox"/> SOUGHT OUTSIDE <input type="checkbox"/>	OTHERS <input type="checkbox"/>	H101
SATISFACTION WITH THE HEALTH SYSTEM			
947	How easy was it to see a health care provider regarding your child ?	VERY EASY/ DID NOT HAVE TO WAIT AT ALL/ RECEIVED IMMEDIATE HELI..... 1 SOMEWHAT EASY/ HAD TO WAIT A SHORT WHILE 2 DIFFICULT/ HAD TO WAIT A LONG WHILE 3 EXTREMELY DIFFICULT/ NOBODY WAS AVAILABLE 4 DON'T KNOW 8	
948	How was the conduct of the physician (who saw the child towards the baby) ?	UNHELPFUL/ DID NOT EXPLAIN ILLNESS TO OR REASSURE CARETAKER 1 SOMEWHAT HELPFUL/ GAVE LITTLE INFORMATION 2 VERY HELPFUL/ EXPLAINED EVERYTHING VERY WELL 3 DON'T KNOW 8	
949	How was the conduct of the physician (who saw the child towards the caretaker of the baby) ?	UNHELPFUL/ DID NOT EXPLAIN ILLNESS TO OR REASSURE CARETAKER 1 SOMEWHAT HELPFUL/ GAVE LITTLE INFORMATION 2 VERY HELPFUL/ EXPLAINED EVERYTHING VERY WELL 3 DON'T KNOW 8	
950	Were you easily able to purchase/ acquire the drugs needed for the child ?	YES 1 NO 2 DON'T KNOW 8	→ 952
951	Why you were not able to purchase/ acquire the drugs ? (CIRCLE ALL MENTIONED)	EXPENSIVE A NOT EASILY AVAILABLE B TOO MANY WERE PRESCRIBED ... C OTHER _____ X (SPECIFY) DON'T KNOW Z	
952	Were you overall satisfied with the quality of care provided at the health facility ?	YES 1 NO 2 DON'T KNOW 8	→ H101
953	What are the reasons of your satisfaction ?	_____ _____ _____ _____	

SECTION 10: HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
H101	What is the main source of drinking water for members of your household?	PIPED WATER PIPED INTO DWELLING 11 PIPED TO YARD/PLOT 12 PUBLIC TAP/STAND PIPE ... 13 TUBE WELL OR BOREHOLE 21 HAND PUMP 22 DUG WELL PROTECTED WELL 31 UNPROTECTED WELL 32 WATER FROM SPRING PROTECTED SPRING/KAREZ ... 41 UNPROTECTED SPRING 42 RAINWATER 51 TANKER TRUCK 61 CART WITH SMALL TANK 71 SURFACE WATER (RIVER/DAM/LAKE/ POND/STREAM/CANAL 81 BOTTLED WATER 91 OTHER _____ 96 (SPECIFY)	<input type="checkbox"/> → H103
H102	How long does it take to go there, get water, and come back?	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> ON PREMISES 996 DON'T KNOW 998	
H103	Do you treat your water in any way to make it safer to drink?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → H105
H104	What do you usually do to the water to make it safer to drink? Anything else? RECORD ALL MENTIONED.	BOIL A ADD BLEACH/CHLORINE B STRAIN THROUGH A CLOTH C USE WATER FILTER (CERAMIC/ SAND/COMPOSITE/ETC.) D SOLAR DISINFECTION E LET IT STAND AND SETTLE F OTHER _____ X (SPECIFY) DON'T KNOW Z	
H105	What kind of toilet facility do members of your household usually use?	FLUSH OR POUR FLUSH TOILET FLUSH TO SEWER SYSTEM ... 11 FLUSH TO SEPTIC TANK 12 FLUSH TO SOMEWHERE ELSE ... 13 FLUSH, DON'T KNOW WHERE ... 14 PIT LATRINE VENTILATED IMPROVED PIT LATRINE (VIP) 21 PIT LATRINE WITH SLAB 22 PIT LATRINE WITHOUT SLAB/ OPEN PIT 23 BUCKET TOILET 41 HANGING TOILET/HANGING LATRINE 51 NO FACILITY/BUSH/FIELD 61 OTHER _____ 96 (SPECIFY)	<input type="checkbox"/> → H107

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																			
H106	Do you share this toilet facility with other households?	YES 1 NO 2																																																				
H107	Does your household have:	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>Electricity?</td> <td>ELECTRICITY 1</td> <td>2</td> </tr> <tr> <td>Radio?</td> <td>RADIO 1</td> <td>2</td> </tr> <tr> <td>Television?</td> <td>TELEVISION 1</td> <td>2</td> </tr> <tr> <td>Refrigerator?</td> <td>REFRIGERATOR 1</td> <td>2</td> </tr> <tr> <td>Mobile telephone or land line telephone?</td> <td>ANY TELEPHONE 1</td> <td>2</td> </tr> <tr> <td>Room cooler, air conditioner?</td> <td>ROOM COOLER, AIR COND. . 1</td> <td>2</td> </tr> <tr> <td>Washing machine?</td> <td>WASHING MACHINE 1</td> <td>2</td> </tr> <tr> <td>Water pump?</td> <td>WATER PUMP 1</td> <td>2</td> </tr> <tr> <td>Bed?</td> <td>BED 1</td> <td>2</td> </tr> <tr> <td>Chairs?</td> <td>CHAIRS 1</td> <td>2</td> </tr> <tr> <td>Almirah / cabinet?</td> <td>ALMIRAH/CABINET 1</td> <td>2</td> </tr> <tr> <td>Clock?</td> <td>CLOCK 1</td> <td>2</td> </tr> <tr> <td>Sofa?</td> <td>SOFA 1</td> <td>2</td> </tr> <tr> <td>Sewing machine?</td> <td>SEWING MACHINE 1</td> <td>2</td> </tr> <tr> <td>Camera?</td> <td>CAMERA 1</td> <td>2</td> </tr> <tr> <td>Personal computer?</td> <td>PERSONAL COMPUTER ... 1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	Electricity?	ELECTRICITY 1	2	Radio?	RADIO 1	2	Television?	TELEVISION 1	2	Refrigerator?	REFRIGERATOR 1	2	Mobile telephone or land line telephone?	ANY TELEPHONE 1	2	Room cooler, air conditioner?	ROOM COOLER, AIR COND. . 1	2	Washing machine?	WASHING MACHINE 1	2	Water pump?	WATER PUMP 1	2	Bed?	BED 1	2	Chairs?	CHAIRS 1	2	Almirah / cabinet?	ALMIRAH/CABINET 1	2	Clock?	CLOCK 1	2	Sofa?	SOFA 1	2	Sewing machine?	SEWING MACHINE 1	2	Camera?	CAMERA 1	2	Personal computer?	PERSONAL COMPUTER ... 1	2	
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H108	What type of fuel does your household mainly use for cooking?	ELECTRICITY 01 CYLINDER GAS 02 NATURAL GAS 03 BIOGAS 04 KEROSENE 05 CHARCOAL 06 WOOD 07 STRAW/SHRUBS/GRASS 08 AGRICULTURAL CROP 09 ANIMAL DUNG 10 NO FOOD COOKED IN HOUSEHOLD 95 OTHER _____ 96 (SPECIFY)																																																				
H109	MAIN MATERIAL OF THE FLOOR: RECORD OBSERVATION	NATURAL FLOOR EARTH / SAND / MUD 11 FINISHED FLOOR CHIPS / TERRAZZO 31 CERAMIC TILES 32 MARBLE 33 CEMENT 34 CARPET 35 BRICKS 36 MATS 37 OTHER _____ 96 (SPECIFY)																																																				

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																					
H110	MAIN MATERIAL OF THE ROOF: RECORD OBSERVATION	NATURAL ROOFING THATCH / BAMBOO / WOOD / MUD 12 RUDIMENTARY ROOFING CARDBOARD / PLASTIC 21 FINISHED ROOFING IRON SHEETS / ASBESTOS ... 31 T-IRON / WOOD / BRICK 32 REINFORCED BRICK CEMENT/RCC 33 OTHER _____ 96 (SPECIFY)																						
H111	MAIN MATERIAL OF THE WALLS: RECORD OBSERVATION	NATURAL WALLS MUD / STONES 11 BAMBOO / STICKS / MUD 12 RUDIMENTARY WALLS UNBAKED BRICKS / MUD 21 PLYWOOD SHEETS 22 CARTON / PLASTIC 23 FINISHED WALLS STONE BLOCKS 31 BAKED BRICKS 32 CEMENT BLOCKS/ CEMENT ... 33 TENT 34 OTHER _____ 96 (SPECIFY)																						
H112	How many rooms in this household are used for sleeping?	ROOMS <input type="text"/> <input type="text"/>																						
H113	Is this house rented, rent-free, mortgaged, or owned by a member of the household?	RENTED 1 RENT-FREE 2 MORTGAGED 3 OWNED 4 OTHER 6																						
H114	Does any member of this household own:	<table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="text-align: center; width: 5%;">YES</th> <th style="text-align: center; width: 5%;">NO</th> </tr> </thead> <tbody> <tr> <td>A watch?</td> <td style="text-align: center;">WATCH 1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>A bicycle?</td> <td style="text-align: center;">BICYCLE 1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>A motorcycle or motor scooter?</td> <td style="text-align: center;">MOTORCYCLE/SCOOTER ... 1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>An animal-drawn cart?</td> <td style="text-align: center;">ANIMAL-DRAWN CART 1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>A car or truck or Tractor?</td> <td style="text-align: center;">CAR/TRUCK 1</td> <td style="text-align: center;">2</td> </tr> <tr> <td>A boat with a motor?</td> <td style="text-align: center;">BOAT WITH MOTOR 1</td> <td style="text-align: center;">2</td> </tr> </tbody> </table>		YES	NO	A watch?	WATCH 1	2	A bicycle?	BICYCLE 1	2	A motorcycle or motor scooter?	MOTORCYCLE/SCOOTER ... 1	2	An animal-drawn cart?	ANIMAL-DRAWN CART 1	2	A car or truck or Tractor?	CAR/TRUCK 1	2	A boat with a motor?	BOAT WITH MOTOR 1	2	
	YES	NO																						
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A car or truck or Tractor?	CAR/TRUCK 1	2																						
A boat with a motor?	BOAT WITH MOTOR 1	2																						
H115	Does any member of this household own any land that can be used for agriculture?	YES 1 NO 2																						
H116	Does this household own any livestock, herds, other farm animals, or poultry?	YES 1 NO 2	→ H118																					

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
H117	<p>How many of the following animals does this household own?</p> <p>Buffalo</p> <p>Milk cows or bulls?</p> <p>Camels?</p> <p>Donkeys, or mules or horses?</p> <p>Goats?</p> <p>Sheep?</p> <p>Chickens?</p> <p>IF NONE, WRITE '00'. IF > 95, WRITE '95'. IF UNKNOWN, WRITE '98'</p>	<p>BUFFALO <input type="checkbox"/> <input type="checkbox"/></p> <p>COWS/BULLS <input type="checkbox"/> <input type="checkbox"/></p> <p>CAMELS <input type="checkbox"/> <input type="checkbox"/></p> <p>DONKEYS/MULES/HORSES . <input type="checkbox"/> <input type="checkbox"/></p> <p>GOATS <input type="checkbox"/> <input type="checkbox"/></p> <p>SHEEP <input type="checkbox"/> <input type="checkbox"/></p> <p>CHICKENS <input type="checkbox"/> <input type="checkbox"/></p>	
H118	<p>Does your household have any mosquito nets that can be used while sleeping?</p>	<p>YES 1</p> <p>NO 2</p>	→H126
H119	<p>How many mosquito nets does your household have?</p>	<p>NUMBER OF NETS <input type="text"/></p>	
H126	<p>Does your household do anything (else) to avoid mosquitos?</p>	<p>YES 1</p> <p>NO 2</p>	→H128
H127	<p>What do you do?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>COIL A</p> <p>MATS B</p> <p>SPRAY C</p> <p>ELECTRIC SPRAY REPELLANT ... D</p> <p>INSECT REPELLANT E</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p>	
H128	<p>Do you have any medicines for treating malaria in your house now?</p>	<p>YES 1</p> <p>NO 2</p> <p>DOES NOT KNOW 8</p>	

NATIONAL INSTITUTE OF POPULATION STUDIES
PAKISTAN DEMOGRAPHIC AND HEALTH SURVEY, 2006

DECEASED WOMAN'S IDENTIFICATION

IDENTIFICATION					
PROVINCE (PUNJAB=1; SINDH=2; NWFP=3; BALOCHISTAN=4; FATA=5) _____ <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></table>				
DISTRICT _____ <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></table>				
TEHSIL _____					
CLUSTER NUMBER <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><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				
HOUSEHOLD NUMBER <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><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>				
NAME OF HOUSEHOLD HEAD _____					
NAME OF DECEASED WOMAN _____	<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></table>				
NAME OF DECEASED WOMAN'S HUSBAND/FATHER (CIRCLE ONE) _____					
DATE OF DECEASED WOMAN'S DEATH AFTER 1 JANUARY, 2003 _____					

INTERVIEWER VISITS								
	1	2	3	FINAL VISIT				
DATE	_____	_____	_____	DAY <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></table>				
				MONTH <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></table>				
				YEAR <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px; text-align: center;">2</td><td style="width: 20px; height: 20px; text-align: center;">0</td><td style="width: 20px; height: 20px; text-align: center;">0</td><td style="width: 20px; height: 20px;"></td></tr></table>	2	0	0	
2	0	0						
INTERVIEWER'S NAME	_____	_____	_____	INT. NUMBER <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><td style="width: 20px; height: 20px;"></td></tr></table>				
RESULT*	_____	_____	_____	RESULT <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td></tr></table>				
NEXT VISIT: DATE TIME	_____ _____	_____ _____		TOTAL NUMBER OF VISITS <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td></tr></table>				

*RESULT CODES:
 1 COMPLETED 4 REFUSED
 2 NOT AT HOME 5 PARTLY COMPLETED 7 OTHER _____
 3 POSTPONED 6 INCAPACITATED (SPECIFY)

LANGUAGE OF QUESTIONNAIRE: **URDU**

SUPERVISOR	FIELD EDITOR	OFFICE EDITOR	KEYED BY										
NAME _____ <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><td style="width: 20px; height: 20px;"></td></tr></table>				NAME _____ <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><td style="width: 20px; height: 20px;"></td></tr></table>				<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></table>			<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></table>		
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Introduction and Consent

AssalamoAlaikum. My name is _____ and I am working with (NIPS, Islamabad). Our institute works on population related issues. Nowadays our institute is conducting a national survey about maternal mortality issues. As you are aware that every year thousands of mothers die during pregnancy and child birth. Most of the time the real cause of death can not be known. By conducting this survey we would like to know the causes of deaths of such women. After the survey government would like to formulate plans and policies for safe motherhood and women lives can be protected. We would very much appreciate your participation in this survey. I will ask you about the death of _____ (NAME of deceased woman). The questionnaire is long and there is repetition in questions. It will usually take about two hours to complete. All of the answers you give will be kept strictly confidential and will not be shown to any other person. If I ask any question you do not want to answer, tell me and I will go to the next question; or you can stop the interview at any time. However, we hope you will participate in the survey since your views are very important, and your participation will help in saving women's lives in future.

At this time, do you want to ask me anything about the survey? May I begin the interview now?

Signature of interviewer: _____ Date: _____

RESPONDENT AGREES TO BE INTERVIEWED 1 RESPONDENT DOES NOT AGREE TO BE INTERVIEWED 2 → END

SECTION 1. INFORMATION ABOUT RESPONDENTS

INTERVIEWER: ASK TO TALK TO THOSE WHO KNOW THE MOST ABOUT THE WOMAN'S LAST ILLNESS AND HER DEATH. IF A NEIGHBOR, FRIEND, OR DAI WAS PRESENT DURING HER ILLNESS OR DEATH, ASK THEM TO COME AND JOIN IN FOR INTERVIEW. GET ALL THE RESPONDENTS TOGETHER FOR THE INTERVIEW AND FILL THE TABLE BELOW.

First, I have a few questions about each of you. Please tell me:

101 NO.	102 What is your name	103 Sex of respondent	104 How old are you? COMPLETED YEARS	105 What was your relationship to (NAME) i.e deceased woman? RELATION	106 What is your education? SEE CODES BELOW (CLASSES PASSED)	107 Were you present when (NAME) first fell ill?	108 Were you present when (NAME) was taken to hospital?	109 Were you present when (NAME) died?	110 CIRCLE LINE NO. OF MAIN RESPONDENT
1		MALE . . . 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES . . 1 NO . . . 2	YES . . . 1 NO 2 NOT TAKEN 3	YES . . 1 NO . . . 2	1
2		MALE . . . 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES . . 1 NO . . . 2	YES . . . 1 NO 2 NOT TAKEN 3	YES . . 1 NO . . . 2	2
3		MALE . . 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES . . 1 NO . . . 2	YES . . . 1 NO 2 NOT TAKEN 3	YES . . 1 NO . . . 2	3
4		MALE . . 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES . . 1 NO . . . 2	YES . . . 1 NO 2 NOT TAKEN 3	YES . . 1 NO . . . 2	4
5		MALE . . 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES . . 1 NO . . . 2	YES . . . 1 NO 2 NOT TAKEN 3	YES . . 1 NO . . . 2	5
6		MALE . . 1 FEMALE . 2	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	YES . . 1 NO . . . 2	YES . . . 1 NO 2 NOT TAKEN 3	YES . . 1 NO . . . 2	6

RELATIONSHIP TO DECEASED WOMAN

- 02 = HUSBAND
- 03 = SON OR DAUGHTER
- 04 = SON-IN-LAW OR DAUGHTER-IN-LAW
- 05 = GRANDCHILD
- 06 = PARENT
- 07 = PARENT-IN-LAW
- 08 = BROTHER OR SISTER

RELATIONSHIP TO DECEASED WOMAN

- 09 = BROTHER/SISTER IN-LAW
- 10 = NIECE/NEPHEW
- 11 = GRAND PARENT
- 12 = AUNTS/UNCLE
- 13 = OTHER RELATIVE
- 14 = ADOPTED/FOSTER/STEPCHILD
- 15 = NOT RELATED
- 16 = DOMESTIC SERVANT

EDUCATION CLASS:

- 00 = LESS THAN 1 YEAR COMPLETED
- 01 = CLASS 1;
- 02 = CLASS 2
- ...
- 10 = MATRIC, CLASS 10
- 11 = CLASS 11
- ...
- 16 = MASTER'S DEGREE OR MBBS, PhD, MPhil, BSc (4 YEARS)

SECTION 2. DECEASED WOMAN'S BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201	RECORD THE TIME AT BEGINNING OF INTERVIEW	HOUR <input type="text"/> <input type="text"/> MINUTES <input type="text"/> <input type="text"/>	
202	I want to talk about the death of (NAME). WRITE WOMAN'S NAME HERE AND ON COVER PAGE	_____	
203	Can you tell me the name of (NAME)'s father?	_____	
204	In what month and year did (NAME) die? PROBE BY ASKING HOW MANY YEARS AGO, WHETHER IT WAS IN SUMMER OR WINTER, WHETHER IT WAS BEFORE OR AFTER EID, ETC. IF NOT IN 2003, 2004, 2005, 2006, OR 2007 END INTERVIEW.	MONTH <input type="text"/> <input type="text"/> DON'T KNOW 98 YEAR <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 9998	END OF INTERVIEW →
205	How old was she (NAME) when she died?	AGE IN YEARS <input type="text"/> <input type="text"/>	
206	At the time she died, was (NAME) a usual member of this household or was she here temporarily?	USUAL MEMBER 1 HERE TEMPORARILY 2	
207	Did she ever attend school?	YES 1 NO 2 DON'T KNOW 8	→ 209
208	What is the highest class she completed? IF CLASS-1 NOT COMPLETED WRITE '00' IF MA, MPHIL, PHD, MBBS, BSC/4 YEARS WRITE '16'	CLASS <input type="text"/> <input type="text"/>	
209	Was she working for wages or salary when she died?	YES 1 NO 2 DON'T KNOW 8	→ 211
210	What was her occupation? That is, what kind of work did she mainly do?	_____ <input type="text"/> <input type="text"/> _____	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
211	What was her mother tongue?	URDU 01 PUNJABI 02 SINDHI 03 PUSHTO 04 BALOCHI 05 ENGLISH 06 BARAUHI 07 SIRAIKI 08 HINDKO 09 KASHMIRI 10 PAHARI 11 POTOWARI 12 MARWARI 13 FARSI 14 OTHER 96	
212	At the time she died, was she married, divorced, widowed, separated or never married?	MARRIED 1 DIVORCED 2 WIDOWED 3 SEPARATED 4 NEVER MARRIED* 5	→ 215 → 401*
213	What was the name of her husband?	_____	
214	How old was her husband at the time of her death?	AGE IN YEARS <input type="text"/> <input type="text"/> DON'T KNOW 98	
215	Did her (last) husband ever attend school?	YES 1 NO 2 DON'T KNOW 8	→ 217
216	What was the highest class completed by her husband? IF CLASS-1 NOT COMPLETED WRITE '00' IF MA, MPHIL, PHD, MBBS, BSC/ 4YEARS WRITE '16'	CLASS <input type="text"/> <input type="text"/> DON'T KNOW 98	
217	What is her husband's occupation? That is, what kind of work does he mainly do?	_____ <input type="text"/> <input type="text"/> _____ DON'T KNOW 98	

*IN CASE OF NEVER MARRIED, CAUTIOUSLY AND CAREFULLY TRY TO ESTABLISH IF THE WOMAN'S DEATH WAS IN ANY WAY RELATED WITH COMPLICATIONS OF PREGNANCY OR CHILDBIRTH. IF SUCH A CASE IS FOUND, PLEASE FILL SECTION 3.

SECTION 3. BIRTH AND PREGNANCY INFORMATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301	Now I would like to ask about all the births (NAME) had during her life. Did she ever have a live birth?	YES 1 NO 2 DON'T KNOW 8	→ 304
302	How many total live births did she have? (Include children who later died)	LIVE BIRTHS <input type="text"/> <input type="text"/>	
303	How many of her sons and daughters are still alive?	TOTAL LIVING CHILDREN .. <input type="text"/> <input type="text"/> BOYS <input type="text"/> <input type="text"/> GIRLS <input type="text"/> <input type="text"/>	
304	Women sometimes have pregnancies that do not end in a live birth. Did (NAME) ever have a pregnancy that ended in miscarriage, abortion or stillbirth?	YES 1 NO 2 DON'T KNOW 8	→ 306
305	How many TOTAL miscarriages, abortions and stillbirths did she have?	PREGNANCY LOSSES <input type="text"/> <input type="text"/> DON'T KNOW 98	
306	CHECK 301 AND 304: AT LEAST ONE LIVE BIRTH OR PREGNANCY LOSS (301 IS 'YES' OR 304 IS 'YES') <input type="checkbox"/> NO LIVE BIRTHS OR PREGNANCY LOSSES BOTH 'NO' OR 'DK' <input type="checkbox"/>		→ 315
307	Did she ever have a Caesarean section operation?	YES 1 NO 2 DON'T KNOW 8	
308	Did she have a pregnancy during last 3 years of her life? (regardless of the result of the pregnancy)	YES 1 NO 2 DON'T KNOW 8	→ 315
309	How long before her death did her last pregnancy end? IF < 24 HOURS, WRITE '00' DAYS. IF < 1 MONTH, WRITE DAYS. IF < 1 YEARS, WRITE MONTHS. IF ONE OR MORE YEARS, WRITE YEARS.	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> DON'T KNOW 998	
310	What was the outcome of her last pregnancy?	LIVE BIRTH 1 STILL BIRTH 2 MISCARRIAGE 3 ABORTION 4 DON'T KNOW 8	→ 315
311	Is her last born child still alive?	YES 1 NO 2 DON'T KNOW 8	→ 313

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
312	How old is that child now?	AGE IN YEARS <input type="text"/> <input type="text"/>	→ 314
313	How old was that child when he/she died? IF < 24 HOURS, WRITE '00' DAYS. IF < 1 MONTH, WRITE DAYS. IF < 2 YEARS, WRITE MONTHS. IF TWO OR MORE YEARS, WRITE YEARS.	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> DON'T KNOW 998	
314	How long after her last birth / delivery / miscarriage / abortion did (NAME) die? IF < 24 HOURS, WRITE '00' DAYS. IF < 1 MONTH, WRITE DAYS. IF < 2 YEARS, WRITE MONTHS. IF TWO OR MORE YEARS, WRITE YEARS.	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> YEARS 3 <input type="text"/> <input type="text"/> DON'T KNOW 998	
315	Was (NAME) pregnant at the time she died?	YES 1 NO 2 DON'T KNOW 8	→ 317
316	How many months was she pregnant at the time she died?	MONTHS <input type="text"/> <input type="text"/> DON'T KNOW 98	
317	Did (NAME) die during delivery, abortion or miscarriage?	YES 1 NO 2 DON'T KNOW 8	→ 319
318	Did she die before labour pains began, before birth or during abortion or miscarriage?	BEFORE LABOUR PAINS BEGAN ... 1 AFTER LABOUR PAINS BEGAN BUT BEFORE BIRTH 2 DURING ABORTION/MISCARRIAGE ... 3 DON'T KNOW 8	
319	Did (NAME) die after delivery, abortion or miscarriage?	YES 1 NO 2 DON'T KNOW 8	→ 321
320	How many days after delivery, abortion or miscarriage did she die? IF < 24 HOURS, WRITE '00' DAYS. IF < 1 MONTH, WRITE DAYS. IF ONE OR MORE MONTH, WRITE MONTHS	DAYS 1 <input type="text"/> <input type="text"/> MONTHS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
321	Did she die within 40 days of delivery, abortion or miscarriage?	YES 1 NO 2 DON'T KNOW 8	

SECTION 4. VERBATIM DESCRIPTION OF ILLNESS AND DEATH

401 Please tell me everything that happened during the last illness before (NAME)'s death, starting from the beginning of the illness and also what happened during the final hours before she died.

a. Focus on the time before any symptoms of illness were identified:

i) How was the general health of the deceased woman; ii) Did she have any apparent physical or emotional distress; iii) Did she have past history of any serious illness

c. Focus on the time around her death:

i) What were her last symptoms and signs? ii) Where did she die? iii) Who was her last healthcare provider (by profession or designation)? iv) What was the probable cause of death

- 1. as perceived by respondent
- 2. as explained by healthcare provider

v. What other factors might have been responsible for her death (e.g., lack of proper and timely care; lack of resources; delay in making the decision to take the woman to hospital; lack of transport; delay in getting to a hospital; lack of facilities and/or healthcare provider at hospital; etc.)

d. Relation of dead to pregnancy, childbirth or postpartum complications: i) Was she pregnant at the time of death, or had recently delivered or aborted? ii) Was the death related with pregnancy, childbirth or postpartum complications (in what way)? iii) Please provide information about the result and outcome of pregnancy (induced abortion, natural abortion, stillbirth, live birth, live or not live born baby, etc.)?

SECTION 5. SYMPTOMS IDENTIFICATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	Where did (NAME) die?	HOSPITAL/CLINIC 1 HUSBAND'S HOME 2 HER PARENTS' HOME 3 IN -TRANSIT 4 OTHER _____ 5 (SPECIFY) DON'T KNOW 8	→ 505
502	What was the name of the hospital / clinic where she died? _____ (NAME)		
503	Did anyone at the hospital / clinic tell you why she died?	YES 1 NO 2 DON'T KNOW 8	→ 505
504	What were the reasons given by the hospital / clinic as to why she died? _____ Any other reason? _____		
505	What do you think is the main cause of her death? _____ _____		
506	Did (NAME) have any chronic disease? (Probe for each disease condition)	Y N DK	
	High blood pressure or hypertension?	HIGH BLOOD PRESSURE 1 2 8	
	Diabetes or high blood sugar?	SUGAR/DIABETES 1 2 8	
	Epilepsy?	EPILEPSY 1 2 8	
	Tuberculosis or TB?	TB 1 2 8	
	Heart disease?	HEART DISEASE 1 2 8	
	Blood disease?	BLOOD DISEASE 1 2 8	
	Asthma?	ASTHMA 1 2 8	
	Severe anemia?	SEVERE ANEMIA 1 2 8	
	Jaundice?	JAUNDICE 1 2 8	
	Hepatitis?	HEPATITIS 1 2 8	
	HIV/AIDS?	HIV/AIDS 1 2 8	
	Cancer? SPECIFY TYPE: _____	CANCER 1 2 8	
	Any other chronic disease? SPECIFY: _____	OTHER DISEASE 1 2 8	
507	Was she ever hospitalized? I mean did she ever stay in the hospital overnight?	YES 1 NO 2 DON'T KNOW 8	→ 511

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
508	How long before she died was she last hospitalized? IF < 24 HOURS, WRITE '00' DAYS. IF < 1 MONTH, WRITE DAYS. IF < 2 YEARS, WRITE MONTHS. IF TWO OR MORE YEARS, WRITE YEARS.	DAYS 1 MONTHS..... 2 YEARS 3 DON'T KNOW 998	
509	Why was she last hospitalized? Any other reason? _____		
510	Did she have any operation before she died?	YES 1 NO 2 DON'T KNOW 8	

Now I would like to ask about the major symptoms that she might have had during her last illness.

INTERVIEWER: PROBE TO GET AN ESTIMATE OF HOW LONG EACH SYMPTOM LASTED FROM WHEN IT FIRST APPEARED UNTIL IT STOPPED, EVEN IF IT STOPPED BEFORE SHE DIED.

511	Did she have fever ?	YES 1 NO 2 DON'T KNOW 8	→ 512
511A	How many days or months did the fever last? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 MONTHS..... 2 DON'T KNOW 998	
511B	Was the fever continuous or on and off?	CONTINUOUS..... 1 ON AND OFF 2 DON'T KNOW 8	
512	Was she breathless doing light work ?	YES 1 NO 2 DON'T KNOW 8	
512A	Was she breathless when she was lying down or when she was asleep?	YES 1 NO 2 DON'T KNOW 8	
513	Did she have rapid heart beat (palpitations)?	YES 1 NO 2 DON'T KNOW 8	
514	Did she have wheezing ?	YES 1 NO 2 DON'T KNOW 8	
515	Did she have a cough ?	YES 1 NO 2 DON'T KNOW 8	→ 516

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
515A	For how long did she have a cough? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
515B	Did the cough produce sputum?	YES 1 NO 2 DON'T KNOW 8	
515C	Did she cough blood?	YES 1 NO 2 DON'T KNOW 8	
516	Did she have chest pain ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 517
516A	How many days or months did she have chest pain? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
516B	Was the chest pain mild, moderate or severe?	MILD 1 MODERATE..... 2 SEVERE 3 DON'T KNOW 8	
516C	Did the chest pain start suddenly or gradually?	SUDDENLY 1 GRADUALLY 2 DON'T KNOW 8	
516D	Was the pain at or near the center of the chest?	NEAR STERNUM 1 SOMEWHERE ELSE/ALL OVER... 2 DON'T KNOW 8	
517	Did she have diarrhea (loose motions)?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 517B
517A	How many times a day did she have loose motions?	TIMES <input type="text"/> <input type="text"/> DON'T KNOW 98	
517B	Was there blood in the stools?	YES 1 NO 2 DON'T KNOW 8	
518	Did she have poor appetite or loss of appetite ?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 519
518A	For how long did she have poor appetite? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
519	Did she have pain in swallowing ?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
520	Did she have difficulty in swallowing ?	YES 1 NO 2 DON'T KNOW 8									
521	Did she have headache ?	YES 1 NO 2 DON'T KNOW 8	→ 522								
521A	How many days or months did she have headache? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
522	Did she pass blood in her urine ?	YES 1 NO 2 DON'T KNOW 8	→ 523								
522A	For how many days or months did she pass blood in her urine? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
523	Did she have pain while urinating ?	YES 1 NO 2 DON'T KNOW 8	→ 524								
523A	For how many days or months did she have pain when urinating? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 8									
524	Was she unable to pass urine ?	YES 1 NO 2 DON'T KNOW 8									
525	Did she urinate many times in a day?	YES 1 NO 2 DON'T KNOW 8									
526	Did she have any type of pain anywhere in the body ?	YES 1 NO 2 DON'T KNOW 8									
527	Did she have abdominal pain ?	YES 1 NO 2 DON'T KNOW 8	→ 528								
527A	How long did the abdominal pain last? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
527B	Was the abdominal pain mild, moderate or severe?	MILD 1 MODERATE 2 SEVERE 3 DON'T KNOW 8									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
527C	Was the abdominal pain in her upper belly, lower belly, or all over her belly?	UPPER ABDOMEN 1 LOWER ABDOMEN 2 ALL OVER THE ABDOMEN 3 DON'T KNOW 8									
528	Did she have abdominal distension ?	YES 1 NO 2 DON'T KNOW 8	→ 529								
528A	How many days or months was her abdomen distended? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
528B	Did the distension come rapidly within days or slowly over several weeks?	RAPIDLY, WITHIN FEW DAYS ... 1 SLOWLY, OVER WEEKS 2 DON'T KNOW 8									
529	Did she have a mass in her abdomen ?	YES 1 NO 2 DON'T KNOW 8									
530	Did she have vomiting ?	YES 1 NO 2 DON'T KNOW 8	→ 531								
530A	For how many days or months did she have vomiting? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
530B	Did she vomit blood?	YES 1 NO 2 DON'T KNOW 8									
531	Did she become mentally confuse ?	YES 1 NO 2 DON'T KNOW 8									
532	Did she lose consciousness ?	YES 1 NO 2 DON'T KNOW 8	→ 533								
532A	For how long she remained unconscious? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
532B	Did she become unconscious suddenly or gradually?	SUDDENLY 1 GRADUALLY 2 DON'T KNOW 8									
533	Did she become paralyze before her death?	YES 1 NO 2 DON'T KNOW 8	→ 534								

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
533A	How long did the paralysis last? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF > 1 MONTH WRITE MONTHS IF ONE OR MORE YEAR WRITE YEARS	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> LASTED TILL DEATH 997 DON'T KNOW 998	
533B	Was the paralysis on only one side of her body or both sides?	ONE SIDE ONLY 1 BOTH SIDES 2 DON'T KNOW 8	
534	Did she have stiffness in her whole body ?	YES 1 NO 2 DON'T KNOW 8	
535	Did she have neck pain ?	YES 1 NO 2 DON'T KNOW 8	
536	Did she have fits or convulsions ?	YES 1 NO 2 DON'T KNOW 8	→ 537
536A	For how many days or months did she have fits? IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
536B	When the fits were most frequent, how many times a day did she have fits?	TIMES <input type="text"/> <input type="text"/> DON'T KNOW 98	
537	Did she have an ulcer or swelling in the breast ?	YES 1 NO 2 DON'T KNOW 8	
538	Did she have vaginal bleeding when she was not having her menstrual period?	YES 1 NO 2 DON'T KNOW 8	→ 539
538A	For how many days or months did she have bleeding? IF < 24 HRS WRITE '00' DAYS IF < 1- MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <input type="text"/> <input type="text"/> MONTHS..... 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
538B	Did the bleeding persist until she died?	YES 1 NO 2 DON'T KNOW 8	
539	Did she have abnormal vaginal discharge ?	YES 1 NO 2 DON'T KNOW 8	
540	Did she have swelling on her ankles ?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
541	Did she have swelling or puffiness on her hands and/or face ?	YES 1 NO 2 DON'T KNOW 8	→ 542								
541A	For how many days or months did she have swelling on her hands and/or face ? IF < 24 HRS WRITE '00' DAYS IF < 1- MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
542	Did she lose weight ?	YES 1 NO 2 DON'T KNOW 8									
543	Did she have sores in her mouth ?	YES 1 NO 2 DON'T KNOW 8									
544	Did she look pale ?	YES 1 NO 2 DON'T KNOW 8									
545	Did she have any skin disease ?	YES 1 NO 2 DON'T KNOW 8									
546	Were her eyes yellowish in color due to jaundice?	YES 1 NO 2 DON'T KNOW 8	→ 547								
546A	For how many days or months did she have yellow eyes? IF < 24 HRS WRITE '00' DAYS IF < 1- MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									
547	Did she ever complain of having blurred vision ?	YES 1 NO 2 DON'T KNOW 8									
548	Did she have difficulty in opening her mouth ?	YES 1 NO 2 DON'T KNOW 8									
549	Did she have difficulty in passing stools ?	YES 1 NO 2 DON'T KNOW 8									
550	Did she feel dizzy ?	YES 1 NO 2 DON'T KNOW 8									
551	Did she have general weakness or fatigue?	YES 1 NO 2 DON'T KNOW 8	→ 552								
551A	For how many days or months did she have Weakness? IF < 24 HRS WRITE '00' DAYS IF < 1- MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS..... 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998									

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
552	Did she have any ulcers on her body?	YES 1 NO 2 DON'T KNOW 8	
553	Was there any other symptom that we did not mention? 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____	PLEASE WRITE IN URDU OR ENGLISH	
554	Did people think she had an evil eye or shadow?	YES 1 NO 2 DON'T KNOW 8	
555	Was a Faith Healer called to or she was taken give amulets or spiritual healing?	YES 1 NO 2 DON'T KNOW 8	→ 601
556	Give Details:	_____ _____ _____	

SECTION 6. DECEASED ILLNESS HISTORY

601	CHECK 511:	614
	YES <input type="checkbox"/>	
	NO / <input type="checkbox"/>	
	DON'T KNOW	

FEVER SECTION

602	How long before she died did the fever start? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> WEEKS 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 4 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998																	
603	How long did it last? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> WEEKS 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 4 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998																	
604	Was the fever very high?	YES 1 NO 2 DON'T KNOW 8																	
605	Did she have fever with chills?	YES 1 NO 2 DON'T KNOW 8																	
606	Was she prescribed anti-malarial tablets for the episodes of fever and chills?	YES 1 NO 2 DON'T KNOW 8																	
607	Did her colour change during her last illness?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 608																
607A	What was the colour?	PALLOR 1 JAUNDICED 2 BLUE 3																	
608	Had she been vomiting during her last illness?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 610																
608A	How long before she died did the vomiting start? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> WEEKS 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 4 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998																	

609	Did she ever vomit pure blood?	YES 1 NO 2 DON'T KNOW 8									
610	Did she have any difficulty with urination?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 611								
610A	Record all that apply. ASK EACH CONDITION (ONE BY ONE):	Y N DK UNABLE TO PASS URINE .. 1 2 8 TOO FREQUENT URINATION 1 2 8 PAINFUL URINATION . . . 1 2 8 BACK PAIN WITH FEVER .. 1 2 8 BLOOD IN URINE 1 2 8 OTHER _____ . . . 1 2 8 (SPECIFY)									
611	When did the fever start?	BEFORE CHILD BIRTH / ABORTION 1 AFTER CHILD BIRTH / ABORTION 2 DON'T KNOW / REMEMBER 8 NOT APPLICABLE 9	→ 613								
612	How long before/after childbirth, miscarriage or abortion did the fever start? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS 1 DAYS 2 WEEKS 3 MONTHS 4 DON'T KNOW 998	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>								
613	Did she have convulsions with fever?	YES 1 NO 2 DON'T KNOW 8									
614	CHECK 515: YES <input type="checkbox"/> NO/ DON'T KNOW <input type="checkbox"/>		→ 621								
COUGH SECTION											
615	How long before she died did the cough start? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS 1 DAYS 2 WEEKS 3 MONTHS 4 DON'T KNOW 998	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>								
616	Was there any sputum when she coughed?	YES 1 NO 2 DON'T KNOW 8									

617	Was there blood in it?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 618												
617A	Give Details:	_____ _____ _____													
618	Did she lose weight during this illness?	YES 1 NO 2 DON'T KNOW 8													
619	Did she have any fever?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 620												
619A	How much fever?	MILD 1 MODERATE 2 HIGH 3 DON'T KNOW 8													
620	Was she short of breath?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 621												
620A	For how long? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF ONE OR MORE WEEK WRITE WEEKS	HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> WEEKS 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998													
621	CHECK 526: YES <input type="checkbox"/> NO / DON'T KNOW <input type="checkbox"/>		<input type="checkbox"/> → 632												
PAIN SECTION															
622	What kind of pain?	CONTINUOUS 1 INTERMITTENT 2 VERY INTENSE 3 INCREASING IN SEVERITY 4 OTHER 5 (SPECIFY) _____													
623	What was / were the site (s) of the pain?	HEAD A ABDOMEN B CHEST C BREAST D LEGS E ALL OVER F OTHERS G (SPECIFY) _____													

624	How long before she died did the pain start? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS 1 DAYS 2 WEEKS 3 MONTHS 4 DON'T KNOW 998	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>									
625	How long did it last? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS 1 DAYS 2 WEEKS 3 MONTHS 4 DON'T KNOW 998	<table border="1"><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>									
626	If it was in abdomen, which specific side?	_____ _____ _____										
627	Was there any pain in the lower abdomen?	YES 1 NO 2 DON'T KNOW 8										
628	Was the pain accompanied by fever?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/>	→ 630								
629	Was the fever mild, moderate or high?	MILD 1 MODERATE 2 HIGH 3 DON'T KNOW 8										
630	Was the pain accompanied by vomiting?	YES 1 NO 2 DON'T KNOW 8										
631	When did the pain start?	BEFORE LABOUR 1 AT TIME OF LABOUR 2 1 DAY AFTER DELIVERY 3 2 DAYS AFTER DELIVERY 4 3 DAYS AFTER DELIVERY 5 > 3 DAYS AFTER DELIVERY 6 DON'T KNOW / DON'T REMEMBER 8 NOT APPLICABLE 9										

632	CHECK 536:	YES <input type="checkbox"/>		NO / DON'T KNOW <input type="checkbox"/>	→ 639
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CONVULSION SECTION

633	Did she have a history of convulsions or epilepsy?	YES 1 NO 2 DON'T KNOW 8							
634	Did she have convulsions in her last illness?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 635						
634A	For how long before death? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	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></table> 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></table> WEEKS 3 <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></table> DON'T KNOW 998							
635	Did she have high blood pressure before she died?	YES 1 NO 2 DON'T KNOW 8							
636	Did she have severe headache before she died?	YES 1 NO 2 DON'T KNOW 8							
637	Did she have change in her vision before she died?	YES 1 NO 2 DON'T KNOW 8							
638	What was her state of consciousness before she died? I mean, was she conscious, semi-conscious or unconscious? (Explain)	_____ _____ _____							

639	CHECK 540 & 541:	YES <input type="checkbox"/>		NO / DON'T KNOW <input type="checkbox"/>	→ 701
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SWELLING SECTION

640	Where was the site of swelling? (Ask for each)	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 15%; text-align: center;">YES</th> <th style="width: 15%; text-align: center;">NO</th> <th style="width: 15%; text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>ABDOMEN</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>FACE</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>LEGS AND FEET</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>WHOLE BODY</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> </tbody> </table>		YES	NO	DK	ABDOMEN	1	2	8	FACE	1	2	8	LEGS AND FEET	1	2	8	WHOLE BODY	1	2	8	
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ABDOMEN	1	2	8																				
FACE	1	2	8																				
LEGS AND FEET	1	2	8																				
WHOLE BODY	1	2	8																				
641	How long before she died did she have this swelling? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	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></table> 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></table> WEEKS 3 <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></table> MONTHS 4 <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></table> DON'T KNOW 998																					

642	When did the swelling start in relation to delivery of the baby or abortion? IF < 1 DAY WRITE HOURS IF < 1 WEEK WRITE DAYS IF < 1 MONTH WRITE WEEKS IF ONE OR MORE MONTH WRITE MONTHS	HOURS 1 <table border="1" data-bbox="1154 254 1252 436"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table> DAYS 2 WEEKS 3 MONTHS 4 DON'T KNOW 998 NOT APPLICABLE 999															
643	At the time of death was she short of breath?	YES 1 NO 2 DON'T KNOW 8															
644	Did her colour change during her last illness?	YES 1 NO 2 DON'T KNOW 8															
645	Did she also have any urinary problems?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 701														
645A	What problems? RECORD ALL THAT APPLY	<table border="0"> <tr> <td></td> <td style="text-align: right;">Y N DK</td> </tr> <tr> <td>UNABLE TO PASS URINE ..</td> <td style="text-align: right;">1 2 8</td> </tr> <tr> <td>TOO FREQUENT URINATION</td> <td style="text-align: right;">1 2 8</td> </tr> <tr> <td>PAINFUL URINATION</td> <td style="text-align: right;">1 2 8</td> </tr> <tr> <td>BLOOD IN URINE</td> <td style="text-align: right;">1 2 8</td> </tr> <tr> <td>OTHER _____</td> <td style="text-align: right;">1 2 8</td> </tr> <tr> <td></td> <td style="text-align: center;">(SPECIFY)</td> </tr> </table>		Y N DK	UNABLE TO PASS URINE ..	1 2 8	TOO FREQUENT URINATION	1 2 8	PAINFUL URINATION	1 2 8	BLOOD IN URINE	1 2 8	OTHER _____	1 2 8		(SPECIFY)	
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	(SPECIFY)																

SECTION 7. ANTENATAL CARE AND CHARACTERISTICS OF LAST PREGNANCY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	CHECK 308: YES <input type="checkbox"/> NO/DON'T KNOW <input type="checkbox"/>		→ 801
702	During her last pregnancy, did (NAME) see anyone for antenatal care?	YES 1 NO 2 DON'T KNOW 8	→ 709
703	Who did she see for antenatal care? <p style="text-align: center;">CIRCLE ALL THAT MENTIONED</p>	HEALTH PERSON DOCTOR A NURSE / MIDWIFE / LHV B OTHER HEALTH PERSON C OTHER OTHER PERSON DAI/TBA D LADY H. WORKER E HOMEOPATH F HAKEEM G OTHER _____ X (SPECIFY) DON'T KNOW Z	
704	The first time she went for antenatal care, did she go because she had a problem or did she go for a check-up?	FOR PROBLEM 1 FOR CHECK-UP ONLY 2 DON'T KNOW 8	→ 706
705	What was the problem she went for?	_____ _____	
706	How many months pregnant was she when she first saw a health provider during the last pregnancy?	MONTHS <input type="text"/> <input type="text"/> DON'T KNOW 98	
707	How many times did she see a health provider during her last pregnancy?	TIMES <input type="text"/> <input type="text"/> DON'T KNOW 98	
708	Was she referred by a health care provider to go to a specialist ?	YES 1 NO 2 DON'T KNOW 8	→ 710
709	Why didn't she see anyone for antenatal care during her last pregnancy? <p style="text-align: center;">CIRCLE ALL THAT MENTIONED</p>	NOT NECESSARY A COSTS TOO MUCH B TOO FAR C NO TRANSPORT D NO ONE TO GO WITH E SERVICE NOT GOOD F NO TIME TO GO G DID NOT KNOW WHERE TO GO ... H DID NOT WANT TO SEE A MALE DOCTOR I LONG WAITING TIME J NOT ALLOWED TO GO K OTHER _____ X (SPECIFY) DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
710	During her last pregnancy, did (NAME) have an injection in her arm/buttocks to prevent the baby from getting tetanus, that is, convulsions after birth?	YES 1 NO 2 DON'T KNOW 8	
711	Did she have her blood pressure measured during this pregnancy?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 714
712	Do you know whether her blood pressure was normal or high or low?	NORMAL 1 HIGH 2 LOW 3 DON'T KNOW 8	→ 714
713	Was she prescribed medicines for blood pressure ?	YES 1 NO 2 DON'T KNOW 8	
714	Was (NAME) using any family planning method before she became pregnant?	YES 1 NO 2 DON'T KNOW 8	
715	Did she want this pregnancy?	YES 1 NO 2 DON'T KNOW 8	
716	Did she do anything to try to end this pregnancy?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 719
717	What did she do?	WENT FOR ABORTION 1 TOOK DRUGS 2 INSERTED OBJECT INTO VAGINA 3 OTHER 4 (SPECIFY) DON'T KNOW 8	
718	Who did she go to for help to end this pregnancy?	HEALTH PERSON DOCTOR 01 NURSE / MIDWIFE / LHV 02 OTHER HEALTH PERSON 03 OTHER PERSON DAI/TBA 04 LADY H. WORKER 05 HOMEOPATH 06 HAKEEM 07 OTHER 08 (SPECIFY) DON'T KNOW 98	
719	CHECK 310: IF MISCARRIAGE OR ABORTION <input type="checkbox"/> NO / DON'T KNOW <input type="checkbox"/>		→ 723
720	Did she have a foul-smelling discharge from her vagina after the miscarriage/abortion?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
721	Did she have fever after the miscarriage/abortion?	YES 1 NO 2 DON'T KNOW 8	
722	Did she have abdominal distension after the miscarriage / abortion?	YES 1 NO 2 DON'T KNOW 8	
723	During her last pregnancy, did she have swelling around her ankles?	YES 1 NO 2 DON'T KNOW 8	
724	Was her face puffy during her pregnancy?	YES 1 NO 2 DON'T KNOW 8	
725	Did she complain of blurred vision during her pregnancy?	YES 1 NO 2 DON'T KNOW 8	
726	During the last illness, did she have bleeding from vagina?	YES 1 NO 2 DON'T KNOW 8	→ 732
727	Did the bleeding wet her clothes?	YES 1 NO 2 DON'T KNOW 8	
728	Did the bleeding wet the bed?	YES 1 NO 2 DON'T KNOW 8	
729	Was there so much blood as to wet the floor?	YES 1 NO 2 DON'T KNOW 8	
730	Was she in pain while bleeding?	YES 1 NO 2 DON'T KNOW 8	
731	Did the bleeding contain clots?	YES 1 NO 2 DON'T KNOW 8	
732	Did someone examine her internally during last pregnancy?	YES 1 NO 2 DON'T KNOW 8	→ 734
733	Did the vaginal examination cause any bleeding or make the bleeding worse?	YES 1 NO 2 DON'T KNOW 8	
734	Did the bleeding persist until she died?	YES 1 NO 2 DON'T KNOW 8	

SECTION 8. FOR DEATHS DURING LABOUR, DELIVERY, OR WITHIN 40 DAYS AFTER DELIVERY

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
801	CHECK 317, 319, 321: IF ANY YES <input type="checkbox"/> NO / DON'T KNOW <input type="checkbox"/>		→ 901
802	Did (NAME) have bleeding from her vagina ?	YES 1 NO 2 DON'T KNOW 8	→ 805
803	Did the bleeding start before or after the birth / delivery ?	BEFORE 1 AFTER 2 DON'T KNOW 8	
804	Was she in pain while bleeding?	YES 1 NO 2 DON'T KNOW 8	
805	Did the pain start before the labor pains started?	YES 1 NO 2 DON'T KNOW 8	
806	Where did she deliver?	HOME HER HOME 11 OTHER HOME 12 PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 OTHER PUBLIC _____ 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/CLINIC 31 OTHER PRIVATE MED. _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY) DID NOT DELIVER 90	→ 814
807	Who assisted with the delivery?	HEALTH PERSON DOCTOR 01 NURSE / MIDWIFE / LHV 02 OTHER PERSON DAI-TBA 03 LADY H. WORKER 04 HOMEOPATH 05 HAKEEM 06 RELATIVE / FRIEND 07 OTHER _____ 96 (SPECIFY) NO ONE 08	
808	Were any instruments used to assist in her last delivery?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
809	During her last delivery, did someone cut her vagina to make room for the baby to come [episiotomy]?	YES 1 NO 2 DON'T KNOW 8	
810	Was there a tear in her vagina after her last delivery?	YES 1 NO 2 DON'T KNOW 8	
811	During the delivery, did her birth attendant examine her vagina using either hands or instruments?	YES 1 NO 2 DON'T KNOW 8	
812	Did her water bag break before the labor pains started?	YES 1 NO 2 DON'T KNOW 8	
813	How long was she in labor?	HOURS <input type="text"/> <input type="text"/> DON'T KNOW 98	
814	Was (NAME) given any drugs just before or during labor?	YES 1 NO 2 DON'T KNOW 8	→ 816
815	What were the drugs used for?	EXPEDITE DELIVERY OF BABY ... 1 EXPEDITE PLACENTA COMING ... 2 TO EASE PAIN 3 TO REDUCE BLEEDING 4 DON'T KNOW 8	
816	Did she have a lot of bleeding <u>before</u> delivering the baby?	YES 1 NO 2 DON'T KNOW 8	→ 820
817	Did the bleeding wet her clothes?	YES 1 NO 2 DON'T KNOW 8	
818	Did the bleeding wet the bed?	YES 1 NO 2 DON'T KNOW 8	
819	Was there so much blood as to wet the floor?	YES 1 NO 2 DON'T KNOW 8	
820	Did she die before or after the baby was born?	BEFORE 1 AFTER 2 DON'T KNOW 8	→ 901
821	Did she have difficulty delivering the baby?	YES 1 NO 2 DON'T KNOW 8	
822	What part of the baby came out first?	HEAD 1 LEG 2 SHOULDER 3 ARMS 4 CAESARIAN SECTION 5 DON'T KNOW 8	→ 826

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
823	Did the placenta come out?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 826
824	How long after the baby came did the placenta come out? IF < 1 HOUR WRITE MINUTES IF ONE OR MORE HOUR WRITE HOURS	MINUTES 1 <input type="text"/> <input type="text"/> HOURS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
825	Did all of the placenta come out or only part?	ALL 1 PART 2 DON'T KNOW 8	
826	Did she have a lot of bleeding <u>after</u> delivering the baby?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 830
827	Did the bleeding wet her clothes?	YES 1 NO 2 DON'T KNOW 8	
828	Did the bleeding wet the bed?	YES 1 NO 2 DON'T KNOW 8	
829	Was there so much blood as to wet the floor?	YES 1 NO 2 DON'T KNOW 8	
830	Did she have a foul-smelling discharge from her vagina after the baby was born?	YES 1 NO 2 DON'T KNOW 8	
831	Did she have a pain in her legs after the baby was born?	YES 1 NO 2 DON'T KNOW 8	
832	Did she have a fever after the baby was born?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 838
833	How long after the delivery did the fever start? IF < 1 DAY WRITE HOURS IF ONE OR MORE DAY WRITE DAYS	HOURS 1 <input type="text"/> <input type="text"/> DAYS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
834	Did she have any fits or rigors with the fever?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 836
835	Did the fits stop after the baby was born?	YES 1 NO 2 DON'T KNOW 8	
836	How long did the fever last? IF < 1 DAY WRITE HOURS IF ONE OR MORE DAY WRITE DAYS	HOURS 1 <input type="text"/> <input type="text"/> DAYS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
837	Was she having the fever when she died?	YES 1 NO 2 DON'T KNOW 8	
838	Was the color of her eyes yellow after the baby was born?	YES 1 NO 2 DON'T KNOW 8	
839	After the delivery, did a birth attendant examine her vagina using either hands or instruments?	YES 1 NO 2 DON'T KNOW 8	

SECTION 9. DEATHS DUE TO INJURY / ACCIDENT / VIOLENCE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP				
901	Did she have any serious accident or injury before she died?	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 1001				
902	Please tell me what happened. WRITE IN DETAIL WHAT IS SAID. THEN CIRCLE THE CODE THAT FITS BEST _____ _____ _____ _____ _____ _____ _____ _____	ROAD / TRAIN ACCIDENT 01 FALL 02 DROWNING 03 SEVERE BURNS / ACID BURNS . 04 POISONING 05 SUFFOCATION 06 CUT / STABBED 07 BEATEN / PUNCHED / KICKED ... 08 RAPE 09 SHOT WITH GUN 10 DOG BITE 11 SNAKE BITE 12 INSECT BITE 13 OTHER _____ 96 (SPECIFY)					
903	How long before she died did this happen? IF < 1-DAY WRITE '00' IF < 1-MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	DAYS 1 MONTHS 2 DON'T KNOW 998	<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>				
904	Did she hurt herself intentionally, did someone else hurt her intentionally, or was this an accident?	HURT HERSELF INTENTIONALLY . 1 SOMEONE HURT HER..... 2 ACCIDENT 3 DON'T KNOW 8	<input type="checkbox"/> → 906				
905	Do you think she was trying to commit suicide?	YES 1 NO 2 DON'T KNOW 8					
906	Do you think this injury was the main cause of her death, did it contribute to her death, or was it not important?	MAIN CAUSE 1 CONTRIBUTED 2 NOT IMPORTANT 3 DON'T KNOW 8					

SECTION 10. CARE-SEEKING BEHAVIOR

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP												
1001	<p>During her last illness, how long after she first started having symptoms, did you recognize that she was having a serious problem or illness?</p> <p>IF < 1 DAY WRITE HOURS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS</p>	<p>IMMEDIATELY 000</p> <table border="1" style="margin-left: 20px;"> <tr> <td>HOURS</td> <td>1</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>DAYS</td> <td>2</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>MONTHS</td> <td>3</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table> <p>DIED IMMEDIATELY 995 DON'T KNOW 998</p>	HOURS	1	<input type="text"/>	<input type="text"/>	DAYS	2	<input type="text"/>	<input type="text"/>	MONTHS	3	<input type="text"/>	<input type="text"/>	
HOURS	1	<input type="text"/>	<input type="text"/>												
DAYS	2	<input type="text"/>	<input type="text"/>												
MONTHS	3	<input type="text"/>	<input type="text"/>												
1002	<p>How serious did she/her family perceive this complication or problem to be?</p>	<p>NOT SERIOUS 1 SOMEWHAT SERIOUS 2 VERY SERIOUS 3 LIFE THREATENING 4</p>	→ 1004												
1003	<p>Did she/her family think that she could have died because of her problem or illness or did you think it was not so serious at first?</p>	<p>THOUGHT SHE COULD DIE 1 DID NOT THINK SHE COULD DIE .. 2</p>													
1004	<p>During (NAME)'s last illness/problem, did she or anyone seek any kind of treatment for her illness?</p>	<p>YES 1 NO 2 DON'T KNOW 8</p>	→ 1007												
1005	<p>Why did you not seek any treatment for her illness?</p> <p>CIRCLE ALL MENTIONED.</p> <p>WRITE DETAILS OF THE REASON GIVEN IN THE SPACE BELOW:</p>	<p>NO TREATMENT NECESSARY ... A NOT CUSTOMARY B COST TOO MUCH C TOO FAR..... D NO TRANSPORT E NO ONE TO ACCOMPANY F FAMILY DID NOT ALLOW G GOOD CARE AT HOME H DID NOT KNOW WHERE TO GO... I NO TIME TO GO J HAVE TO GO TO A MALE DOCTOR K DID NOT REALIZE SERIOUSNESS . L OTHER _____ X (SPECIFY) DON'T KNOW Z</p>													
1006	<p>Who was involved in making the decision that (NAME) should NOT go for treatment?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>DECEASED HERSELF..... A HUSBAND B MOTHER IN LAW/FATHER IN LAW . C MOTHER / FATHER D SISTER / SISTER IN LAW E OTHER HUSBAND'S FAMILY F DECEASED'S FAMILY MEMBERS . G RELATIVES H FRIENDS /NEIGHBOURS..... I DAI / LHV / FIELDWORKER..... J OTHER _____ X (SPECIFY) NO ONE Y DON'T KNOW Z</p>	→ H101												

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP						
1007	<p>From whom did she receive treatment?</p> <p>Anyone else?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>HEALTH PERSON</p> <p>DOCTOR A</p> <p>NURSE / MIDWIFE / LHV B</p> <p>OTHER PERSON</p> <p>DAI-TBA C</p> <p>LADY H. WORKER D</p> <p>HOMEOPATH E</p> <p>HAKEEM F</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p> <p>NO ONE Y</p> <p>DON'T KNOW Z</p>							
1008	<p>Where was the treatment provided?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>HOME</p> <p>HER HOME A</p> <p>OTHER HOME B</p> <p>PUBLIC SECTOR</p> <p>GOVT. HOSPITAL C</p> <p>RHC/MCH D</p> <p>OTHER PUBLIC _____ E</p> <p>(SPECIFY)</p> <p>PRIVATE MED. SECTOR</p> <p>PVT. HOSPITAL/CLINIC F</p> <p>OTHER PRIVATE MED. _____ G</p> <p>(SPECIFY)</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p> <p>NO ONE Y</p> <p>DON'T KNOW Z</p>							
1009	<p>Who was involved in making the decision that (NAME) should go for treatment?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>DECEASED HERSELF A</p> <p>HUSBAND B</p> <p>MOTHER IN LAW/FATHER IN LAW . C</p> <p>MOTHER / FATHER..... D</p> <p>SISTER / SISTER IN LAW E</p> <p>OTHER HUSBAND'S FAMILY F</p> <p>DECEASED'S FAMILY MEMBERS . G</p> <p>RELATIVES H</p> <p>FRIENDS /NEIGHBOURS..... I</p> <p>DAI / LHV / FIELDWORKER..... J</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p> <p>NO ONE Y</p> <p>DON'T KNOW Z</p>							
1010	<p>How long after the problem was recognized, was it decided that she should go for treatment?</p> <p>IF < 24 HRS WRITE '00' DAYS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS</p>	<p>HOURS 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p> <p>DAYS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p> <p>MONTHS 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table></p> <p>DON'T KNOW 998</p>							
1011	<p>Once you decided to go for treatment, did you try to go immediately, or did you wait?</p>	<p>YES, TRIED TO GO IMMEDIATELY . 1</p> <p>NO, WAITED 2</p> <p>DON'T KNOW 8</p>	<p>→ 1013</p> <p>→ 1013</p>						

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1012	Why did you not try to go immediately?	HOSPITAL TOO FAR A DID NOT REALIZE SERIOUSNESS B LACK OF FUNDS C HAVE TO GO TO A MALE DOCTOR D NIGHT TIME E NO TRANSPORT F HUSBAND AWAY G NEED PERMISSION FROM ELDERS H OTHER X DON'T KNOW Z	
1013	What was the time lag between first recognition of the seriousness of symptoms and taking (NAME) to hospital? IF < 1 DAY WRITE HOURS IF ONE OR MORE DAY WRITE DAYS	HOURS 1 <input type="text"/> <input type="text"/> DAYS 2 <input type="text"/> <input type="text"/> DON'T KNOW 998	
1014	CHECK 1008: CARE OUTSIDE HOME <input type="checkbox"/> (ANY CODE 'C' THROUGH 'X' CIRCLED)	(CODE A,B Y,Z) <input type="checkbox"/>	<input type="checkbox"/> → 1043
1015	Where did she first get treatment for her last illness?	PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 OTHER PUBLIC 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/CLINIC 31 OTHER PRIVATE MED. 36 (SPECIFY) OTHER 96 DON'T KNOW 98	
1016	Who went with her when she went to the first place for treatment? CHECK ALL THAT APPLY	HUSBAND B MOTHER IN LAW/FATHER IN LAW C MOTHER / FATHER D SISTER / SISTER IN LAW E OTHER HUSBAND'S FAMILY F DECEASED'S FAMILY MEMBERS G RELATIVES H FRIENDS /NEIGHBOURS I DAI / LHV / FIELDWORKER J OTHER X (SPECIFY) NO ONE Y DON'T KNOW Z	
1017	How far is the (HEALTH FACILITY / PROVIDER) from her home / where she was staying?	KILOMETERS <input type="text"/> <input type="text"/> <input type="text"/> DON'T KNOW 998	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																
1018	How did she go to the first place she went for treatment?	ON FOOT A PRIVATE CAR/JEEP B BUS C TRAIN D AMBULANCE E ANIMAL CART F TAXI/RENTED VEHICLE G OTHER _____ X (SPECIFY) DON'T KNOW Z	→ 1020 → 1021																																																
1019	Was it difficult to get transport?	YES 1 NO 2 DON'T KNOW 8																																																	
1020	How long did it take to get there? IF < 1 HOUR WRITE MINUTES IF ONE OR MORE HOUR WRITE HOURS	MINUTES 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> HOURS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998																																																	
1021	After she arrived at the first hospital / clinic, how long did she wait before until she was examined by a doctor or nurse or other health care provider? IF < 1 HOUR WRITE MINUTES IF ONE OR MORE HOUR WRITE HOURS	IMMEDIATELY 000 MINUTES 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> HOURS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998																																																	
1022	What treatment was given to (NAME)? Did she receive: a. An injection in her arm? b. An injection in her buttock? c. A needle in her vein attached to a bag (drip)? d. A blood transfusion? e. An operation? f. Pills or capsules? g. Oxygen?	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">YES</th> <th style="width: 10%; text-align: center;">NO</th> <th style="width: 10%; text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>INJECTION IN ARM</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>INJECTION IN BUTT ...</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>DRIP</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>TRANSFUSION</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>OPERATION</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>PILLS/CAPSULES ...</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>OXYGEN</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">8</td> </tr> <tr> <td>OTHER -1 _____</td> <td colspan="3" style="text-align: right;">1</td> </tr> <tr> <td style="text-align: center;">(SPECIFY)</td> <td colspan="3"></td> </tr> <tr> <td>OTHER -2 _____</td> <td colspan="3" style="text-align: right;">1</td> </tr> <tr> <td style="text-align: center;">(SPECIFY)</td> <td colspan="3"></td> </tr> </tbody> </table>		YES	NO	DK	INJECTION IN ARM	1	2	8	INJECTION IN BUTT ...	1	2	8	DRIP	1	2	8	TRANSFUSION	1	2	8	OPERATION	1	2	8	PILLS/CAPSULES ...	1	2	8	OXYGEN	1	2	8	OTHER -1 _____	1			(SPECIFY)				OTHER -2 _____	1			(SPECIFY)				
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1023	Did (NAME)'s condition improve after treatment in this place or did it stay the same or get worse?	IMPROVED 1 STAYED SAME 2 GOT WORSE 3 DIED 4 DON'T KNOW 8	→ 1025 → 1025																																																
1024	How long after she arrived in the first hospital / clinic did she die? IF < 1 HOUR WRITE MINUTES IF < 1 DAY WRITE HOURS IF ONE OR MORE DAYS WRITE DAYS	IMMEDIATELY 000 MINUTES 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> HOURS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998													→ 1043																																				

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																
1025	Did the first hospital / clinic / provider refer (NAME) to another hospital / clinic?	YES 1 NO 2 DON'T KNOW 8	→ 1031																
1026	Where was she referred to?	PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 OTHER PUBLIC 26 _____ (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/CLINIC 31 OTHER PRIVATE MED. 36 _____ (SPECIFY) OTHER 96 _____ (SPECIFY)																	
1027	How long after she arrived in the first hospital / clinic did they refer her to the second hospital / clinic? IF < 1 HOUR WRITE MINUTES IF < 1 DAY WRITE HOURS IF < 1 MONTH WRITE DAYS IF ONE OR MORE MONTH WRITE MONTHS	IMMEDIATELY 000 MINUTES 1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> HOURS 2 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DAYS 3 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> MONTHS 4 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> DON'T KNOW 998																	
1028	Why did they refer (NAME) to the second place?	NO EQUIPMENT FOR OPERATION A HIGH BLOOD PRESSURE B TO GET BETTER CARE C NO DOCTOR WAS AVAILABLE ... D NO WAY TO GIVE BLOOD E NO PROPER ARRANGEMENTS FOR RESOLVING PROBLEM ... F BABY WENT HIGHER G PART OF BABY CAME OUT H BABY PASSED STOOL INSIDE UTERUS I CERVIX DID NOT OPEN J OTHER X _____ (SPECIFY) DON'T KNOW Z																	
1029	Did she go to the place they referred her to?	YES 1 NO 2 DON'T KNOW 8	→ 1032 → 1031																

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
1030	Why did she not go there for treatment? CIRCLE ALL MENTIONED. BE SURE TO GET A GOOD REASON. WRITE NOTES IF NECESSARY.	NO TREATMENT NECESSARY ... A NOT CUSTOMARY B COST TOO MUCH C TOO FAR D NO TRANSPORT E NO ONE TO ACCOMPANY F FAMILY DID NOT ALLOW G GOOD CARE AT HOME H DID NOT KNOW WHERE TO GO I NO TIME TO GO J HAVE TO GO TO A MALE DOCTOR K DID NOT REALIZE SERIOUSNESS L OTHER X (SPECIFY) DON'T KNOW Z	
1031	Did she go anywhere else for treatment?	YES 1 NO 2 DON'T KNOW 8	→ 1043
1032	Where did she go the last time she got treatment for her last illness?	PUBLIC SECTOR GOVT. HOSPITAL 21 RHC/MCH 22 OTHER PUBLIC 26 (SPECIFY) PRIVATE MED. SECTOR PVT. HOSPITAL/CLINIC 31 OTHER PRIVATE MED. 36 (SPECIFY) OTHER 96 (SPECIFY) DON'T KNOW 98	
1033	Who went with her when she went to the last place for treatment?	HUSBAND B MOTHER IN LAW/FATHER IN LAW C MOTHER / FATHER D SISTER / SISTER IN LAW E OTHER HUSBAND'S FAMILY F DECEASED'S FAMILY MEMBERS G RELATIVES H FRIENDS / NEIGHBOURS I DAI / LHV / FIELDWORKER J OTHER X (SPECIFY) NO ONE Y DON'T KNOW Z	
1034	How did she get to this last place she went for treatment?	ON FOOT A PRIVATE CAR/JEEP B BUS C TRAIN D AMBULANCE E ANIMAL CART F TAXI/RENTED VEHICLE G OTHER X (SPECIFY) DON'T KNOW Z	→ 1036 → 1036
1035	Was it difficult to get transport?	YES 1 NO 2 DON'T KNOW 8	

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP												
1036	<p>After she arrived at this last hospital / clinic, how long did she wait until she was examined by a doctor or nurse or other health care provider?</p> <p>IF < 1 HOUR WRITE MINUTES IF ONE OR MORE HOUR WRITE HOURS</p>	<p>IMMEDIATELY 000</p> <p>MINUTES 1 <table border="1" data-bbox="1161 302 1247 394"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table></p> <p>HOURS 2 <table border="1" data-bbox="1161 344 1247 436"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table></p> <p>DON'T KNOW 998</p>													
1037	<p>What treatment was given to (NAME)? Did she receive:</p> <p>a. An injection in her arm?</p> <p>b. An injection in her buttock?</p> <p>c. A needle in her vein attached to a bag (drip)?</p> <p>d. A blood transfusion?</p> <p>e. An operation?</p> <p>f. Pills or capsules?</p> <p>g. Oxygen?</p>	<p>YES NO DK</p> <p>INJECTION IN ARM 1 2 8</p> <p>INJECTION IN BUTT 1 2 8</p> <p>DRIP 1 2 8</p> <p>TRANSFUSION 1 2 8</p> <p>OPERATION 1 2 8</p> <p>PILLS/CAPSULES 1 2 8</p> <p>OXYGEN 1 2 8</p> <p>OTHER -1 1</p> <p>(SPECIFY)</p> <p>OTHER -2 1</p> <p>(SPECIFY)</p>													
1038	<p>Did (NAME)'s condition improve after treatment in this last place or did it stay the same or get worse?</p>	<p>IMPROVED 1</p> <p>STAYED SAME 2</p> <p>GOT WORSE 3</p> <p>DIED 4</p> <p>DON'T KNOW 8</p>	<p>→ 1040</p> <p>→ 1040</p>												
1039	<p>How long after she arrived in the last hospital / clinic did she die?</p> <p>IF < 1 HOUR WRITE MINUTES IF < 1 DAY WRITE HOURS IF ONE OR MORE DAY WRITE DAYS</p>	<p>IMMEDIATELY 000</p> <p>MINUTES 1 <table border="1" data-bbox="1161 1058 1247 1150"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table></p> <p>HOURS 2 <table border="1" data-bbox="1161 1100 1247 1192"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table></p> <p>DAYS 3 <table border="1" data-bbox="1161 1142 1247 1234"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table></p> <p>DON'T KNOW 998</p>													<p>→ 1043</p>
1040	<p>Before she died, did this last hospital / clinic / provider refer (NAME) to another hospital / clinic?</p>	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>	<p>→ 1043</p>												
1041	<p>Where was she referred to?</p>	<p>PUBLIC SECTOR</p> <p>GOVT. HOSPITAL 21</p> <p>RHC/MCH 22</p> <p>OTHER PUBLIC</p> <p>_____ 26</p> <p>(SPECIFY)</p> <p>PRIVATE MED. SECTOR</p> <p>PVT. HOSPITAL/CLINIC 31</p> <p>OTHER PRIVATE</p> <p>MED. _____ 36</p> <p>(SPECIFY)</p> <p>OTHER _____ 96</p> <p>DON'T KNOW 98</p>													

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
1042	Why did they refer (NAME) to this place?	NO EQUIPMENT FOR OPERATION A HIGH BLOOD PRESSURE B TO GET BETTER CARE C NO DOCTOR WAS AVAILABLE ... D NO ARRANGEMENTS FOR GIVING BLOOD E NO PROPER ARRANGEMENTS FOR RESOLVING PROBLEM ... F BABY WENT HIGHER G PART OF BABY CAME OUT H BABY PASSED STOOL INSIDE UTERUS I CERVIX DID NOT OPEN J OTHER _____ X (SPECIFY) DON'T KNOW Z									
1043	How much did it cost in total for the treatment for her last illness? IF > 990000 WRITE 990000	RUPEES <table border="1" data-bbox="998 646 1247 688" style="display: inline-table; vertical-align: middle;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> DON'T KNOW 999998									
1044	Where did you get the funds to pay for her care? CIRCLE ALL MENTIONED	FAMILY FUNDS A BORROWED B SOLD ASSETS C GIVEN BY RELATIVES/FRIENDS... D MORTGAGED PROPERTY E OTHER _____ X (SPECIFY) DON'T KNOW Z									
1045	Did she die in the hospital?	YES 1 NO 2 DON'T KNOW 8	→ 1047								
1046	Where did she die?	ON HER WAY TO NEXT HOSPITAL 1 ON HER WAY BACK TO HOME . 2 AT HOME 3 OTHERS 4 DON'T KNOW 8	→ H101								
1047	How long after she died did they remove the body from the hospital / clinic? IF < 1 HOUR WRITE "00" IF < 1 DAY WRITE HOURS IF ONE OR MORE DAY WRITE DAYS	HOURS 1 <table border="1" data-bbox="1161 1203 1247 1276" 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> DAYS 2 <table border="1" data-bbox="1161 1276 1247 1350" 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> DON'T KNOW 998									

SECTION 11: HOUSEHOLD CHARACTERISTICS

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
H101	What is the main source of drinking water for members of your household?	PIPED WATER PIPED INTO DWELLING 11 PIPED TO YARD/PLOT 12 PUBLIC TAP/STAND PIPE ... 13 TUBE WELL OR BOREHOLE 21 HAND PUMP 22 DUG WELL PROTECTED WELL 31 UNPROTECTED WELL 32 WATER FROM SPRING PROTECTED SPRING/KAREZ ... 41 UNPROTECTED SPRING 42 RAINWATER 51 TANKER TRUCK 61 CART WITH SMALL TANK 71 SURFACE WATER (RIVER/DAM/LAKE/ POND/STREAM/CANAL 81 BOTTLED WATER 91 OTHER _____ 96 (SPECIFY)	→ H103
H102	How long does it take to go there, get water, and come back?	MINUTES <input type="text"/> <input type="text"/> <input type="text"/> ON PREMISES 996 DON'T KNOW 998	
H103	Do you treat your water in any way to make it safer to drink?	YES 1 NO 2 DON'T KNOW 8	→ H105
H104	What do you usually do to the water to make it safer to drink? Anything else? RECORD ALL MENTIONED.	BOIL A ADD BLEACH/CHLORINE B STRAIN THROUGH A CLOTH C USE WATER FILTER (CERAMIC/ SAND/COMPOSITE/ETC.) D SOLAR DISINFECTION E LET IT STAND AND SETTLE F OTHER _____ X (SPECIFY) DON'T KNOW Z	
H105	What kind of toilet facility do members of your household usually use?	FLUSH OR POUR FLUSH TOILET FLUSH TO SEWER SYSTEM ... 11 FLUSH TO SEPTIC TANK 12 FLUSH TO SOMEWHERE ELSE ... 13 FLUSH, DON'T KNOW WHERE ... 14 PIT LATRINE VENTILATED IMPROVED PIT LATRINE (VIP) 21 PIT LATRINE WITH SLAB 22 PIT LATRINE WITHOUT SLAB/ OPEN PIT 23 BUCKET TOILET 41 HANGING TOILET/HANGING LATRINE 51 NO FACILITY/BUSH/FIELD 61 OTHER _____ 96 (SPECIFY)	→ H107

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																			
H106	Do you share this toilet facility with other households?	YES 1 NO 2																																																				
H107	Does your household have:	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>Electricity?</td> <td>ELECTRICITY 1</td> <td>2</td> </tr> <tr> <td>Radio?</td> <td>RADIO 1</td> <td>2</td> </tr> <tr> <td>Television?</td> <td>TELEVISION 1</td> <td>2</td> </tr> <tr> <td>Refrigerator?</td> <td>REFRIGERATOR 1</td> <td>2</td> </tr> <tr> <td>Mobile telephone or land line telephone?</td> <td>ANY TELEPHONE 1</td> <td>2</td> </tr> <tr> <td>Room cooler, air conditioner?</td> <td>ROOM COOLER, AIR COND. . 1</td> <td>2</td> </tr> <tr> <td>Washing machine?</td> <td>WASHING MACHINE 1</td> <td>2</td> </tr> <tr> <td>Water pump?</td> <td>WATER PUMP 1</td> <td>2</td> </tr> <tr> <td>Bed?</td> <td>BED 1</td> <td>2</td> </tr> <tr> <td>Chairs?</td> <td>CHAIRS 1</td> <td>2</td> </tr> <tr> <td>Almirah / cabinet?</td> <td>ALMIRAH/CABINET 1</td> <td>2</td> </tr> <tr> <td>Clock?</td> <td>CLOCK 1</td> <td>2</td> </tr> <tr> <td>Sofa?</td> <td>SOFA 1</td> <td>2</td> </tr> <tr> <td>Sewing machine?</td> <td>SEWING MACHINE 1</td> <td>2</td> </tr> <tr> <td>Camera?</td> <td>CAMERA 1</td> <td>2</td> </tr> <tr> <td>Personal computer?</td> <td>PERSONAL COMPUTER ... 1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	Electricity?	ELECTRICITY 1	2	Radio?	RADIO 1	2	Television?	TELEVISION 1	2	Refrigerator?	REFRIGERATOR 1	2	Mobile telephone or land line telephone?	ANY TELEPHONE 1	2	Room cooler, air conditioner?	ROOM COOLER, AIR COND. . 1	2	Washing machine?	WASHING MACHINE 1	2	Water pump?	WATER PUMP 1	2	Bed?	BED 1	2	Chairs?	CHAIRS 1	2	Almirah / cabinet?	ALMIRAH/CABINET 1	2	Clock?	CLOCK 1	2	Sofa?	SOFA 1	2	Sewing machine?	SEWING MACHINE 1	2	Camera?	CAMERA 1	2	Personal computer?	PERSONAL COMPUTER ... 1	2	
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H108	What type of fuel does your household mainly use for cooking?	ELECTRICITY 01 CYLINDER GAS 02 NATURAL GAS 03 BIOGAS 04 KEROSENE 05 CHARCOAL 06 WOOD 07 STRAW/SHRUBS/GRASS 08 AGRICULTURAL CROP 09 ANIMAL DUNG 10 NO FOOD COOKED IN HOUSEHOLD 95 OTHER _____ 96 (SPECIFY)																																																				
H109	MAIN MATERIAL OF THE FLOOR: RECORD OBSERVATION	NATURAL FLOOR EARTH / SAND / MUD 11 FINISHED FLOOR CHIPS / TERRAZZO 31 CERAMIC TILES 32 MARBLE 33 CEMENT 34 CARPET 35 BRICKS 36 MATS 37 OTHER _____ 96 (SPECIFY)																																																				

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
H110	<p>MAIN MATERIAL OF THE ROOF:</p> <p>RECORD OBSERVATION</p>	<p>NATURAL ROOFING</p> <p>THATCH / BAMBOO / WOOD / MUD 12</p> <p>RUDIMENTARY ROOFING</p> <p>CARDBOARD / PLASTIC 21</p> <p>FINISHED ROOFING</p> <p>IRON SHEETS / ASBESTOS ... 31</p> <p>T-IRON / WOOD / BRICK 32</p> <p>REINFORCED BRICK CEMENT/RCC 33</p> <p>OTHER _____ 96</p> <p>(SPECIFY)</p>	
H111	<p>MAIN MATERIAL OF THE WALLS:</p> <p>RECORD OBSERVATION</p>	<p>NATURAL WALLS</p> <p>MUD / STONES 11</p> <p>BAMBOO / STICKS / MUD 12</p> <p>RUDIMENTARY WALLS</p> <p>UNBAKED BRICKS / MUD 21</p> <p>PLYWOOD SHEETS 22</p> <p>CARTON / PLASTIC 23</p> <p>FINISHED WALLS</p> <p>STONE BLOCKS 31</p> <p>BAKED BRICKS 32</p> <p>CEMENT BLOCKS/ CEMENT ... 33</p> <p>TENT 34</p> <p>OTHER _____ 96</p> <p>(SPECIFY)</p>	
H112	How many rooms in this household are used for sleeping?	ROOMS <input type="text"/> <input type="text"/>	
H113	Is this house rented, rent-free, mortgaged, or owned by a member of the household?	<p>RENTED 1</p> <p>RENT-FREE 2</p> <p>MORTGAGED 3</p> <p>OWNED 4</p> <p>OTHER 6</p>	
H114	Does any member of this household own:	<p style="text-align: right;">YES NO</p> <p>A watch? WATCH 1 2</p> <p>A bicycle? BICYCLE 1 2</p> <p>A motorcycle or motor scooter? MOTORCYCLE/SCOOTER ... 1 2</p> <p>An animal-drawn cart? ANIMAL-DRAWN CART 1 2</p> <p>A car or truck or Tractor? CAR/TRUCK 1 2</p> <p>A boat with a motor? BOAT WITH MOTOR 1 2</p>	
H115	Does any member of this household own any land that can be used for agriculture?	<p>YES 1</p> <p>NO 2</p>	
H116	Does this household own any livestock, herds, other farm animals, or poultry?	<p>YES 1</p> <p>NO 2</p>	→ H118

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
H117	<p>How many of the following animals does this household own?</p> <p>Buffalo</p> <p>Milk cows or bulls?</p> <p>Camels?</p> <p>Donkeys, or mules or horses?</p> <p>Goats?</p> <p>Sheep?</p> <p>Chickens?</p> <p>IF NONE, WRITE '00'. IF > 95, WRITE '95'. IF UNKNOWN, WRITE '98'</p>	<p>BUFFALO <input type="checkbox"/> <input type="checkbox"/></p> <p>COWS/BULLS <input type="checkbox"/> <input type="checkbox"/></p> <p>CAMELS <input type="checkbox"/> <input type="checkbox"/></p> <p>DONKEYS/MULES/HORSES . <input type="checkbox"/> <input type="checkbox"/></p> <p>GOATS <input type="checkbox"/> <input type="checkbox"/></p> <p>SHEEP <input type="checkbox"/> <input type="checkbox"/></p> <p>CHICKENS <input type="checkbox"/> <input type="checkbox"/></p>	
H118	<p>Does your household have any mosquito nets that can be used while sleeping?</p>	<p>YES 1</p> <p>NO 2</p>	→H126
H119	<p>How many mosquito nets does your household have?</p>	<p>NUMBER OF NETS <input type="text"/></p>	
H126	<p>Does your household do anything (else) to avoid mosquitos?</p>	<p>YES 1</p> <p>NO 2</p>	→H128
H127	<p>What do you do?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>COIL A</p> <p>MATS B</p> <p>SPRAY C</p> <p>ELECTRIC SPRAY REPELLANT ... D</p> <p>INSECT REPELLANT E</p> <p>OTHER _____ X</p> <p>(SPECIFY)</p>	
H128	<p>Do you have any medicines for treating malaria in your house now?</p>	<p>YES 1</p> <p>NO 2</p> <p>DOES NOT KNOW 8</p>	

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT RESPONDENT:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

NAME OF SUPERVISOR: _____ DATE: _____

EDITOR'S OBSERVATIONS

NAME OF EDITOR: _____ DATE: _____