

DEMOGRAPHIC AND HEALTH SURVEYS
 SUPPLEMENTAL MODULE ON MATERNAL HEALTH CARE
 MODEL WOMAN'S QUESTIONNAIRE

[NAME OF COUNTRY]
 [NAME OF ORGANIZATION]

IDENTIFICATION (1)								
PLACE NAME _____								
NAME OF HOUSEHOLD HEAD _____								
CLUSTER NUMBER				<table border="1" style="width: 100%; height: 20px;"> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>				
HOUSEHOLD NUMBER				<table border="1" style="width: 100%; height: 20px;"> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>				
NAME AND LINE NUMBER OF WOMAN _____								
INTERVIEWER VISITS								
	1	2	3	FINAL VISIT				
DATE	_____	_____	_____	DAY <table border="1" style="width: 20px; height: 20px;"> </table>				
				MONTH <table border="1" style="width: 20px; height: 20px;"> </table>				
INTERVIEWER'S NAME	_____	_____	_____	YEAR <table border="1" style="width: 20px; height: 20px;"> </table>				
RESULT*	_____	_____	_____	INT. NO. <table border="1" style="width: 20px; height: 20px;"> </table>				
NEXT VISIT: DATE	_____	_____		RESULT* <table border="1" style="width: 20px; height: 20px;"> </table>				
TIME	_____	_____		TOTAL NUMBER OF VISITS <table border="1" style="width: 20px; height: 20px;"> </table>				
*RESULT CODES: 1 COMPLETED 4 REFUSED 2 NOT AT HOME 5 PARTLY COMPLETED 7 OTHER _____ 3 POSTPONED 6 INCAPACITATED SPECIFY _____								
LANGUAGE OF QUESTIONNAIRE** <table border="1" style="width: 20px; height: 20px;">0</table> <table border="1" style="width: 20px; height: 20px;">1</table>		LANGUAGE OF INTERVIEW** <table border="1" style="width: 20px; height: 20px;"> </table> <table border="1" style="width: 20px; height: 20px;"> </table>		NATIVE LANGUAGE OF RESPONDENT** <table border="1" style="width: 20px; height: 20px;"> </table> <table border="1" style="width: 20px; height: 20px;"> </table>				
LANGUAGE OF QUESTIONNAIRE** ENGLISH		**LANGUAGE CODES: 01 ENGLISH 03 LANGUAGE 3 05 LANGUAGE 5 02 LANGUAGE 2 04 LANGUAGE 4 06 LANGUAGE 6						
SUPERVISOR		FIELD EDITOR		OFFICE EDITOR				
_____ <table border="1" style="width: 40px; height: 20px;"> </table> <table border="1" style="width: 40px; height: 20px;"> </table> <table border="1" style="width: 40px; height: 20px;"> </table> <table border="1" style="width: 40px; height: 20px;"> </table>		_____ <table border="1" style="width: 40px; height: 20px;"> </table> <table border="1" style="width: 40px; height: 20px;"> </table> <table border="1" style="width: 40px; height: 20px;"> </table> <table border="1" style="width: 40px; height: 20px;"> </table>		_____ <table border="1" style="width: 40px; height: 20px;"> </table> <table border="1" style="width: 40px; height: 20px;"> </table>				
NAME NUMBER		NAME NUMBER		NUMBER NUMBER				

Note: Questions with green highlighting in the question number column are the maternal health care module questions.

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

401 (1)	CHECK 224: ONE OR MORE BIRTHS IN 2010-2015 <input type="checkbox"/>	NO BIRTHS IN 2010-2015 <input type="checkbox"/>	NEXT SECT
<p>402 (1) CHECK 215. RECORD THE BIRTH HISTORY NUMBER IN 403 AND THE NAME AND SURVIVAL STATUS IN 404 FOR EACH BIRTH IN 2010-2015. ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH. IF THERE ARE MORE THAN 2 BIRTHS, USE LAST COLUMN OF ADDITIONAL QUESTIONNAIRE(S).</p> <p>Now I would like to ask some questions about your children born in the last five years. (We will talk about each separately.)</p>			
403	BIRTH HISTORY NUMBER FROM 212 IN BIRTH HISTORY.	<p align="center">LAST BIRTH</p> BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/>	<p align="center">NEXT-TO-LAST BIRTH</p> BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/>
404	FROM 212 AND 216:	<p>NAME _____</p> LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>	<p>NAME _____</p> LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>
405	When you got pregnant with (NAME), did you want to get pregnant at that time?	YES 1 (SKIP TO 408) ← <input type="checkbox"/> NO 2	YES 1 (SKIP TO 426) ← <input type="checkbox"/> NO 2
406	<p>CHECK 208:</p> <p align="center"> <input type="checkbox"/> ONLY ONE BIRTH <input type="checkbox"/> MORE THAN ONE BIRTH </p> <p>a) Did you want to have a baby later on, or did you not want any children?</p> <p>b) Did you want to have a baby later on, or did you not want any more children?</p>	LATER 1 NO MORE/NONE 2 (SKIP TO 408) ← <input type="checkbox"/>	LATER 1 NO MORE/NONE 2 (SKIP TO 426) ← <input type="checkbox"/>
407	How much longer did you want 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
408	When you were pregnant with (NAME), did you see anyone for antenatal care?	YES 1 NO 2 (SKIP TO 414) ← <input type="checkbox"/>	
409 (2)	Whom did you see? Anyone else? PROBE TO IDENTIFY EACH TYPE OF PERSON AND RECORD ALL MENTIONED.	<p>HEALTH PERSONNEL</p> DOCTOR A NURSE/MIDWIFE B AUXILIARY MIDWIFE C <p>OTHER PERSON</p> TRADITIONAL BIRTH ATTENDANT D COMMUNITY/ VILLAGE HEALTH VOLUNTEER E OTHER _____ X (SPECIFY)	

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH		NEXT-TO-LAST BIRTH																																					
		NAME _____	NAME _____	NAME _____	NAME _____																																				
410 (2)	<p>Where did you receive antenatal care for this pregnancy?</p> <p>Anywhere else?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p align="center">(NAME OF PLACE)</p>	<p>HOME</p> <p>HER HOME A</p> <p>OTHER HOME B</p> <p>PUBLIC SECTOR</p> <p>GOVERNMENT HOSPITAL .. C</p> <p>GOVERNMENT HEALTH CENTER D</p> <p>GOVERNMENT HEALTH POST E</p> <p>OTHER PUBLIC SECTOR</p> <p>_____ F</p> <p align="center">(SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/ CLINIC G</p> <p>OTHER PRIVATE MEDICAL SECTOR</p> <p>_____ H</p> <p align="center">(SPECIFY)</p> <p>OTHER _____ X</p> <p align="center">(SPECIFY)</p>																																							
411	How many months pregnant were you when you first received antenatal care for this pregnancy?	MONTHS <input type="text"/> <input type="text"/>																																							
		DON'T KNOW 98																																							
412	How many times did you receive antenatal care during this pregnancy?	NUMBER OF TIMES <input type="text"/> <input type="text"/>																																							
		DON'T KNOW 98																																							
413	<p>As part of your antenatal care during this pregnancy, were any of the following done at least once:</p> <p>a) Was your blood pressure measured?</p> <p>b) Did you give a urine sample?</p> <p>c) Did you give a blood sample?</p> <p>d) Was your weight measured?</p> <p>e) Was baby's heart beat listened to?</p> <p align="center">SHOW PICTURES</p> <p>f) Did you discuss with a health provider when the baby is due or will arrive?</p> <p>g) Did a health provider ask if you had vaginal bleeding?</p> <p>h) Were you told to pay attention to the baby's movements?</p>	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> <th>DK</th> </tr> </thead> <tbody> <tr> <td>a) BP</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) URINE</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>c) BLOOD</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>d) WEIGHT</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>e) BABY'S HEART ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>f) BABY'S DUE DATE ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>g) BLEEDING</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>h) BABY'S MOVEMENTS ..</td> <td>1</td> <td>2</td> <td>8</td> </tr> </tbody> </table>		YES	NO	DK	a) BP	1	2	8	b) URINE	1	2	8	c) BLOOD	1	2	8	d) WEIGHT	1	2	8	e) BABY'S HEART ..	1	2	8	f) BABY'S DUE DATE ..	1	2	8	g) BLEEDING	1	2	8	h) BABY'S MOVEMENTS ..	1	2	8			
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MH1	During (any of) your antenatal care visit(s), were you told by a health worker about danger signs that might indicate problems with the pregnancy?	<p>YES 1</p> <p>NO 2</p> <p>DON'T KNOW 8</p>																																							

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____																												
MH2	Were you told by a health worker where to go if you experienced danger signs of serious health problems during the pregnancy?	YES 1 NO 2 DON'T KNOW 8																													
MH3	Did you discuss with a health provider a plan for preparing for your delivery?	YES 1 NO 2 DON'T KNOW 8																													
MH4	During (any of) your antenatal care visit(s), did you discuss with a health provider any of the following preparations for giving birth: a) Where you plan to deliver your baby? b) If you wanted to have a relative, friend or neighbor with you during labor or delivery? c) Transportation to where the baby would be born? d) What funds or finances you would use for the delivery? e) Ask someone to be a blood donor if you need blood? f) Finding a healthcare professional to deliver your child?	<table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> <td style="text-align: center;">DK</td> </tr> <tr> <td>a) DELIVERY</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>b) HELP</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>c) TRANSPORT</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>d) FUNDS</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>e) BLOOD DONOR</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>f) HEALTH PROFESSIONAL</td> <td style="text-align: center;">..... 1</td> <td style="text-align: center;">..... 2</td> <td style="text-align: center;">..... 8</td> </tr> </table>		YES	NO	DK	a) DELIVERY 1 2 8	b) HELP 1 2 8	c) TRANSPORT 1 2 8	d) FUNDS 1 2 8	e) BLOOD DONOR 1 2 8	f) HEALTH PROFESSIONAL 1 2 8	
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414 (3)	During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?	YES 1 NO 2 (SKIP TO 417) ← DON'T KNOW 8																													
415	During this pregnancy, how many times did you get a tetanus injection?	TIMES <input style="width: 40px; height: 20px;" type="text"/> DON'T KNOW 8																													
416	CHECK 415:	2 OR MORE TIMES <input style="width: 20px; height: 20px;" type="checkbox"/> OTHER <input style="width: 20px; height: 20px;" type="checkbox"/> (SKIP TO 420) ←																													
417	At any time before this pregnancy, did you receive any tetanus injections?	YES 1 NO 2 (SKIP TO 420) ← DON'T KNOW 8																													
418	Before this pregnancy, how many times did you receive a tetanus injection? IF 7 OR MORE TIMES, RECORD '7'.	TIMES <input style="width: 40px; height: 20px;" type="text"/> DON'T KNOW 8																													
419	CHECK 418: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">ONLY ONE <input style="width: 20px; height: 20px;" type="checkbox"/></td> <td style="width: 50%; text-align: center;">MORE THAN ONE <input style="width: 20px; height: 20px;" type="checkbox"/></td> </tr> <tr> <td style="border-right: 1px dashed black;">a) How many years ago did you receive that tetanus injection?</td> <td>b) How many years ago did you receive the last tetanus injection prior to this pregnancy?</td> </tr> </table>	ONLY ONE <input style="width: 20px; height: 20px;" type="checkbox"/>	MORE THAN ONE <input style="width: 20px; height: 20px;" type="checkbox"/>	a) How many years ago did you receive that tetanus injection?	b) How many years ago did you receive the last tetanus injection prior to this pregnancy?	YEARS AGO <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>																									
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SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH		NEXT-TO-LAST BIRTH	
		NAME _____		NAME _____	
420 (4)	During this pregnancy, were you given or did you buy any iron tablets or iron syrup? SHOW TABLETS/SYRUP.	YES	1		
		NO	2		
		(SKIP TO 422) ←			
		DON'T KNOW	8		
421 (4) (5)	During the whole pregnancy, for how many days did you take the tablets or syrup? IF ANSWER IS NOT NUMERIC, PROBE FOR APPROXIMATE NUMBER OF DAYS.	DAYS	<input type="text"/> <input type="text"/> <input type="text"/>		
		DON'T KNOW	998		
422 (6)	During this pregnancy, did you take any drug for intestinal worms?	YES	1		
		NO	2		
		DON'T KNOW	8		
423 (7)	During this pregnancy, did you take SP/Fansidar to keep you from getting malaria?	YES	1		
		NO	2		
		(SKIP TO 426) ←			
		DON'T KNOW	8		
424 (7)	How many times did you take SP/Fansidar during this pregnancy?	TIMES	<input type="text"/> <input type="text"/>		
425 (7)	Did you get the SP/Fansidar during any antenatal care visit, during another visit to a health facility or from another source? IF MORE THAN ONE SOURCE, RECORD THE HIGHEST SOURCE ON THE LIST.	ANTENATAL VISIT	1		
		ANOTHER FACILITY VISIT	2		
		OTHER SOURCE	6		
426 (2)	Who assisted with the delivery of (NAME)? Anyone else? PROBE FOR THE TYPE(S) OF PERSON(S) AND RECORD ALL MENTIONED. IF RESPONDENT SAYS NO ONE ASSISTED, PROBE TO DETERMINE WHETHER ANY ADULTS WERE PRESENT AT THE DELIVERY.	HEALTH PERSONNEL DOCTOR	A	HEALTH PERSONNEL DOCTOR	A
		NURSE/MIDWIFE	B	NURSE/MIDWIFE	B
		AUXILIARY MIDWIFE	C	AUXILIARY MIDWIFE	C
		OTHER PERSON TRADITIONAL BIRTH		OTHER PERSON TRADITIONAL BIRTH	
		ATTENDANT	D	ATTENDANT	D
		RELATIVE/FRIEND	E	RELATIVE/FRIEND	E
		OTHER _____	X	OTHER _____	X
		(SPECIFY)		(SPECIFY)	
		NO ONE ASSISTED	Y	NO ONE ASSISTED	Y

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
427 (2)	<p>Where did you give birth to (NAME)?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____ (NAME OF PLACE)</p>	<p>HOME</p> <p>HER HOME 11 (SKIP TO 430) ←</p> <p>OTHER HOME 12</p> <p>PUBLIC SECTOR</p> <p>GOVERNMENT HOSPITAL .. 21 GOVERNMENT HEALTH CENTER 22 GOVERNMENT HEALTH POST 23 OTHER PUBLIC SECTOR _____ 26 (SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/ CLINIC 31 OTHER PRIVATE MEDICAL SECTOR _____ 36 (SPECIFY)</p> <p>OTHER _____ 96 (SPECIFY) (SKIP TO 430) ←</p>	<p>HOME</p> <p>HER HOME 11 (SKIP TO 430) ←</p> <p>OTHER HOME 12</p> <p>PUBLIC SECTOR</p> <p>GOVERNMENT HOSPITAL .. 21 GOVERNMENT HEALTH CENTER 22 GOVERNMENT HEALTH POST 23 OTHER PUBLIC SECTOR _____ 26 (SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/ CLINIC 31 OTHER PRIVATE MEDICAL SECTOR _____ 36 (SPECIFY)</p> <p>OTHER _____ 96 (SPECIFY) (SKIP TO 430) ←</p>
428	<p>Was (NAME) delivered by caesarean, that is, did they cut your belly open to take the baby out?</p>	<p>YES 1 NO 2 (SKIP TO MH5) ←</p>	<p>YES 1 NO 2 (SKIP TO 430) ←</p>
429	<p>When was the decision made to have the caesarean section? Was it before or after your labor pains started?</p>	<p>BEFORE 1 (SKIP TO 430) ←</p> <p>AFTER 2</p>	<p>BEFORE 1 AFTER 2</p>
MH5	<p>Were you told you could have a person with you during labor or delivery, such as a relative, friend, or neighbor?</p>	<p>YES 1 NO 2 DON'T KNOW 8</p>	

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
MH6	Did you have a person with you during labor or delivery, such as a relative, friend, or neighbor?	YES 1 NO 2 (SKIP TO MH8) ← DON'T KNOW 8	
MH7 (8)	Who was with you? RECORD ALL MENTIONED	HUSBAND A MOTHER/MOTHER-IN-LAW .. B SISTER/SISTER-IN-LAW C OTHER RELATIVE D FRIEND/NEIGHBOR..... E TBA F CHW G OTHER _____ X (SPECIFY)	
MH8	When you were in labor with or giving birth to (NAME), did you ever feel like you were being ignored or neglected by health facility staff?	YES 1 NO 2 DON'T KNOW 8	
MH9	When you were in labor with or giving birth to (NAME), did you have privacy, for example, were you surrounded by curtains, or did you have a separate room? IF YES, PROBE TO IDENTIFY TYPE OF PRIVACY	YES, SEPARATE ROOM 1 YES, CURTAINS 2 YES, OTHER SPECIFY: _____ 3 NO 4 DON'T KNOW 8	
MH10	CHECK 428: CAESAREAN SECTION	YES <input type="checkbox"/> NO <input type="checkbox"/> (SKIP TO 430) ←	
MH11	When [NAME] was born, was an instrument used to help pull the baby out, such as forceps or vacuum suction? SHOW PICTURES	YES, FORCEPS 1 YES, SUCTION 2 YES, DON'T KNOW WHAT INSTRUMENT 3 NO 4 DON'T KNOW 8	
430	Immediately after the birth, was (NAME) put on your chest?	YES 1 NO 2 (SKIP TO 431) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 431) ← DON'T KNOW 8
430A	Was (NAME)'s bare skin touching your bare skin?	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____												
431	When (NAME) was born, was (NAME) very large, larger than average, average, smaller than average, or very small?	VERY LARGE 1 LARGER THAN AVERAGE 2 AVERAGE 3 SMALLER THAN AVERAGE 4 VERY SMALL 5 DON'T KNOW 8	VERY LARGE 1 LARGER THAN AVERAGE 2 AVERAGE 3 SMALLER THAN AVERAGE 4 VERY SMALL 5 DON'T KNOW 8												
432	Was (NAME) weighed at birth?	YES 1 NO 2 (SKIP TO 433A) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 459) ← DON'T KNOW 8												
433	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 99998	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 99998 (SKIP TO 471) ←												
433A	CHECK 427: PLACE OF DELIVERY	CODE 11, 12, OR 96 <input type="text"/> OTHER <input type="text"/> CIRCLED (SKIP TO 449) ←													
MH12	Did a health care provider measure your blood pressure at the health facility before you gave birth to (NAME)?	YES 1 NO 2 DON'T KNOW 8													
MH13	At any time during your stay in the health facility, did you: a) Share a bed with another patient? b) Rest or sleep on the floor without any mattress?	<table border="0"> <tr> <td></td> <td>YES</td> <td>NO</td> <td>DK</td> </tr> <tr> <td>a) SHARE BED</td> <td>1</td> <td>2</td> <td>8</td> </tr> <tr> <td>b) SLEEP ON FLOOR</td> <td>1</td> <td>2</td> <td>8</td> </tr> </table>		YES	NO	DK	a) SHARE BED	1	2	8	b) SLEEP ON FLOOR	1	2	8	
	YES	NO	DK												
a) SHARE BED	1	2	8												
b) SLEEP ON FLOOR	1	2	8												
MH14	At any time during your stay in the health facility, were you denied medical services due to a lack of money?	YES 1 NO 2 DON'T KNOW 8													
MH15	Were you delayed or prevented from leaving the health facility due to lack of payment?	YES 1 NO 2 DON'T KNOW 8													

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH			NEXT-TO-LAST BIRTH		
		NAME _____			NAME _____		
MH16	At any time during your stay in the health facility, did any staff member: a) Slap you? b) Hit or punch you? c) Physically threaten you? d) Physically mistreat or harm you in any other way?		YES	NO	DK		
		a) HIT	1	2	8		
		b) SLAP	1	2	8		
		c) PHYSICALLY THREATEN	1	2	8		
MH17	At any time during your stay in the health facility, did any staff member: a) Shout at you? b) Say or do something to humiliate you? c) Verbally threaten you? d) Verbally mistreat you in any other way?		YES	NO	DK		
		a) SHOUT	1	2	8		
		b) HUMILIATE ..	1	2	8		
		c) VERBALLY THREATEN	1	2	8		
MH18	Did the health facility have a toilet or latrine for patients?	YES	1				
		NO	2				
		(SKIP TO 434) ←					
		DON'T KNOW	8				
MH19	Was there any time when you wanted to use the toilet or latrine, but it was not working?	YES	1				
		NO	2				
		DON'T KNOW	8				
		434	How long after (NAME) was delivered did you stay in the health facility? IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.	HOURS	1		
		DAYS	2				
		WEEKS	3				
		DON'T KNOW	998				
435	I would like to talk to you about checks on your health after delivery, for example, someone asking you questions about your health or examining you. Did anyone check on your health while you were still in the facility?	YES	1				
		NO	2				
		(SKIP TO 438) ←					
		436	How long after delivery did the first check take place? IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.	HOURS	1		
		DAYS	2				
		WEEKS	3				
		DON'T KNOW	998				

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____						
437 (2)	<p>Who checked on your health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p>HEALTH PERSONNEL DOCTOR 11 NURSE/MIDWIFE 12 AUXILIARY MIDWIFE 13 OTHER PERSON TRADITIONAL BIRTH ATTENDANT 21 COMMUNITY/ VILLAGE HEALTH VOLUNTEER 22 OTHER _____ 96 (SPECIFY)</p>							
438	<p>Now I would like to talk to you about checks on (NAME)'s health after delivery – for example, someone examining (NAME), checking the cord, or seeing if (NAME) is OK. Did anyone check on (NAME)'s health while you were still in the facility?</p>	<p>YES 1 NO 2 (SKIP TO 441) ← DON'T KNOW 8</p>							
439	<p>How long after delivery was (NAME)'s health first checked?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</p>	<p>HOURS 1 <table border="1" data-bbox="954 850 1084 905"><tr><td></td><td></td></tr></table> DAYS 2 <table border="1" data-bbox="954 905 1084 959"><tr><td></td><td></td></tr></table> WEEKS 3 <table border="1" data-bbox="954 959 1084 1014"><tr><td></td><td></td></tr></table> DON'T KNOW 998</p>							
440 (2)	<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 12 AUXILIARY MIDWIFE 13 OTHER PERSON TRADITIONAL BIRTH ATTENDANT 21 COMMUNITY/ VILLAGE HEALTH VOLUNTEER 22 OTHER _____ 96 (SPECIFY)</p>							
441	<p>Now I want to talk to you about what happened after you left the facility. Did anyone check on your health after you left the facility?</p>	<p>YES 1 NO 2 (SKIP TO 445) ←</p>							

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____												
442	<p>How long after delivery did that check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</p>	<p>HOURS 1 <table border="1" data-bbox="954 254 1084 302"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DAYS 2 <table border="1" data-bbox="954 302 1084 350"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>WEEKS 3 <table border="1" data-bbox="954 350 1084 399"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW 998</p>													
443 (2)	<p>Who checked on your health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p>HEALTH PERSONNEL DOCTOR 11 NURSE/MIDWIFE 12 AUXILIARY MIDWIFE 13</p> <p>OTHER PERSON TRADITIONAL BIRTH ATTENDANT 21 COMMUNITY/ VILLAGE HEALTH VOLUNTEER..... 22</p> <p>OTHER _____ 96 (SPECIFY)</p>													
444 (2)	<p>Where did the check take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____ (NAME OF PLACE)</p>	<p>HOME HER HOME 11 OTHER HOME 12</p> <p>PUBLIC SECTOR GOVERNMENT HOSPITAL .. 21 GOVERNMENT HEALTH CENTER 22 GOVERNMENT HEALTH POST 23 OTHER PUBLIC SECTOR _____ 26 (SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/ CLINIC 31 OTHER PRIVATE MEDICAL SECTOR _____ 36 (SPECIFY)</p> <p>OTHER _____ 96 (SPECIFY)</p>													
445	<p>I would like to talk to you about checks on (NAME)'s health after you left (FACILITY IN 427). Did any health care provider or a traditional birth attendant check on (NAME)'s health in the two months after you left (FACILITY IN 427)?</p>	<p>YES 1 NO 2 (SKIP TO 457) ← DON'T KNOW 8</p>													

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____												
446	<p>How many hours, days or weeks after the birth of (NAME) did that check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</p>	<p>HOURS 1 <table border="1" data-bbox="954 254 1084 306"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DAYS 2 <table border="1" data-bbox="954 306 1084 359"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>WEEKS 3 <table border="1" data-bbox="954 359 1084 411"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW 998</p>													
447 (2)	<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 12 AUXILIARY MIDWIFE 13 OTHER PERSON TRADITIONAL BIRTH ATTENDANT 21 COMMUNITY/ VILLAGE HEALTH WORKER 22 OTHER _____ 96 (SPECIFY)</p>													
448 (2)	<p>Where did this check of (NAME) take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____</p> <p>(NAME OF PLACE)</p>	<p>HOME HER HOME 11 OTHER HOME 12 PUBLIC SECTOR GOVERNMENT HOSPITAL .. 21 GOVERNMENT HEALTH CENTER 22 GOVERNMENT HEALTH POST 23 OTHER PUBLIC SECTOR _____ 26 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/ CLINIC 31 OTHER PRIVATE MEDICAL SECTOR _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY) (SKIP TO 457) ←</p>													

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____													
449	I would like to talk to you about checks on your health after delivery, for example, someone asking you questions about your health or examining you. Did anyone check on your health after you gave birth to (NAME)?	YES 1 NO 2 (SKIP TO 453) ←														
450	How long after delivery did the first check take place? IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, 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> 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														
451 (2)	Who checked on your health at that time? PROBE FOR MOST QUALIFIED PERSON.	HEALTH PERSONNEL DOCTOR 11 NURSE/MIDWIFE 12 AUXILIARY MIDWIFE 13 OTHER PERSON TRADITIONAL BIRTH ATTENDANT 21 COMMUNITY/ VILLAGE HEALTH WORKER 22 OTHER _____ 96 (SPECIFY)														
452 (2)	Where did this first check take place? PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	HOME HER HOME 11 OTHER HOME 12 PUBLIC SECTOR GOVERNMENT HOSPITAL .. 21 GOVERNMENT HEALTH CENTER 22 GOVERNMENT HEALTH POST 23 OTHER PUBLIC SECTOR _____ 26 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/ CLINIC 31 OTHER PRIVATE MEDICAL SECTOR _____ 36 (SPECIFY) OTHER _____ 96 (SPECIFY)														

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH NAME _____	NEXT-TO-LAST BIRTH NAME _____
453	I would like to talk to you about checks on (NAME)'s health after delivery – for example, someone examining (NAME), checking the cord, or seeing if (NAME) is OK. In the two months after (NAME) was born, did any health care provider or a traditional birth attendant check on (NAME)'s health?	YES 1 NO 2 (SKIP TO 457) ← DON'T KNOW 8	
454	How many hours, days or weeks after the birth of (NAME) did the first check take place? IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.	HOURS AFTER BIRTH 1 DAYS AFTER BIRTH 2 WEEKS AFTER BIRTH 3 DON'T KNOW 998	
455 (2)	Who checked on (NAME)'s health at that time? PROBE FOR MOST QUALIFIED PERSON.	HEALTH PERSONNEL DOCTOR 11 NURSE/MIDWIFE 12 AUXILIARY MIDWIFE 13 OTHER PERSON TRADITIONAL BIRTH ATTENDANT 21 COMMUNITY/ VILLAGE HEALTH WORKER 22 OTHER _____ 96 (SPECIFY)	
456 (2)	Where did this first check of (NAME) take place? PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	HOME HER HOME 11 OTHER HOME 12 PUBLIC SECTOR GOVERNMENT HOSPITAL .. 21 GOVERNMENT HEALTH CENTER 22 GOVERNMENT HEALTH POST 23 OTHER PUBLIC SECTOR _____ 26 (SPECIFY) PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/ CLINIC 31 OTHER PRIVATE MEDICAL SECTOR _____ 36 (SPECIFY) OTHER _____ 96 SPECIFY	

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH			NEXT-TO-LAST BIRTH		
		NAME _____			NAME _____		
457	During the first two days after (NAME)'s birth, did any health care provider do the following: a) Examine the cord? b) Measure (NAME)'s temperature? c) Counsel you on danger signs for newborns? d) Counsel you on breastfeeding? e) Observe (NAME) breastfeeding?		YES	NO	DK		
		a) CORD	1	2	8		
		b) TEMP.	1	2	8		
		c) SIGNS	1	2	8		
		d) COUNSEL BREAST-FEED	1	2	8		
		e) OBSERVE BREAST-FEED	1	2	8		
MH20	During the first two days after (NAME)'s birth, did any health care provider do the following: a) Examine for or ask you about vaginal bleeding? b) Measure your blood pressure? c) Ask if you are having any problems with urination, such as not being able to urinate or not being able to control your urination? d) Ask you if you had any pain? e) Counsel you about methods to prevent pregnancy? f) Ask if you feel sad or depressed?		YES	NO	DK		
		a) BLEEDING ..	1	2	8		
		b) BP	1	2	8		
		c) URINATION ..	1	2	8		
		d) PAIN	1	2	8		
		e) PREVENT PREGNANCY	1	2	8		
		f) SAD OR DEPRESSED	1	2	8		
458	Has your menstrual period returned since the birth of (NAME)?	YES	1				
		(SKIP TO 460) ←					
		NO	2				
		(SKIP TO 461) ←					
459	Did your period return between the birth of (NAME) and your next pregnancy?					YES	1
						NO	2
						(SKIP TO 463) ←	
460	For how many months after the birth of (NAME) did you not have a period?	MONTHS	<input type="text"/>	<input type="text"/>		MONTHS	<input type="text"/>
		DON'T KNOW	98			DON'T KNOW	98
461	CHECK 226: IS RESPONDENT PREGNANT?	NOT PREGNANT <input type="checkbox"/>		PREGNANT OR UNSURE <input type="checkbox"/>			
		(SKIP TO 463) ←					
462	Have you had sexual intercourse since the birth of (NAME)?	YES	1				
		NO	2				
		(SKIP TO 464) ←					
463	For how many months after the birth of (NAME) did you not have sexual intercourse?	MONTHS	<input type="text"/>	<input type="text"/>		MONTHS	<input type="text"/>
		DON'T KNOW	98			DON'T KNOW	98
464	Did you ever breastfeed (NAME)?	YES	1			YES	1
		(SKIP TO 466) ←				NO	2
		NO	2				

SECTION 4. PREGNANCY, DELIVERY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	LAST BIRTH		NEXT-TO-LAST BIRTH									
		NAME _____	NAME _____	NAME _____	NAME _____								
465	CHECK 404: IS CHILD LIVING?	LIVING <input type="checkbox"/> (SKIP TO 470) ←	DEAD <input type="checkbox"/> (SKIP TO 471) ←										
466	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 <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>											
467	In the first three days after delivery, was (NAME) given anything to drink other than breast milk?	YES 1 NO 2											
468	CHECK 404: IS CHILD LIVING?	LIVING <input type="checkbox"/> ↓ (SKIP TO 471) ←	DEAD <input type="checkbox"/> (SKIP TO 471) ←	LIVING <input type="checkbox"/> ↓ (SKIP TO 471) ←	DEAD <input type="checkbox"/> (SKIP TO 471) ←								
469	Are you still breastfeeding (NAME)?	YES 1 NO 2											
470	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							
471		GO BACK TO 405 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 501A.		GO BACK TO 405 IN NEXT-TO-LAST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 501A.									

SECTION 4. FOOTNOTES

- (1) Year of fieldwork is assumed to be 2015. For fieldwork beginning in 2016, all references to calendar years should be increased by one; for example, 2009 should be changed to 2010, 2010 should be changed to 2011, 2011 should be changed to 2012, and similarly for all years throughout the questionnaire.
- (2) Coding categories to be developed locally; however, the broad categories must be maintained. Additions to the codes under the private medical sector heading may include religious affiliated sources and NGO sources.
- (3) Vaccination practices may vary; this question should specify where the injection is given, e.g. arm or shoulder.
- (4) Syrup should be deleted in countries where syrup is not used.
- (5) In countries where it is important to know the number of iron tablets taken per day, an appropriate question may be added.
- (6) The question should be deleted in surveys in countries where there is no program for deworming.
- (7) The question should be deleted in surveys in countries where there is no program for intermittent preventive treatment against malaria during pregnancy.
- (8) Other types of support companions may be added to the list, such as a doula.