

2016 LIBERIA MALARIA INDICATOR SURVEY
WOMAN'S QUESTIONNAIRE
NATIONAL MALARIA CONTROL PROGRAM-MINISTRY OF HEALTH
LIBERIA INSTITUTE OF STATISTICS AND GEO-INFORMATION SERVICES

IDENTIFICATION														
PLACE NAME _____														
NAME OF HOUSEHOLD HEAD _____														
LMIS CLUSTER NUMBER					<table border="1" style="border-collapse: collapse; width: 60px;"> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>									
HOUSEHOLD NUMBER														
NAME AND LINE NUMBER OF WOMAN _____														
INTERVIEWER VISITS														
	1	2	3	FINAL VISIT										
DATE	_____	_____	_____	DAY	<table border="1" style="border-collapse: collapse; width: 40px;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>									
INTERVIEWER'S NAME	_____	_____	_____	MONTH	<table border="1" style="border-collapse: collapse; width: 40px;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>									
RESULT*	_____	_____	_____	YEAR	<table border="1" style="border-collapse: collapse; width: 60px;"> <tr><td style="text-align: center;">2</td><td style="text-align: center;">0</td><td style="text-align: center;">1</td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>	2	0	1						
2	0	1												
NEXT VISIT: DATE	_____	_____		INT. NO.	<table border="1" style="border-collapse: collapse; width: 60px;"> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>									
TIME	_____	_____		RESULT*	<table border="1" style="border-collapse: collapse; width: 40px;"> <tr><td> </td></tr> </table>									
<div style="display: flex; justify-content: space-between;"> <div> <p>*RESULT CODES: 1 COMPLETED</p> <p>2 NOT AT HOME</p> <p>3 POSTPONED</p> </div> <div> <p>4 REFUSED</p> <p>5 PARTLY COMPLETED</p> <p>6 INCAPACITATED</p> </div> <div> <p>7 OTHER _____</p> <p style="text-align: right;">SPECIFY</p> </div> </div>														
<div style="display: flex; justify-content: space-between;"> <div> <p>SUPERVISOR</p> <p>_____</p> <p>NAME</p> </div> <div> <table border="1" style="border-collapse: collapse; width: 60px;"> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table> <p>NUMBER</p> </div> </div>							<div style="display: flex; justify-content: space-between;"> <div> <p>OFFICE EDITOR</p> <p>_____</p> <p>NUMBER</p> </div> <div> <p>KEYED BY</p> <p>_____</p> <p>NUMBER</p> </div> </div>							

INTRODUCTION AND CONSENT

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

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

Do you have any questions?

May I begin the interview now?

SIGNATURE OF INTERVIEWER _____ DATE _____

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.	HOURS MINUTES	
102	In what month and year were you born?	MONTH DON'T KNOW MONTH 98 YEAR DON'T KNOW YEAR9998	
103	How old were you at your last birthday? COMPARE AND CORRECT 102 AND/OR 103 IF INCONSISTENT.	AGE IN COMPLETED YEARS	
104	Have you ever attended school?	YES 1 NO 2	→ 108
105	What is the highest level of school you attended: elementary, junior high, senior high, or higher?	ELEMENTARY (1-6) 1 JUNIOR HIGH (7-9) 2 SENIOR HIGH (10-12) 3 HIGHER 4	→ 106A
106	What is the highest grade you completed? IF COMPLETED NO GRADES, RECORD '00'.	GRADE	→ 107
106A	How many years of higher education did you complete? IF COMPLETED LESS THAN ONE YEAR OF HIGHER EDUCATION, RECORD '00'.	YEARS	
107	CHECK 105: ELEMENTARY OR JUNIOR HIGH OR SENIOR HIGH <input type="checkbox"/> HIGHER <input type="checkbox"/>		→ 109

SECTION 1. RESPONDENT'S BACKGROUND

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
108	<p>Now I would like you to read this sentence to me.</p> <p>SHOW CARD TO RESPONDENT.</p> <p>IF RESPONDENT CANNOT READ WHOLE SENTENCE, PROBE:</p> <p>Can you read any part of the sentence to me?</p>	<p>CANNOT READ AT ALL 1</p> <p>ABLE TO READ ONLY PART OF THE SENTENCE 2</p> <p>ABLE TO READ WHOLE SENTENCE 3</p> <p>NO CARD WITH REQUIRED LANGUAGE 4</p> <p align="center">(SPECIFY LANGUAGE)</p> <p>BLIND/VISUALLY IMPAIRED 5</p>	
109	<p>What is your religion?</p>	<p>CHRISTIAN 01</p> <p>MUSLIM 02</p> <p>TRADITIONAL RELIGION 03</p> <p>NO RELIGION 04</p> <p>OTHER 96</p> <p align="center">(SPECIFY)</p>	
110A	<p>What dialect do you speak well (besides English)?</p> <p>IF RESPONDENT CAN SPEAK SEVERAL DIALECTS, ASK WHICH ONE SHE SPEAKS MOST, OR WHICH IS HER FIRST LANGUAGE, OR MOTHER TONGUE</p>	<p>BASSA 01</p> <p>GBANDI 02</p> <p>BELLE 03</p> <p>DEY 04</p> <p>GIO 05</p> <p>GOLA 06</p> <p>GREBO 07</p> <p>KISSI 08</p> <p>KPELLE 09</p> <p>KRAHN 10</p> <p>KRU 11</p> <p>LORMA 12</p> <p>MANDINGO 13</p> <p>MANO 14</p> <p>MENDE 15</p> <p>SAPRO 16</p> <p>VAI 17</p> <p>NONE / ONLY ENGLISH 18</p> <p>OTHER 96</p>	

SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP								
201	Now I would like to ask about all the births you have had during your life. Have you ever given birth?	YES 1 NO 2	→ 206								
202	Do you have any sons or daughters to whom you have given birth (belly born) who are now living with you?	YES 1 NO 2	→ 204								
203	a) How many sons live with you? b) And how many daughters live with you? IF NONE, RECORD '00'.	a) 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> b) 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 (belly born) who are alive but do not live with you?	YES 1 NO 2	→ 206								
205	a) How many sons are alive but do not live with you? b) And how many daughters are alive but do not live with you? IF NONE, RECORD '00'.	a) 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> b) 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 belly born alive but later died? IF NO, PROBE: Any baby who cried, who made any movement, sound, or effort to breathe, or who showed any other signs of life even if for a very short time?	YES 1 NO 2	→ 208								
207	a) How many boys have died? b) And how many girls have died? IF NONE, RECORD '00'.	a) 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> b) 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, AND 207, AND ENTER TOTAL. IF NONE, RECORD '00'.	TOTAL BIRTHS <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 (belly born) during your life. Is that correct? <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> YES <input type="checkbox"/> ↓ </div> <div style="text-align: center;"> NO <input type="checkbox"/> ↓ PROBE AND CORRECT 201-208 AS NECESSARY. </div> </div>										
210	CHECK 208: <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> ONE OR MORE BIRTHS <input type="checkbox"/> ↓ </div> <div style="text-align: center;"> NO BIRTHS <input type="checkbox"/> → 225 </div> </div>										
211	Now I'd like to ask you about your more recent births. How many births have you had since January 2011? RECORD NUMBER OF LIVE BIRTHS FROM 2011-2016 IF NONE CIRCLE '00'	TOTAL IN 2011-2016 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr></table> NONE 00			→ 225						

SECTION 2. REPRODUCTION

212 Now I would like to record the names of all your births in 2011-2016, whether still alive or not, starting with the most recent one you had.
 RECORD IN 213 NAMES OF ALL THE BIRTHS IN 2011-2016. RECORD TWINS AND TRIPLETS ON SEPARATE ROWS. IF THERE ARE MORE THAN 5 BIRTHS, USE AN ADDITIONAL QUESTIONNAIRE STARTING WITH THE SECOND ROW.

213	214	215	216	217	218 IF ALIVE:	219 IF ALIVE:	220 IF ALIVE:	221
What name was given to your (most recent/ previous) baby? RECORD NAME. BIRTH HISTORY NUMBER.	Is (NAME) a boy or a girl?	Were any of these births twins?	On what day, month, and year was (NAME) born?	Is (NAME) still alive?	How old was (NAME) at (NAME)'s last birthday? RECORD AGE IN COMPLETED YEARS.	Is (NAME) living with you?	RECORD HOUSEHOLD LINE NUMBER OF CHILD. RECORD '00' IF CHILD NOT LISTED IN HOUSEHOLD.	Were there any other live births between (NAME) and (NAME OF PREVIOUS BIRTH), including any children who died after birth?
01	BOY 1 GIRL 2	SING 1 MULT 2	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"/>	YES 1 NO 2 ↓ (NEXT BIRTH)	AGE IN YEARS <input type="text"/> <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/> ↓ (NEXT BIRTH)	
02	BOY 1 GIRL 2	SING 1 MULT 2	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"/>	YES 1 NO 2 ↓ (SKIP TO 221)	AGE IN YEARS <input type="text"/> <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/>	YES (ADD BIRTH) 1 NO (NEXT BIRTH) 2
03	BOY 1 GIRL 2	SING 1 MULT 2	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"/>	YES 1 NO 2 ↓ (SKIP TO 221)	AGE IN YEARS <input type="text"/> <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/>	YES (ADD BIRTH) 1 NO (NEXT BIRTH) 2
04	BOY 1 GIRL 2	SING 1 MULT 2	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"/>	YES 1 NO 2 ↓ (SKIP TO 221)	AGE IN YEARS <input type="text"/> <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/>	YES (ADD BIRTH) 1 NO 2 (NEXT BIRTH)
05	BOY 1 GIRL 2	SING 1 MULT 2	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"/>	YES 1 NO 2 ↓ (SKIP TO 221)	AGE IN YEARS <input type="text"/> <input type="text"/>	YES 1 NO 2	HOUSEHOLD LINE NUMBER <input type="text"/> <input type="text"/>	YES (ADD BIRTH) 1 NO 2 (NEXT BIRTH)

SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
222	Have you had any live births since the birth of (NAME OF MOST RECENT BIRTH)?	YES 1 (RECORD BIRTH(S) IN TABLE) ← NO 2	
223	COMPARE 211 WITH NUMBER OF BIRTHS IN BIRTH HISTORY <div style="display: flex; justify-content: space-around;"> <div> NUMBERS ARE SAME <input type="checkbox"/> ↓ </div> <div> NUMBERS ARE DIFFERENT <input type="checkbox"/> (PROBE AND RECONCILE) ← </div> </div>		
224	CHECK 216: ENTER THE NUMBER OF BIRTHS IN 2011-2016	NUMBER OF BIRTHS <input type="text"/> NONE 0	
225	Are you pregnant now?	YES 1 NO 2 UNSURE 8	→ 226A
226	How many months pregnant are you? RECORD NUMBER OF COMPLETED MONTHS.	MONTHS <input type="text"/> <input type="text"/>	→ 227
226A	Are you or your partner currently doing something or using any method to delay or avoid getting pregnant?	YES 1 NO 2	→ 226D
226B	Which method are you using? RECORD ALL MENTIONED. IF MORE THAN ONE METHOD MENTIONED, FOLLOW SKIP INSTRUCTION FOR HIGHEST METHOD IN LIST.	FEMALE STERILIZATION A MALE STERILIZATION B IUD C INJECTABLES/DEPO D IMPLANTS E PILL F CONDOM G FEMALE CONDOM H EMERGENCY CONTRACEPTION I CYCLEBEADS/STANDARD DAYS METHOD J LACTATIONAL AMENORRHEA METHOD K RHYTHM METHOD L WITHDRAWAL M OTHER MODERN METHOD X OTHER TRADITIONAL METHOD Y	→ 227 → 227 → 227

SECTION 2. REPRODUCTION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
226C	<p>Where did you obtain (CURRENT METHOD) the last time?</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>PUBLIC SECTOR</p> <p>GOVERNMENT HOSPITAL 11</p> <p>GOVERNMENT HEALTH CENTER 12</p> <p>HEALTH CLINIC 13</p> <p>MOBILE CLINIC 14</p> <p>COMMUNITY HEALTH</p> <p> WORKER/ OUTREACH 15</p> <p>OTHER PUBLIC SECTOR 16</p> <p align="center">_____ (SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/CLINIC 21</p> <p>PHARMACY/ MED. STORE 22</p> <p>PRIVATE DOCTOR 23</p> <p>PLANNED PARENTHOOD</p> <p> ASSOCIATION OF LIBERIA 25</p> <p>OTHER PRIVATE MEDICAL SECTOR 26</p> <p align="center">_____ (SPECIFY)</p> <p>OTHER SOURCE</p> <p>SHOP 31</p> <p>CHURCH 32</p> <p>FRIEND/RELATIVE 33</p> <p>OTHER 96</p> <p align="center">_____ (SPECIFY)</p>	<p>→ 227</p>
226D	Do you know of a place where you can obtain a method of family planning?	<p>YES 1</p> <p>NO 2</p>	
227	<p>CHECK 224:</p> <p>ONE OR MORE BIRTHS IN 2011-2016 <input type="checkbox"/></p> <p align="right">(GO TO 301) ←</p>	<p>NO BIRTHS IN 2011-2016 <input type="checkbox"/></p> <p>Q. 224 IS BLANK <input type="checkbox"/></p>	<p>→ 701</p> <p>→ 701</p>

SECTION 3. PREGNANCY AND INTERMITTENT PREVENTIVE TREATMENT

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301	RECORD BIRTH HISTORY NUMBER FOR THE MOST RECENT BIRTH IN 2011-2016 FROM 213 IN BIRTH HISTORY.	<div align="center">MOST RECENT BIRTH</div> <hr/> BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/>	
301A	RECORD THE NAME AND SURVIVAL STATUS OF THE MOST RECENT BIRTH FROM 213 AND 217, LINE 01:	NAME <div> LIVING <input type="checkbox"/> DEAD <input type="checkbox"/> </div> <div> <div></div> <div></div> </div>	
302	Now I would like to ask you some questions about your last pregnancy that resulted in a live birth. When you got pregnant with (NAME), did you see anyone for antenatal care for this pregnancy?	YES 1 NO 2	→ 303E
303	Whom did you see? Anyone else? PROBE TO IDENTIFY EACH TYPE OF PERSON AND RECORD ALL MENTIONED.	HEALTH PERSONNEL DOCTOR A NURSE/MIDWIFE B PHYSICIAN ASSISTANT C OTHER PERSON TRADITIONAL BIRTH ATTENDANT D COMMUNITY HEALTH WORKER/ OUTREACH E OTHER X <div align="center">(SPECIFY)</div>	
303A	Where did you receive antenatal care for this pregnancy? Anywhere else? PROBE TO IDENTIFY THE TYPE OF SOURCE. IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE. _____ <div align="center">(NAME OF PLACE)</div>	HOME HER HOME A OTHER HOME B PUBLIC SECTOR GOVERNMENT HOSPITAL C GOVERNMENT HEALTH CENTER D GOVERNMENT HEALTH CLINIC E COMMUNITY HEALTH WORKER/ OUTREACH F OTHER PUBLIC MEDICAL SECTOR G <div align="center">(SPECIFY)</div> PRIVATE MEDICAL SECTOR PRIVATE HOSPITAL/ CLINIC H PRIVATE DOCTOR I PLANNED PARENTHOOD ASSN. LIB. J OTHER PRIVATE MEDICAL SECTOR K <div align="center">(SPECIFY)</div> OTHER X <div align="center">(SPECIFY)</div>	
303B	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/ DON'T REMEMBER 98	
303C	How many times did you receive antenatal care during this pregnancy?	NUMBER OF TIMES <input type="text"/> <input type="text"/> DON'T KNOW/ DON'T REMEMBER 98	

SECTION 3. PREGNANCY AND INTERMITTENT PREVENTIVE TREATMENT

NO.	QUESTIONS AND FILTERS	<div align="center">MOST RECENT BIRTH</div> NAME _____	SKIP
303D	Did you get a mosquito net during any ANC visit?	YES 1 NO 2 DON'T KNOW/ DON'T REMEMBER 8	
303E	Did you get a mosquito net during your delivery?	YES 1 NO 2 DON'T KNOW/ DON'T REMEMBER 8	
303F	During this pregnancy, did anyone tell you that you were supposed to get two mosquito nets, one at an ANC visit and one at delivery?	YES 1 NO 2 DON'T KNOW/ DON'T REMEMBER 8	
303G	During this pregnancy, did anyone tell you that pregnant women need to take some kind of medicine to keep them from getting malaria? EMPHASIZE THE WORD "KEEP".	YES 1 NO 2 DON'T KNOW/ DON'T REMEMBER 8	
304	During this pregnancy, did you take any medicine to keep you from getting malaria? EMPHASIZE 'KEEP'. DO NOT CIRCLE '1' IF SHE WAS ONLY GIVEN DRUGS BECAUSE SHE HAD MALARIA.	YES 1 NO 2 DON'T KNOW 8	<input type="checkbox"/> → 403
304A	What medicine did you take to keep you from getting malaria? RECORD ALL MENTIONED. IF SHE DOES NOT KNOW THE TYPE OF DRUGS, SHOW HER TYPICAL ANTIMALARIAL DRUGS. TREATMENT WITH SP/FANSIDAR USUALLY CONSISTS OF TAKING 3 BIG WHITE TABLETS AT THE HEALTH FACILITY.	SP/FANSIDAR A CHLOROQUINE B OTHER X <div align="center">(SPECIFY)</div> DON'T KNOW Z	
304B	CHECK 304A: DRUGS TAKEN FOR MALARIA PREVENTION <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> CODE 'A' CIRCLED ↓ <input type="checkbox"/> </div> <div style="text-align: center;"> CODE 'B' OR 'X' OR 'Z' CIRCLED BUT NOT 'A' <input type="checkbox"/> </div> </div>		<input type="checkbox"/> → 403
305	How many times did you take SP/Fansidar during this pregnancy?	TIMES <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/>	
306	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	

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
403	RECORD BIRTH HISTORY NUMBER FOR THE MOST RECENT BIRTH FROM 213 IN BIRTH HISTORY.	<p align="center">MOST RECENT BIRTH</p> <p>BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/></p>	
404	FROM 213 AND 217:	<p>NAME _____</p> <p>LIVING <input type="checkbox"/> DEAD <input type="checkbox"/></p>	
405	<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>_____</p> <p align="center">(NAME OF PLACE)</p>	<p>HOME</p> <p>HER HOME 11</p> <p>OTHER HOME 12</p> <p>PUBLIC SECTOR</p> <p>GOV. HOSPITAL 21</p> <p>GOVERNMENT HEALTH CENTER 22</p> <p>GOVERNMENT HEALTH CLINIC 23</p> <p>OTHER PUBLIC SECTOR _____ 26</p> <p align="center">(SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/CLINIC 31</p> <p>OTHER PRIVATE MEDICAL SECTOR _____ 36</p> <p align="center">(SPECIFY)</p> <p>OTHER _____ 96</p> <p align="center">(SPECIFY)</p>	
405A	CHECK 405: PLACE OF DELIVERY	<p>CODE 11, 12, OR 96 CIRCLED <input type="checkbox"/> OTHER <input type="checkbox"/></p> <p>(SKIP TO 420) ←</p>	
406	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?	<p>YES 1</p> <p>NO 2</p> <p align="center">(SKIP TO 409) ←</p>	

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	MOST RECENT BIRTH NAME _____													
407	<p>How long after delivery did the first 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="906 300 1045 353"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DAYS 2 <table border="1" data-bbox="906 353 1045 407"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>WEEKS 3 <table border="1" data-bbox="906 407 1045 461"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW 998</p>													
408	<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 12</p> <p>PHYSICIAN ASST. 13</p> <p>OTHER PERSON</p> <p>TRADITIONAL BIRTH</p> <p>ATTENDANT 21</p> <p>COMMUNITY HEALTH</p> <p>WORKER/</p> <p>OUTREACH 22</p> <p>OTHER 96</p> <p align="center">(SPECIFY)</p>													
409	<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</p> <p>NO 2</p> <p align="center">(SKIP TO 412) ←</p> <p>DON'T KNOW 8</p>													
410	<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="906 1245 1045 1299"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DAYS 2 <table border="1" data-bbox="906 1299 1045 1352"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>WEEKS 3 <table border="1" data-bbox="906 1352 1045 1406"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW 998</p>													
411	<p>Who checked on (NAME)'s health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p>HEALTH PERSONNEL</p> <p>DOCTOR 11</p> <p>NURSE/MIDWIFE 12</p> <p>PHYSICIAN ASST. 13</p> <p>OTHER PERSON</p> <p>TRADITIONAL BIRTH</p> <p>ATTENDANT 21</p> <p>COMMUNITY HEALTH</p> <p>WORKER/</p> <p>OUTREACH 22</p> <p>OTHER 96</p> <p align="center">(SPECIFY)</p>													
412	<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</p> <p>NO 2</p> <p align="center">(SKIP TO 416) ←</p>													

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	MOST RECENT BIRTH NAME _____													
413	<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="906 313 1045 371"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DAYS 2 <table border="1" data-bbox="906 371 1045 432"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>WEEKS 3 <table border="1" data-bbox="906 432 1045 490"><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></p> <p>DON'T KNOW 998</p>													
414	<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 12</p> <p>PHYSICIAN ASST. 13</p> <p>OTHER PERSON</p> <p>TRADITIONAL BIRTH ATTENDANT 21</p> <p>COMMUNITY HEALTH WORKER/ OUTREACH 22</p> <p>OTHER 96 (SPECIFY) _____</p>													
415	<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>_____</p> <p>(NAME OF PLACE)</p>	<p>HOME</p> <p>HER HOME 11</p> <p>OTHER HOME 12</p> <p>PUBLIC SECTOR</p> <p>GOV. HOSPITAL 21</p> <p>GOVERNMENT HEALTH CENTER 22</p> <p>GOVERNMENT HEALTH CLINIC 23</p> <p>OTHER PUBLIC SECTOR 26 (SPECIFY) _____</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/ CLINIC 31</p> <p>OTHER PRIVATE MEDICAL SECTOR 36 (SPECIFY) _____</p> <p>OTHER 96 (SPECIFY) _____</p>													
416	<p>I would like to talk to you about checks on (NAME)'s health after you left (FACILITY IN 405). Did any health care provider or a traditional birth attendant check on (NAME)'s health in the two months after you left (FACILITY IN 405)?</p>	<p>YES 1</p> <p>NO 2</p> <p>(SKIP TO 501) ←</p> <p>DON'T KNOW 8</p>													

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	MOST RECENT BIRTH NAME _____																			
417	<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" 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></p> <p>DAYS 2 <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></p> <p>WEEKS 3 <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></p> <p>DON'T KNOW 998</p>																			
418	<p>Who checked on (NAME)'s health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p>HEALTH PERSONNEL</p> <p>DOCTOR 11</p> <p>NURSE/MIDWIFE 12</p> <p>PHYSICIAN ASST. 13</p> <p>OTHER PERSON</p> <p>TRADITIONAL BIRTH ATTENDANT 21</p> <p>COMMUNITY HEALTH WORKER/ OUTREACH 22</p> <p>OTHER 96 (SPECIFY)</p>																			
419	<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 align="center">(NAME OF PLACE)</p>	<p>HOME</p> <p>HER HOME 11</p> <p>OTHER HOME 12</p> <p>PUBLIC SECTOR</p> <p>GOV. HOSPITAL 21</p> <p>GOVERNMENT HEALTH CENTER 22</p> <p>GOVERNMENT HEALTH CLINIC 23</p> <p>OTHER PUBLIC SECTOR 26 _____ (SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/ CLINIC 31</p> <p>OTHER PRIVATE MEDICAL SECTOR 36 _____ (SPECIFY)</p> <p>OTHER 96 _____ (SPECIFY)</p> <p align="right">(SKIP TO 501) ←</p>																			
420	<p>I would like to talk to you about checks on your health after delivery, for example, someone asking you questions about your health or examining you. Did anyone check on your health after you gave birth to (NAME)?</p>	<p>YES 1</p> <p>NO 2</p> <p align="right">(SKIP TO 424) ←</p>																			

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	MOST RECENT BIRTH NAME _____	
421	<p>How long after delivery did the first check take place?</p> <p>IF LESS THAN ONE DAY, RECORD HOURS; IF LESS THAN ONE WEEK, RECORD DAYS.</p>	<p>HOURS 1</p> <p>DAYS 2</p> <p>WEEKS 3</p> <p>DON'T KNOW 998</p>	
422	<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 12</p> <p>PHYSICIAN ASST. 13</p> <p>OTHER PERSON</p> <p>TRADITIONAL BIRTH ATTENDANT 21</p> <p>COMMUNITY HEALTH WORKER/ OUTREACH 22</p> <p>OTHER 96 (SPECIFY)</p>	
423	<p>Where did this first check take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____ (NAME OF PLACE)</p>	<p>HOME</p> <p>HER HOME 11</p> <p>OTHER HOME 12</p> <p>PUBLIC SECTOR</p> <p>GOV. HOSPITAL 21</p> <p>GOVERNMENT HEALTH CENTER 22</p> <p>GOVERNMENT HEALTH CLINIC 23</p> <p>OTHER PUBLIC SECTOR 26 (SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/ CLINIC 31</p> <p>OTHER PRIVATE MEDICAL SECTOR 36 (SPECIFY)</p> <p>OTHER 96 (SPECIFY)</p>	
424	<p>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?</p>	<p>YES 1</p> <p>NO 2</p> <p align="center">(SKIP TO 501) ←</p> <p>DON'T KNOW 8</p>	

SECTION 4. PREGNANCY AND POSTNATAL CARE

NO.	QUESTIONS AND FILTERS	MOST RECENT BIRTH NAME _____	
425	<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.</p>	<p>HOURS AFTER BIRTH 1</p> <p>DAYS AFTER BIRTH 2</p> <p>WEEKS AFTER BIRTH 3</p> <p>DON'T KNOW 998</p>	
426	<p>Who checked on (NAME)'s health at that time?</p> <p>PROBE FOR MOST QUALIFIED PERSON.</p>	<p>HEALTH PERSONNEL</p> <p>DOCTOR 11</p> <p>NURSE/MIDWIFE 12</p> <p>PHYSICIAN ASST. 13</p> <p>OTHER PERSON</p> <p>TRADITIONAL BIRTH ATTENDANT 21</p> <p>COMMUNITY HEALTH WORKER/ OUTREACH 22</p> <p>OTHER 96 (SPECIFY)</p>	
427	<p>Where did this first check of (NAME) take place?</p> <p>PROBE TO IDENTIFY THE TYPE OF SOURCE.</p> <p>IF UNABLE TO DETERMINE IF PUBLIC OR PRIVATE SECTOR, WRITE THE NAME OF THE PLACE.</p> <p>_____ (NAME OF PLACE)</p>	<p>HOME</p> <p>HER HOME 11</p> <p>OTHER HOME 12</p> <p>PUBLIC SECTOR</p> <p>GOV. HOSPITAL 21</p> <p>GOVERNMENT HEALTH CENTER 22</p> <p>GOVERNMENT HEALTH CLINIC 23</p> <p>OTHER PUBLIC SECTOR 26 (SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/ CLINIC 31</p> <p>OTHER PRIVATE MEDICAL SECTOR 36 (SPECIFY)</p> <p>OTHER 96 SPECIFY</p>	

SECTION 5. FEVER IN CHILDREN

501	<p>CHECK 213: RECORD THE BIRTH HISTORY NUMBER IN 502 AND THE NAME AND SURVIVAL STATUS IN 503 FOR EACH BIRTH IN 2011-2016. ASK QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE MOST RECENT BIRTH. IF THERE WERE MORE THAN 2 BIRTHS, USE ADDITIONAL QUESTIONNAIRES.</p> <p>Now I would like to ask some questions about the health of your children born in 2011-2016. (We will talk about each separately.)</p>		
502	BIRTH HISTORY NUMBER FROM 213 IN BIRTH HISTORY.	<p align="center">MOST RECENT BIRTH</p> <p>BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/></p>	<p align="center">NEXT-TO MOST RECENT BIRTH</p> <p>BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/></p>
503	FROM 213 AND 217:	<p>NAME _____</p> <p>LIVING <input type="checkbox"/> DEAD <input type="checkbox"/></p> <p>↓ (SKIP TO 528) ←</p>	<p>NAME _____</p> <p>LIVING <input type="checkbox"/> DEAD <input type="checkbox"/></p> <p>↓ (SKIP TO 528) ←</p>
504	Has (NAME) been ill with a fever at any time in the last 2 weeks?	<p>YES 1</p> <p>NO 2</p> <p align="right">(SKIP TO 528) ←</p> <p>DON'T KNOW 8</p>	<p>YES 1</p> <p>NO 2</p> <p align="right">(SKIP TO 528) ←</p> <p>DON'T KNOW 8</p>
506	Did you seek advice or treatment for the illness from any source?	<p>YES 1</p> <p>NO 2</p> <p align="right">(SKIP TO 511) ←</p>	<p>YES 1</p> <p>NO 2</p> <p align="right">(SKIP TO 511) ←</p>
507	<p>Where did you seek advice or treatment?</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(S).</p> <p>_____</p> <p align="center">(NAME OF PLACE)</p>	<p>PUBLIC SECTOR</p> <p>GOV. HOSPITAL A</p> <p>GOVERNMENT HEALTH CENTER B</p> <p>GOVERNMENT HEALTH CLINIC C</p> <p>MOBILE CLINIC D</p> <p>CHW/OUTREACH E</p> <p>OTHER PUBLIC SECTOR</p> <p align="right">_____ F</p> <p align="center">(SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/CLINIC G</p> <p>PHARMACY/MED.STORE .. H</p> <p>PRIVATE DOCTOR I</p> <p>PLANNED PARENTHOOD ASSOC. OF LIBERIA J</p> <p>OTHER PRIVATE MEDICAL SECTOR</p> <p align="right">_____ K</p> <p align="center">(SPECIFY)</p> <p>OTHER SOURCE</p> <p>TRADITIONAL PRACTITIONER L</p> <p>MARKET M</p> <p>BLACK BAGGER/DRUG PEDDLER N</p> <p>OTHER _____ X</p> <p align="center">(SPECIFY)</p>	<p>PUBLIC SECTOR</p> <p>GOV. HOSPITAL A</p> <p>GOVERNMENT HEALTH CENTER B</p> <p>GOVERNMENT HEALTH CLINIC C</p> <p>MOBILE CLINIC D</p> <p>CHW/OUTREACH E</p> <p>OTHER PUBLIC SECTOR</p> <p align="right">_____ F</p> <p align="center">(SPECIFY)</p> <p>PRIVATE MEDICAL SECTOR</p> <p>PRIVATE HOSPITAL/CLINIC G</p> <p>PHARMACY/MED.STORE .. H</p> <p>PRIVATE DOCTOR I</p> <p>PLANNED PARENTHOOD ASSOC. OF LIBERIA J</p> <p>OTHER PRIVATE MEDICAL SECTOR</p> <p align="right">_____ K</p> <p align="center">(SPECIFY)</p> <p>OTHER SOURCE</p> <p>TRADITIONAL PRACTITIONER L</p> <p>MARKET M</p> <p>BLACK BAGGER/DRUG PEDDLER N</p> <p>OTHER _____ X</p> <p align="center">(SPECIFY)</p>

SECTION 5. FEVER IN CHILDREN

NO.	QUESTIONS AND FILTERS	MOST RECENT BIRTH NAME _____	NEXT-TO-MOST RECENT BIRTH NAME _____
508	CHECK 507:	<div style="display: flex; justify-content: space-around;"> <div> TWO OR MORE CODES CIRCLED <input type="checkbox"/> </div> <div> ONLY ONE CODE CIRCLED <input type="checkbox"/> </div> </div> <div style="text-align: right;">(SKIP TO 510) ←</div>	<div style="display: flex; justify-content: space-around;"> <div> TWO OR MORE CODES CIRCLED <input type="checkbox"/> </div> <div> ONLY ONE CODE CIRCLED <input type="checkbox"/> </div> </div> <div style="text-align: right;">(SKIP TO 510) ←</div>
509	Where did you first seek advice or treatment? USE LETTER CODE FROM 507	FIRST PLACE <input type="checkbox"/>	FIRST PLACE <input type="checkbox"/>
510	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"/>
510A	At any time during the illness, did (NAME) have blood taken from (NAME)'s finger or heel for testing?	YES 1 NO 2 (SKIP TO 511) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 511) ← DON'T KNOW 8
510B	Were you given malaria medicine for (NAME) after this test?	YES 1 (SKIP TO 512) ← NO 2 DON'T KNOW 8	YES 1 (SKIP TO 512) ← NO 2 DON'T KNOW 8
511	At any time during the illness, did (NAME) take any drugs for the illness?	YES 1 NO 2 (SKIP TO 528) ← DON'T KNOW 8	YES 1 NO 2 (SKIP TO 528) ← DON'T KNOW 8
512	What drugs did (NAME) take? Any other drugs? RECORD ALL MENTIONED. PROBE: IF AMODIAQUINE IS NAMED CLARIFY TO VERIFY IF IT IS ACT.	ANTIMALARIAL DRUGS ARTEMISININ COMBINATION THERAPY (ACT) A SP/FANSIDAR B CHLOROQUINE C AMODIAQUINE D QUININE: PILLS E INJECTION/IV F ARTESUNATE: RECTAL G INJECTION/IV H OTHER ANTIMALARIAL I _____ (SPECIFY) ANTIBIOTIC DRUGS PILL/SYRUP J INJECTION/IV K OTHER DRUGS ASPIRIN L PARACETAMOL M IBUPROFEN N OTHER X _____ (SPECIFY) DON'T KNOW Z	ANTIMALARIAL DRUGS ARTEMISININ COMBINATION THERAPY (ACT) A SP/FANSIDAR B CHLOROQUINE C AMODIAQUINE D QUININE: PILLS E INJECTION/IV F ARTESUNATE: RECTAL G INJECTION/IV H OTHER ANTIMALARIAL I _____ (SPECIFY) ANTIBIOTIC DRUGS PILL/SYRUP J INJECTION/IV K OTHER DRUGS ASPIRIN L PARACETAMOL M IBUPROFEN N OTHER X _____ (SPECIFY) DON'T KNOW Z

SECTION 5. FEVER IN CHILDREN

NO.	QUESTIONS AND FILTERS	MOST RECENT BIRTH NAME _____	NEXT-TO-MOST RECENT BIRTH NAME _____
513	CHECK 512: ANY CODE A-I CIRCLED?	YES <input type="checkbox"/> NO <input type="checkbox"/> ↓ (SKIP TO 528) ←	YES <input type="checkbox"/> NO <input type="checkbox"/> ↓ (SKIP TO 528) ←
514	CHECK 512: ARTEMISININ COMBINATION THERAPY ('A') GIVEN	CODE 'A' CIRCLED <input type="checkbox"/> CODE 'A' NOT CIRCLED <input type="checkbox"/> ↓ (SKIP TO 516) ←	CODE 'A' CIRCLED <input type="checkbox"/> CODE 'A' NOT CIRCLED <input type="checkbox"/> ↓ (SKIP TO 516) ←
515	How long after the fever started did (NAME) first take an artemisinin combination therapy?	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8
516	CHECK 512: SP/FANSIDAR ('B') GIVEN	CODE 'B' CIRCLED <input type="checkbox"/> CODE 'B' NOT CIRCLED <input type="checkbox"/> ↓ (SKIP TO 518) ←	CODE 'B' CIRCLED <input type="checkbox"/> CODE 'B' NOT CIRCLED <input type="checkbox"/> ↓ (SKIP TO 518) ←
517	How long after the fever started did (NAME) first take SP/Fansidar?	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8
518	CHECK 512: CHLOROQUINE ('C') GIVEN	CODE 'C' CIRCLED <input type="checkbox"/> CODE 'C' NOT CIRCLED <input type="checkbox"/> ↓ (SKIP TO 520) ←	CODE 'C' CIRCLED <input type="checkbox"/> CODE 'C' NOT CIRCLED <input type="checkbox"/> ↓ (SKIP TO 520) ←
519	How long after the fever started did (NAME) first take chloroquine?	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8
520	CHECK 512: AMODIAQUINE ('D') GIVEN	CODE 'D' CIRCLED <input type="checkbox"/> CODE 'D' NOT CIRCLED <input type="checkbox"/> ↓ (SKIP TO 522) ←	CODE 'D' CIRCLED <input type="checkbox"/> CODE 'D' NOT CIRCLED <input type="checkbox"/> ↓ (SKIP TO 522) ←
521	How long after the fever started did (NAME) first take amodiaquine?	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8

SECTION 5. FEVER IN CHILDREN

NO.	QUESTIONS AND FILTERS	MOST RECENT BIRTH NAME _____	NEXT-TO-MOST RECENT BIRTH NAME _____
522	CHECK 512: QUININE ('E' OR 'F') GIVEN	<div style="display: flex; justify-content: space-between;"> <div> CODE 'E' OR 'F' CIRCLED <input type="checkbox"/> ↓ </div> <div> CODE 'E' OR 'F' NOT CIRCLED <input type="checkbox"/> (SKIP TO 524) ← </div> </div>	<div style="display: flex; justify-content: space-between;"> <div> CODE 'E' OR 'F' CIRCLED <input type="checkbox"/> ↓ </div> <div> CODE 'E' OR 'F' NOT CIRCLED <input type="checkbox"/> (SKIP TO 524) ← </div> </div>
523	How long after the fever started did (NAME) first take quinine?	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8
524	CHECK 512: ARTESUNATE ('G' OR 'H') GIVEN	<div style="display: flex; justify-content: space-between;"> <div> CODE 'G' OR 'H' CIRCLED <input type="checkbox"/> ↓ </div> <div> CODE 'G' OR 'H' NOT CIRCLED <input type="checkbox"/> (SKIP TO 526) ← </div> </div>	<div style="display: flex; justify-content: space-between;"> <div> CODE 'G' OR 'H' CIRCLED <input type="checkbox"/> ↓ </div> <div> CODE 'G' OR 'H' NOT CIRCLED <input type="checkbox"/> (SKIP TO 526) ← </div> </div>
525	How long after the fever started did (NAME) first take artesunate?	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8
526	CHECK 512: OTHER ANTIMALARIAL ('I') GIVEN	<div style="display: flex; justify-content: space-between;"> <div> CODE 'I' CIRCLED <input type="checkbox"/> ↓ </div> <div> CODE 'I' NOT CIRCLED <input type="checkbox"/> (SKIP TO 528) ← </div> </div>	<div style="display: flex; justify-content: space-between;"> <div> CODE 'I' CIRCLED <input type="checkbox"/> ↓ </div> <div> CODE 'I' NOT CIRCLED <input type="checkbox"/> (SKIP TO 528) ← </div> </div>
527	How long after the fever started did (NAME) first take (OTHER ANTIMALARIAL)?	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8	SAME DAY 0 NEXT DAY 1 TWO DAYS AFTER FEVER 2 THREE OR MORE DAYS AFTER FEVER 3 DON'T KNOW 8
528		GO BACK TO 503 IN NEXT COLUMN; OR, IF NO MORE BIRTHS, GO TO 601A.	GO TO 503 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR, IF NO MORE BIRTHS, GO TO 601A.

SECTION 6A. CHILD IMMUNIZATION (MOST RECENT BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601A	CHECK 216 IN THE BIRTH HISTORY: ANY BIRTHS IN 2013-2016? ONE OR MORE BIRTHS IN 2013-2016 <input type="checkbox"/> NO BIRTHS IN 2013-2016 <input type="checkbox"/>		→ 701
602A	RECORD THE NAME AND BIRTH HISTORY NUMBER FROM 213 OF THE LAST CHILD BORN IN 2013-2016. NAME OF MOST RECENT BIRTH _____ BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/>		
603A	CHECK 217 FOR CHILD: LIVING <input type="checkbox"/> DEAD <input type="checkbox"/>		→ 601B
604A	Do you have a card or other document where (NAME)'s vaccinations are written down?	YES, HAS ONLY A CARD 1 YES, HAS ONLY AN OTHER DOCUMENT 2 YES, HAS CARD AND OTHER DOCUMENT 3 NO, NO CARD AND NO OTHER DOCUMENT .. 4	→ 607A → 607A
605A	Did you ever have a vaccination card for (NAME)?	YES 1 NO 2	
606A	CHECK 604A: CODE '2' CIRCLED <input type="checkbox"/> CODE '4' CIRCLED <input type="checkbox"/>		→ 611A
607A	May I see the card or other document where (NAME)'s vaccinations are written down?	YES, ONLY CARD SEEN 1 YES, ONLY OTHER DOCUMENT SEEN 2 YES, CARD AND OTHER DOCUMENT SEEN .. 3 NO CARD AND NO OTHER DOCUMENT SEEN .. 4	→ 611A

SECTION 6A. CHILD IMMUNIZATION (MOST RECENT BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																																																																																																																												
	NAME OF MOST RECENT BIRTH _____ BIRTH HISTORY NUMBER 																																																																																																																																																														
607A1	<p>CHECK THE CARD:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> CHILD HEALTH CARD NEW VERSION <input type="checkbox"/> </div> <div style="text-align: center;"> CHILD HEALTH CARD PREVIOUS VERSIONS <input type="checkbox"/> </div> </div>		608A2																																																																																																																																																												
608A1	<p>COPY DATES FROM THE CARD OR OTHER DOCUMENT. WRITE '44' IN 'DAY' COLUMN IF CARD OR OTHER DOCUMENT SHOWS THAT A DOSE WAS GIVEN, BUT NO DATE IS RECORDED.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;">No of Visit</th> <th style="width:40%;">FROM THE CHILD HEALTH CARD NEW VERSION</th> <th style="width:10%;">DAY</th> <th style="width:10%;">MONTH</th> <th style="width:30%;">YEAR</th> </tr> </thead> <tbody> <tr> <td rowspan="2" style="text-align: center; vertical-align: middle;">1</td> <td>POLIO- 0 (At birth)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>BCG (Anti-TB Vaccine at Birth)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td rowspan="4" style="text-align: center; vertical-align: middle;">2</td> <td>POLIO-1</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>ROTA- 1</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>PENTA- 1</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>PNEUMO- 1</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td rowspan="4" style="text-align: center; vertical-align: middle;">3</td> <td>POLIO- 2</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>ROTA- 2</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>PENTA- 2</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>PNEUMO- 2</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td rowspan="4" style="text-align: center; vertical-align: middle;">4</td> <td>POLIO- 3</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>ROTA- 3</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>PENTA- 3</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>PNEUMO- 3</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td rowspan="2" style="text-align: center; vertical-align: middle;">5</td> <td>MEASLES</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>YELLOW FEVER</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>			No of Visit	FROM THE CHILD HEALTH CARD NEW VERSION	DAY	MONTH	YEAR	1	POLIO- 0 (At birth)									BCG (Anti-TB Vaccine at Birth)									2	POLIO-1									ROTA- 1									PENTA- 1									PNEUMO- 1									3	POLIO- 2									ROTA- 2									PENTA- 2									PNEUMO- 2									4	POLIO- 3									ROTA- 3									PENTA- 3									PNEUMO- 3									5	MEASLES									YELLOW FEVER										
No of Visit	FROM THE CHILD HEALTH CARD NEW VERSION	DAY	MONTH	YEAR																																																																																																																																																											
1	POLIO- 0 (At birth)																																																																																																																																																														
	BCG (Anti-TB Vaccine at Birth)																																																																																																																																																														
2	POLIO-1																																																																																																																																																														
	ROTA- 1																																																																																																																																																														
	PENTA- 1																																																																																																																																																														
	PNEUMO- 1																																																																																																																																																														
3	POLIO- 2																																																																																																																																																														
	ROTA- 2																																																																																																																																																														
	PENTA- 2																																																																																																																																																														
	PNEUMO- 2																																																																																																																																																														
4	POLIO- 3																																																																																																																																																														
	ROTA- 3																																																																																																																																																														
	PENTA- 3																																																																																																																																																														
	PNEUMO- 3																																																																																																																																																														
5	MEASLES																																																																																																																																																														
	YELLOW FEVER																																																																																																																																																														
609A1	<p>CHECK 608A1: 'BCG' TO 'YELLOW FEVER' ALL RECORDED?</p> <div style="display: flex; justify-content: space-between; align-items: center;"> <div> NO <input type="checkbox"/> </div> <div> YES <input type="checkbox"/> </div> </div>		<div style="display: flex; justify-content: space-between; align-items: center;"> <div>→ 610A</div> <div>→ 626A</div> </div>																																																																																																																																																												

SECTION 6A. CHILD IMMUNIZATION (MOST RECENT BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																																				
	NAME OF MOST RECENT BIRTH _____ BIRTH HISTORY NUMBER 																																																																						
608A2	<p>COPY DATES FROM THE CARD OR OTHER DOCUMENT. WRITE '44' IN 'DAY' COLUMN IF CARD OR OTHER DOCUMENT SHOWS THAT A DOSE WAS GIVEN, BUT NO DATE IS RECORDED.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">FROM THE CHILD HEALTH CARD PREVIOUS VERSIONS</th> <th style="width:10%;">DAY</th> <th style="width:10%;">MONTH</th> <th style="width:30%;">YEAR</th> </tr> </thead> <tbody> <tr><td>BCG</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 1</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 2</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 3</td><td></td><td></td><td></td></tr> <tr><td>PENTA-1</td><td></td><td></td><td></td></tr> <tr><td>PENTA-2</td><td></td><td></td><td></td></tr> <tr><td>PENTA-3</td><td></td><td></td><td></td></tr> <tr><td>MEASLES</td><td></td><td></td><td></td></tr> <tr><td>YELLOW FEVER</td><td></td><td></td><td></td></tr> <tr><td>ROTA-1</td><td></td><td></td><td></td></tr> <tr><td>ROTA-2</td><td></td><td></td><td></td></tr> <tr><td>ROTA-3</td><td></td><td></td><td></td></tr> <tr><td>PNEUMO-1</td><td></td><td></td><td></td></tr> <tr><td>PNEUMO-2</td><td></td><td></td><td></td></tr> <tr><td>PNEUMO-3</td><td></td><td></td><td></td></tr> </tbody> </table>	FROM THE CHILD HEALTH CARD PREVIOUS VERSIONS	DAY	MONTH	YEAR	BCG				ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)				ORAL POLIO VACCINE (OPV) 1				ORAL POLIO VACCINE (OPV) 2				ORAL POLIO VACCINE (OPV) 3				PENTA-1				PENTA-2				PENTA-3				MEASLES				YELLOW FEVER				ROTA-1				ROTA-2				ROTA-3				PNEUMO-1				PNEUMO-2				PNEUMO-3					
FROM THE CHILD HEALTH CARD PREVIOUS VERSIONS	DAY	MONTH	YEAR																																																																				
BCG																																																																							
ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)																																																																							
ORAL POLIO VACCINE (OPV) 1																																																																							
ORAL POLIO VACCINE (OPV) 2																																																																							
ORAL POLIO VACCINE (OPV) 3																																																																							
PENTA-1																																																																							
PENTA-2																																																																							
PENTA-3																																																																							
MEASLES																																																																							
YELLOW FEVER																																																																							
ROTA-1																																																																							
ROTA-2																																																																							
ROTA-3																																																																							
PNEUMO-1																																																																							
PNEUMO-2																																																																							
PNEUMO-3																																																																							
609A2	<p>CHECK 608A2: 'BCG' TO 'PNEUMO-3" ALL RECORDED?</p> <p align="center">NO <input type="checkbox"/> YES <input type="checkbox"/></p> <p align="center">↓</p>		→ 626A																																																																				
610A	<p>In addition to what is recorded on (this document/these documents), did (NAME) receive any other vaccinations, including vaccinations received in campaigns or immunization days or child health days?</p> <p>RECORD 'YES' ONLY IF THE RESPONDENT MENTIONS AT LEAST ONE OF THE VACCINATIONS IN 608A1 OR 608A2 THAT ARE NOT RECORDED AS HAVING BEEN GIVEN.</p>	<p>YES 1] (PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 608A1 OR 608A2 THEN WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN) (THEN SKIP TO 626A) ←</p> <p>NO 2] DON'T KNOW 8] (WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN) (THEN SKIP TO 626A) ←</p>																																																																					

SECTION 6A. CHILD IMMUNIZATION (MOST RECENT BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	NAME OF MOST RECENT BIRTH _____	BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/>	
611A	Did (NAME) ever receive any vaccinations to prevent (NAME) from getting diseases, including vaccinations received in campaigns or immunization days or child health days?	YES 1 NO 2 DON'T KNOW 8	→ 626A
612A	Has (NAME) ever received a BCG vaccination against tuberculosis, that is, an injection in the upper right arm that usually causes a scar?	YES 1 NO 2 DON'T KNOW 8	
614A	Has (NAME) ever received oral polio vaccine, that is, about two drops in the mouth to prevent polio?	YES 1 NO 2 DON'T KNOW 8	→ 617A
615A	Did (NAME) receive the first oral polio vaccine in the first two weeks after birth or later?	FIRST TWO WEEKS 1 LATER 2	
616A	How many times did (NAME) receive the oral polio vaccine?	NUMBER OF TIMES <input type="text"/>	
617A	Has (NAME) ever received a pentavalent vaccination, that is, an injection given in the upper left thigh sometimes at the same time as polio drops?	YES 1 NO 2 DON'T KNOW 8	→ 619A
618A	How many times did (NAME) receive the pentavalent vaccine?	NUMBER OF TIMES <input type="text"/>	
619A	Has (NAME) ever received a pneumococcal vaccination, that is, an injection in the upper right thigh to prevent pneumonia?	YES 1 NO 2 DON'T KNOW 8	→ 621A
620A	How many times did (NAME) receive the pneumococcal vaccine?	NUMBER OF TIMES <input type="text"/>	
621A	Has (NAME) ever received a rotavirus vaccination, that is, liquid in the mouth to prevent diarrhea?	YES 1 NO 2 DON'T KNOW 8	→ 623A
622A	How many times did (NAME) receive the rotavirus vaccine?	NUMBER OF TIMES <input type="text"/>	
623A	Has (NAME) ever received a measles vaccination, that is, an injection in the upper left arm to prevent measles?	YES 1 NO 2 DON'T KNOW 8	
625A	Has (NAME) ever received a yellow fever vaccination, that is, an injection in the upper right arm to prevent yellow fever?	YES 1 NO 2 DON'T KNOW 8	
626A	Did you ever have a certificate for outstanding parent for (NAME)?	YES 1 NO 2	→ 628A
627A	May I see the certificate for outstanding parent for (NAME)?	YES, SEEN 1 YES, NOT SEEN 2	
628A	CONTINUE WITH 601B.		

SECTION 6B. CHILD IMMUNIZATION (NEXT MOST RECENT BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
601B	CHECK 216 IN THE BIRTH HISTORY: ANY MORE BIRTHS IN 2013-2016? <div style="display: flex; justify-content: space-around; align-items: center;"> <div>MORE BIRTHS IN 2013-2016 <input type="checkbox"/></div> <div>NO MORE BIRTHS IN 2013-2016 <input type="checkbox"/></div> </div> <div style="text-align: center; margin-top: 5px;">↓</div>		→ 701
602B	RECORD THE NAME AND BIRTH HISTORY NUMBER FROM 213 OF NEXT-TO-MOST RECENT CHILD BORN IN 2013-2016. NAME OF NEXT-TO-MOST RECENT BIRTH _____ BIRTH HISTORY NUMBER 		
603B	CHECK 217 FOR CHILD: <div style="display: flex; justify-content: space-around; align-items: center;"> <div>LIVING <input type="checkbox"/></div> <div>DEAD <input type="checkbox"/></div> </div> <div style="text-align: center; margin-top: 5px;">↓</div>		→ 628B
604B	Do you have a card or other document where (NAME)'s vaccinations are written down?	YES, HAS ONLY A CARD 1 YES, HAS ONLY AN OTHER DOCUMENT 2 YES, HAS CARD AND OTHER DOCUMENT 3 NO, NO CARD AND NO OTHER DOCUMENT .. 4	→ 607B → 607B
605B	Did you ever have a vaccination card for (NAME)?	YES 1 NO 2	
606B	CHECK 604B: <div style="display: flex; justify-content: space-around; align-items: center;"> <div>CODE '2' CIRCLED <input type="checkbox"/></div> <div>CODE '4' CIRCLED <input type="checkbox"/></div> </div> <div style="text-align: center; margin-top: 5px;">↓</div>		→ 611B
607B	May I see the card or other document where (NAME)'s vaccinations are written down?	YES, ONLY CARD SEEN 1 YES, ONLY OTHER DOCUMENT SEEN 2 YES, CARD AND OTHER DOCUMENT SEEN .. 3 NO CARD AND NO OTHER DOCUMENT SEEN .. 4	→ 611B

SECTION 6B. CHILD IMMUNIZATION (NEXT MOST RECENT BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																																										
	NAME OF NEXT-TO-MOST RECENT BIRTH _____ BIRTH HISTORY NUMBER 																																																																												
607B1	<p>CHECK THE CARD:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> CHILD HEALTH CARD NEW VERSION <input type="checkbox"/> </div> <div style="text-align: center;"> CHILD HEALTH CARD PREVIOUS VERSIONS <input type="checkbox"/> </div> </div>		608B2																																																																										
608B1	<p>COPY DATES FROM THE CARD OR OTHER DOCUMENT. WRITE '44' IN 'DAY' COLUMN IF CARD OR OTHER DOCUMENT SHOWS THAT A DOSE WAS GIVEN, BUT NO DATE IS RECORDED.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:5%;">№ of Visit</th> <th style="width:40%;">FROM THE CHILD HEALTH CARD NEW VERSION</th> <th style="width:10%;">DAY</th> <th style="width:10%;">MONTH</th> <th style="width:10%;">YEAR</th> </tr> </thead> <tbody> <tr> <td rowspan="2" style="text-align: center; vertical-align: middle;">1</td> <td>POLIO- 0 (At birth)</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>BCG (Anti-TB Vaccine at Birth)</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td rowspan="4" style="text-align: center; vertical-align: middle;">2</td> <td>POLIO- 1</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>ROTA- 1</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>PENTA- 1</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>PNEUMO- 1</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td rowspan="4" style="text-align: center; vertical-align: middle;">3</td> <td>POLIO- 2</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>ROTA- 2</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>PENTA- 2</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>PNEUMO- 2</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td rowspan="4" style="text-align: center; vertical-align: middle;">4</td> <td>POLIO- 3</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>ROTA- 3</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>PENTA- 3</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>PNEUMO- 3</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td rowspan="2" style="text-align: center; vertical-align: middle;">5</td> <td>MEASLES</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>YELLOW FEVER</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>			№ of Visit	FROM THE CHILD HEALTH CARD NEW VERSION	DAY	MONTH	YEAR	1	POLIO- 0 (At birth)	<input type="text"/>	<input type="text"/>	<input type="text"/>	BCG (Anti-TB Vaccine at Birth)	<input type="text"/>	<input type="text"/>	<input type="text"/>	2	POLIO- 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	ROTA- 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	PENTA- 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	PNEUMO- 1	<input type="text"/>	<input type="text"/>	<input type="text"/>	3	POLIO- 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	ROTA- 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	PENTA- 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	PNEUMO- 2	<input type="text"/>	<input type="text"/>	<input type="text"/>	4	POLIO- 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	ROTA- 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	PENTA- 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	PNEUMO- 3	<input type="text"/>	<input type="text"/>	<input type="text"/>	5	MEASLES	<input type="text"/>	<input type="text"/>	<input type="text"/>	YELLOW FEVER	<input type="text"/>	<input type="text"/>	<input type="text"/>
№ of Visit	FROM THE CHILD HEALTH CARD NEW VERSION	DAY	MONTH	YEAR																																																																									
1	POLIO- 0 (At birth)	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	BCG (Anti-TB Vaccine at Birth)	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
2	POLIO- 1	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	ROTA- 1	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	PENTA- 1	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	PNEUMO- 1	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
3	POLIO- 2	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	ROTA- 2	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	PENTA- 2	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	PNEUMO- 2	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
4	POLIO- 3	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	ROTA- 3	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	PENTA- 3	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	PNEUMO- 3	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
5	MEASLES	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
	YELLOW FEVER	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																									
609B1	<p>CHECK 608B1: 'BCG' TO 'YELLOW FEVER' ALL RECORDED?</p> <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> NO <input type="checkbox"/> </div> <div style="text-align: center;"> YES <input type="checkbox"/> </div> </div>		<div style="text-align: right;">→ 610B</div> <div style="text-align: right;">→ 626B</div>																																																																										

SECTION 6B. CHILD IMMUNIZATION (NEXT MOST RECENT BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																																																																				
	NAME OF NEXT-TO-MOST RECENT BIRTH _____ BIRTH HISTORY NUMBER <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin: 0 5px;"></div> <div style="display: inline-block; width: 20px; height: 20px; border: 1px solid black; margin: 0 5px;"></div>																																																																						
608B2	<p>COPY DATES FROM THE CARD OR OTHER DOCUMENT. WRITE '44' IN 'DAY' COLUMN IF CARD OR OTHER DOCUMENT SHOWS THAT A DOSE WAS GIVEN, BUT NO DATE IS RECORDED.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">FROM THE CHILD HEALTH CARD PREVIOUS VERSIONS</th> <th style="width:10%;">DAY</th> <th style="width:10%;">MONTH</th> <th style="width:30%;">YEAR</th> </tr> </thead> <tbody> <tr><td>BCG</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 1</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 2</td><td></td><td></td><td></td></tr> <tr><td>ORAL POLIO VACCINE (OPV) 3</td><td></td><td></td><td></td></tr> <tr><td>PENTA-1</td><td></td><td></td><td></td></tr> <tr><td>PENTA-2</td><td></td><td></td><td></td></tr> <tr><td>PENTA-3</td><td></td><td></td><td></td></tr> <tr><td>MEASLES</td><td></td><td></td><td></td></tr> <tr><td>YELLOW FEVER</td><td></td><td></td><td></td></tr> <tr><td>ROTA-1</td><td></td><td></td><td></td></tr> <tr><td>ROTA-2</td><td></td><td></td><td></td></tr> <tr><td>ROTA-3</td><td></td><td></td><td></td></tr> <tr><td>PNEUMO-1</td><td></td><td></td><td></td></tr> <tr><td>PNEUMO-2</td><td></td><td></td><td></td></tr> <tr><td>PNEUMO-3</td><td></td><td></td><td></td></tr> </tbody> </table>	FROM THE CHILD HEALTH CARD PREVIOUS VERSIONS	DAY	MONTH	YEAR	BCG				ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)				ORAL POLIO VACCINE (OPV) 1				ORAL POLIO VACCINE (OPV) 2				ORAL POLIO VACCINE (OPV) 3				PENTA-1				PENTA-2				PENTA-3				MEASLES				YELLOW FEVER				ROTA-1				ROTA-2				ROTA-3				PNEUMO-1				PNEUMO-2				PNEUMO-3					
FROM THE CHILD HEALTH CARD PREVIOUS VERSIONS	DAY	MONTH	YEAR																																																																				
BCG																																																																							
ORAL POLIO VACCINE (OPV) 0 (BIRTH DOSE)																																																																							
ORAL POLIO VACCINE (OPV) 1																																																																							
ORAL POLIO VACCINE (OPV) 2																																																																							
ORAL POLIO VACCINE (OPV) 3																																																																							
PENTA-1																																																																							
PENTA-2																																																																							
PENTA-3																																																																							
MEASLES																																																																							
YELLOW FEVER																																																																							
ROTA-1																																																																							
ROTA-2																																																																							
ROTA-3																																																																							
PNEUMO-1																																																																							
PNEUMO-2																																																																							
PNEUMO-3																																																																							
609B2	<p>CHECK 608B2: 'BCG' TO 'PNEUMO-3' ALL RECORDED?</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div>NO <input type="checkbox"/></div> <div>YES <input type="checkbox"/></div> </div>		<div style="text-align: right;">→ 626B</div>																																																																				
610B	<p>In addition to what is recorded on (this document/these documents), did (NAME) receive any other vaccinations, including vaccinations received in campaigns or immunization days or child health days?</p> <p>RECORD 'YES' ONLY IF THE RESPONDENT MENTIONS AT LEAST ONE OF THE VACCINATIONS IN 608B1 OR 608B2 THAT ARE NOT RECORDED AS HAVING BEEN GIVEN.</p>	<p>YES 1 (PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN 608B1 OR 608B2 THEN WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN) (THEN SKIP TO 626B)</p> <p>NO 2 DON'T KNOW 8 (WRITE '00' IN THE CORRESPONDING DAY COLUMN FOR ALL VACCINATIONS NOT GIVEN) (THEN SKIP TO 626B)</p>																																																																					

SECTION 6B. CHILD IMMUNIZATION (NEXT MOST RECENT BIRTH)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
	NAME OF NEXT-TO-MOST RECENT BIRTH _____	BIRTH HISTORY NUMBER <input type="text"/> <input type="text"/>	
611B	Did (NAME) ever receive any vaccinations to prevent (NAME) from getting diseases, including vaccinations received in campaigns or immunization days or child health days?	YES 1 NO 2 DON'T KNOW 8	→ 626B
612B	Has (NAME) ever received a BCG vaccination against tuberculosis, that is, an injection in the upper right arm that usually causes a scar?	YES 1 NO 2 DON'T KNOW 8	
614B	Has (NAME) ever received oral polio vaccine, that is, about two drops in the mouth to prevent polio?	YES 1 NO 2 DON'T KNOW 8	→ 617B
615B	Did (NAME) receive the first oral polio vaccine in the first two weeks after birth or later?	FIRST TWO WEEKS 1 LATER 2	
616B	How many times did (NAME) receive the oral polio vaccine?	NUMBER OF TIMES <input type="text"/>	
617B	Has (NAME) ever received a pentavalent vaccination, that is, an injection given in the upper left thigh sometimes at the same time as polio drops?	YES 1 NO 2 DON'T KNOW 8	→ 619B
618B	How many times did (NAME) receive the pentavalent vaccine?	NUMBER OF TIMES <input type="text"/>	
619B	Has (NAME) ever received a pneumococcal vaccination, that is, an injection in the upper right thigh to prevent pneumonia?	YES 1 NO 2 DON'T KNOW 8	→ 621B
620B	How many times did (NAME) receive the pneumococcal vaccine?	NUMBER OF TIMES <input type="text"/>	
621B	Has (NAME) ever received a rotavirus vaccination, that is, liquid in the mouth to prevent diarrhea?	YES 1 NO 2 DON'T KNOW 8	→ 623B
622B	How many times did (NAME) receive the rotavirus vaccine?	NUMBER OF TIMES <input type="text"/>	
623B	Has (NAME) ever received a measles vaccination, that is, an injection in the upper left arm to prevent measles?	YES 1 NO 2 DON'T KNOW 8	
625B	Has (NAME) ever received a yellow fever vaccination, that is, an injection in the upper right arm to prevent yellow fever?	YES 1 NO 2 DON'T KNOW 8	
626B	Did you ever have a certificate for outstanding parent for (NAME)?	YES 1 NO 2	→ 628B
627B	May I see the certificate for outstanding parent for (NAME)?	YES, SEEN 1 YES, NOT SEEN 2	
628B	CHECK 216 IN BIRTH HISTORY: ANY MORE BIRTHS IN 2013-2016? MORE BIRTHS IN 2013-2016 <input type="checkbox"/> (GO TO 602B IN AN ADDITIONAL QUESTIONNAIRE) →	NO MORE BIRTHS IN 2013-2016 <input type="checkbox"/>	→ 701

SECTION 7. KNOWLEDGE OF MALARIA

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
701	Now I would like to talk about something else. Before this interview, had you ever heard of a sickness called malaria?	YES 1 NO 2	→ 717
702	What are the things that can happen to you when you have malaria? Anything else? CIRCLE ALL MENTIONED.	FEVER A CHILLS B HEADACHE C JOINT PAIN D POOR APPETITE E BODY PAIN F VOMITING G WEAKNESS H DEATH J OTHER X (SPECIFY) DOES NOT KNOW ANY Z	
703	Who do you think can get sick from malaria more often? Who else? CIRCLE ALL MENTIONED.	CHILDREN A PREGNANT WOMEN B ADULTS C ELDERLY D EVERYONE E DOES NOT KNOW Z	
704	In your opinion, what causes malaria? Anything else? CIRCLE ALL MENTIONED.	MOSQUITOES A DIRTY WATER B DIRTY SURROUNDINGS C BEER D CERTAIN FOODS E PLASMODIUM PARASITE F OTHER X (SPECIFY) DOES NOT KNOW ANY Z	
705	Are there things people can do to stop them from getting malaria?	YES 1 NO 2	→ 708
706	What are some of these things that you think people can do to stop them from getting malaria? What else? CIRCLE ALL MENTIONED.	SLEEP UNDER MOSQUITO NET A USE MOSQUITO COILS B USE INSECTICIDE SPRAY C KEEP DOORS AND WINDOWS CLOSED D USE INSECT REPELLENT E KEEP SURROUNDINGS CLEAN F CUT THE GRASS G PREGNANT WOMEN TAKE MEDICINE H OTHER X (SPECIFY)	
707	Why do you think people are not doing these things to stop them from getting malaria? Anything else? CIRCLE ALL MENTIONED.	DON'T TAKE SERIOUSLY (NO RISK) A COSTS TOO MUCH B DON'T KNOW WHAT TO DO C DON'T THINK THESE WILL WORK D OTHER X (SPECIFY) DON'T KNOW Z	
708	Can malaria be treated?	YES 1 NO 2 DON'T KNOW 8	→ 714

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
709	<p>Why do you think people do not go for treatment as soon as they feel that they have got malaria?</p> <p>Anything else?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>NO ACCESS/DISTANCE TO HEALTH CENTER .. A</p> <p>COSTS TOO MUCH B</p> <p>DIDN'T KNOW WHERE TO GO C</p> <p>THINK THEY CAN TREAT AT HOME D</p> <p>NO DRUGS AT HEALTH CENTER E</p> <p>NEGATIVE BEHAVIOR OF PROVIDER F</p> <p>GO TO TRADITIONAL HEALER G</p> <p>WENT TO DRUG STORE H</p> <p>ILLNESS NOT SERIOUS I</p> <p>WEAKNESS/ TOO SICK TO GO J</p> <p>OTHER X</p> <p>(SPECIFY)</p> <p>DON'T KNOW Z</p>	
710	<p>What medicines are mainly used to treat malaria?</p> <p>Anything else?</p> <p>CIRCLE ALL MENTIONED.</p> <p>PROBE: IF AMODIAQUINE IS NAMED CLARIFY TO VERIFY IF IT IS ACT</p>	<p>SP/FANSIDAR A</p> <p>CHLOROQUINE B</p> <p>QUININE C</p> <p>ACT/AS-AQ D</p> <p>AMADIOQUINE E</p> <p>ASPIRIN, PANADOL, PARACETEMOL F</p> <p>OTHER X</p> <p>(SPECIFY)</p> <p>DOES NOT KNOW ANY Z</p>	→ 710B
710A	<p>Have you heard of a medicine called SP/Fansidar?</p>	<p>YES 1</p> <p>NO 2</p>	→ 714
710B	<p>What is SP/Fansidar used for?</p> <p>Anything else?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>PREVENTON OF MALARIA DURING PREGNANCY A</p> <p>MALARIA TREATMENT B</p> <p>OTHER X</p> <p>(SPECIFY)</p> <p>DON'T KNOW Z</p>	
710C	<p>CHECK 710B: CODE 'A' PREVENTON OF MALARIA DURING PREGNANCY CIRCLED?</p> <p>YES, CODE 'A' CIRCLED <input type="checkbox"/></p> <p>OTHER <input type="checkbox"/></p>		→ 714
711	<p>Why do you think pregnant women don't take any or enough SP/Fansidar during pregnancy?</p> <p>Anything else?</p> <p>CIRCLE ALL MENTIONED.</p>	<p>NO ACCESS TO HEALTH CENTER A</p> <p>COSTS TOO MUCH B</p> <p>DON'T THINK/KNOW THEY NEED TO C</p> <p>DON'T THINK IT WORKS D</p> <p>WORRIED ABOUT SIDE EFFECTS E</p> <p>DON'T KNOW WHERE TO GET IT F</p> <p>NOT AVAILABLE/STOCK-OUTS G</p> <p>PROVIDER DIDN'T EXPLAIN/NO INFO H</p> <p>NEGATIVE PROVIDER INTERACTION I</p> <p>EMPTY STOMACH J</p> <p>NO WATER TO TAKE MEDICINE K</p> <p>HUSBAND WOULDN'T LET HER GO L</p> <p>OTHER X</p> <p>(SPECIFY)</p> <p>DOES NOT KNOW ANY Z</p>	
714	<p>In the past few months, have you seen or heard any messages about malaria?</p>	<p>YES 1</p> <p>NO 2</p>	→ 717

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP																										
715	<p>In the past few months, have you heard or seen any of the following malaria messages?</p> <p>a) If have fever, go to the health facility?</p> <p>b) Everywhere, Every night. Sleep under the net?</p> <p>c) Pregnant women should take drugs to prevent malaria?</p> <p>d) Hang up keep up?</p> <p>e) Use your mosquito net?</p> <p>f) Other malaria messages?</p>	<table border="0"> <thead> <tr> <th></th><th>YES</th><th>NO</th></tr> </thead> <tbody> <tr> <td>a) IF HAVE FEVER, GO TO HEALTH FACILITY</td><td>1</td><td>2</td></tr> <tr> <td>b) EVERYWHERE, EVERY NIGHT SLEEP UNDER THE NET</td><td>1</td><td>2</td></tr> <tr> <td>c) PREGNANT WOMEN SHOULD TAKE DRUGS TO PREVENT MALARIA</td><td>1</td><td>2</td></tr> <tr> <td>d) HANG UP KEEP UP</td><td>1</td><td>2</td></tr> <tr> <td>e) USE YOUR MOSQUITO NET</td><td>1</td><td>2</td></tr> <tr> <td>f) OTHER</td><td>1</td><td>2</td></tr> <tr> <td colspan="3" style="text-align: center;">_____ (SPECIFY)</td></tr> </tbody> </table>		YES	NO	a) IF HAVE FEVER, GO TO HEALTH FACILITY	1	2	b) EVERYWHERE, EVERY NIGHT SLEEP UNDER THE NET	1	2	c) PREGNANT WOMEN SHOULD TAKE DRUGS TO PREVENT MALARIA	1	2	d) HANG UP KEEP UP	1	2	e) USE YOUR MOSQUITO NET	1	2	f) OTHER	1	2	_____ (SPECIFY)					
	YES	NO																											
a) IF HAVE FEVER, GO TO HEALTH FACILITY	1	2																											
b) EVERYWHERE, EVERY NIGHT SLEEP UNDER THE NET	1	2																											
c) PREGNANT WOMEN SHOULD TAKE DRUGS TO PREVENT MALARIA	1	2																											
d) HANG UP KEEP UP	1	2																											
e) USE YOUR MOSQUITO NET	1	2																											
f) OTHER	1	2																											
_____ (SPECIFY)																													
715A	<p>CHECK 715: ANY MALARIA MESSAGES HEARD OR SEEN</p> <p>YES, ANY CODE '1' CIRCLED <input type="checkbox"/></p>	<p>OTHER <input type="checkbox"/> _____ →</p>	717																										
716	<p>Where did you hear or see the messages?</p> <p>Anywhere else?</p> <p>CIRCLE ALL MENTIONED.</p>	<table border="0"> <tbody> <tr><td>RADIO</td><td>A</td></tr> <tr><td>BILLBOARD</td><td>B</td></tr> <tr><td>POSTER</td><td>C</td></tr> <tr><td>T-SHIRT</td><td>D</td></tr> <tr><td>LEAFLET/FACT SHEET/ BROCHURE</td><td>E</td></tr> <tr><td>TELEVISION</td><td>F</td></tr> <tr><td>VIDEO CLUB</td><td>G</td></tr> <tr><td>SCHOOL</td><td>H</td></tr> <tr><td>COMMUNITY HEALTH WORKERS</td><td></td></tr> <tr><td>TTM, TBA, HEALTH PROMOTERS</td><td>I</td></tr> <tr><td>PEER EDUCATORS</td><td>J</td></tr> <tr> <td>OTHER _____</td><td>X</td></tr> <tr> <td colspan="2" style="text-align: center;">(SPECIFY)</td></tr> </tbody> </table>	RADIO	A	BILLBOARD	B	POSTER	C	T-SHIRT	D	LEAFLET/FACT SHEET/ BROCHURE	E	TELEVISION	F	VIDEO CLUB	G	SCHOOL	H	COMMUNITY HEALTH WORKERS		TTM, TBA, HEALTH PROMOTERS	I	PEER EDUCATORS	J	OTHER _____	X	(SPECIFY)		
RADIO	A																												
BILLBOARD	B																												
POSTER	C																												
T-SHIRT	D																												
LEAFLET/FACT SHEET/ BROCHURE	E																												
TELEVISION	F																												
VIDEO CLUB	G																												
SCHOOL	H																												
COMMUNITY HEALTH WORKERS																													
TTM, TBA, HEALTH PROMOTERS	I																												
PEER EDUCATORS	J																												
OTHER _____	X																												
(SPECIFY)																													
717	<p>RECORD THE TIME.</p>	<table border="1"> <tbody> <tr> <td>HOUR</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>MINUTES</td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>	HOUR	<input type="text"/>	<input type="text"/>	MINUTES	<input type="text"/>	<input type="text"/>																					
HOUR	<input type="text"/>	<input type="text"/>																											
MINUTES	<input type="text"/>	<input type="text"/>																											

INTERVIEWER'S OBSERVATIONS

TO BE FILLED IN AFTER COMPLETING INTERVIEW

COMMENTS ABOUT INTERVIEW:

COMMENTS ON SPECIFIC QUESTIONS:

ANY OTHER COMMENTS:

SUPERVISOR'S OBSERVATIONS

EDITOR'S OBSERVATIONS
