

PMA-Ethiopia Panel Cohort 1 Six-month Follow-up Survey Female Questionnaire (post-covid19)

Note: This questionnaire was used for women who were interviewed for 6-month follow-up survey after the start of the COVID-19 pandemic and after the pause in data collection.

ETHIOPIA PANEL INTERVIEW 2–6 MONTH IN PERSON POSTPARTUM	
A1. Your name: \${your_name} Is this your name?	<input type="radio"/> Yes <input type="radio"/> No
A2. Enter your name below. <i>Please record your name</i>	
B. Current date and time.	Day: Month: Year:
Is this date and time correct?	<input type="radio"/> Yes <input type="radio"/> No
C. Record the correct date and time.	Day: Month: Year:
D. QR Code <i>Scan the QR code that appears on the ID card given at enrollment. If you are unable to scan the QR code enter the number on the next screen. Confirm that the scanned code matches the code on the card before advancing.</i>	
This is what the QR code scanner found: \${barcode_scanned} Is that correct?	<input type="radio"/> Yes <input type="radio"/> No
D1. Record the correct number on the ID card. Confirm that the QR code matches the code on the card before advancing.	
D2. Does the QR code match what is on the paper? QR code: \${barcode}	<input type="radio"/> Yes <input type="radio"/> No
E1. Region:	<input type="radio"/> Tigray <input type="radio"/> Afar <input type="radio"/> Amhara <input type="radio"/> Oromiya <input type="radio"/> Snnp <input type="radio"/> Addis Ababa

E2. Zone:	
E3. District/Woredas:	
E4. Locality/Kebele Name	
E5. Enumeration area	
E6. Structure number <i>Please record the structure number from the household listing form.</i>	
E7. Household number <i>Please record the household number from the household listing form.</i>	
E8. CHECK: Have you already sent a form for this structure and household? <i>DO NOT DUPLICATE ANY FORM UNLESS YOU ARE CORRECTING A MISTAKE IN AN EARLIER FORM.</i>	<input type="radio"/> Yes <input type="radio"/> No
WARNING: Contact your supervisor before sending this form again.	
E9. CHECK: Why are you resending this form? <i>Choose all that apply.</i>	<input type="checkbox"/> I am correcting a mistake made on a previous form <input type="checkbox"/> The previous form disappeared from my phone without being sent <input type="checkbox"/> I submitted the previous form and my supervisor told me that it was not received <input type="checkbox"/> Other reason(s)
F. Mother's name <i>Enter the mother's name exactly as it appears on the ID card given at enrollment.</i>	
G. Is the mother present and available to be interviewed today?	<input type="radio"/> Yes <input type="radio"/> No, unavailable <input type="radio"/> No, died
H. Date of death <i>Probe well for the date/month/year of death. If the respondent does not know enter in Jan 1, 2030 for DNK</i>	Day: Month: Year:
INFORMED CONSENT <i>Confirm that this woman, or caregiver if the woman has died, is willing to participate in the study.</i>	
I. Do you still consent to participate in the study?	<input type="radio"/> Yes <input type="radio"/> No
CAREGIVER INFORMED CONSENT <i>Find the caregiver who is responsible for taking care of the child in the event that the mother died. The interview must have auditory privacy. Read the following greeting:</i>	
Hello. My name is _____ and I am working for the Addis Ababa University, and Federal Ministry of Health. We are conducting a local survey using a smartphone that asks women about their health and the health of their	

<p>infants during pregnancy and for the first year after their baby was born. The survey helps monitor the state of public health and questions will be used for research purposes. As the caregiver for this child, we would very much appreciate your participation in this survey. We will only be asking you questions about the health and well-being of this child. This information will help us inform the government to better plan health services. The survey usually takes between 20 and 30 minutes to complete. Whatever information you provide will be kept strictly confidential. The information you provide will not be linked to your identity or the identity of the child when conducting analyses, presenting results, or sharing data.</p> <p>Participation in this survey is entirely voluntary. If we should come to 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. However, we hope that you will participate in this survey since your views are important. If you choose to participate in the survey, you will receive 25 birr airtime credit.</p> <p>If you have any questions about the study and your rights as a research participant, you may ask me now or you may also contact the principal investigators of the study, Solomon Shiferaw (251-911-406845) or Assefa Seme (251-911-228193). For any ethical issues, please call Dr. Adamu Addissie, the IRB chairperson (251 911 40495) at the Addis Ababa University, College of Health Sciences.</p> <p>At this time, do you want to ask me anything about the survey?</p>	
<p>K. Do you consent to participate in the study?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>L. What was your relationship to the mother of the child?</p>	<p><input type="radio"/> Mother <input type="radio"/> Husband <input type="radio"/> Mother-in-law <input type="radio"/> Sibling <input type="radio"/> Aunt <input type="radio"/> Co-wife <input type="radio"/> Child <input type="radio"/> Other <input type="radio"/> No response</p>
<p>La. Caregiver's name <i>Enter the caregiver's name</i></p>	
<p>M. Interviewer's name: \${your_name} <i>Mark your name as a witness to the consent process.</i></p>	<p><input type="radio"/></p>
<p>M. Interviewer's name Please record your name as a witness to the consent process. You previously entered "\${name_typed}."</p>	
<p>AWARENESS, RISK PERCEPTION AND FOOD SECURITY RELATED TO COVID-19 <i>The next series of questions are about COVID-19, also called Coronavirus</i></p>	

<p>COV1. How much, if anything, have you heard or read about the recent Coronavirus (COVID-19) outbreak? <i>Read all options.</i></p>	<p><input type="radio"/> A lot <input type="radio"/> Some <input type="radio"/> A little <input type="radio"/> Not at all <input type="radio"/> No response</p>
<p>COV2. How did you learn about Coronavirus (COVID-19)? <i>Do not read responses. Select all that apply</i></p>	<p><input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Poster/billboard <input type="checkbox"/> Phone message <input type="checkbox"/> Ethio telecom <input type="checkbox"/> Family <input type="checkbox"/> Friends/neighbors <input type="checkbox"/> Community/religious leaders <input type="checkbox"/> Social media (Twitter, Facebook, WhatsApp, Telegram) <input type="checkbox"/> Health personnel <input type="checkbox"/> Messages from government or Authorities or town crier <input type="checkbox"/> School/Teacher <input type="checkbox"/> Other <input type="checkbox"/> No response</p>
<p>COV3. Which of these sources do you trust for accurate information about Coronavirus (COVID-19)? <i>Read all options Select all that apply</i></p>	<p><input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Poster/billboard <input type="checkbox"/> Phone message <input type="checkbox"/> Ethio telecom <input type="checkbox"/> Family <input type="checkbox"/> Friends/neighbors <input type="checkbox"/> Community/religious leaders <input type="checkbox"/> Social media (Twitter, Facebook, WhatsApp, Telegram) <input type="checkbox"/> Health personnel <input type="checkbox"/> Messages from government or Authorities or town crier <input type="checkbox"/> School/Teacher <input type="checkbox"/> Other <input type="checkbox"/> No response</p>
<p>COV4. How concerned are you about the spread of Coronavirus (COVID-19) in your community? <i>Read all options</i></p>	<p><input type="radio"/> Very concerned <input type="radio"/> Concerned <input type="radio"/> A little concerned <input type="radio"/> Not concerned <input type="radio"/> No response</p>
<p>COV5. How concerned are you about getting infected yourself? <i>Read all options</i></p>	<p><input type="radio"/> Very concerned <input type="radio"/> Concerned <input type="radio"/> A little concerned <input type="radio"/> Not concerned</p>

	<input type="radio"/> I was infected with COVID-19 <input type="radio"/> No response
<p>COV6. Are you able to avoid contact with people outside of your household? <i>Select "No" if she used public transport, go to market place etc.</i></p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>COV7. What are some of the following reasons why you might not be able to avoid contact with people outside of your household? <i>Read all options Select all that apply</i></p>	<input type="checkbox"/> My work or way of earning money requires me to leave the house <input type="checkbox"/> I need to visit the market <input type="checkbox"/> I need to visit the water source/well <input type="checkbox"/> My studies require me to leave the household <input type="checkbox"/> I need to attend funerals in the community <input type="checkbox"/> I need to attend religious services <input type="checkbox"/> I need to visit my family/relatives <input type="checkbox"/> To seek out health care <input type="checkbox"/> Other <input type="checkbox"/> No response
<p>COV8. Since the Coronavirus (COVID-19) restrictions began, how much of a loss of income has your household experienced? <i>Read all options</i></p>	<input type="radio"/> No change <input type="radio"/> Partial <input type="radio"/> Complete <input type="radio"/> No response
<p>COV9. Since the Coronavirus (COVID-19) restrictions began, how much of a loss of income have you personally experienced? <i>Read all options</i></p>	<input type="radio"/> Large <input type="radio"/> Moderate <input type="radio"/> Small <input type="radio"/> No change <input type="radio"/> Has no income <input type="radio"/> No response
<p>COV10. During the past 4 weeks , did you or any household member go a whole day and night without eating anything because there was not enough food?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>COV11. During the past 4 weeks, how often did this happen?</p>	<input type="radio"/> Rarely (1-2 times) <input type="radio"/> Sometimes (3-10 times) <input type="radio"/> Often (more than 10 times) <input type="radio"/> Don't know <input type="radio"/> No response

Section 1 – Infant

Mothers: I would like to ask you some questions about the child/ren you gave birth to six months ago
Caregiver: I would like to ask you some questions about the child/ren you are taking care of.

In case of multiples, ODK will repeat questions in this section. Questions 2-28 will be asked about children from that recent pregnancy who are still alive. Questions 29-44 will be asked about any children) who has died since the last interview. Questions will be repeated for twins/triplets etc

01a. On what day and month did you give birth? <i>If the respondent cannot remember the exact date of birth remind her of the information you recorded in the QR code and ask her to confirm</i>	
01b. On what day and month was the child/ren born? <i>if the respondent cannot remember the exact date of birth let him/her know the information you recorded in the QR code and ask him/her to confirm</i>	
Enter the date	Day: Month: Year:
You can not interview the respondent before it is more than 6 months after delivery. Please go back and correct the date of birth.	
You entered that the mother died on approximately \${respondent_death_lab}. That is before the date of birth on \${birthday_lab}. Go back and update these dates so that they are consistent.	
1A. How many children were in this pregnancy? (eg twin or triplet?) <i>Fill in the following from the ID card given at enrollment:</i>	<input type="radio"/> Single <input type="radio"/> Twin <input type="radio"/> Triplet + <input type="radio"/> No response
I will now ask you some questions about the baby. If there was more than one child, we will start with the first child born. <i>ODK will repeat questions Q1b-Q27 for each child born in this pregnancy</i>	
#####	<input type="radio"/> X weeks <input type="radio"/> X months <input type="radio"/> Do not know <input type="radio"/> No response
Child	
1D. Type name given to baby if name given. Otherwise, type BABY <i>ODK Will repeat I for each child identified in 1A.</i>	
1B. Is \${child_name} a boy or a girl?	<input type="radio"/> Boy <input type="radio"/> Girl <input type="radio"/> No response

1C. Is $\{child_name\}$ alive?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
2. Has $\{child_name\}$'s birth ever been registered with the Woreda or Kebele?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
3. Now I would like to ask you about foods that $\{child_name\}$ had yesterday during the day or at night. I am interested in whether your child had the item I mention even if it was combined with other foods or liquids. <i>Yesterday, refers to the period of time the child woke up yesterday morning to the time the child woke up today, including any drinks or food consumed overnight</i>	

4a. Yesterday during the day or at night did $\{child_name\}$ drink: 1 = Yes 0 = No -88 = Do not know -99 = No response				
	1	0	Do not know	No response
A) Breast milk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) Milk - powdered or fresh animal milk? (such as Nido)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) Infant formula (such as Plan, S-26)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D) Yogurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4b. Yesterday during the day or at night did $\{child_name\}$ drink: 1 = Yes 0 = No -88 = Do not know -99 = No response				
	1	0	Do not know	No response
A) Plain water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) Fresh juice or unsweetened juice drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) Clear broth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D) Tea, with no honey or sugar added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E) Gruel (atmit) with no sugar, or honey added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F) Fenugreek (abish) with no sugar, or honey added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G) Thin porridge (aja soup)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H) Any other non-sweetened liquids?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4bi. Yesterday during the day or at night did $\{child_name\}$ drink: 1 = Yes 0 = No -88 = Do not know -99 = No response				
	1	0	Do not know	No response

A) Sugar-sweetened juice, juice drinks soft drinks, soda, or fizzy drinks? (e.g. Runi)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) Honey-sweetened juice or juice drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) Tea, with sugar added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D) Tea with honey added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E) Gruel (atmit) with sugar added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F) Gruel (atmit) with honey added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G) Fenugreek (abish) with sugar added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H) Fenugreek (abish) with honey added	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I) Any other sweetened liquids?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4c. Yesterday during the day or at night did $\{child_name\}$ eat:
1 = Yes 0 = No -88 = Do not know -99 = No response

	1	0	Do not know	No response
A) Any commercial fortified baby food like Fafa, Hilina, Cerilak, Plumdynut, Cerifam, Mother Choice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) Injera, bread, rice, noodles, porridge, or other foods made from grains such as teff, oats, maize, barley	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) Any foods made from beans, peas, lentils, or nuts?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D) Cheese or other food made from milk?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4d. Yesterday during the day or at night did $\{child_name\}$ eat:
1 = Yes 0 = No -88 = Do not know -99 = No response

	1	0	Do not know	No response
A) Pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) White potatoes, white yams, bulla, kocho, manioc, cassava, or any other foods made from roots?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) Any dark green, leafy vegetables like kale, spinach,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D) Ripe mangoes, papayas?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E) Any other fruits or vegetables?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4e. Yesterday during the day or at night did $\{child_name\}$ eat:
1 = Yes 0 = No -88 = Do not know -99 = No response

	1	0	Do not know	No response
A) Liver, kidney, heart, or other organ meats?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<p>B) Any meat, such as beef, pork, lamb, goat, chicken, or duck?</p> <p>C) Eggs?</p> <p>D) Fresh or dried fish or shellfish?</p> <p>E) Any other solid, semi-solid, or soft food?</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
<p>4f. At what age did $\{child_name\}$ first take any food regularly other than breastmilk? <i>Record age in months. 0 is a possible answer. Enter -77 for Not yet started. Enter -88 for Do not know. Enter -99 for No response.</i></p>				
<p>4. Did $\{child_name\}$ get any vaccinations?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response			
<p>COV14. Did $\{child_name\}$ miss any vaccinations during COVID restriction? <i>Date of COVID 19 restriction has been placed since March 16, 2020</i></p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response			
<p>COV12. Did you experience any difficulties in accessing vaccine services for $\{child_name\}$ since the Coronavirus (COVID-19) restrictions began? <i>Date of COVID 19 restriction has been placed since March 16, 2020</i></p>	<input type="radio"/> Yes <input type="radio"/> Sought care, but had no difficulties <input type="radio"/> Did not seek vaccination services <input type="radio"/> Do not know <input type="radio"/> No response			
<p>COV13. What difficulties did you experience in accessing vaccine services since the Coronavirus (COVID-19) restrictions began? <i>Select all that apply</i></p>	<input type="checkbox"/> Healthcare facility or doctor's office close or service not available <input type="checkbox"/> HEW stopped visiting community <input type="checkbox"/> Partner does not approve <input type="checkbox"/> No transportation to access healthcare services <input type="checkbox"/> Unable to access services because of government restrictions on movement <input type="checkbox"/> Unable to afford healthcare services <input type="checkbox"/> Fear of getting or spreading COVID-19 <input type="checkbox"/> Vaccination outreach program interrupted <input type="checkbox"/> Other <input type="checkbox"/> No response			
<p>5. Do you have a formal vaccination card with an official Ministry of Health logo where $\{child_name\}$'s vaccinations are written down? <i>If yes: May I see it please?</i></p>	<input type="radio"/> Yes, seen <input type="radio"/> Yes, not seen <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response			

<p>6. Did you ever have a formal vaccination card for \${child_name}?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>7. What happened to \${child_name}'s formal vaccination card?</p>	<p><input type="radio"/> Never given a card <input type="radio"/> Card was lost or destroyed <input type="radio"/> Card at health facility <input type="radio"/> Card is locked away/inaccessible at moment <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>7b. Do you have any paper or card with vaccination information of \${child_name} written down? <i>This does not have to be an official vaccination card, but please make sure it has a list of vaccines and the dates that they were given.</i> <i>If yes: May I see it please?</i></p>	<p><input type="radio"/> Yes, seen <input type="radio"/> Yes, not seen <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>
	<p>8a. Looking at the vaccine card, does \${child_name} have ... ?</p>
<p>BCG</p>	<p><input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response</p>
<p>Polio-0</p>	<p><input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response</p>
<p>Polio-1</p>	<p><input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response</p>
<p>Pentavalent-1 (DPT-Hep B-Hib1)</p>	<p><input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response</p>
<p>PCV-1</p>	<p><input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response</p>
<p>Rota-1</p>	<p><input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response</p>

Polio-2	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
Pentavalent-2 (DPT-Hep B-Hib2)	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
PCV-2	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
Rota-2	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
Polio-3	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
Pentavalent-3 (DPT-Hep B-Hib3)	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
PCV-3	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
IPV	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
Measles-1	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response
Vitamin A Supplementation	<input type="radio"/> Yes, legible <input type="radio"/> No, not given <input type="radio"/> Yes, but month or day illegible <input type="radio"/> No response

8c. Vaccine Card

(1) Copy date from the card for each vaccine that the child has (2) If either the day or month are illegible select the respective checkbox to indicate which date is not legible.

One vaccine per screen.

BCG	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Polio-0	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Polio-1	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Pentavalent-1 (DPT-Hep B-Hib1)	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
PCV-1	
##### <i>Birthdate: \${birthday_lab}</i>	

Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Rota-1	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Polio-2	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Pentavalent-2 (DPT-Hep B-Hib2)	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
PCV-2	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:

Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Rota-2	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Polio-3	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Pentavalent-3 (DPT-Hep B-Hib3)	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
PCV-3	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>

IPV	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Measles-1	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
Vitamin A Supplementation	
##### <i>Birthdate: \${birthday_lab}</i>	
Enter the date	Day: Month: Year:
Check here if the DAY is uncertain or illegible	<input type="checkbox"/>
Check here if the MONTH is uncertain or illegible	<input type="checkbox"/>
9. Did \${child_name} receive a BCG vaccination against tuberculosis, that is, an injection in the right arm or right shoulder that usually causes a scar?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
10. Did \${child_name} receive an oral polio vaccine, that is, about two drops in the mouth, to prevent polio?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
11. Did \${child_name} receive the first oral polio vaccine in the first two weeks after birth or later?	<input type="radio"/> Within the first two weeks <input type="radio"/> After the first two weeks <input type="radio"/> Do not know <input type="radio"/> No response
12. How many times did \${child_name} receive the oral polio vaccine?	

<i>Enter -88 for Do not know. Enter -99 for No response.</i>	
<p>Please verify with the respondent how many times the child received the vaccine. You recorded \${polio_count}. Is that correct? <i>How many times did \${child_name} receive the oral polio vaccine?</i></p>	<input type="radio"/> Yes <input type="radio"/> No
<p>13. Did \${child_name} receive the injection polio vaccine on the right thigh?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>14. Did \${child_name} receive a pentavalent (DPT-Hep B-Hib1) vaccination, that is, an injection given in the left upper thigh, usually at the same time as polio drops?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>15. How many times did \${child_name} receive the pentavalent vaccine? <i>Enter -88 for Do not know. Enter -99 for No response.</i></p>	
<p>Please verify with the respondent how many times the child received the vaccine. You recorded \${pentavalent_count}. Is that correct? <i>How many times did \${child_name} receive the pentavalent vaccine?</i></p>	<input type="radio"/> Yes <input type="radio"/> No
<p>16. Did \${child_name} receive a PCV vaccination, that is, an injection usually given in the right upper thigh to prevent pneumonia?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>17. How many times did \${child_name} receive the PCV vaccine? <i>Enter -88 for Do not know. Enter -99 for No response.</i></p>	
<p>Please verify with the respondent how many times the child received the vaccine. You recorded \${pcv_count}. Is that correct? <i>How many times did \${child_name} receive the PCV vaccine?</i></p>	<input type="radio"/> Yes <input type="radio"/> No
<p>18. Did \${child_name} receive a Rota vaccination, that is, liquid in the mouth to prevent diarrheal disease?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>19. How many times did \${child_name} receive the rotavirus vaccine? <i>Enter -88 for Do not know. Enter -99 for No response.</i></p>	
<p>Please verify with the respondent how many times the child received the vaccine. You recorded \${rota_count}. Is that correct? <i>How many times did \${child_name} receive the rotavirus vaccine?</i></p>	<input type="radio"/> Yes <input type="radio"/> No
<p>20. Did \${child_name} receive an injection to prevent measles, that is an injection in the arm and given usually at 9 months?</p>	<input type="radio"/> Yes <input type="radio"/> No

	<input type="radio"/> Do not know <input type="radio"/> No response			
21. Has \${child_name} received any Vitamin A supplementation, that is oily drops in the mouth? <i>A photo of vitamin A supplements will appear on the screen</i> [VitaminA_image.png]	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response			
22b. Did \${child_name} suffer any of these illnesses in the last two weeks? <i>Read out all answer options.</i> 1 = Yes 0 = No -88 = Do not know -99 = No response				
	1	0	Do not know	No response
(a) Difficulties feeding/ unable to suck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(b) Red eye/passage of pus from eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(c) Skin rash/skin lesion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(d) Convulsion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(e) Reduced alertness (lethargy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(f) Unconscious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(g) Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(h) Cold/cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(i) Sore throat/Tonsillitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(j) Fast breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(k) Difficulty in breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(l) Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(m) Vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(n) Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(o) Abdominal/body swelling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(p) Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COV15. Did you experience any difficulties in accessing health care services for \${child_name} after the Coronavirus (COVID-19) restrictions began? <i>Date of COVID 19 restriction has been placed since March 16, 2020</i>	<input type="radio"/> Yes <input type="radio"/> Sought care, but had no difficulties <input type="radio"/> Did not seek treatment <input type="radio"/> Do not know <input type="radio"/> No response			
COV16. What difficulties did you experience in accessing health services since the Coronavirus (COVID-19) restrictions began?	<input type="checkbox"/> Healthcare facility or doctor's office close or service not available <input type="checkbox"/> HEW stopped visiting community <input type="checkbox"/> Partner does not approve <input type="checkbox"/> No transportation to access healthcare services <input type="checkbox"/> Unable to access services because of government restrictions on movement			

	<input type="checkbox"/> Unable to afford healthcare services <input type="checkbox"/> Fear of getting or spreading COVID-19 <input type="checkbox"/> Other <input type="checkbox"/> No response
<p>23a. Did you go to seek treatment, or were you visited by a professional health worker at your home for \${child_name}'s cough?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>23b. Where did you seek treatment for \${child_name}'s cough?</p>	<input type="checkbox"/> Provider made home visit <input type="checkbox"/> Other home <input type="checkbox"/> Government hospital <input type="checkbox"/> Government health center <input type="checkbox"/> Government health post <input type="checkbox"/> Other public sector <input type="checkbox"/> Private hospital/clinic <input type="checkbox"/> Other private medical sector <input type="checkbox"/> NGO/Faith-based health facility <input type="checkbox"/> Pharmacy / Drugstore <input type="checkbox"/> Retail store <input type="checkbox"/> Traditional healer / medicine <input type="checkbox"/> Religious Treatment/Holy water <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>23c. How soon after the onset of \${child_name}'s cough did you seek treatment? <i>Enter number of days. Do not restrict number of days. Enter -88 for Do not know. Enter -99 for No response</i></p>	
<p>23d. During \${child_name}'s treatment for cough, did s/he get any of the following treatments: <i>Read all options and select all that apply</i></p>	<input type="checkbox"/> Advised to continue breastfeeding <input type="checkbox"/> Counseled to give warm/hot drinks <input type="checkbox"/> Given oral antibiotic <input type="checkbox"/> Given pain reliver (oral or suppository) <input type="checkbox"/> Given cough syrup <input type="checkbox"/> Given injections <input type="checkbox"/> Given an inhaled medicine <input type="checkbox"/> Advised when to seek care immediately <input type="checkbox"/> Got a follow-up appointment <input type="checkbox"/> Referred to higher health facility <input type="checkbox"/> Other <input type="checkbox"/> Did not receive treatment <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>24a. Did you go to seek treatment, or were you visited by a professional health worker at your home for \${child_name}'s fast breathing or difficulty breathing?</p>	<input type="radio"/> Yes <input type="radio"/> No

	<input type="radio"/> Do not know <input type="radio"/> No response
<p>24b. Where did you seek treatment for \${child_name}'s fast breathing or difficulty breathing?</p>	<input type="checkbox"/> Provider made home visit <input type="checkbox"/> Other home <input type="checkbox"/> Government hospital <input type="checkbox"/> Government health center <input type="checkbox"/> Government health post <input type="checkbox"/> Other public sector <input type="checkbox"/> Private hospital/clinic <input type="checkbox"/> Other private medical sector <input type="checkbox"/> NGO/Faith-based health facility <input type="checkbox"/> Pharmacy / Drugstore <input type="checkbox"/> Retail store <input type="checkbox"/> Traditional healer / medicine <input type="checkbox"/> Religious Treatment/Holy water <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>24c. How soon after the onset of \${child_name}'s fast breathing or difficulty breathing did you seek treatment? <i>Enter number of days. Do not restrict number of days. Enter -88 for Do not know. Enter -99 for No response</i></p>	
<p>24d. During \${child_name}'s treatment for fast breathing or difficult breathing, did s/he get any of the following treatments: <i>Read all options and select all that apply</i></p>	<input type="checkbox"/> Advised to continue breastfeeding <input type="checkbox"/> Counseled to give warm/hot drinks <input type="checkbox"/> Given oral antibiotic <input type="checkbox"/> Given pain reliver (oral or suppository) <input type="checkbox"/> Given cough syrup <input type="checkbox"/> Given injections <input type="checkbox"/> Given an inhaled medicine <input type="checkbox"/> Advised when to seek care immediately <input type="checkbox"/> Got a follow-up appointment <input type="checkbox"/> Referred to higher health facility <input type="checkbox"/> Other <input type="checkbox"/> Did not receive treatment <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>25a. Did \${child_name}'s diarrhea have blood in it (blood stained or mixed)?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>25b. Did you go to seek treatment, or were you visited by a professional health worker at your home for \${child_name}'s diarrhea?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>25c. Where did you seek treatment for \${child_name}'s the diarrhea?</p>	<input type="checkbox"/> Provider made home visit <input type="checkbox"/> Other home

	<input type="checkbox"/> Government hospital <input type="checkbox"/> Government health center <input type="checkbox"/> Government health post <input type="checkbox"/> Other public sector <input type="checkbox"/> Private hospital/clinic <input type="checkbox"/> Other private medical sector <input type="checkbox"/> NGO/Faith-based health facility <input type="checkbox"/> Pharmacy / Drugstore <input type="checkbox"/> Retail store <input type="checkbox"/> Traditional healer / medicine <input type="checkbox"/> Religious Treatment/Holy water <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>25d. How soon after the onset of \${child_name}'s diarrhea did you seek treatment?</p> <p><i>Enter number of days. Do not restrict number of days. Enter -88 for Do not know. Enter -99 for No response</i></p>	
<p>25e. During \${child_name}'s diarrhea treatment, did s/he get any of the following treatments:</p> <p><i>Read all options and select all that apply</i></p>	<input type="checkbox"/> Stool examination <input type="checkbox"/> Counseled to give more fluids <input type="checkbox"/> Counseled to give more food <input type="checkbox"/> Advised to continue breastfeeding <input type="checkbox"/> Given ORS sachets to take home <input type="checkbox"/> Given ORS to drink in facility <input type="checkbox"/> Given Zinc tablets <input type="checkbox"/> Given oral antibiotic <input type="checkbox"/> Given pain reliver (oral or suppository) <input type="checkbox"/> Given IV fluid infusion <input type="checkbox"/> Given injections <input type="checkbox"/> Advised when to seek care immediately <input type="checkbox"/> Got a follow-up appointment <input type="checkbox"/> Referred to higher health facility <input type="checkbox"/> Other <input type="checkbox"/> Did not receive treatment <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>26a. Did you go to seek treatment, or were you visited by a professional health worker at your home for \${child_name}'s fever?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>26b. Where did you seek treatment for \${child_name}'s fever?</p>	<input type="checkbox"/> Provider made home visit <input type="checkbox"/> Other home <input type="checkbox"/> Government hospital <input type="checkbox"/> Government health center <input type="checkbox"/> Government health post <input type="checkbox"/> Other public sector <input type="checkbox"/> Private hospital/clinic

	<input type="checkbox"/> Other private medical sector <input type="checkbox"/> NGO/Faith-based health facility <input type="checkbox"/> Pharmacy / Drugstore <input type="checkbox"/> Retail store <input type="checkbox"/> Traditional healer / medicine <input type="checkbox"/> Religious Treatment/Holy water <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>26c. How soon after the onset of \${child_name}'s fever did you seek treatment? <i>Enter number of days. Do not restrict number of days. Enter -88 for Do not know. Enter -99 for No response</i></p>	
<p>26d. During \${child_name}'s fever treatment, did s/he get any of the following treatments: <i>Read all options and select all that apply</i></p>	<input type="checkbox"/> Blood examination <input type="checkbox"/> Advised to continue breastfeeding <input type="checkbox"/> Given oral antimalarial <input type="checkbox"/> Given oral antibiotic <input type="checkbox"/> Given pain reliver (oral or suppository) <input type="checkbox"/> Given IV fluid infusion <input type="checkbox"/> Given injections <input type="checkbox"/> Advised when to seek care immediately <input type="checkbox"/> Got a follow-up appointment <input type="checkbox"/> Referred to higher health facility <input type="checkbox"/> Other <input type="checkbox"/> Did not receive treatment <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>27. Did \${child_name} sleep under an insecticide treated bed net last night?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>##### <i>I am going to ask some questions about your deceased infant. These questions are important to the study. Some of these questions may be difficult to you. We can pause at any time. If you do not feel comfortable answering any of the questions, please let me know and I will move onto the next question</i></p>	
<p>29. What date did \${child_name} die?</p>	<p style="text-align: right;">Day: Month: Year:</p>
<p>Check here if respondent does not know the DAY</p>	<input type="checkbox"/>
<p>Check here if respondent does not know the MONTH</p>	<input type="checkbox"/>
<p>30. Exactly how old was \${child_name} when (he/she) died? <i>If respondent says her response in days record 0 for week</i></p>	<input type="radio"/> X weeks <input type="radio"/> X months

	<input type="radio"/> Do not know <input type="radio"/> No response
Enter a value for "{\$age_at_death_lab}" <i>Exactly how old was \${child_name} when (he/she) died?</i>	
31. Where did \${child_name} die?	<input type="radio"/> Her home <input type="radio"/> Other home <input type="radio"/> Government hospital <input type="radio"/> Government health center <input type="radio"/> Government health post <input type="radio"/> Other public sector <input type="radio"/> Private hospital/clinic <input type="radio"/> Other private medical sector <input type="radio"/> NGO/Faith-based health facility <input type="radio"/> Traditional healer / medicine <input type="radio"/> Religious Treatment/Holy water <input type="radio"/> Church / religious institution <input type="radio"/> On the way to health facility/treatment <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
32. Is death of \${child_name} registered with the Woreda or Kebele?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
33. Did \${child_name} suffer from any injury or accident that led to her/his death?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
34. What type of accident/injury did \${child_name} sustain?	<input type="radio"/> Road traffic accident <input type="radio"/> Fall accident <input type="radio"/> Drowning <input type="radio"/> Animal bite/attack <input type="radio"/> Insect bite or sting <input type="radio"/> Violence or assault <input type="radio"/> Burn injury <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
35. What were \${child_name}'s main symptoms or health problems before her/his death? <i>Select all that apply</i>	<input type="checkbox"/> Difficulties feeding/ unable to suck <input type="checkbox"/> Red eye/passage of pus from eyes <input type="checkbox"/> Skin rash/skin lesion <input type="checkbox"/> Convulsion <input type="checkbox"/> Reduced alertness (lethargy) <input type="checkbox"/> Unconscious <input type="checkbox"/> Fever <input type="checkbox"/> Cold/cough

	<input type="checkbox"/> Sore throat/Tonsillitis <input type="checkbox"/> Fast breathing <input type="checkbox"/> Difficulty in breathing <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal/body swelling <input type="checkbox"/> Other <input type="checkbox"/> No illness <input type="checkbox"/> No response
<p>36. What do you think \${child_name}'s cause of death was? <i>DO NOT READ THE ANSWER OPTIONS OUT LOUD.</i> <i>Select all that apply</i></p>	<input type="checkbox"/> Premature birth <input type="checkbox"/> Pregnancy/delivery related <input type="checkbox"/> Sudden death <input type="checkbox"/> Tetanus <input type="checkbox"/> Malaria <input type="checkbox"/> Pneumonia <input type="checkbox"/> Measles <input type="checkbox"/> Whooping cough <input type="checkbox"/> Diarrhea/vomiting <input type="checkbox"/> Malnutrition <input type="checkbox"/> Meningitis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Typhus/Typhoid <input type="checkbox"/> Tuberculosis <input type="checkbox"/> AIDS <input type="checkbox"/> Unknown cause/illness <input type="checkbox"/> Provider negligence <input type="checkbox"/> Evil eye/witchcraft <input type="checkbox"/> Corona Virus <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>37. Was \${child_name} vaccinated any time before her/his death?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>38. Did \${child_name} receive any treatment for the illness or injury that led to death?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>39. Where did \${child_name} get treatment?</p>	<input type="checkbox"/> Provider made home visit <input type="checkbox"/> Other home <input type="checkbox"/> Government hospital <input type="checkbox"/> Government health center <input type="checkbox"/> Government health post <input type="checkbox"/> Other public sector <input type="checkbox"/> Private hospital/clinic <input type="checkbox"/> Other private medical sector

	<input type="checkbox"/> NGO/Faith-based health facility <input type="checkbox"/> Pharmacy / Drugstore <input type="checkbox"/> Retail store <input type="checkbox"/> Traditional healer / medicine <input type="checkbox"/> Religious Treatment/Holy water <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
40. In the final days to his/her death, was \${child_name} taken to a hospital or health facility?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
41. How was \${child_name} transported to the health facility? <i>Select all that apply</i>	<input type="checkbox"/> On foot <input type="checkbox"/> Animal transport <input type="checkbox"/> Motorized transport <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
42. Did it take more than 2 hours to get to the health facility?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
43. In the final days before \${child_name}'s death, were there any doubts about whether medical care was needed?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
44. In the final days before \${child_name}'s death, was traditional medicine or religious treatments used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

Section 2 – Post-Natal

I would like to ask some questions about where you gave birth and to follow up on how you are and checks for your health since delivery. I will also ask you some questions about the child you gave birth to six months ago

45. Where did you give birth to \${first_child_name}?	<input type="radio"/> Her home <input type="radio"/> Other home <input type="radio"/> Government hospital <input type="radio"/> Government health center <input type="radio"/> Government health post <input type="radio"/> Other public sector <input type="radio"/> Private hospital/clinic <input type="radio"/> Other private medical sector <input type="radio"/> NGO/Faith-based health facility
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	<input type="radio"/> Other <input type="radio"/> No response
<p>46. After $\{first_child_name\}$ was delivered, how long did you stay in the health facility? <i>If less than one day, record hours. If less than one week, record days.</i></p>	<input type="radio"/> Hours <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Do not know <input type="radio"/> No response
<p>Enter a value for "$\{facility_stay_lab\}$" <i>After $\{first_child_name\}$ was delivered, how long did you stay in the health facility?</i></p>	
<p>47. After delivery, did you go to a maternity waiting home in the health facility?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>48. After delivery, how long did you stay at the maternity waiting home? <i>If less than one day, record hours. If less than one week, record days.</i></p>	<input type="radio"/> Hours <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Do not know <input type="radio"/> No response
<p>Enter a value for "$\{maternity_stay_lab\}$" <i>After delivery, how long did you stay at the maternity waiting home?</i></p>	
<p>49. Did you interview this respondent for the six-week questionnaire? <i>This question should not be read out to the respondent. The RE, you, must verify with information on the QR code</i></p>	<input type="radio"/> Yes <input type="radio"/> No
<p>50. Did any health worker extension worker visited you to check on your health in the first two months after delivery?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>51. How many days after birth did the health extension worker visit you? <i>If less than 24 hours, write 0 days No response: -99; Do not know: -88</i></p>	
<p>52. Did you go visit a health extension worker in the first two months after delivery, either for yourself or for the baby?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>53. How many days after birth did you go visit the health extension worker? <i>If less than 24 hours, write 0 days No response: -99; Do not know: -88</i></p>	
<p>54. Did you go visit another professional healthcare provider other than an HEW in the first two months after delivery, either for yourself or for the baby?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

55. How many days after birth did you go visit the other professional healthcare provider? <i>If less than 24 hours, write 0 days No response: -99; Do not know: -88</i>				
56. Whom did you see, not including an HEW? Anyone else? <i>Select all that apply</i> <i>Probe to identify each type of person and record all mentioned.</i>		<input type="checkbox"/> Doctor <input type="checkbox"/> Health officer <input type="checkbox"/> Nurse/midwife <input type="checkbox"/> Professional healthcare provider, cannot distinguish <input type="checkbox"/> Traditional healer <input type="checkbox"/> Other <input type="checkbox"/> No response		
57. Have you had any health checks either for yourself or your baby since delivery (either by a HEW or other professional healthcare provider)?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response		
58. Has the baby had any health checks since his/her birth (either by a HEW or other professional healthcare provider)?		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response		
60. At any health check after delivery (either by a HEW or other professional healthcare provider) did the provider discuss: 1 = Yes 0 = No -88 = Do not know -99 = No response				
	1	0	Do not know	No response
Breastfeeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not feeding water or other liquids before 6 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Introducing food and liquids (other than breast milk) when the baby reaches 6 months of age	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Giving a variety of foods when the baby starts feeding after 6 months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Giving animal source foods specifically (e.g. eggs, milk, meat, fish)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often to feed foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not feeding sugar-sweetened beverages	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
61. Since your baby's birth, has any health care provider measured your baby's: 1 = Yes 0 = No -88 = Do not know -99 = No response				
	1	0	Do not know	No response
Weight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Length of height	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Around their upper arm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
62. Since your baby was born, did you ever breastfeed him/her?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response			
63a. Have you experienced any difficulties breastfeeding?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response			
63b. What kind of difficulties?	<input type="checkbox"/> Cracked nipples <input type="checkbox"/> Inadequate breastmilk <input type="checkbox"/> Breast engorgement <input type="checkbox"/> Mastitis <input type="checkbox"/> Difficulty latching <input type="checkbox"/> Other difficulty <input type="checkbox"/> Do not know <input type="checkbox"/> No response			
64a. Did you seek help for these difficulties?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response			
64b. Who did you seek help from? <i>Select all that apply</i>	<input type="checkbox"/> Doctor <input type="checkbox"/> Health officer <input type="checkbox"/> Nurse/midwife <input type="checkbox"/> Professional healthcare provider, cannot distinguish <input type="checkbox"/> Health extension worker <input type="checkbox"/> Health development army <input type="checkbox"/> Traditional birth attendant <input type="checkbox"/> Traditional healer <input type="checkbox"/> Family member <input type="checkbox"/> Other <input type="checkbox"/> No response			
65a. Have you had any health checks for yourself or baby since delivery, not including immunization?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response			
65b. Did you receive any family planning information, referrals or services at any of these visits?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response			
COV17. Did you experience any difficulties in accessing postnatal care services after the Coronavirus (COVID-19) restrictions began? <i>Date of COVID 19 restriction has been placed since March 16, 2020</i> <i>Select all that apply Postnatal care refers to care for the mother and/or baby after birth</i>	<input type="radio"/> Yes <input type="radio"/> Sought care, but had no difficulties <input type="radio"/> No, did not seek PNC care <input type="radio"/> Do not know <input type="radio"/> No response			

<p>COV18. What difficulties did you experience in accessing postnatal care services since the Coronavirus (COVID-19) restrictions began? <i>Select all that apply</i></p>	<p><input type="checkbox"/> Healthcare facility or doctor's office closed or service not available <input type="checkbox"/> HEW stopped visiting community <input type="checkbox"/> Partner does not approve <input type="checkbox"/> No transportation to access healthcare services <input type="checkbox"/> Unable to access services because of government restrictions on movement <input type="checkbox"/> Unable to afford healthcare services <input type="checkbox"/> Fear of getting or spreading COVID-19 <input type="checkbox"/> Vaccination outreach program interrupted <input type="checkbox"/> Other <input type="checkbox"/> No response</p>
<p>66a. Did you receive any family planning information, referrals, or services during any of the immunization visits for your baby?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>66b. Did you sleep under an insecticide treated bed net last night?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>Section 3 – Family Planning</p> <p>Now, I would like to ask you a few questions about your health, family planning and desires to have more children. Some of the questions I will ask are about sensitive topics, including sex. Remember that all of the information you share is confidential and will not be shared with other people outside of the study team. If you are uncomfortable at any time and would like to skip to the next question, please let me know.</p>	
<p>67a. Are you currently pregnant?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>67b. If you got pregnant now, how would you feel?</p>	<p><input type="radio"/> Very happy <input type="radio"/> Sort of happy <input type="radio"/> Mixed happy and unhappy <input type="radio"/> Sort of unhappy <input type="radio"/> Very unhappy <input type="radio"/> No response</p>
<p>68. Has your menstrual cycle returned since delivery?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response</p>
<p>69. When did your last menstrual period start?</p>	<p><input type="radio"/> X days ago <input type="radio"/> X weeks ago <input type="radio"/> X months ago <input type="radio"/> Do not know <input type="radio"/> No response</p>

Enter a value for "\${cycle_return_lab}" <i>When did your last menstrual period start?</i>	
70a. Have you resumed sexual activity since the birth of your most recent child?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
70b. How long after the delivery did you wait before resuming sexual activity? <i>Enter in "months."</i> <i>If less than a month record 0 for number of months.</i> <i>Enter -99 for No response.</i>	
71. When was the last time you had sexual intercourse?	<input type="radio"/> X days ago <input type="radio"/> X weeks ago <input type="radio"/> X months ago <input type="radio"/> Do not know <input type="radio"/> No response
Enter a value for "\${last_sex_lab}" <i>When was the last time you had sexual intercourse?</i>	
72. Would you like to have another child or would you prefer not to have any more children?	<input type="radio"/> Yes, more children <input type="radio"/> No, no more children <input type="radio"/> Do not know <input type="radio"/> No response
72b. How long would you like to wait before the birth of your next child?	<input type="radio"/> X months <input type="radio"/> X years <input type="radio"/> Do not know <input type="radio"/> No response
Enter a value for "\${wait_child_lab}"	
COV19. Did the COVID-19 pandemic affect your desire to have any more children?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
COV20. Did the COVID-19 pandemic affect how long you would like to wait before having another child?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
COV21. Do you want to have another child sooner or later than you did before the COVID-19 pandemic?	<input type="radio"/> Sooner <input type="radio"/> Later <input type="radio"/> No response
72c. Are you or your partner currently doing something or using any family planning method to delay or avoid getting pregnant?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
73. Which method or methods are you using? <i>Probe: Anything else</i> <i>Select all methods mentioned. Be sure to scroll to bottom to see all choices in the list.</i>	<input type="checkbox"/> Female Sterilization <input type="checkbox"/> Male Sterilization <input type="checkbox"/> Implant <input type="checkbox"/> IUD <input type="checkbox"/> Injectables <input type="checkbox"/> Pill <input type="checkbox"/> Emergency Contraception

	<input type="checkbox"/> Male Condom <input type="checkbox"/> Female Condom <input type="checkbox"/> Std. Days/Cycle beads <input type="checkbox"/> LAM <input type="checkbox"/> Rhythm method <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other traditional methods <input type="checkbox"/> No response
<p>COV22. Have you used emergency contraception since the Coronavirus (COVID-19) restrictions began? <i>Date of COVID 19 restriction has been placed since March 16, 2020</i></p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>COV23. Did you experience any difficulties in accessing family planning services since the Coronavirus (COVID-19) restrictions began? <i>Date of COVID 19 restriction has been placed since March 16, 2020</i></p>	<input type="radio"/> Yes <input type="radio"/> Sought care, but had no difficulties <input type="radio"/> No, did not seek FP services <input type="radio"/> Do not know <input type="radio"/> No response
<p>COV24. What difficulties did you experience in accessing family planning services since the Coronavirus (COVID-19) restrictions began?</p>	<input type="checkbox"/> Healthcare facility or doctor's office closed or service not available <input type="checkbox"/> HEW stopped visiting community <input type="checkbox"/> Partner does not approve <input type="checkbox"/> Unable to afford FP services <input type="checkbox"/> No transportation to access healthcare services <input type="checkbox"/> Preferred method not available <input type="checkbox"/> Concern that no medical staff will be available <input type="checkbox"/> Unable to access services because of government restrictions on movement <input type="checkbox"/> Fear of getting or spreading COVID-19 <input type="checkbox"/> Other <input type="checkbox"/> No response
<p>IMP_301a. CHECK. In the previous question, the respondent mentioned that she had been using implants. Is that correct? <i>If she says she is not currently using implants, please verify her answer and go back and select the correct method.</i></p>	<input type="radio"/> Yes <input type="radio"/> No
<p>IMP_302. At the visit when the implant was inserted, were you told for how long the implant would protect you from pregnancy?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>IMP_303. Were you told how much it would cost to get your implant removed?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>IMP_304. Were you told where you could go to have the implant removed?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>74. Since what month and year have you been using \${current_method_lab} without stopping?</p>	<p>Month:</p>

<p>Calculate backwards from birth of the baby Most Recent Birth: \${birthday_lab} Must be before today. Respondent must be at least 10 years old. Select 'Do not know' for month and '2030' for year to indicate 'No Response'. CALENDAR: Enter episode of contraceptive use in the visual aide/paper calendar.</p>	<p>Year:</p>
<p>Check here if respondent does not know the MONTH</p>	<p><input type="checkbox"/></p>
<p>75. Since this most recent birth have you used any method to delay or avoid being pregnant?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response</p>
<p>76. Did you use any other methods of family planning since this most recent birth?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>77. What Method Were You using in:</p>	
<p>Month of Delivery+12</p>	<p><input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response</p>
<p>Month of Delivery+11</p>	<p><input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads</p>

	<input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
<p>Month of Delivery+10</p>	<input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
<p>Month of Delivery+9</p>	<input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
<p>Month of Delivery+8</p>	<input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization

	<ul style="list-style-type: none"> <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
<p>Month of Delivery+7</p>	<ul style="list-style-type: none"> <input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
<p>Month of Delivery+6</p>	<ul style="list-style-type: none"> <input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal

	<input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
Month of Delivery+5	<input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
Month of Delivery+4	<input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
Month of Delivery+3	<input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables

	<ul style="list-style-type: none"> <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
<p>Month of Delivery+2</p>	<ul style="list-style-type: none"> <input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
<p>Month of Delivery+1</p>	<ul style="list-style-type: none"> <input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies

	<input type="radio"/> T. Terminations <input type="radio"/> No response
Month of Delivery	<input type="radio"/> 0. No method used <input type="radio"/> 1. Female Sterilization <input type="radio"/> 2. Male Sterilization <input type="radio"/> 3. Implant <input type="radio"/> 4. IUD <input type="radio"/> 5. Injectables <input type="radio"/> 7. Pill <input type="radio"/> 8. Emergency Contraception <input type="radio"/> 9. Male Condom <input type="radio"/> 10. Female Condom <input type="radio"/> 13. Std Days / Cycle beads <input type="radio"/> 14. LAM <input type="radio"/> 30. Rhythm method <input type="radio"/> 31. Withdrawal <input type="radio"/> 39. Other traditional methods <input type="radio"/> B. Births <input type="radio"/> P. Pregnancies <input type="radio"/> T. Terminations <input type="radio"/> No response
CHECK: You just recorded in the calendar that the respondent is not using any method. However, earlier in the survey, the respondent said she currently uses $\{\text{current_method_lab}\}$. Please go back and correct this inconsistency.	
CHECK: You just recorded in the calendar that the respondent is currently using " $\{\text{cc_current_method_lab}\}$ ". However, earlier in the survey, the respondent said she is not using any contraceptive method. Please go back and correct this inconsistency.	
CHECK: You just recorded in the calendar that the respondent is currently using " $\{\text{cc_current_method_lab}\}$ ". However, earlier in the survey, the respondent said she currently uses " $\{\text{current_method_lab}\}$ ". The methods are different. Please go back and correct this inconsistency.	
78. Why did you stop using	
$\{\text{m11_method}\}$ in month of Delivery+11	<input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned

	<ul style="list-style-type: none"> <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m10_method} in month of Delivery+10</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m9_method} in month of Delivery+9</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away

	<ul style="list-style-type: none"> <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m8_method} in month of Delivery+8</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other

	<input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m7_method} in month of Delivery+7</p>	<input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m6_method} in month of Delivery+6</p>	<input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use

	<ul style="list-style-type: none"> <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m5_method} in month of Delivery+5</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m4_method} in month of Delivery+4</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method

	<ul style="list-style-type: none"> <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m3_method} in month of Delivery+3</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m2_method} in month of Delivery+2</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about

	<p>but did not experience</p> <ul style="list-style-type: none"> <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m1_method} in month of Delivery+1</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>#{m0_method} in month of Delivery</p>	<ul style="list-style-type: none"> <input type="radio"/> Healthcare facility or doctor's office closed or service not available

	<ul style="list-style-type: none"> <input type="radio"/> Became pregnant while using <input type="radio"/> Infrequent sex / husband / partner away <input type="radio"/> Wanted to become pregnant <input type="radio"/> Side effects you experienced <input type="radio"/> Side effects you were worried about but did not experience <input type="radio"/> Advised not to take method <input type="radio"/> Menstrual cycle has not returned <input type="radio"/> Husband did not approve <input type="radio"/> Other person did not approve <input type="radio"/> Wanted more effective method <input type="radio"/> Preferred method not available <input type="radio"/> Unable to access services because of government restrictions on movement <input type="radio"/> Lack of access / too far <input type="radio"/> Costs too much <input type="radio"/> Inconvenient to use <input type="radio"/> Fatalistic <input type="radio"/> Difficult to get pregnant / menopausal <input type="radio"/> Fear of getting or spreading COVID-19 <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>79. When you obtained your \${current_recent_method_lab}, did you obtain the method you wanted to delay or avoid getting pregnant?</p>	<ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>80. Why did you choose the \${current_method_lab}?</p> <p><i>Select all that apply</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Long duration of protection <input type="checkbox"/> Less need for follow-up <input type="checkbox"/> Unavailability of other methods <input type="checkbox"/> Provider recommended <input type="checkbox"/> Fewer side effects than other methods <input type="checkbox"/> Can use without husband's knowledge <input type="checkbox"/> Other <input type="checkbox"/> No response
<p>81. When you obtained your \${current_recent_method_lab}, were you told by the provider about side effects or problems you might have with a method to delay or avoid pregnancy?</p>	<ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>82a. At that time, were you told that you could switch to a different method in the future?</p>	<ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>82b. Did you feel pressured from any health service providers to accept \${current_recent_method_lab}?</p>	<ul style="list-style-type: none"> <input type="radio"/> Yes <input type="radio"/> No

	<input type="radio"/> Do not know <input type="radio"/> No response
83. Are you experiencing any side effects?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
83. Did you experience any side effects?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
84. What are the side effects that you are currently experiencing? <i>Do not read option choices aloud</i>	<input type="checkbox"/> Less bleeding or no bleeding <input type="checkbox"/> Heavier bleeding <input type="checkbox"/> Irregular bleeding / spotting <input type="checkbox"/> Uterine cramping / lower abdominal pain <input type="checkbox"/> Gained weight <input type="checkbox"/> Lost weight <input type="checkbox"/> Facial spotting <input type="checkbox"/> Headaches <input type="checkbox"/> Got infection <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Increased menstrual cramping <input type="checkbox"/> Lowered sex drive <input type="checkbox"/> Decreased sexual pleasure <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> General weakness/pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Partner feels during sex <input type="checkbox"/> Pain at insertion site <input type="checkbox"/> Mood swings <input type="checkbox"/> Backache <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
84. What were the side effects that you EXPERIENCED while using the method? <i>Do not read option choices aloud</i>	<input type="checkbox"/> Less bleeding or no bleeding <input type="checkbox"/> Heavier bleeding <input type="checkbox"/> Irregular bleeding / spotting <input type="checkbox"/> Uterine cramping / lower abdominal pain <input type="checkbox"/> Gained weight <input type="checkbox"/> Lost weight <input type="checkbox"/> Facial spotting <input type="checkbox"/> Headaches <input type="checkbox"/> Got infection <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Increased menstrual cramping <input type="checkbox"/> Lowered sex drive <input type="checkbox"/> Decreased sexual pleasure <input type="checkbox"/> Vaginal dryness

	<input type="checkbox"/> General weakness/pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Partner feels during sex <input type="checkbox"/> Pain at insertion site <input type="checkbox"/> Mood swings <input type="checkbox"/> Backache <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>85. Where did you obtain \${current_recent_method_lab} when you started using it after the birth of your baby? <i>Probe to identify the type of source and select the appropriate code.</i></p>	<input type="radio"/> Govt. Hospital <input type="radio"/> Govt. Health Center <input type="radio"/> Govt. Health Post/HEW <input type="radio"/> Other Public <input type="radio"/> NGO Health Facility <input type="radio"/> Other NGO <input type="radio"/> Private Hospital <input type="radio"/> Private Clinic <input type="radio"/> Pharmacy <input type="radio"/> Other Private Medical <input type="radio"/> Drug Vendor/Store <input type="radio"/> Shop <input type="radio"/> Friend/Relative <input type="radio"/> Self <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
<p>IMP_305a. Do you want to have your implant removed?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>IMP_305b. In the past 6 months, have you tried to have your current implant removed?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>IMP_305c. Where did you go to try to have your implant removed?</p>	<input type="checkbox"/> Govt. Hospital <input type="checkbox"/> Govt. Health Center <input type="checkbox"/> Govt. Health Post/HEW <input type="checkbox"/> Other Public <input type="checkbox"/> NGO Health Facility <input type="checkbox"/> Other NGO <input type="checkbox"/> Private Hospital <input type="checkbox"/> Private Clinic <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other Private Medical <input type="checkbox"/> Drug Vendor/Store <input type="checkbox"/> Shop <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Self <input type="checkbox"/> Other

	<input type="checkbox"/> Do not know <input type="checkbox"/> No response
IMP_305d. Who tried to remove the implant?	<input type="radio"/> Self <input type="radio"/> Friend/Relative <input type="radio"/> Partner <input type="radio"/> HEW <input type="radio"/> Doctor <input type="radio"/> Health officer <input type="radio"/> Nurse/midwife <input type="radio"/> Other professional healthcare provider, cannot distinguish <input type="radio"/> No one tried <input type="radio"/> Do not know <input type="radio"/> No response
IMP_306. Why were you not able to have your implant removed?	<input type="checkbox"/> Facility not open <input type="checkbox"/> Qualified provider not available <input type="checkbox"/> Provider attempted but could not remove the implant <input type="checkbox"/> Provider refused <input type="checkbox"/> Cost of removal services <input type="checkbox"/> Travel cost <input type="checkbox"/> Provider counseled against removal <input type="checkbox"/> Told to return another day <input type="checkbox"/> Referred elsewhere <input type="checkbox"/> Other (specify) <input type="checkbox"/> Do not know <input type="checkbox"/> No response
Specify "other" <i>Why were you not able to have your implant removed?</i>	
86. Before you started using $\{cc_first_method_lab\}$, had you discussed the decision to delay or avoid pregnancy with your husband/partner?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
87. Would you say that using contraception is mainly your decision, mainly your husband/partner's decision or did you both decide together?	<input type="radio"/> Mainly respondent <input type="radio"/> Mainly husband/partner <input type="radio"/> Joint decision <input type="radio"/> Other <input type="radio"/> No response
88. Would you say that not using contraception is mainly your decision, mainly your husband/partner's decision or did you both decide together?	<input type="radio"/> Mainly respondent <input type="radio"/> Mainly husband/partner <input type="radio"/> Joint decision <input type="radio"/> Other <input type="radio"/> No response
89. Why did you decide not to use a family planning method after the birth of your baby? <i>Do not read out aloud answer options</i>	<input type="checkbox"/> Worried about side effects <input type="checkbox"/> Currently breastfeeding <input type="checkbox"/> Family planning might make getting pregnant again difficult

	<input type="checkbox"/> Has not resumed menstruation <input type="checkbox"/> Do not know enough about family planning <input type="checkbox"/> Infrequent sex/husband/partner away <input type="checkbox"/> Prefers abstinence <input type="checkbox"/> Has not resumed sexual intercourse <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Wants to become pregnant <input type="checkbox"/> Religious prohibition <input type="checkbox"/> Husband/partner disapproves <input type="checkbox"/> The desired method is unavailable <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
90. Do you think you will use a contraceptive method to delay or avoid getting pregnant in the future?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
91. When do you think you will start using a method?	<input type="radio"/> In X months <input type="radio"/> In X years <input type="radio"/> Soon/now <input type="radio"/> After finishing breastfeeding <input type="radio"/> After menses returns <input type="radio"/> After having another baby <input type="radio"/> After having all the children I want <input type="radio"/> Do not know <input type="radio"/> No response
Enter a value for "\${when_method_lab}"	
Now I'm going to ask you a question about safety. If you feel uncomfortable discussing or if you do not think our conversation is confidential, we can end the interview now and you can still participate in future surveys. Would you like to continue?	
COV25. In the PAST FOUR weeks, has your partner done or said anything to make you feel afraid for yours safety?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
Thank the respondent for her time and update the ID card <i>Before you leave, update the ID card, including information on whether the baby or mother is still alive.</i>	
FU1Ya. Date of one-year interview <i>Enter Jan 1, 2030 if no date scheduled for upcoming interview</i>	Day: Month: Year:
FU1Yb. Did the respondent refuse future follow-up?	<input type="radio"/> Yes <input type="radio"/> No

PN001. Can you provide a number where we can reach you?	<input type="radio"/> Yes <input type="radio"/> No
PN002. What is a number where we can reach you? <i>Enter number:</i>	
PN003. Can you repeat that number again?	
M. Did the interview take place at the respondent's home or her family home?	<input type="radio"/> Respondent's home <input type="radio"/> Her family home <input type="radio"/> Respondent's home but different household location
N. Location <i>Take a GPS point near the entrance to the household. Record location when the accuracy is smaller than 6m. GPS coordinates can only be collected when outside.</i>	
O. Did you have to step away from the respondent's home to take the GPS reading?	<input type="radio"/> Yes <input type="radio"/> No
O1. Take a photo of the QR code. <i>Make sure you have taken a picture of the full page and not just the QR code image and number</i>	
QUESTIONNAIRE RESULT	
P. How many times have you visited this household to interview this female respondent?	<input type="radio"/> 1st time <input type="radio"/> 2nd time <input type="radio"/> 3rd time
Q. What language was this interview conducted in?	<input type="radio"/> English <input type="radio"/> Amharic <input type="radio"/> Afan Oromo <input type="radio"/> Tigrigna <input type="radio"/> Sidamigna <input type="radio"/> Wolayitigna <input type="radio"/> Afar <input type="radio"/> Somali <input type="radio"/> Kefigna <input type="radio"/> Other
R. Was a translator used for this interview?	<input type="radio"/> Yes <input type="radio"/> No
S. Questionnaire result	<input type="radio"/> Mother completed <input type="radio"/> Caregiver completed form <input type="radio"/> Not at home <input type="radio"/> Postponed <input type="radio"/> Refused <input type="radio"/> Partly completed <input type="radio"/> Incapacitated <input type="radio"/> Mother dead, no caregiver <input type="radio"/> Respondent moved <input type="radio"/> Household moved <input type="radio"/> Mother absent for indefinite period <input type="radio"/> Interview date exceeded eligibility

	<p>window</p> <ul style="list-style-type: none"><input type="radio"/> Refused in-person, but consented to phone follow-up<input type="radio"/> Enrolled by mistake / Unknown pregnancy outcome
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