

## PMA-Ethiopia Panel Cohort 1 Six-week Follow-up Survey Female Questionnaire (pre-covid19)

**Note: This questionnaire was used for women who were interviewed for 6-week follow-up survey prior to the start of the COVID-19 pandemic.**

ETHIOPIA PANEL INTERVIEW 1–6 WEEK POSTPARTUM	
001a. Your name: \${your_name} Is this your name?	<input type="radio"/> Yes <input type="radio"/> No
001b. Enter your name below. <i>Please record your name</i>	
Current date and time:	Day: Month: Year:
B. Is this date and time correct?	<input type="radio"/> Yes <input type="radio"/> No
C. Record the correct date and time.	Day: Month: Year:
QR Code Scan the QR code that appears on the ID card given at enrollment.	
CHECK :Are the last 4 digits the same as the two digit EA number and the two digit number on the ID card?" <i>If no, enter the 2 digit ID number on the next screen</i>	<input type="radio"/> Yes <input type="radio"/> No
QR CODE: Record the correct number on the ID card <i>Enter 2 digit ID number from card</i>	
E1. Region	<input type="radio"/> Tigray <input type="radio"/> Afar <input type="radio"/> Amhara <input type="radio"/> Oromiya <input type="radio"/> Snp <input type="radio"/> Addis Ababa
E2. Zone	
E3. District	
E4. Locality Name	

E5. Enumeration Area	
E6. Structure number <i>Please record the structure number from the woman's ID card</i>	
E7. Household number <i>Please record the household number from the woman's ID card</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)
WARNING: Each household should have ONLY ONE household roster with all household members listed on the same form. <i>Please contact your supervisor before sending this form.</i>	
F. Respondent's name <i>Enter the respondent's name exactly as it appears on the ID card given at enrollment.</i>	
H. Is the respondent present and available to be interviewed today?	<input type="radio"/> Yes <input type="radio"/> No, unavailable <input type="radio"/> No, died
I. When did the woman die; before delivery, during delivery or after delivery?	<input type="radio"/> Before delivery <input type="radio"/> During delivery <input type="radio"/> After delivery <input type="radio"/> Do not know <input type="radio"/> No response
J. Date of death <i>Enter '01-01-2030' for Do not know</i>	Day: Month: Year:
INFORMED CONSENT Confirm that this woman is still willing to participate in the study.	
K. Do you still consent to participate in the study?	<input type="radio"/> Yes <input type="radio"/> No
L. Interviewer's name: \${your_name}	
L. Interviewer's name You previously entered "\${name_typed}." <i>Mark your name as a witness to the consent process.</i>	

## Section 1 - Background

The following questions are about the child(ren) born from your recent pregnancy.

<p>P6W01. On what day and month did you give birth/did the pregnancy end? <i>Please record the date you gave birth/the pregnancy ended?. Select 'Do not know' for month and '2030' for year to indicate 'No Response'.</i></p>	
<p>Day, Month and Year</p>	<p>Day: Month: Year:</p>
<p>Check here if respondent does not know month.</p>	<input type="checkbox"/>

Warning! Respondent's delivery date was \${recent\_birth\_w} weeks ago. You should be administering this survey to women 5-8 weeks post-partum. Please go back and confirm that you entered the correct date of delivery

P6W02. How many children were in this pregnancy? (eg twin or triplet?)

- Single
- Twin
- Triplet +
- No response

I will now ask you some questions about the baby that was just born. If there was more than one child, we will start with the first child born.  
*ODK will repeat questions P6W03-P6W08 for each child born in this pregnancy*

### Each Child Info

P6W03. What was the outcome of this pregnancy for the \${order\_en} baby born?

- Live birth
- Still birth
- Miscarriage (spontaneous)
- Abortion
- No response

P6W04. Did the baby cry or show any signs of life?

- Yes
- No
- No response

CHECK: The outcome of this pregnancy is live birth. Go back and correct P6W03.

P6W05. What was the name given to the baby that was just born?  
*Write 'Baby' if no name given*

P6W06. Is \${baby\_name} a boy or a girl?

- Boy
- Girl
- No response

P6W07. Is \${baby_name} still alive?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W08a. IF DEAD: Exactly how many days or weeks old was \${baby_name} when (he/she) died? <i>If less than 1 week, select days</i>	<input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Do not know <input type="radio"/> No response
P6W08b. Enter the number of \${when_died_lab}	

## Section 2 - Antenatal Care

Now I would like to ask about the care that you received during pregnancy.

P6W09. At any point in your pregnancy, did you see a health extension worker for antenatal care?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W10. Where did you see the HEW? <i>Select all that apply</i>	<input type="checkbox"/> Home <input type="checkbox"/> Government health post <input type="checkbox"/> Other health facility <input type="checkbox"/> Other <input type="checkbox"/> No response
P6W11. How many times did you receive antenatal care during this pregnancy from a health extension worker, either at a health post or at home? <i>Don't know: -88 No response: -99</i>	
P6W12. How many months pregnant were you when you first talked to a health extension worker about your pregnancy? <i>Don't know: -88 No response: -99</i>	
P6W13. Did you see a professional healthcare provider, other than an HEW, for antenatal care during this pregnancy?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W14. 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, can't distinguish <input type="checkbox"/> Other <input type="checkbox"/> No response
P6W15. How many times did you receive antenatal care during this pregnancy from a professional healthcare provider, other than an HEW? <i>Don't know: -88 No response: -99</i>	

P6W16. How many months pregnant were you when you first received antenatal care from a professional healthcare provider other than an HEW for this pregnancy?

*Don't know: -88 No response: -99*

P6W17. Where did you receive antenatal care for this pregnancy, not including from the HEW? Anywhere else?

*Select all that apply*

*Probe to identify the type of source and record all mentioned*

- Her home
- Other home
- Government hospital
- Government health center
- Government health post
- Other public sector
- Private hospital/clinic
- Other private medical sector
- NGO/Faith-based health facility
- Traditional healer/medicine
- Other
- Nowhere, no treatment sought
- No response

P6W18. As part of your antenatal care during this pregnancy were any of the following measured at least once:

*This includes any ANC from any provider*

A) Was your blood pressure measured?

- Yes
- No
- Do not know
- No response

B) Was your weight taken?

- Yes
- No
- Do not know
- No response

C) Did you give a urine sample that was not for a pregnancy test?

- Yes
- No
- Do not know
- No response

D) Did you give a blood sample?

- Yes
- No
- Do not know
- No response

E) Did you give a stool sample?

- Yes
- No
- Do not know
- No response

P6W19. I don't want to know the results, but as part of your antenatal care were you:

*This includes any ANC from any provider*

A) Tested for syphilis?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
B) Did you receive the results of your test?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
C) Did someone discuss the results with you after you were tested?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W20. I don't want to know the results, but as part of your antenatal care were you: <i>This includes any ANC from any provider</i>	
A) Tested for HIV?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
B) Did you receive the results of your test?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
C) Did someone discuss the results with you after you were tested?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W21a. During your antenatal care, did your provider discuss breastfeeding as a method to prevent pregnancy? <i>This includes any ANC from any provider</i>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W21b. During your antenatal care visit, did your provider talk with you about postpartum family planning? <i>This includes any ANC from any provider.</i>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W22. Which family planning method or methods did you discuss with the provider? <i>Select all that apply</i> <i>Note: breastfeeding was included previously and is not part of this 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"/> Rhythm method

	<input type="checkbox"/> Withdrawal <input type="checkbox"/> Other traditional methods <input type="checkbox"/> No response
P6W23. During this pregnancy, were you given an injection in the arm to prevent the baby from getting tetanus, that is convulsions (locked jaw) after birth?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W24. During this pregnancy, how many times have you gotten a tetanus injection? <i>Enter -88 for Do not know, -99 for No Response</i>	
CHECK: You entered that the respondent received \${tetanus_inj_times} tetanus injections in question P6W24. Confirm that these were received only during this pregnancy.	
P6W25. During this pregnancy did you consume any multivitamins that contain iron, iron tablets, iron syrup, or folic acid/iron co-packs? <i>A photo of iron tablets will appear on the screen</i> [iron_tablets_syrup.png]	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W26. During this pregnancy, did you consume any drug for intestinal worms? <i>A photo of intestinal worms tablets will appear on the screen</i> [albendazole.png]	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

P6W27. Did you experience any of the following problems during this pregnancy:	
A) Severe headache with blurred vision?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
B) High blood pressure?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
C) Edema face/feet/body?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
D) Convulsion/fits?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
E) Vaginal bleeding before delivery?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

F) High fever?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
G) Abnormal vaginal discharge (foul smelling/dark)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
H) Lower abdominal pain?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
I) Worsening vision, particularly at night?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

P6W28A. Did you seek treatment at a health facility for Severe headache with blurred vision?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W28B. Did you seek treatment at a health facility for High blood pressure?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W28C. Did you seek treatment at a health facility for Edema face/feet/body?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W28D. Did you seek treatment at a health facility for Convulsion/fits?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W28E. Did you seek treatment at a health facility for Vaginal bleeding before delivery?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W28F. Did you seek treatment at a health facility for High fever?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W28G. Did you seek treatment at a health facility for Abnormal vaginal discharge (foul smelling/dark)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W28H. Did you seek treatment at a health facility for Lower abdominal pain?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W28I. Did you seek treatment at a health facility for Difficulty seeing at night?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response



P6W29. During (any of) your antenatal care visit(s) was there any discussion about the following:	
A) Place of delivery?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
B) Delivery by a skilled attendant?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
C) Arrangement for transport for delivery?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
D) Where to go if experience of pregnancy danger signs?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
E) Severe headaches with blurred vision as a danger sign in pregnancy?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
F) High blood pressure as a danger sign in pregnancy?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
G) Edema/swelling of the face/feet/body as a danger sign in pregnancy?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
H) Convulsions/fits as a danger sign in pregnancy?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
I) Bleeding before delivery as a danger sign in pregnancy?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

P6W30. Did you receive any tablets that should be taken to prevent bleeding after delivery?

- Yes  
 No  
 Do not know  
 No response

<p>P6W31. As part of your antenatal care visits, did a healthcare worker or HEW talk with you about your nutrition or diet?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>P6W32. What information or messages did you receive during your pregnancy about nutrition or diet? <i>Probe: From either a health provider at a facility or an HEW? Read all responses aloud.</i></p>	<p><input type="checkbox"/> Eat more (quantity) <input type="checkbox"/> Eat a variety of foods / foods rich with iron (quality) <input type="checkbox"/> Take iron-containing tablets (IFAS) <input type="checkbox"/> Take preventive malaria treatment <input type="checkbox"/> Take deworming tablet <input type="checkbox"/> How much weight to gain <input type="checkbox"/> Regularly exercise <input type="checkbox"/> How to manage nausea/vomiting <input type="checkbox"/> Reduce salt intake <input type="checkbox"/> Do not eat raw meat <input type="checkbox"/> None of the above <input type="checkbox"/> No response</p>
<p>P6W33. During your most recent pregnancy, did you participate in a 1 to 5 meeting to discuss pregnancy-related issues with your team or team leader?</p>	<p><input type="radio"/> Yes <input type="radio"/> No, member but did not participate <input type="radio"/> No, not member <input type="radio"/> No response</p>
<p>P6W34. Did your partner encourage you to go to the clinic for antenatal care?</p>	<p><input type="radio"/> Yes, encouraged <input type="radio"/> No, did not encourage <input type="radio"/> No, actively discouraged <input type="radio"/> No partner <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>P6W35. While you were pregnant, did you and your partner discuss where you planned to deliver?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> Partner not involved <input type="radio"/> No response</p>

### Section 3 - Delivery

Now I would like to talk more about the delivery of your last baby.

<p>P6W36. Did you go to a maternity waiting home before going into labor? <i>This is a room or home where women go to live before they deliver. It is not the waiting room in the health center</i></p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response</p>
<p>P6W37. Where did you give birth? <i>Probe to identify the type of facility.</i></p>	<p><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</p>

	<input type="radio"/> Other private medical sector <input type="radio"/> NGO/Faith-based health facility <input type="radio"/> Other <input type="radio"/> No response
<p>P6W38. What are the reasons you did not go to a health facility for delivery?  <i>Any other reason?</i>  <i>Select all that apply</i></p>	<input type="checkbox"/> Not necessary <input type="checkbox"/> Not understand that service is needed <input type="checkbox"/> Not customary <input type="checkbox"/> Cost too much <input type="checkbox"/> Lack of money <input type="checkbox"/> Too far <input type="checkbox"/> Transport problem <input type="checkbox"/> No one to accompany <input type="checkbox"/> No provider available <input type="checkbox"/> Baby came too fast <input type="checkbox"/> Providers mistreat women <input type="checkbox"/> Provider not competent <input type="checkbox"/> Sent home previously <input type="checkbox"/> Concern about privacy <input type="checkbox"/> Family did not allow <input type="checkbox"/> Better care at home <input type="checkbox"/> Not know how to go <input type="checkbox"/> Not know where to go <input type="checkbox"/> For fear <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>P6W39. Who assisted with the delivery?  <i>If Respondent says 'No one assisted,' probe to determine whether any adults were present at the delivery. If Respondent says more than one person, ask who was the primary attendant.</i></p>	<input type="radio"/> No one assisted <input type="radio"/> Doctor <input type="radio"/> Health officer <input type="radio"/> Nurse/Midwife <input type="radio"/> Skilled attendant can't distinguish <input type="radio"/> Health extension worker <input type="radio"/> Health development army <input type="radio"/> Traditional birth attendant <input type="radio"/> Family member <input type="radio"/> Other <input type="radio"/> No response
<p>P6W40. Was the baby weighed at birth?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
<p>P6W41. Did you experience any of the following problems during the delivery:</p>	
<p>A) Severe bleeding?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

B) Leaking/rupture of membrane and no labor pain for >24 hours?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
C) Leaking/rupture of membrane before 9 months?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
D) Malpresentation (the feet/hand came out first) or malposition (baby lied transversely during pregnancy)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
E) Prolonged labor (>12 hours)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
F) Convulsions/fits?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

P6W42. Where did you seek treatment for the complications you experienced during delivery?

*Select all that apply.*

- Her home
- Other home
- Government hospital
- Government health center
- Government health post
- Other public sector
- Private hospital/clinic
- Other private medical sector
- NGO/Faith-based health facility
- Traditional healer/medicine
- Pharmacy
- Other
- Nowhere, no treatment sought
- No response

P6W43. Did you experience any of the following problems within the first 24 hours after the delivery:	
A) Retained placenta? (more than 30 minutes)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
B) High fever with foul/smelly discharge or lower abdominal pain?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

C) Severe/heavy bleeding?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
D) Convulsion/fits?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

P6W44A. Where did you seek treatment for Retained placenta? (more than 30 minutes)	<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"/> Pharmacy <input type="radio"/> Other <input type="radio"/> Nowhere, no treatment sought <input type="radio"/> No response
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P6W44B. Where did you seek treatment for High fever with foul/smelly discharge or lower abdominal pain?	<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"/> Pharmacy <input type="radio"/> Other <input type="radio"/> Nowhere, no treatment sought <input type="radio"/> No response
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P6W44C. Where did you seek treatment for Severe/heavy bleeding?	<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"/> Pharmacy
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	<input type="radio"/> Other <input type="radio"/> Nowhere, no treatment sought <input type="radio"/> No response
P6W44D. Where did you seek treatment for Convulsion/fits?	<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"/> Pharmacy <input type="radio"/> Other <input type="radio"/> Nowhere, no treatment sought <input type="radio"/> No response
P6W45. Did you receive an injection in your thigh immediately after you delivered to prevent excess bleeding?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W46. How long were you in labor before you left your home to seek care? <i>You will enter a number for x on the next screen.</i>	<input type="radio"/> Minutes <input type="radio"/> Hours <input type="radio"/> Before labour started <input type="radio"/> Do not know <input type="radio"/> No response
Enter duration in $\${\text{how\_long\_labour\_lab}}$	
P6W47. Was your delivery by caesarean, that is, did they cut your belly open to take the baby out?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W48. Did you receive blood transfusion for this delivery?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not remember <input type="radio"/> No response
The next set of questions asks specifically about your experiences during labor, delivery and immediate postpartum care (P6W49-P6W62).	
P6W49. Did the doctors, nurses, or other staff at the facility treat you with respect?	<input type="radio"/> No, never <input type="radio"/> Yes, a few times <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, all the time <input type="radio"/> Do not remember <input type="radio"/> No response
P6W50. Did the doctors, nurses, and other staff at the facility treat you in a friendly manner?	<input type="radio"/> No, never <input type="radio"/> Yes, a few times <input type="radio"/> Yes, most of the time

	<input type="radio"/> Yes, all the time <input type="radio"/> Do not remember <input type="radio"/> No response
P6W51. Did the doctors or nurses explain to you why they were doing examinations or procedures on you?	<input type="radio"/> No, never <input type="radio"/> Yes, a few times <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, all the time <input type="radio"/> Do not remember <input type="radio"/> No response
P6W52. Did the doctors or nurses ask your permission/consent before doing procedures or examinations on you?	<input type="radio"/> No, never <input type="radio"/> Yes, a few times <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, all the time <input type="radio"/> Do not remember <input type="radio"/> No response
P6W53. Did the doctors or nurses explain to you why they were giving you any medicine?	<input type="radio"/> No, never <input type="radio"/> Yes, a few times <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, all of the time <input type="radio"/> Did not get any medicine <input type="radio"/> Do not remember <input type="radio"/> No response
P6W54. Did you feel you could ask the doctors, nurses or other staff at the facility any questions you had?	<input type="radio"/> No, never <input type="radio"/> Yes, a few times <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, all the time <input type="radio"/> Do not remember <input type="radio"/> No response
P6W55. During the delivery, do you feel like you were able to be in the position that you preferred?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not remember <input type="radio"/> No response
P6W56. Did you feel like the doctors or nurses at the facility involved you in decisions about your care?	<input type="radio"/> No, never <input type="radio"/> Yes, a few times <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, all of the time <input type="radio"/> Did not have to make any decisions <input type="radio"/> Do not remember <input type="radio"/> No response
P6W57. When you needed help, did you feel the doctors, nurses or other staff at the facility paid attention?	<input type="radio"/> No, never <input type="radio"/> Yes, a few times <input type="radio"/> Yes, most of the time <input type="radio"/> Yes, all the time <input type="radio"/> Do not remember <input type="radio"/> No response

<p>P6W58. Did the doctors or nurses at the facility talk to you about how you were feeling?</p>	<p><input type="radio"/> No, never  <input type="radio"/> Yes, a few times  <input type="radio"/> Yes, most of the time  <input type="radio"/> Yes, all the time  <input type="radio"/> Do not remember  <input type="radio"/> No response</p>
<p>P6W59. Did you feel the doctors, nurses or other staff at the facility took the best care of you?</p>	<p><input type="radio"/> No, never  <input type="radio"/> Yes, a few times  <input type="radio"/> Yes, most of the time  <input type="radio"/> Yes, all the time  <input type="radio"/> Do not remember  <input type="radio"/> No response</p>
<p>P6W60. During examinations in the labor room, were you covered up with a cloth or blanket or screened with a curtain so that you did not feel exposed?</p>	<p><input type="radio"/> No, never  <input type="radio"/> Yes, a few times  <input type="radio"/> Yes, most of the time  <input type="radio"/> Yes, all the time  <input type="radio"/> Do not remember  <input type="radio"/> No response</p>
<p>P6W61. Did the doctors, nurses, or other healthcare providers call you by your preferred name?</p>	<p><input type="radio"/> No, never  <input type="radio"/> Yes, a few times  <input type="radio"/> Yes, most of the time  <input type="radio"/> Yes, all the time  <input type="radio"/> Do not remember  <input type="radio"/> No response</p>
<p>P6W62. Were you allowed to have someone you wanted (outside of staff at the facility, such as family or friends) stay with you during labor?</p>	<p><input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> Do not remember  <input type="radio"/> No response</p>

### Section 4 - Immediate Post-Partum

Now I would like to ask you about what happened right after delivery.

<p>P6W63. Did anyone check on YOUR health after delivery, while you were still in the facility, other than a family member? For example, did someone ask you questions about your health or examine you?</p>	<p><input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> Do not remember  <input type="radio"/> No response</p>
<p>P6W64. Who checked on your health?</p>	<p><input type="radio"/> Doctor  <input type="radio"/> Health officer  <input type="radio"/> Nurse/Midwife  <input type="radio"/> Skilled attendant, can't distinguish</p>



	<input type="radio"/> Health extension worker <input type="radio"/> Other <input type="radio"/> No response
P6W65. How long after delivery did the first check take place?	<input type="radio"/> Minutes <input type="radio"/> Hours <input type="radio"/> Days <input type="radio"/> Do not remember <input type="radio"/> No response
Enter duration in \${first_check_post_lab}	
P6W66. Before you left the facility after delivery, did a provider talk with you about using a family planning method?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W67. Before you left the facility after delivery, did you receive a method of family planning or a referral for a method?	<input type="radio"/> Yes, received method <input type="radio"/> Yes, received referral <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W68. What method of family planning did you receive immediately after delivery?	<input type="radio"/> Female Sterilization <input type="radio"/> Male Sterilization <input type="radio"/> Implant <input type="radio"/> IUD <input type="radio"/> Injectables <input type="radio"/> Pill <input type="radio"/> Emergency Contraception <input type="radio"/> Male Condom <input type="radio"/> Female Condom <input type="radio"/> Std. Days/Cycle beads <input type="radio"/> No response
Now we are going to ask you a few questions specific to the baby that was just born.	
P6W69a. Was the cord tied before it was cut?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W69b. What was used to cut the cord?	<input type="radio"/> Surgical blade <input type="radio"/> Razor blade <input type="radio"/> Bamboo strips <input type="radio"/> Scissor <input type="radio"/> Others <input type="radio"/> Do not know <input type="radio"/> No response
P6W70. Was the instrument boiled before cutting the cord?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> New blade/ no need to boil

	<input type="radio"/> Do not know <input type="radio"/> No response
P6W71. Was anything applied to the cord after cutting it?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W72. What was applied to the cord after cutting the cord? <i>Select all that apply.</i>	<input type="checkbox"/> Chlorhexidine <input type="checkbox"/> Other antiseptic/Savlon <input type="checkbox"/> Antibiotics (Powder/Ointment ) <input type="checkbox"/> Spirit/Alcohol <input type="checkbox"/> Gentian violet (GV) <input type="checkbox"/> Butter <input type="checkbox"/> Mustard oil with garlic <input type="checkbox"/> Chewed rice <input type="checkbox"/> Turmeric juice/powder <input type="checkbox"/> Ginger juice <input type="checkbox"/> Petroleum jelly <input type="checkbox"/> Body/Hair lotion <input type="checkbox"/> Cattle dung <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
P6W73. Was there any bleeding after the cord was cut and/or tied?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W74. What did they do for the bleeding cord?	<input type="radio"/> Pressure <input type="radio"/> Sponge bath (water and soap) <input type="radio"/> Alcohol <input type="radio"/> Chlorhexidine <input type="radio"/> Injection was given <input type="radio"/> Unknown substance applied <input type="radio"/> Nothing was applied <input type="radio"/> No response
Questions 75-93 will be repeated based on answers to question 02. If the respondent had twins or triplets, this series of question will appear for each child born in this pregnancy	
P6W75. Did \${child_name} cry/breathe normally immediately after birth?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W76. Was anything done to help \${child_name} cry or breathe immediately after birth? <i>Do not suggest any answers. Ask: Anything else? Select all that apply.</i>	<input type="checkbox"/> Dried the baby <input type="checkbox"/> Wrapped the baby <input type="checkbox"/> Rubbed the back for stimulation <input type="checkbox"/> Rubbed the feet for stimulation <input type="checkbox"/> Use of ambu-bag <input type="checkbox"/> Heated the cord <input type="checkbox"/> Slapped the baby

	<input type="checkbox"/> Hold the baby upside down <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
P6W77. Who took initiative to resuscitate or to help the baby cry?	<input type="radio"/> Doctor <input type="radio"/> Health officer <input type="radio"/> Nurse/Midwife <input type="radio"/> Skilled attendant, can't distinguish <input type="radio"/> Health extension worker <input type="radio"/> Health development army <input type="radio"/> Traditional birth attendant <input type="radio"/> Family member <input type="radio"/> Other <input type="radio"/> Do not know <input type="radio"/> No response
P6W78. Did the baby receive eye ointment following delivery?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W79. Did someone place the baby naked on your chest against your skin, immediately after delivery of the baby?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W80. After delivery, was \${child_name} wrapped with a cloth?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W81. How many minutes after delivery of \${child_name} was he/she wrapped?	
P6W82. When was \${child_name} given a bath for the first time?	<input type="radio"/> Immediately after birth <input type="radio"/> Within 24 hours <input type="radio"/> Second day <input type="radio"/> Third day <input type="radio"/> Days 4-6 <input type="radio"/> Day 7 and later <input type="radio"/> Not given <input type="radio"/> Do not know <input type="radio"/> No response
P6W83a. How long after birth did you first put \${child_name} to the breast? <i>Enter a number for Minutes, Hours, or Days on the next screen.</i> <i>If less than 1 hour, record minutes. If less than 24 hours, record hours; otherwise, record days.</i>	<input type="radio"/> Minutes <input type="radio"/> Hours <input type="radio"/> Days <input type="radio"/> Not yet <input type="radio"/> Do not know <input type="radio"/> No response
P6W83b. Number of \${baby_first_breast_lab} <i>If immediately, record 0 minutes</i>	

P6W84. Did anyone check on \${child_name}'s health after delivery, while you were still in the facility other than a family member? For example did someone ask you questions about \${child_name}'s health or examine him/her?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not remember <input type="radio"/> No response																
P6W85. Who checked on \${child_name}'s health?	<input type="radio"/> Doctor <input type="radio"/> Health officer <input type="radio"/> Nurse/Midwife <input type="radio"/> Skilled attendant can't distinguish <input type="radio"/> Health extension worker <input type="radio"/> No response																
P6W86. How long after delivery did the first check take place?	<input type="radio"/> Minutes <input type="radio"/> Hours <input type="radio"/> Days <input type="radio"/> Do not remember <input type="radio"/> No response																
Enter value in \${how_1st_child_chk_lab}																	
<table border="1"> <tr> <td>P6W87. Yesterday during the day or night, did \${child_name} receive any of the following?</td> <td></td> </tr> <tr> <td>Breast milk?</td> <td> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> Do not know  <input type="radio"/> No response         </td> </tr> <tr> <td>Vitamin, mineral supplements or medicine?</td> <td> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> Do not know  <input type="radio"/> No response         </td> </tr> <tr> <td>Plain water?</td> <td> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> Do not know  <input type="radio"/> No response         </td> </tr> <tr> <td>Sweetened, flavored water or fruit juice or tea or infusion?</td> <td> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> Do not know  <input type="radio"/> No response         </td> </tr> <tr> <td>Oral rehydration solution (ORS)?</td> <td> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> Do not know  <input type="radio"/> No response         </td> </tr> <tr> <td>Infant formula?</td> <td> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> Do not know  <input type="radio"/> No response         </td> </tr> <tr> <td>Tinned, powered or fresh milk?</td> <td> <input type="radio"/> Yes  <input type="radio"/> No         </td> </tr> </table>		P6W87. Yesterday during the day or night, did \${child_name} receive any of the following?		Breast milk?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response	Vitamin, mineral supplements or medicine?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response	Plain water?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response	Sweetened, flavored water or fruit juice or tea or infusion?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response	Oral rehydration solution (ORS)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response	Infant formula?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response	Tinned, powered or fresh milk?	<input type="radio"/> Yes <input type="radio"/> No
P6W87. Yesterday during the day or night, did \${child_name} receive any of the following?																	
Breast milk?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response																
Vitamin, mineral supplements or medicine?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response																
Plain water?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response																
Sweetened, flavored water or fruit juice or tea or infusion?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response																
Oral rehydration solution (ORS)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response																
Infant formula?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response																
Tinned, powered or fresh milk?	<input type="radio"/> Yes <input type="radio"/> No																

	<input type="radio"/> Do not know <input type="radio"/> No response
Herbal tonic/drinks	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
Any other liquids?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
Anything else?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
P6W88. Has $\{child\_name\}$ ever received a BCG vaccination against tuberculosis, that is, an injection in the arm or 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
P6W89. Has $\{child\_name\}$ ever received 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
P6W90. Do you have a card where $\{child\_name\}$ 's vaccinations are written down? <i>If yes: May I see it please?</i>	<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
<b>P6W91. BCG Vaccine</b> <i>(1) Copy date from the card for each vaccine (2) If any of the date record/s is/are missing or not legible, -88 for the day and month and 2022 for the year for specific missing or illegible records</i>	
Day	
Month	
Year	
<b>P6W91. Vaccine Polio 0</b> <i>(1) Copy date from the card for each vaccine (2) If any of the date record/s is/are missing or not legible, -88 for the day and month and 2022 for the year for specific missing or illegible records</i>	
Day	
Month	

Year	
P6W91. Vaccine Polio 1 <i>(1) Copy date from the card for each vaccine (2) If any of the date record/s is/are missing or not legible, -88 for the day and month and 2022 for the year for specific missing or illegible records</i>	
Day	
Month	
Year	

<p>P6W92. What illness, if any, has \${child_name} suffered from since birth? <i>Select all that apply.</i> <i>Do not read aloud.</i></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Poor feeding or unable to suck</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Pus in the umbilicus</li> <li><input type="checkbox"/> Redness of the umbilicus</li> <li><input type="checkbox"/> Red eye/passage of pus from eyes</li> <li><input type="checkbox"/> Hypothermia (temp 95.5-97.5 F)</li> <li><input type="checkbox"/> Jaundice</li> <li><input type="checkbox"/> Convulsion</li> <li><input type="checkbox"/> Skin rash/skin lesion</li> <li><input type="checkbox"/> Baby doesn't cry/breathe</li> <li><input type="checkbox"/> Fever (temp more than 101 F)</li> <li><input type="checkbox"/> Unconscious</li> <li><input type="checkbox"/> Fast breathing</li> <li><input type="checkbox"/> Sore throat/Tonsillitis</li> <li><input type="checkbox"/> Difficulty in breathing</li> <li><input type="checkbox"/> Chest in drawing</li> <li><input type="checkbox"/> Doesn't pass urine</li> <li><input type="checkbox"/> Doesn't pass stool</li> <li><input type="checkbox"/> Cold/cough</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Reduced alertness (lethargy)</li> <li><input type="checkbox"/> No illness</li> <li><input type="checkbox"/> Other</li> <li><input type="checkbox"/> No response</li> </ul>
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<p>P6W93. Where did you seek treatment for Poor feeding or unable to suck?</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Her home</li> <li><input type="checkbox"/> Other home</li> <li><input type="checkbox"/> Government hospital</li> <li><input type="checkbox"/> Government health center</li> <li><input type="checkbox"/> Government health post</li> <li><input type="checkbox"/> Other public sector</li> <li><input type="checkbox"/> Private hospital/clinic</li> <li><input type="checkbox"/> Other private medical sector</li> <li><input type="checkbox"/> NGO/Faith-based health facility</li> <li><input type="checkbox"/> Traditional healer/medicine</li> <li><input type="checkbox"/> Pharmacy</li> <li><input type="checkbox"/> Other</li> </ul>
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	<input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Diarrhea?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Pus in the umbilicus?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Redness of the umbilicus?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Red eye/passage of pus from eyes?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Hypothermia (temp 95.5-97.5 F)?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Jaundice?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Convulsion?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy



	<input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Skin rash/skin lesion?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Baby doesn't cry/breathe?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Fever (temp more than 101 F)?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Unconscious?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Fast breathing?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for "Sore throat/Tonsillitis</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Difficulty in breathing?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine

	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Chest in drawing?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Doesn't pass urine?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Doesn't pass stool?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Cold/cough?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Vomiting?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response
<p>P6W93. Where did you seek treatment for Reduced alertness (lethargy)?</p>	<input type="checkbox"/> Her home <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"/> Traditional healer/medicine <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other <input type="checkbox"/> Nowhere, no treatment sought <input type="checkbox"/> No response

**Section 5 - Post-Partum**

Now I would like to ask you about what happened after delivery.

<p>P6W94. Has any health extension worker visited you since delivery?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response</p>
<p>P6W95. How many days after birth did the health extension worker visit you? <i>If less than 24 hours, write 0 days</i> <i>No response: -99; Do not know: -88</i></p>	
<p>P6W96. Did you go visit a health extension worker since delivery, either for yourself or for the baby?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response</p>
<p>P6W97. How many days after birth did you go visit the health extension worker? <i>If less than 24 hours, write 0 days</i> <i>No response: -99; Do not know: -88</i></p>	
<p>P6W98. Did you go visit another professional healthcare provider other than an HEW since delivery, either for yourself or for the baby?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response</p>
<p>P6W99. How many days after birth did you go visit the other professional healthcare provider? <i>If less than 24 hours, write 0 days</i> <i>No response: -99; Do not know: -88</i></p>	
<p>P6W100. 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></p>	<p><input type="checkbox"/> Doctor <input type="checkbox"/> Health officer <input type="checkbox"/> Nurse/Midwife <input type="checkbox"/> Professional healthcare provider, can't distinguish <input type="checkbox"/> Traditional healer <input type="checkbox"/> Other <input type="checkbox"/> No response</p>
<p>P6W101a. At your visit after delivery (either by a HEW or other professional healthcare provider) did the provider discuss:</p>	
<p>A) Family planning?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>
<p>P6W101b. At your visit after delivery (either by a HEW or other professional healthcare provider) did the provider discuss:</p>	
<p>A) Family planning?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response</p>

B) Exclusive breastfeeding?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
C) Immunization?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
D) Infant feeding?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
E) Infant growth?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response
F) Other infant development issues?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Do not know <input type="radio"/> No response

Sometimes a woman can have problems in holding urine and/or feces after delivering a baby. She may feel shy to talk about this problem in public. Now, with your kind permission I would like to ask you some questions regarding this. Your responses to these questions are private and will not be shared with anyone.

FIST01. Do you have problem in controlling urine, that is does your urine leak continuously, even when you are not urinating/ trying to urinate?

Yes  
 No  
 No response

FIST02. Do you have problem in controlling feces, that is do you currently experience feces passing through the birth canal that you cannot stop, even when you are not defecating?

Yes  
 No  
 No response

FIST03. Currently, does your clothing get wet with your urine during sleep every night?

Yes  
 No  
 No response

FIST04. Did this problem (leakage of urine and/or feces) start after you delivered this baby?

Yes  
 No  
 Do not know  
 No response

FIST05. How many days after the delivery did this problem start?

Within 2 weeks of delivery  
 Between 2 - 4 weeks of delivery  
 Between 4 - 6 weeks of delivery  
 Over 6 weeks  
 No response

Based on your answers, you may have a health condition that requires further attention. Health workers at the nearest health post or health center can screen you and provide more information on treatment options.	
P6W102. Are you currently breastfeeding?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W103. Are you using breastfeeding as a family planning method to delay or avoid getting pregnant?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W104. How long do you plan to breastfeed?	<input type="radio"/> Months <input type="radio"/> Years <input type="radio"/> Do not know <input type="radio"/> No response
Enter the value in \${how_long_brfeed_lab}.	
P6W105. Are you currently using a method of family planning?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W106. Which method or methods are you using? <i>Probe: Anything else? Select all methods mentioned. Be sure to scroll to bottom to see all choices.</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
P6W107. When did you start using this method of family planning?	<input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> No response
Enter the value in \${when_start_method_lab}.	
P6W108. Do you plan to use a contraceptive method to delay or avoid getting pregnant in the next year?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W109. During your postpartum care, did you feel pressured to use a method?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
P6W110. Who did you feel pressured by? <i>READ ALL OPTIONS, SELECT ALL THAT APPLY</i>	<input type="checkbox"/> Doctor <input type="checkbox"/> Health officer

	<input type="checkbox"/> Nurse/Midwife <input type="checkbox"/> Skilled worker can't distinguish <input type="checkbox"/> Health extension worker <input type="checkbox"/> Health development army <input type="checkbox"/> Traditional birth attendant <input type="checkbox"/> Partner <input type="checkbox"/> Family member <input type="checkbox"/> Friends/community <input type="checkbox"/> Other <input type="checkbox"/> Do not know <input type="checkbox"/> No response
<p>P6W111. During your postpartum care, did any of the health service providers force you to accept or insisted that you should accept to use a SPECIFIC method?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>P6W112. Which method did you feel pressured to use?</p>	<input type="radio"/> Female Sterilization <input type="radio"/> Male Sterilization <input type="radio"/> Implant <input type="radio"/> IUD <input type="radio"/> Injectables <input type="radio"/> Pill <input type="radio"/> Emergency Contraception <input type="radio"/> Male Condom <input type="radio"/> Female Condom <input type="radio"/> Std. Days/Cycle beads <input type="radio"/> LAM <input type="radio"/> Rhythm method <input type="radio"/> Withdrawal <input type="radio"/> Other traditional methods <input type="radio"/> No response
<p>Now I'm going to ask you a few questions about sexual activity. 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.</p>	
<p>P6W113a. Have you resumed sexual activity since the birth of your most recent child?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
<p>P6W113b. When was the last time you had sexual intercourse? <i>If less than 12 months ago, answer must be recorded in months, weeks, or days. Enter 0 days for today. You will enter a number for X on the next screen</i></p>	<input type="radio"/> Days ago <input type="radio"/> Weeks ago <input type="radio"/> Months ago <input type="radio"/> No response
<p>Enter in \${last_intercourse_lab}</p>	
<p>P6W114. Sometimes conflict can occur in relationships. At any time during your pregnancy, did your husband/partner do any of the following things to you:</p>	



A. Push you, shake you, or throw something at you?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
B. Slap you?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
C. Twist your arm or pull your hair?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
D. Punch you with his fist or with something that could hurt you?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
E. Kick you, drag you, or beat you up?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
F. Try to choke you or burn you on purpose?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
G. Threaten or attack you with a knife, gun, or other weapon?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
H. Physically force you to have sexual intercourse with him when you did not want to?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
I. Physically force you to perform any other sexual acts you did not want to?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response
J. Used threats or pressure to make you have sex when you didn't want to, but did not use physical force?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No response

We understand that this interview may have raised some difficult issues. How are you feeling after we've asked these questions? Would you like to speak with a trained care provider further? We can connect you to the local health center for follow-up care.

Thank the respondent for her time and update the ID card  
*Before you leave, update the ID card with the respondent's name, baby's name (if given), the outcome of the birth (live birth, still birth, miscarriage), whether there were multiple births, and whether the baby is still alive.*

**FOLLOW UP INTERVIEW DATES**

FU6Ma. Date of six-month interview  
*The 6-month follow-up should occur 2 weeks before or 2 weeks after \${birth\_plus\_6m}*

Day:

<i>Enter Jan 1, 2030 if no date scheduled for upcoming interview</i>	Month: Year:
FU6Mb. Did the respondent refuse future follow-up?	<input type="radio"/> Yes <input type="radio"/> No
FU1Y. Date of one-year interview <i>The 1-Year follow-up should occur 2 weeks before or 2 weeks after \${birth_plus_1y}</i> <i>Enter Jan 1, 2030 if woman refuses to schedule upcoming interview</i>	Day: Month: Year:
Location	
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
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 step away from the respondent's home to take the GPS reading?	<input type="radio"/> Yes <input type="radio"/> No
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"/> Completed <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"/> Respondent death <input type="radio"/> Respondent moved <input type="radio"/> Household moved