HOUSEHOLD HEALTH SURVEY - 1991

DEPARTMENT OF CENSUS AND STATISTICS

3/7/91

Identification Information

1. Address :-.....
2. District :-.....
3. A.G.A.Division :-.....
4. Sector (Urban/ Rural/ Estate) :-.....
5. Name of M.C/U.C/T.C (If Urban) :-.....

   .....

   Ward No :-.....
6. G.N.Division Number (If Rural or Estate):-.....

   Name:-.....
7. Name of Village/ Eatate :-.....
8. i. Census block No.:-.....

   ii. Serial No. of Housing Unit:-.....
9. Number of Households in the housing unit :- ☐
10. Name of Head of Household:-.....

    .....
11. Interviewer's Name:-..... ☐☐

    Signature:-..... Date:-.....
12. Supervising Officer's Name:-..... ☐☐

    Signature:-..... Date:-.....
13. Co-ordinator's Name:-..... ☐☐

    Signature:-..... Date:-.....

For office use only

Location Code: ☐☐☐☐☐☐

Block I.D.: ☐☐☐☐☐☐

District	Sector	Block No. (within the stratum)	Housing unit Number (within the block)	Household No.
☐	☐	☐☐☐	☐☐	☐

Control Data

Interviewers visists	1st	2nd	3rd
1. Date			
2. Result*	☐	☐	☐
3. Time taken to complete the schedule (Minutes)	☐☐☐	☐☐☐	☐☐☐

*Result Codes

Completed	1
Deferred	2
** Ineligible	3
No competent respondent at home	4
Refused	5
Housing unit temporarily closed	6
Other (Specify)	7

** Specify the reason that the unit is ineligible

For office use only

Final result code	☐
Completed	1
Partially completed	2
Not completed	3
Ineligible	4

(i) Vacant
(ii) Seasonal
(iii) Non residential
(iv) Destroyed

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Sector - 1

CODES FOR PERSONAL CHARACTERISTICS

Col.4 : Relationship to Head of Household

Head of Household	1
Wife/ Husband	2
Son/ Daughter	3
Parents	4
Mother in law/ Father in law	5
Other Relatives	6
Other	9

Col.5 : Sex

Male	1
Female	2

Col. 7 : Ethnic Group

Sinhalese	1
Sri Lanka Tamil	2
Indian Tamil	3
Sri Lanka Moor	4
Malay	5
Burgher	6
Other	9

Col.8 : Religion

Buddhist	1
Hindu	2
Muslim	3
Roman Catholic	4
Other Christian	5
Other	9

Col. 9 : Marital Status

Never Married	1
Married (Registered)	2
Married (Customary)	3
Widowed	4
Divorced	5
Separated	6

Col. 10 : Educational Attainment

No Schooling	0
Passed Grade 0 - 4/passed 1 - 5 year	1
Passed Grade 5 - 7/passed 6 - 8 year	2
Passed Grade 8 - 9/passed 9 - 10 year	3
Passed G.C.E.(O/L)/N.C.G.E.	4
Passed G.C.E.(A/L)/H.N.C.E.	5
Degree	6
Post Graduate Degree/Diploma	7

PERSONAL CHARACTERISTICS OF HOUSEHOLD MEMBERS

Serial No	Names of Individuals who usually live here including those who are temporarily absent. (Include boarders, lodgers, servants,etc. and exclude temporary visitors) (Members of the household who have died during the last four weeks are also to be included)	Is this member alive Yes 1 No 2	Relationship to Head of Household	Sex	Age (as at last Birthday) (in years)	Ethnic Group	Religion	Marital Status	Educational Attainment (5 years & older)	Did (S) He have Voc/Tech Training (10 years & older) Yes 1 No 2
1	2	3	4	5	6	7	8	9	10	11
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
11										
12										
13										
14										
15										

Section - 2

Information on Social Conditions & Health of the Household Members

Enter the name and the corresponding serial number of all members specified in Section 1 and then record answers to questions from 2.1 onwards.

	Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
2.1	Principal Activity: (Most of the time spent during last 12 months)					
	Employed	1 Go to 2.2	1 Go to 2.2	1 Go to 2.2	1 Go to 2.2	1 Go to 2.2
	Available for work	2	2	2	2	2
	Household work	3	3	3	3	3
	Retired	4 Go to 2.5	4 Go to 2.5	4 Go to 2.5	4 Go to 2.5	4 Go to 2.5
	Student	5	5	5	5	5
	Age less than 10 years	6	6	6	6	6
	Other	7	7	7	7	7
2.2	Employment status:					
	Employer	1	1	1	1	1
	Employee	2	2	2	2	2
	Self-employed	3	3	3	3	3
	Unpaid family worker	4	4	4	4	4
2.3	Occupation: (Specify your principal occupation)					
	Legislator, Senior officials & Managers	1	1	1	1	1
	Professionals	2	2	2	2	2
	Technicians & Associate professionals	3	3	3	3	3
	Clerks, and allied grades	4	4	4	4	4
	Service workers & shop & Market Salesworkers	5	5	5	5	5
	Skilled Agricultural & Fishery Workers	6	6	6	6	6
	Craft & Related workers	7	7	7	7	7
	Plant & Machine Operators & Assemblers	8	8	8	8	8
	Elementary Occupations	9	9	9	9	9
	Armed Forces	0	0	0	0	0

	Name:- Serial No:-	..... □□	..... □□	..... □□	..... □□	..... □□
2.4	Sector of Employment: Government Corporations/Boards/Public-Private Comps Private Sector Own work/Household enterprice	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
2.5	Does he/she receive any income through Food Stamps/Janasaviya or transfers from a relative? Yes No	1 Go to 2.6 2 Go to 2.7	1 Go to 2.7 2 Go to 2.8	1 Go to 2.7 2 Go to 2.8	1 Go to 2.7 2 Go to 2.8	1 Go to 2.7 2 Go to 2.8
2.6	The average amount so received per month:	□□□□□	□□□□□	□□□□□	□□□□□	□□□□□
2.7	Average monthly income (in rupees):	□□□□□	□□□□□	□□□□□	□□□□□	□□□□□
2.8	What is his/her height? (c.m.)	□□□	□□□	□□□	□□□	□□□
2.9	What is his/her weight? (k.g.)	□□□ . □	□□□ . □	□□□ . □	□□□ . □	□□□ . □
2.10	Does he/she smoke? Yes No	1 2	1 2	1 2	1 2	1 2
2.11	Does he/she consume liquor? Yes No	1 2	1 2	1 2	1 2	1 2
2.12	Does he/she suffer from a Chronic illness? Yes No	1 Go to 2.13 2 Go to 2.14	1 Go to 2.13 2 Go to 2.14	1 Go to 2.13 2 Go to 2.14	1 Go to 2.13 2 Go to 2.14	1 Go to 2.13 2 Go to 2.14

Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
2.13 Specify the Chronic illness? (If more than one chronic illness, specify the severe most 3 Chronic illnesses)	Illness Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐	Illness Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐	Illness Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐	Illness Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐	Illness Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐

List of Chronic Illnesses

01. Skin Ailments	17. Cataract
02. Catarrah	18. Low Vision
03. Asthma	19. Glaucoma
04. Respiratory Diseases	20. Problem with Ear
05. Tuberculosis	21. Hypertension
06. Malaria	22. Heart Diseases
07. Filaria	23. Haemorrhoids
08. Malignancies of	24. Hernia
Oesophagus	25. Warm infestations
09. Maliganancies of	26. Amoebiasis
Breast	27. Liver Diseases
10. Maliganancies of	28. Gall Bladder Diseases
Womb	29. Prolapse of Uterus
11. Malignancies of	30. Enlarge Prostate
Bones & Skin	31. Veneral Diseases
12. Other Malignancies	32. Arthrites/ Rheumatism
13. Diabetes	33. Varicose Veins
14. Anaemia	34. Effects of Stroke
15. Mental Disorders	35. Other (Specify)
16. Epilepsy	

Name:- Serial No:-	.....	.....	.....	.....	.....
	☐☐	☐☐	☐☐	☐☐	☐☐
2.14 Does he/she has a physical disability?					
Yes	1 Go to 2.15	1 Go to 2.15	1 Go to 2.15	1 Go to 2.15	1 Go to 2.15
No	2 Go to 2.16	2 Go to 2.16	2 Go to 2.16	2 Go to 2.16	2 Go to 2.16
2.15 Specify the disability? (In the case of multiple disabilities, specify three disabilities)	Disability Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐	Disability Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐	Disability Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐	Disability Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐	Disability Code 1. ..... ☐☐ 2. ..... ☐☐ 3. ..... ☐☐
List of Disabilities 01. Blindness 02. Deafness 03. Dumbness 04. Deaf and Dumb 05. Loss of one arm 06. Loss of both arms 07. Loss of one leg 08. Loss of both legs 09. Paralysis of one arm 10. Paralysis of both arms 11. Paralysis of one leg 12. Paralysis of both legs 13. Other (Specify)					
2.16 Is he/she mentally fit?					
Yes	1	1	1	1	1
No	2	2	2	2	2
2.17 Would you describe .....'s health as (Name)					
Excellent	1	1	1	1	1
Good	2	2	2	2	2
Fair	3	3	3	3	3
Poor	4	4	4	4	4
2.18 Does his/her health limit him/her in any way in vigorous activity?					
Yes	1 Go to 2.19	1 Go to 2.19	1 Go to 2.19	1 Go to 2.19	1 Go to 2.19
No	2 Go to 2.20	2 Go to 2.20	2 Go to 2.20	2 Go to 2.20	2 Go to 2.20
2.19 If so, For how long?					
More than 5 years	1	1	1	1	1
1-5 years	2	2	2	2	2
3 months - 1 year	3	3	3	3	3
Less than 3 months	4 Go to 2.20	4 Go to 2.20	4 Go to 2.20	4 Go to 2.20	4 Go to 2.20

Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
es his/her health limit him/her in way in moderate activity? Yes / No	1 Go to 2.21 2 Go to 2.22	1 Go to 2.21 2 Go to 2.22	1 Go to 2.21 2 Go to 2.22	1 Go to 2.21 2 Go to 2.22	1 Go to 2.21 2 Go to 2.22
ɔ, For how long? More than 5 years 1-5 years 3 months - 1 year Less than 3 months	1 2 3 4 Go to 2.22	1 2 3 4 Go to 2.22	1 2 3 4 Go to 2.22	1 2 3 4 Go to 2.22	1 2 3 4 Go to 2.22
s his/her health limit him/her in way in walking uphill? Yes / No	1 Go to 2.23 2 Go to 2.24	1 Go to 2.23 2 Go to 2.24	1 Go to 2.23 2 Go to 2.24	1 Go to 2.23 2 Go to 2.24	1 Go to 2.23 2 Go to 2.24
, For how long? More than 5 years 1-5 years 3 months - 1 year Less than 3 months	1 2 3 4 Go to 2.24	1 2 3 4 Go to 2.24	1 2 3 4 Go to 2.24	1 2 3 4 Go to 2.24	1 2 3 4 Go to 2.24
his/her health limit him/her in vay in Bending/Stooping? Yes / No	1 Go to 2.25 2 Go to 2.26	1 Go to 2.25 2 Go to 2.26	1 Go to 2.25 2 Go to 2.26	1 Go to 2.25 2 Go to 2.26	1 Go to 2.25 2 Go to 2.26
For how long? More than 5 years 1-5 years 3 months - 1 year Less than 3 months	1 2 3 4 Go to 2.26	1 2 3 4 Go to 2.26	1 2 3 4 Go to 2.26	1 2 3 4 Go to 2.26	1 2 3 4 Go to 2.26
his/her health limit him/her in ay in walking? Yes / No	1 Go to 2.27 2 Go to 2.28	1 Go to 2.27 2 Go to 2.28	1 Go to 2.27 2 Go to 2.28	1 Go to 2.27 2 Go to 2.28	1 Go to 2.27 2 Go to 2.28

	Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
2.27	If so, For how long? More than 5 years 1-5 years 3 months - 1 year Less than 3 months	1 2 3 4 Go to 2.28	1 2 3 4 Go to 2.28	1 2 3 4 Go to 2.28	1 2 3 4 Go to 2.28	1 2 3 4 Go to 2.28
2.28	Does his/her health limit him/her in any way in eating, dressing, bathing, using the toilet? Yes	1 Go to 2.29	1 Go to 2.29	1 Go to 2.29	1 Go to 2.29	1 Go to 2.29
	No	2 Go to 2.30	2 Go to 2.30	2 Go to 2.30	2 Go to 2.30	2 Go to 2.30
2.29	If so, For how long? More than 5 years 1-5 years 3 months - 1 year Less than 3 months	1 2 3 4 Go to 2.30	1 2 3 4 Go to 2.30	1 2 3 4 Go to 2.30	1 2 3 4 Go to 2.30	1 2 3 4 Go to 2.30
2.30	Has he/she had any symptoms or injury during the past four weeks? Yes	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person
	No	2	2	2	2	2

After Completing this Section for all the Persons Go to Section 3

Section - 3

Availability of Health Services

If the answer is ' No ' to question No. 2.30 for all the persons, go to Section 4. For the persons with answer ' Yes ' to question 2.30 enter the name and the corresponding serial number (according to Col. 1 and 2 in Section 1) in the relevant columns. Then record answers to questions 3.1 onwards.

Name:- Serial No:-	.... ☐☐	.... ☐☐	.... ☐☐	.... ☐☐	.... ☐☐
3.1 Which of the following symptoms occurred with the illness or injury that he/she suffered during the past 4 weeks? (If more than one symptom, specify the severe most 4 symptoms)	Symptom / Code 1. .... ☐☐ 2. .... ☐☐ 3. .... ☐☐ 4. .... ☐☐	Symptom / Code 1. .... ☐☐ 2. .... ☐☐ 3. .... ☐☐ 4. .... ☐☐	Symptom / Code 1. .... ☐☐ 2. .... ☐☐ 3. .... ☐☐ 4. .... ☐☐	Symptom / Code 1. .... ☐☐ 2. .... ☐☐ 3. .... ☐☐ 4. .... ☐☐	Symptom / Code 1. .... ☐☐ 2. .... ☐☐ 3. .... ☐☐ 4. .... ☐☐

List of Symptoms

01. Cough
02. Sneezing
03. Fever
04. Vomiting
05. Stomach Ache
06. Diarrhoea
07. Weekness
08. Headache
09. Sore throat
10. Eye problem
11. Ear problem
12. Worms
13. Muscle aches and pains
14. Joint pains
15. Giddiness
16. Breathlessness
17. Urinary problems
18. Rash or other skin problems
19. Fites
20. Losing Consciousness
21. Lumps & Growths
22. Passing Blood (Per Rectum, Nose, Vomiting)
23. Vaginal bleeding
24. Vaginal discharge
25. Mental problem
26. Enlarged lymph nodes
27. Swelling of feet
28. Burns
29. Bites or stings
30. Poison
31. Fracture
32. Dislocation Sprains etc
33. Injury due to assault
34. Injury due to accident
35. Other symptoms (Specify)

3.2 When did the symptom or injury frist occur?					
More than 4 weeks ago	1	1	1	1	1
3-4 weeks	2	2	2	2	2
2-3 weeks	3	3	3	3	3
1-2 weeks	4	4	4	4	4
Less than 1 week	5	5	5	5	5

Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
3.3 For how many days during the past 4 weeks did member suffer from this symptom/ injury? More than 3 weeks 2 - 3 weeks 1 - 2 weeks less than 1 week	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
3.4 For how many days was the member unable to carry out normal activities? (Not just during the last 4 weeks)	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
3.5 What did member do first about the symptoms or injury? Did nothing Self medication Sought outside assistance	1 Go to 3.24 2 Go to 3.6 3 Go to 3.8	1 Go to 3.24 2 Go to 3.6 3 Go to 3.8	1 Go to 3.24 2 Go to 3.6 3 Go to 3.8	1 Go to 3.24 2 Go to 3.6 3 Go to 3.8	1 Go to 3.24 2 Go to 3.6 3 Go to 3.8
3.6 Were any drugs purchased if self medication? Yes No	1 Go to 3.7 2 Go to 3.24	1 Go to 3.7 2 Go to 3.24	1 Go to 3.7 2 Go to 3.24	1 Go to 3.7 2 Go to 3.24	1 Go to 3.7 2 Go to 3.24
3.7 Where were the drugs obtained? a. Name of place b. Address c. Location Code: d. Facility Code:	.... ☐☐☐☐☐☐ ☐☐☐☐☐☐ Go To 3.19	.... ☐☐☐☐☐☐ ☐☐☐☐☐☐ Go To 3.19	.... ☐☐☐☐☐☐ ☐☐☐☐☐☐ Go To 3.19	.... ☐☐☐☐☐☐ ☐☐☐☐☐☐ Go To 3.19	.... ☐☐☐☐☐☐ ☐☐☐☐☐☐ Go To 3.19

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	Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
3.8	Who was consulted first?					
	Doctor Western (State Sector)	01	01	01	01	01
	Doctor Western (Private Sector)	02	02	02	02	02
	Doctor Ayurvedic (State Sector)	03	03	03	03	03
	Doctor Ayurvedic (Private Sector)	04	04	04	04	04
	RMP/AMP	05	05	05	05	05
	Nurse	06	06	06	06	06
	Midwife	07	07	07	07	07
	Public Health Inspector	08	08	08	08	08
	Pharmacist	09	09	09	09	09
	Healer	10	10	10	10	10
	Other	11 ..... (Specify)	11 ..... (Specify)	11 ..... (Specify)	11 ..... (Specify)	11 ..... (Specify)
3.9	Where did the first consultation take place:-					
	Within the housing unit	1	1	1	1	1
	Out side the hosing unit	2	2	2	2	2
3.10	Name of place of consultation:-					
	a. Name of place	.....	.....	.....	.....	.....
	b. Address	....	....	....	....	....
	c. Location Code:	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐
	d. Facility I.D.:	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐
3.11	Were you admitted as an in-patient? Yes	1 Go to 3.12	1 Go to 3.12	1 Go to 3.12	1 Go to 3.12	1 Go to 3.12
	No	2 Go to 3.13	2 Go to 3.13	2 Go to 3.13	2 Go to 3.13	2 Go to 3.13
3.12	If admitted for how many days?	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐
3.13	How far was this consultation from here? (k.m.)	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐
3.14	How long did it take to get to this place (one way) Hrs.	☐☐	☐☐	☐☐	☐☐	☐☐
	Mns.	☐☐	☐☐	☐☐	☐☐	☐☐

Name:- Serial No:-	..... □□	..... □□	..... □□	..... □□	..... □□
3.15 What was the mode of transport? (Circle all relevant codes) Private vihicle Hiring car/van Motor Bicycle/Scooter Bus/Train Tri Shaw Walk Other	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)
3.16 How much was the transportation cost to this consultation? (one way) Rs. Cts.	□□□□□ □□	□□□□□ □□	□□□□□ □□	□□□□□ □□	□□□□□ □□
3.17 Why did you choose this facility or practitioner? (Circle all relevant codes) Distance Reputation Past experience Advice from other person To obtain better facilities For economic reasons Other	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)
3.18 How many visits did the household member make to this facility or practitioner for this illness? (Total visits not just during the past 4 weeks)	□□□	□□□	□□□	□□□	□□□
3.19 What was the total money cost for the illness or injury including Consultations, Medical Investigations, drugs, dressings, hospital charges & transportation etc.? Rs.	□□□□□□	□□□□□□	□□□□□□	□□□□□□	□□□□□□

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	Name:- Serial No:-	.....	.....	.....	.....	.....
3.20	Of this what was the					
	(a) Amount paid to the practitioner? Rs.					
	(b) Amount paid to the practitioner which includes cost of drugs? Rs.					
	(c) Amount spent on hospital charges? Rs.					
	(d) Amount spent on drugs Rs.					
3.21	Did someone else pay all or part of the cost? Yes / No	1 Go to 3.22 2 Go to 3.24	1 Go to 3.22 2 Go to 3.24	1 Go to 3.22 2 Go to 3.24	1 Go to 3.22 2 Go to 3.24	1 Go to 3.22 2 Go to 3.24
3.22	Who paid this part? (Circle all relevant codes)					
	Relative (excluding HH members)	1	1	1	1	1
	Friend	2	2	2	2	2
	Employer	3	3	3	3	3
	Insurance (Private)	4	4	4	4	4
	Insurance provied by employer	5	5	5	5	5
	Other	6 ..... (Specify)	6 ..... (Specify)	6 ..... (Specify)	6 ..... (Specify)	6 ..... (Specify)
3.23	What proportion of the total cost did they pay?					
	Total cost	1	1	1	1	1
	More than $^3/_4$ of the total	2	2	2	2	2
	Between $^1/_2$ - $^3/_4$ of the total	3	3	3	3	3
	Between $^1/_4$ - $^1/_2$ of the total	4	4	4	4	4
	Less than $^1/_4$ of the total	5	5	5	5	5
3.24	If you know, what was the actual illness or injury?					
	* Illness Code	.....	.....	.....	.....	.....
	* Refer to the list of illnesses/injuries					

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Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
3.25 Did the member recover as a result of this Medical attention, the self medication or doing nothing?					
Yes	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person
Somewhat	2 Go to 3.26	2 Go to 3.26	2 Go to 3.26	2 Go to 3.26	2 Go to 3.26
No	3 Go to 3.26	3 Go to 3.26	3 Go to 3.26	3 Go to 3.26	3 Go to 3.26
Death	4 Go to next person	4 Go to next person	4 Go to next person	4 Go to next person	4 Go to next person
3.26 Is the member well now?					
Yes	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person
No	2 Go to 3.27	2 Go to 3.27	2 Go to 3.27	2 Go to 3.27	2 Go to 3.27
3.27 What did the member do next (second) for the same illness/injury?					
Did nothing more	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person
Self medication	2 Go to 3.28	2 Go to 3.28	2 Go to 3.28	2 Go to 3.28	2 Go to 3.28
Sought outside assistance	3 Go to 3.30	3 Go to 3.30	3 Go to 3.30	3 Go to 3.30	3 Go to 3.30
3.28 Were any drugs purchased if self medication?					
Yes	1 Go to 3.29	1 Go to 3.29	1 Go to 3.29	1 Go to 3.29	1 Go to 3.29
No	2 Go to 3.46	2 Go to 3.46	2 Go to 3.46	2 Go to 3.46	2 Go to 3.46
3.29 Where were the drugs obtain:-					
a. Name of place	.....	.....	.....	.....	.....
b. Address	.....	.....	.....	.....	.....
	.....	.....	.....	.....	.....
c. Location Code:	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐
d. Facility Code:	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐

Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
3.30 Who was consulted second?					
Doctor Western (State Sector)	01	01	01	01	01
Doctor Western (Private Sector)	02	02	02	02	02
Doctor Ayurvedic (State Sector)	03	03	03	03	03
Doctor Ayurvedic (Private Sector)	04	04	04	04	04
RMP/AMP	05	05	05	05	05
Nurse	06	06	06	06	06
Midwife	07	07	07	07	07
Public Health Inspector	08	08	08	08	08
Pharmacist	09	09	09	09	09
Healer	10	10	10	10	10
Other	11 ..... (Specify)	11 ..... (Specify)	11 ..... (Specify)	11 ..... (Specify)	11 ..... (Specify)
3.31 Where did the second consultation take place?					
Within the housing unit	1	1	1	1	1
Out side the housing unit	2	2	2	2	2
3.32 Name of place of consultation:-					
a. Name of place	.....	.....	.....	.....	.....
b. Address	....	....	....	....	....
c. Location Code:	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐
d. Facility Code:	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐	☐☐☐☐☐☐
3.33 Were you admitted as an in-patient?					
Yes	1 Go to 3.34	1 Go to 3.34	1 Go to 3.34	1 Go to 3.34	1 Go to 3.34
No	2 Go to 3.35	2 Go to 3.35	2 Go to 3.35	2 Go to 3.35	2 Go to 3.35
3.34 If admitted for how many days?	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐
3.35 How far was this consultation from here? (km)	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐

Name:- Serial No:-	.....	.....	.....	.....	.....
3.36 How long did it take to get to this place? Hrs. Mns.					
3.37 What was the mode of transport? (Circle all relevant codes) Private vehicle Hiring car/ van Motor Bicycle/ Scooter Bus/ Train Tri Shaw Walk Other	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)
3.38 How much was the transportation cost to this consultation? (one way) Rs. Cts..					
3.39 Why did you choose this facility or practitioner? (Circle all relevant codes) Distance Reputation Past experience Advice from other person To obtain better facilities For economic reasons Other	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)	1 2 3 4 5 6 7 ..... (Specify)
3.40 How many visits did the household member make to this facility or practitioner for this illness? (Total visits not just during the past 4 weeks)					

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	Name:- Serial No:-	.....	.....	.....	.....	.....
3.41	What was the total money cost for the illness or injury including consultations, medical investigations, drugs dressings, hospital charges & transportation cost etc.? Rs.					
3.42	Of this what was the					
	(a) Amount paid to the practitioner? Rs.					
	(b) Amount paid to the practitioner which includes cost of drugs? Rs.					
	(c) Amount spent on hospital charges? Rs.					
	(d) Amount spent on drugs Rs.					
3.43	Did someone else pay all or part of the cost?					
	Yes	1 Go to 3.44	1 Go to 3.44	1 Go to 3.44	1 Go to 3.44	1 Go to 3.44
	No	2 Go to 3.46	2 Go to 3.46	2 Go to 3.46	2 Go to 3.46	2 Go to 3.46
3.44	Who paid this part? (Circle all relevant codes)					
	Relative (excluding HH members)	1	1	1	1	1
	Friend	2	2	2	2	2
	Employer	3	3	3	3	3
	Insurance (Private)	4	4	4	4	4
	Insurance provided by employer	5	5	5	5	5
	Other	6 ..... (Specify)	6 ..... (Specify)	6 ..... (Specify)	6 ..... (Specify)	6 ..... (Specify)
3.45	What proportion of the total cost did they pay?					
	Total cost	1	1	1	1	1
	More than 3/4 of the total	2	2	2	2	2
	Between 1/2 - 3/4 of the total	3	3	3	3	3
	Between 1/4 - 1/2 of the total	4	4	4	4	4
	Less than 1/4 of the total	5	5	5	5	5

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	Name:- Serial No:-	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐	..... ☐☐
3.46	Did the member recover as a result of this medical attention, the self medication or doing nothing?					
	Yes	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person
	Somewhat	2 Go to 3.47	2 Go to 3.47	2 Go to 3.47	2 Go to 3.47	2 Go to 3.47
	No	3	3	3	3	3
	Death	4 Go to next person	4 Go to next person	4 Go to next person	4 Go to next person	4 Go to next person
3.47	Is the member well now?					
	Yes	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person	1 Go to next person
	No	2	2	2	2	2

After Completing this Section for all relevant Persons, Go to Section 4.

Section - 4

Utilization of Maternal and Child Health Services

(for ever married females aged 15 - 49)

These questions should be asked from the individual only

For the ever married females aged 15 - 49 in the household (according to Col. 5, 6 & 9 in section 1) specify the name & the corresponding serial No. (as in section 1) and proceed. If there are no such females go to section 5.

	Name:-	.....	.....	.....	.....	.....
	Serial No:-	☐☐	☐☐	☐☐	☐☐	☐☐
4.1 Are you currently pregnant?	Yes	1 Go to 4.2	1 Go to 4.2	1 Go to 4.2	1 Go to 4.2	1 Go to 4.2
	No	2 Go to 4.5	2 Go to 4.5	2 Go to 4.5	2 Go to 4.5	2 Go to 4.5
	Uncertain	3	3	3	3	3
4.2 Have you consulted a health provider about your pregnancy?	Yes	1 Go to 4.3	1 Go to 4.3	1 Go to 4.3	1 Go to 4.3	1 Go to 4.3
	No	2 Go to 4.5	2 Go to 4.5	2 Go to 4.5	2 Go to 4.5	2 Go to 4.5
4.3 Were did this consultation take place?						
	Within the housing unit	1	1	1	1	1
	Outside the housing unit	2	2	2	2	2
4.4 Name of place of consultation:-						
a.	Name of place	.....	.....	.....	.....	.....
b.	Address	.....	.....	.....	.....	.....
		.....	.....	.....	.....	.....
c.	Location Code:					
d.	Facility I.D.:					
4.5 How many children do/ did you want to have? **Enter the number of children in the cage. Enter 'oo' if the respondent do not want any children. Enter '98' if the answer is not decisive.**		☐☐	☐☐	☐☐	☐☐	☐☐
4.6 (a) Do you have living children?	Yes	1 Go to 4.6 (b)	1 Go to 4.6 (b)	1 Go to 4.6 (b)	1 Go to 4.6 (b)	1 Go to 4.6 (b)
	No	2 Go to next Female	2 Go to next Female	2 Go to next Female	2 Go to next Female	2 Go to next Female
(b) Date of birth of last live birth?		Year Month Date 19☐☐ ☐☐ ☐☐	Year Month Date 19☐☐ ☐☐ ☐☐	Year Month Date 19☐☐ ☐☐ ☐☐	Year Month Date 19☐☐ ☐☐ ☐☐	Year Month Date 19☐☐ ☐☐ ☐☐

If the answer to Q. 4.6 (a) is 'Yes' for at least 1 feamale, Go to Q. 4.7 Otherwise Go to Section 5.

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For one woman only

Record answers to question 4.7 onwards, for the female with response 'yes' to question 4.6 (a) who has most recently had a child. If no such female available, record answers for a eligible female specify in section 4.

	Name:- Serial No:-	..... ☐☐
4.7	Have you had an abortion within the last 12 months?	
	Yes	1 Go to 4.8
	No	2 Go to 4.10
4.8	When did this occur?	
	6 - 12 months	1
	3 - 6 months	2
	1 - 3 months	3
	Less than 1 month	4
4.9	What is due to natural causes?	
	Yes	1
	No	2
4.10	Have you ever used any contraceptive method to avoid or to delay a pregnancy?	
	Yes	1 Go to 4.11
	No	2 Go to 4.12

4.11 Utilization of Contraceptive Methods

Specify the Method and the duration of use in the sequential order of use.

(a) Order of use	(b) Method *	(c) Date of begining use (year)	(d) Duration of use (months)
1	□□	1 9 □□	□□□
2	□□	1 9 □□	□□□
3	□□	1 9 □□	□□□
4	□□	1 9 □□	□□□
5	□□	1 9 □□	□□□

4.12 How many of your children are alive?	□□
4.13 Number of children dead? (including those born alove who lived even a short period)	□□
4.14 Total number of live births? (Sum in 4.12 & 4.13)	□□

* **Codes for the Method**

01. Pill
02. IUD
03. Injection
04. Condom
05. Jelly, Cream/ Diaphram
06. Norplant
07. Female sterilization
08. Male sterilization
09. Safe period
10. Withdrawal
11. Other

Mothers Serial NO. [ ]

Inquire the following information for the live births mentioned in Q. 4.14.

Information on live births		1 st live birth	2 nd live birth	3 rd live birth	4 th live birth	5 th live birth
4.15 Name of Child		3 1	3 2	3 3	3 4	3 5 .....
4.16 Sex		Male [1] Female [2]	Male [1] Female [2]	Male [1] Female [2]	Male [1] Female [2]	Male [1] Female [2]
4.17 Date of Birth		1 9 [ ][ ] Month [ ][ ]	1 9 [ ][ ] Month [ ][ ]	1 9 [ ][ ] Month [ ][ ]	1 9 [ ][ ] Month [ ][ ]	1 9 [ ][ ] Month [ ][ ]
4.18 District of Birth	District	.....	.....	.....	.....	.....
	Code	[ ]	[ ]	[ ]	[ ]	[ ]
4.19 Birth weight (kg)		[ ] . [ ]	[ ] . [ ]	[ ] . [ ]	[ ] . [ ]	[ ] . [ ]
4.20 Frequency of mothers participation in clinics/ Consultation of doctor?		[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]
4.21 Has the child been immunized? (Yes 1, No 2, not known 3)						
1. B.C.G		[ ]	[ ]	[ ]	[ ]	[ ]
2. Triple 1		[ ]	[ ]	[ ]	[ ]	[ ]
3. Polio 1		[ ]	[ ]	[ ]	[ ]	[ ]
4. Triple 2		[ ]	[ ]	[ ]	[ ]	[ ]
5. Polio 2		[ ]	[ ]	[ ]	[ ]	[ ]
6. Triple 3		[ ]	[ ]	[ ]	[ ]	[ ]
7. Polio 3		[ ]	[ ]	[ ]	[ ]	[ ]
8. Measles		[ ]	[ ]	[ ]	[ ]	[ ]
4.22 Is he/ she alive?	Yes	[1] Go to next live birth	[1] Go to next live birth	[1] Go to next live birth	[1] Go to next live birth	[1] Go to next live birth
	No	[2] Go to 4.23	[2] Go to 4.23	[2] Go to 4.23	[2] Go to 4.23	[2] Go to 4.23
4.23 Age of death if born alive?	Years	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]
	Months	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]
	Days	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]	[ ][ ]
4.24 Cause of death? (Refer to the list of cau se of death)	Cause	.....	.....	.....	.....	.....
	Code	[ ][ ] Go to next live birth	[ ][ ] Go to next live birth	[ ][ ] Go to next live birth	[ ][ ] Go to next live birth	[ ][ ] Go to next live birth

After completing this section go to Section 5.

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6 th live birth	7 th live birth	8 th live birth	9 th live birth	10 th live birth	11 th live birth	12 th live birth
3 6	3 7	3 8	3 9	4 0	4 1	4 2 .....
Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2	Male 1 Female 2
1 9 □□ Month □□	1 9 □□ Month □□	1 9 □□ Month □□	1 9 □□ Month □□	1 9 □□ Month □□	1 9 □□ Month □□	1 9 □□ Month □□
..... □	..... □	..... □	..... □	..... □	..... □	..... □
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□	□	□	□	□	□	□
□	□	□	□	□	□	□
1 Go to next live birth 2 Go to 4.23	1 Go to next live birth 2 Go to 4.23	1 Go to next live birth 2 Go to 4.23	1 Go to next live birth 2 Go to 4.23	1 Go to next live birth 2 Go to 4.23	1 Go to next live birth 2 Go to 4.23	1 Go to next live birth 2 Go to 4.23
□□	□□	□□	□□	□□	□□	□□
□□	□□	□□	□□	□□	□□	□□
□□	□□	□□	□□	□□	□□	□□
.....	.....	.....	.....	.....	.....	.....
□□ Go to next live birth	□□ Go to next live birth	□□ Go to next live birth	□□ Go to next live birth	□□ Go to next live birth	□□ Go to next live birth	□□ Go to next live birth

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Section - 5

Preventive Care

Answers to the questions in Section 5 are to be obtained from a responsible member in the household.

5.1 Has any household member used a health facility or seen a practitioner during the last 4 weeks for reason of pregnancy, well baby services, immunization, family planning or health education?

Yes [1] Go to 5.2
No [2] Go to 5.3

5.2 Description of the services obtained?
(for members who have obtained any such service)

(a) Serial No. of the member (as in section 1)	(b) Name of the member	(c) * Service Name	(c) * Service Code	(d) Name & address of the facility	(e) Location Code	(f) Facility I.D.	(g) Transportation cost (one way) Rs.	(g) Transportation cost (one way) cts.	(h) Total money cost to obtain this service (including transportation cost) Rs.	(h) Total money cost to obtain this service (including transportation cost) cts.

*** Codes for the service**

1. Reason of Pregnancy
2. Well baby services
3. Immunization
4. Family Planning
5. Health Education
6. ROther (Specify)

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5.3 What are the three main available sources of health services for your household members?

(a) Name and address of the facility where the services can be obtain?	(b) Location Code	(c) Facility I.D.	(d) Type of facility +	(e) Whether any service was obtained during the past 2 years?	(f) For what illness/ injury ? * (Specify the names and the corresponding codes for 3 major illnesses/ injuries)
1.				Yes [1] No [2] Go to next facility	....
2.				Yes [1] No [2] Go to next facility	....
3.				Yes [1] No [2] Go to 5.4	....

* **Refer to the list of illnesses/ injuries**

\+ **Codes for Type of Facility**

1 State Sector

Western

101 Gramodaya Health Unit
102 Central Dispensary
103 Maternity Home
104 Central Dispensary & Maternity Home
105 Rural Hospital
106 Peripheral Unit
107 District Hospital
108 Teaching Hospital
109 Base Hospital
110 Health Unit
111 Special Instruction

Indigenous

112 Dispensary
113 Hospital

2 Private Sector

Western

201 Surgery
202 Dispensary
203 Clinic/ Health centre
204 Channel Consultation Room (Public)
205 Private residence consultation room (doctor owned)
206 Maternity Home
207 Hospital

Indigenous

208 Private residence consultation room (doctor owned)
209 Dispensary
210 Clinic
211 Hospital

5.4 Has any member in the household died during the last 4 weeks?

Yes [1] Go to 5.5

No [2] Go to section 6

5.5 Finish the following information regrading the members who have so died?

(a) Serial number as in section 1	(b) Name of the member	(c) Cause of Death*	
		Name	Code
☐☐	.....	.....	☐☐
☐☐	.....	.....	☐☐
☐☐	.....	.....	☐☐
☐☐	.....	.....	☐☐

* Refer to the list of cause of death

Section - 6

Housing and other facilities

Circle only one code for the questions in this section

Details of the housing unit

Type of principle construction meterial			
6.1 Wall	6.2 Floor	6.3 Roof	6.4 Ceiling
Cement block 1	Terrazo tiles 1	Tiles 1	No ceiling 1
Brick/Cabok 2	Floor tiles 2	Asbestos 2	Asbestos 2
Mud 3	Cement 3	Tin sheet 3	Wooden 3
Planks/Tin sheet 4	Sand/Planks 4	Cadjan/Palmyrah 4	Other (Specify) 4
Cadjan 5	Mud 5	Other (Specify) 5	.....
Other (Specify) 6	Other (Specify) 6	.....	
.....	.....		

6.5 Unit usage	6.6 Type of structure	6.7 Type of house	6.8 Number of rooms
Residential only 1	Single house 1	Private (Owned) 1	Only one room 1
Residential & Commercial 2	Flat 2	Private (Rented) 2	More than one room 2
	Attached house 3	Official house (Government) 3	
	Row house 4	Official house (Other) 4	
	Other (Specify) 5	Housing scheme 5	
	.....	Other (Specify) 6	
		.....	

Other facilities

Toilet facilities		
6.9 Is there a toilet exclusively for this housing unit?	6.10 Type of toilet (Go to 6.12)	6.11 Are your toilet facilities
Yes 1	Pit 1	Shared with other units 1
No 2 Go to 6.11	Bucket lavatory 2	Public toilet 2
	Squatting pan (water seal) 3	No toilet 3
	Commode 4	
	Other (Specify) 5	
	.....	

Water supply facilities
6.12 Source of drinking water
Protected well 1
Unprotected well 2
Public tap 3
Tube well 4
Tap within unit 5
Tap outside the unit 6
River/ Tank/ Streams 7
Other (Specify) 8
.....

Power	
6.13 Principle type of lighting	6.14 Principle type of cooking fuel
None 1	Fire wood 1
Kerosene 2	Saw dust/ Paddy husk 2
Electricity 3	Kerosene 3
Other (Specify) 4	Gas 4
.....	Electricity 5
	Other (Specify) 6
	.....

Section - 7

Information of the Property Ownership

7.1 Which of the following equipment do you have in the household? (Circle all the relevant codes)

01.	Radio	Yes	1	No	2
02.	Radio casette player	Yes	1	No	2
03.	Television	Yes	1	No	2
04.	V.C.R	Yes	1	No	2
05.	Sewing machine	Yes	1	No	2
06.	Electric fan	Yes	1	No	2
07.	Kerosene cooker	Yes	1	No	2
08.	Gas cooker	Yes	1	No	2
09.	Electric cooker	Yes	1	No	2
10.	Refrigerator	Yes	1	No	2
11.	Airconditioner	Yes	1	No	2

7.2 Which of the following vehicles do you have in the household? (Circle all the relevant codes)

1.	Car	Yes	1	No	2
2.	Lorry/ Bus	Yes	1	No	2
3.	Van	Yes	1	No	2
4.	Tractor (2 wheel)	Yes	1	No	2
5.	Tractor (4 wheel)	Yes	1	No	2
6.	Scooter/ Motor cycle	Yes	1	No	2
7.	Bicycle	Yes	1	No	2
8.	Cart	Yes	1	No	2
9.	Other (Specify)	Yes	1	No	2
	.....				

7.3 Resouce ownership of the household
If ' Yes ' in 7.3 (b) record answers for 7.3 (c) & (d)

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(a) Type	Whether owned	(b) How much/ How many	(a) Current value (Rs.)
1 Paddy land	Yes 1 No 2	Ac ☐☐☐ R ☐ P ☐☐	☐☐☐☐☐☐
2 High land	Yes 1 No 2	Ac ☐☐☐ R ☐ P ☐☐	☐☐☐☐☐☐
3 Residence	Yes 1 No 2	No. ☐	☐☐☐☐☐☐
4 Other houses	Yes 1 No 2	No. ☐☐	☐☐☐☐☐☐
5 Business places	Yes 1 No 2	No. ☐☐	☐☐☐☐☐☐
6 Cattle	Yes 1 No 2	No. ☐☐☐☐☐	☐☐☐☐☐☐
7 Buffaloes	Yes 1 No 2	No. ☐☐☐☐☐	☐☐☐☐☐☐
8 Goats	Yes 1 No 2	No. ☐☐☐☐☐	☐☐☐☐☐☐
9 Pigs	Yes 1 No 2	No. ☐☐☐☐☐	☐☐☐☐☐☐
10 Poultry	Yes 1 No 2	No. ☐☐☐☐☐	☐☐☐☐☐☐

After recording answers to Q. 7.3, Go to Q. 2.5 for all persons.