International Institute for Population Sciences

District Level Household and Facility Survey (DLHS-4)

Bid Document

INVITATION FOR PROPOSAL FOR SELECTION OF FIELD AGENCIES
FOR CONDUCTING DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY

(DLHS-4)

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CONTENTS

ACRONYM

AHS	Annual Health Survey
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
BP	Blood Pressure
CAB	Clinical Anthropometric Biochemical (Test)
CAPI	Computer Assisted Personnel Interview
CHC	Community Health Centre
DBS	Dried Blood Spot
DH	District Hospital
DLHS	District Level Household and Facility Survey
FA	Field Agency
FBS	Fasting Blood Sugar
FOD	Field Operation Division
FP	Family Planning
FS	Female Sterilization
FSU	First Stage Unit
GPS	Global Positioning System
HH	Household
HIV	Human Immuno Deficiency Virus
IEC	Information, Education and Communication
IIPS	International Institute for Population Sciences
IUD	Intra-uterine Device
JSY	Janani Suraksha Yojana
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
MTP	Medical Termination of Pregnancy
NC	Natal Care
NIHFW	National Institute of Health and Family Welfare
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organization
NSV	Non-scalpel Vasectomy
PHC	Primary Health Centre
PNC	Post Natal Care
PRC	Population Research Centre
PPS	Probability Proportional to Size
PSU	Primary Sampling Unit
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Sammitti
RTI	Reproductive Tract Infection
SDH	Sub-Divisional Hospital
SDRD	Survey Design and Research Division
STI	Sexually Transmitted Infection
TBA	Trained Birth Attendant
TOT	Training of Trainers
UFS	Urban Frame Survey
USU	Ultimate Stage Sampling Unit
VHSC	Village Health and Sanitation Committee

I. INTRODUCTION

1.1. Purpose of Invitation For Proposal (IFP)

The purpose/intent for IFP is to appoint Field Agency (s) for conducting District Level Household and Facility Survey in the country.

1.2. Background of the Survey

Three rounds of District Level Household and Facility Surveys (DLHS) have been undertaken in the past (Round- I in 1998-99, Round-II in 2002-04, and Round-III in 2007-08) with the main objective to provide reproductive and child health database at district level in India. The data from these surveys have been useful in setting the benchmarks and examining the progress the country has made after the implementation of RCH programme. These surveys were useful for the central and state governments in evaluation, monitoring and planning strategies. In view of the completion of six years of National Rural Health Mission (2005-12), there is a felt need to focus on the achievements and improvements so far. It is, therefore, proposed to conduct DLHS-4 during 2011-2012.

1.3. Objective of the Survey

The overall objective of the survey is to assess the performance with regard to implementation of various programmes under NRHM at district level. The specific objectives are to estimate or assess:

1. Ante natal care and immunization coverage.
2. Extent of safe delivery and coverage of JSY.
3. Contraceptive prevalence and unmet need for family planning.
4. Awareness about RTI/STI and HIV/AIDS
5. Assessment of the quality of RCH services
6. Contribution of public-private sectors to RCH services
7. Availability of RCH services nearest to the selected PSUs
8. To Know the level of aneamia, blood sugar, BP and anthropometric parameters through the Clinical, Anthropometric and Bio-Chemical (CAB) test and measurements.
9. Availability of critical inputs in public health care establishments through Facility Survey

1.4. Geographical Coverage

District Level Household and Facility Survey -4 (DLHS-4) has household survey and facility survey components. Both these components of DLHS-4 shall be implemented in the districts of all states and union territories other than the nine states of Uttar Pradesh, Uttarakhand, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Odisha, Rajasthan and Assam which are covered under Annual Health Survey (AHS). The facility survey component of DLHS-4 shall also be implemented in these nine states.

The following States/UTs are to be covered under DLHS-4

States/UTs (For Household and Facility Survey)	States/UTs (Only For Facility Survey)
1. Jammu & Kashmir, 2. Himachal Pradesh, 3. Punjab,4. Chandigarh, 5. Haryana, 6. Delhi, 7. West Bengal, 8. Gujarat, 9. Daman & Diu, 10. Dadra & Nagar Haveli, 11. Maharashtra, 12. Andhra Pradesh, 13. Karnataka,14. Goa, 15. Lakshadweep, 16. Kerala, 17. Tamil Nadu,18. Puducherry, 19. Andaman & Nicobar Islands, 20. Arunachal Pradesh, 21. Manipur, 22. Mizoram, 23. Meghalaya, 24. Nagaland, 25. Tripura, 26. Sikkim	1. Assam, 2. Bihar, 3. Chhattisgarh, 4. Jharkhand, 5. Madhya Pradesh, 6. Odisha, 7. Rajasthan, 8. Uttar Pradesh, 9. Uttarakhand,
Total States / UTs= 26	**Total States=9**

1.5. Important steps in the DLHS-4 implementation

The following steps are important in the implementation of DLHS-4 for timely and effective completion of the survey:

1. In DLHS-4, it is proposed to complete the field survey in all the districts within a period of 6 months.

2. In EAG states including Assam (9 states), IIPS will undertake only the facility survey. In all other states, IIPS will carry out both household and facility survey together.

3. The NIHFW will be the nodal agency for the CAB component of DLHS-4, under the overall coordination of IIPS.

4. In DLHS-3, the district-wise sample size vary (1000, 1200, 1500 households) across districts. In DLHS-4, it varies from 1000 to 1750 households (See annexure A).

5. One of the main factors that influence the quality of data is the length of training period and monitoring of field work. In DLHS-4, the length of training of trainers (TOT) will be of at-least 14 days including 2 days of field practice. Later, the field agencies would be asked to provide the training to their investigators for a minimum of three weeks which includes the field practice.

6. Another factor that influences the quality of data is the monitoring mechanism at the nodal agency (coordinators, project managers and project officers). It is proposed to strengthen the monitoring by involving more PI/ Coordinators and project personnel at IIPS. In addition to this, the Principal Investigator/Project Coordinators will be regularly visiting and supervising each state during the field work. Along with the IIPS officials, MoHFW officials would also be involved in the monitoring of the survey.

7. As proposed by the Ministry, few officials of the Population Research Centres (PRCs) would be undertaking the monitoring work in the assigned states under the overall coordination of IIPS.

1.6. Sampling Design

a. Selection of households

1.6.1. A multi-stage, stratified, probability proportional to size sample with replacement shall be adopted in DLHS-4. The First Stage Unit (FSU) for urban areas is the NSSO Urban Frame Survey (UFS) blocks and Ultimate Stage Sampling Unit (USU) is the household. UFS blocks in each district shall be stratified into million-class cities and non-million class cities and allocation of sample shall be proportional to relative sizes. SDRD Division of NSSO shall be requested to make selection or provide sample frame for selection of primary sampling units (PSU) for urban areas. Urban areas in some districts shall be oversampled by taking more PSUs for districts with less than projected 30% urban population. The number of households per PSU is 25, however this shall vary for North-Eastern states and hilly districts elsewhere, particularly in J&K and Himachal Pradesh. For rural areas, census 2001 villages shall framed First Stage Unit(FSU) of sampling stratified by size class and selection by probability proportional to size (PPS) sampling.

1.6.2. The listing of all households in each first stage unit will provide the sampling frame for selecting households at the second stage. The household listing would provide up-to-date location and layout sketch maps of each selected PSU, and number to each structure and households within the structure. Like DLHS-3, large sample villages (usually more than 300 households) will be segmented. In case the village size is 300-600 HHs, we will have two segments (each almost of the same size) and one will be selected randomly. For villages with more than 600 HHs, more than three segments shall be made with approximately 150 households each and two will be selected at random. In urban areas, such situation may not come up, as UFSs have no more than 300 HHs. Each household listing team will have one lister and one mapper. This operation will be completed at least one month in advance of the household survey. FAs is expected to prepare excel sheet containing the particulars of listing.

b. Selection of health facilities

1.6.3. The selected village (PSU) will be under the jurisdiction of one Sub Centre and that Sub Centre will be covered for the survey. The PHC to which this Sub Centre is attached, will also be covered in the survey. All CHCs, Sub Divisional Hospitals and District Hospitals will be covered in facility survey. For identification of the Sub Centre and PHC of each selected PSU, one has to approach the Chief Medical Officer's office and to obtain the list and verify the jurisdiction of the Sub Centre and PHC from Sarpanch, PHC, CHC/BPHC/RH. In some cases DH may be attached to some teaching facility. In that case, such DHs have to be identified and covered for the survey. In some districts, there might be two District Hospitals, in this situation both will be surveyed.

1.7.   Data collection Procedure

Household Survey

1.7.1. In DLHS-4, it is proposed to use Computer Assisted Personal Interview (CAPI) for data collection. Therefore, each investigator will be provided a mini laptop that will have bilingual questionnaire. This will save a lot of time usually taken for transferring the filled- in questionnaires from field to office, data editing, data entry, etc. The data collected through CAPI will be directly uploaded to the server located in IIPS (FTP account) on a day to day basis. Mini laptops will be provided to the Field Agency after loading required software and other materials.

Facility Survey

1.7.2. Facility survey would be conducted using the paper-pencil format as the information has to be collected from different officials/departments in each facility and more than one visit is required to gather all the required information. Separate data entry software would be prepared and would be sent to field agencies for the data entry of facility survey. Besides aggregated information, individual facility level information shall also be disseminated.

CAB Component

1.7.3. FA will record the test results for the CAB tests as well as other relevant information on CAPI. Field Agency would also need to take the consent on the ‑consent form‖ from the eligible individuals/ households (as required) before conducting the tests in each household.

1.8. Key Events and Dates

1	Tender Inviting Authority	International Institute for Population Sciences, Govandi Station Road, Deonar, Mumbai-400 088
2	Job Requirement	Appointment of Field Agency for conducting DLHS-4.
3	Last date for receiving quarries	12th October 2011
4	Pre-Bid Meeting	2.30 PM to 5.00PM on 12th October 2011
5	Last Date for submission of bid	5 PM on 31st October 2011
6	Opening of technical bids	7th November 2011 at IIPS, Mumbai.
7	Opening of financial bid based on technical bid evaluation	11 AM 2nd December 2011 at IIPS, Mumbai.
8	Pre-contract/ Negotiation discussion (If necessary)	5th to 9th December 2011

2.   PRE-QUALIFICATION/ELIGIBILITY CRITERIA

The pre-qualification/eligibility criteria for the Field Agencies have been provided in the table below (these conditions are not applicable to PRCs.):

Sl. No.	Pre-Qualification Criteria	Proof Required
1	I. Name and address of the Organisation, II. year of establishment III. Whether the Organisation is registered under Society Registration ACT or is an autonomous body or a Limited company or partnership firm, etc. and details thereof (e.g.-name (s) of partners, Managing Directors, Chief Executive Officers, Key persons)	Copy of Certificate of Incorporation/Registration/MoU as applicable
2	The Field Agency should have a valid PAN and Service Tax Registration in India.	Copy of PAN card and Service Tax Registration
3	The Field Agency should have a minimum average annual turnover of Rs. 2 Crores (Rupees Two Crores) from survey related activities during the last three years (2008-09, 2009-10 & 2010-11)	Copy of Audited Profit and Loss Statement and Balance sheet
4	Field Agency should have conducted a minimum of 2 large scale surveys in health/demographic sector. The sample size of such survey should not be less than 5000 households.	Copy of the work order and certificate of completion
5	Field Agency should not have been blacklisted by Central/State Government departments/Undertakings	No Conviction certificate duly signed as per Format A

3. SCOPE OF WORK

The proposal should be prepared on the basis of the following scope of the work

3.1. The Field Agency will be required to put in place the following manpower

Sl. No.	Name of Position	No.	Educational Qualification	Experience
	State Level Staff			
1	Project Coordinator (Full time) One x per State x per FA	1	Ph D./Masters Degree in Mathematics/ Statistics/Social Science / Demography	**1. Experience in large scale surveys** ÉAt least 5 years experience of handling large scale demographic/health surveys as a team leader
2	I.T. Consultant (Full time) One x per State x per FA	1	Post Graduate degree/Diploma in any Computer Science Application	5 years of experience in handling Large Scale Demographic Survey data
3	Health Coordinator (Full time) One x per State x per FA	1	MBBS/BAMS or any other medical degree	At least two years experience in Bio-marker in Health surveys
4	Statistician/ Demographer (Consultant)	1	Ph D./M.Phil/ Masters Degree in the relevant field	3 years of experience for Ph.D./M. Phil holders 5 years of experience for Master Degree holder in handling Large Scale Demographic Survey data
	Field Team	**No.**	**Qualification**	**Experience**
5	Mapper	1	Graduate in any discipline (Preferably Social Sciences)	
6	Lister	1	Graduate in any discipline (Preferably Social Sciences)	
7	Supervisor	1	Graduate in any Social Science (Prefer knowledge of Biology)	Experience in at the supervisor level
8	Investigator (3 Females and 1 Male)	4	Graduate in any discipline (Preferably Social Sciences)	
9	Health Investigator (CAB)	2	The minimum qualification for health investigator in CAB should be Diploma in Nursing/ANM/B.Sc. Nursing/Diploma in Medical lab technology/ Bachelor in Medical lab technology/ B.Sc. Nutrition/DDPHN/ Diploma in Physiotherapy/ B Pharma/BUMS/BHMS/ BAMS	
10	Health Investigator (Facility Survey)	2	The minimum qualification for health investigator should be Diploma or degree in Para medical courses	.

3.2. Mapping and Listing

The purpose of mapping and listing operation in DLHS-4 is to prepare a mapping of each PSU depicting all lanes or paths, landmarks, dwelling and non-dwelling structures and identification boundaries with accuracy and to carry out listing of structures with systematic numbering, identifying whether a structure is residential or not, and also mentioning the name of the head of household.

3.3. Training of Field Investigators

Field Agency should organise state level training for field investigators, including field supervisors, along with health investigators for both CAB and facility survey to understand DLHS-4 survey protocol to facilitate the field work. To understand and familiarize with the questionnaires, FA should arrange training of about 3 weeks (including 3 days field practice in both rural and urban areas). The master trainers who attended the training organized by IIPS must only provide the training. The PIs/Project Coordinators and Project Officers from IIPS and MoHFW officials would also be present at the time of training.

3.4. Transportation/Accommodation for investigators

To facilitate the field work and to ensure good data quality, every FA should provide required transportation facility (separate vehicle for each team consists of 7 member) along with proper accommodation to each survey team during the field work.

3.5. Canvassing the Questionnaires

The DLHS-4 survey will have three separate questionnaires

Sr. No.	Type of Questionnaire	Contents of the questionnaire
1	Household	**Information on:** • All members of the household • Socio-economic characteristics • Assets possessed • Number of marriages and deaths • Information on morbidity of each individual • CAB (All members of the household, specified age blood test).
2	Ever married women (15 to 49 years)	**Maternal and Child Care** • Timing of Registration for antenatal check up. • Coverage of women for different required services during pregnancy. • Institutional deliveries and home deliveries attended by skilled attendant. • JSY beneficiaries • Post-natal care for mothers. • Quality of care during pregnancy and during post-natal care. • Vaccination coverage of children. • Newborn Care. • Differentials in utilization of MCH services. **Contraceptive Prevalence and Unmet Need**

		• Uses of various methods of contraception by currently married women aged 15-49 • Public-private shares in the provision of contraceptive services • Quality of services in terms of information provided before use, follow up after acceptance and contraceptive morbidity • Extent of unmet need for contraception **Reproductive Morbidity** • Extent of awareness and correct knowledge about RTI/STI among ever married women aged 15-49. • Source of information regarding HIV/AIDS.
	Village Questionnaire	**The information on:** • Availability of health & education facilities and services. • Other facilities in the village • Accessibility of these facilities throughout the year.
3	Facility	**Detailed enquiries would be made about human resources available, physical infrastructure and services provided at Sub Centre, PHC, CHC, Sub-Divisional Hospital and District Hospital**
i	Sub Centre (Serving for the sampled PSU)	• Supply of critical materials/inputs under RCH project. • Manpower availability • Availability and utilization of services
ii	Primary Health Centre (PHC) (Serving for the sampled PSU)	
iii	Community Health Centre (CHC)-all CHCs in the district.	
iv	Sub Divisional Hospital (SDH)-all SDHs in the district.	
v	District Hospital-all DHs in the district.	

NOTE: Draft questionnaires are given in the Annexure-C. Any addition or deletion of questions are possible in the given questionnaires. Workload may increase slightly if information on causes of death found in sampled households is to be introduced.

3.6. Obtaining information on Facility Survey

Facility Survey is expected to provide information on the availability of manpower, supply of critical materials/inputs under RCH project and availability & utilization of services at Sub Centre, Primary Health Centre (PHC), Community Health Centre (CHC), Sub Divisional Hospital (SDH) and District Hospital (DH) level.

3.7.   CAB Component

3.7.1. The Field Agency(s) would, inter-alia, be responsible for undertaking the CAB tests, canvassing of CAB schedules, undertaking prescribed internal and external quality checks regularly to ensure adherence to protocol and quality of data, handing over the sample, and transportation of samples to designated Partner Institute within the stipulated time. CAB tests and in DLHS-4 aim to produce district level estimates for nutritional status and prevalence of certain life style disorders   among all   members of households through measuring

- a. Anemia testing: Every one aged 6 months and above
- b. Height: Every one aged 1 month & above
- c. Weight: Every one aged 1 month & above (except pregnant women)
- d. Blood pressure: Aged 18 years & above
- e. Blood Glucose: Aged 18 years & above
- f. Testing of salt used by household for iodine component

Team Composition

3.7.2. The CAB tests will be carried out by two health Investigators in each of the field survey team. Prior to commencement of work, adequate training shall be provided to the Health Investigators of the field survey team along with the team supervisor by Partner Institutes.

Training

3.7.3. Training for the CAB component is to be organized at the premises of the Partner Institute. Wherever the partner institutes have the requisite infrastructure and are willing to take up the responsibility, the training of the field staff for the main survey of DLHS-4 may also be held at the campus of the partner institute along with the CAB training. Partner Institutes can charge the amount for organizing the training from the Field Agency as the provision is made for this in the budget of the Field Agency in the State(s) assigned, training of Health Investigators and Supervisors of Field Agency will be conducted in batches of 15-20 in a schedule that ensures a smooth, uninterrupted flow of training. On completion of the training of Health Investigators, NIHFW and its partner institutions will certify those Health Investigators/Supervisors who have successfully completed the training and has acquired the adequate skills to conduct the CAB tests for the survey. In case a Health Investigator/Supervisor is not able to successfully complete the training even after additional training, NIHFW and its partner institutions under intimation to MoHFW & IIPS will communicate the same to the respective Field Agency for not engage him/her for field work and replace with other staff after proper training. In order to take care of additional training requirements arising during the course of the survey due to attrition of field survey staff or otherwise, Partner Institutes in coordination with NIHFW would impart training to the new recruits or refresher training on any other account. The cost for the additional training shall be borne by the respective Field Agency(s).

Supplies and Equipments

3.7.4. The requisite CAB equipments and consumables will be centrally procured through centrally appointed Agency namely M/s HLL and made available to the Field agency through respective Partner Institutes. The CAB equipments will be provided to the Field Agency(s) at the time of training by the Partner Institutes. To ensure quality of equipments they will be checked for accuracy by Partner institutes before they are handed over to the Field Agency(s). The maintenance or repair or replacement of faulty equipments will be the responsibility of the Supplier Agency(s). The Field agency will not be responsible for procurement or maintenance of CAB equipments. The consumables will be delivered to the respective Offices of Partner Institutes. As regards sub standard consumables, the PI would intimate about the same to the supplier agency through NIHFW and IIPS using the fastest mode of communication and seek the replacement on most urgent basis. While doing so, it is to be ensured by the supplier agency that the field work should not be interrupted due to lack of consumables

Informed consent

3.7.5. Before undertaking the CAB tests in any household, FA will be responsible for communicating to each member of the household the details given in the ōSurvey Information Sheetö. Further, the field survey team of the Field agency will explain the details of the consent forms to each member and take their prior consent before the tests. If the household member is of age 6 months or below 18 years, the consent needs to be taken from either of the parent /guardian. However, if the member is above 6 months of age and below the age of 18 years then the consent needs to be taken from that household member as well as from his/her parent/guardian. In case the household member is above 18 years of age, then the consent needs to be taken from that member only. The Survey Information Sheet and consent form will be made available to the Field Agency(s) by IIPS.

Collection of Blood samples

3.7.6. CAB tests in DLHS-4 aim to produce district level estimates for nutritional status and prevalence of certain life style disorders among all members of the households aged 6 months and above. The blood samples will be taken to estimate the prevalence of anemia among the respondents above 6 months of age. The blood samples will also be collected to find out the prevalence of diabetes among all respondents aged 18 years and above.

Transportation of blood samples to designated partner institutes

3.7.7. All tests other than Hb estimation test shall yield ÷onóthe-spotø results and they should be recorded immediately in the CAB module of CAPI. As regards test for Hb estimation, the Field Agency(s) needs to ensure that the samples of blood spot are collected on filter paper, dried, put in a self-sealing bag, properly labeled and delivered to the earmarked lab(s) of designated Partner Institute in good condition (dried and sealed), in order to yield accurate results. These samples should reach the lab(s) of designated Partner Institute within one week from the date of collection. Any sample reaching beyond one week from the date of collection shall be rejected straight away. The above stated lab(s) of designated Partner Institute shall test the samples preferably within one week of the receipt of the samples and

send the test results to IIPS and NIHFW by email. The FA needs to follow up with the concerned lab of designated Partner Institute for ensuring timely receipt of the test results. Tentative mapping of partner institutes for each state / UTs is given in Annexure-A2. One person from each FA will be specifically designated with the responsibility of taking the Dried Blood Spot Samples (DBS) from the survey district to designated partner institute, while team supervisors will be responsible for supplying it to district level. All these procedures will use barcodes in triplicate and transmittal sheets should accompany the DBS and a copy of the same should be supplied to nodal agency by field agency. It will also be ensured that partner institutions use barcodes while sending the test results for integration to NIHFW and IIPS.

Quality Assurance

3.7.8. At any stage during the conduct of survey if it is found that the originally trained team or any member thereof has been replaced by someone without proper training at the respective Partner institutes, the CAB tests performed as well as the data collected by them would be summarily rejected and the field agency will have to re-do the work.

3.8. Establishment of State Level Field Office of Field Agency

Field Agency(s) appointed for each state is expected to establish a regular functional office with appropriate seating space for all core team members for that state with proper electricity, IT infrastructure, etc. The office should also compulsorily have a safe storage space to ensure that the consumables of CAB delivered to the office of the Field Agency(s) are stored in good condition. **And the office should be situated in the same city where Partner Institute is located**. This office should be functional during the entire duration of the Survey.

3.9. Data management & Tabulation

The software for the data collection will be prepared and the translated questionnaires will be loaded in the mini-laptop at IIPS. Besides, the software developed for the data collection would be pre-tested for the field situation before loading to the computer. The collected data by each investigator in the mini-laptop should be uploaded via FTP to the server located at IIPS on a daily basis by the field supervisor. The Field agencies should also send the data of the facility survey through FTP to IIPS. The supervisor of each team will be given the responsibilities of sending the data to the head quarter. The Head quarter staff will be responsible for uploading the data on FTP on a regular basis, as prescribed by IIPS. After validation and checking the data, feedback will be given to concerned Field Agency and Project Officer based in that state.

3.10. Fact Sheet generation

The factsheet containing selected indicators for all districts for each of the state covered by the field agency will be prepared by the field agency, according to the format given by IIPS. National and state level reports will be prepared by IIPS.

4. Roles and Responsibilities of Field Agencies (FAs)

DLHS-4 will be conducted in 26 States & UTs. However facility survey will be carried out in all the states and UTs. The FAs selected for DLHS-4 will be signing a contract for each state

& UT with IIPS for implementing DLHS-4. The household survey will be conducted using mini laptops (CAPI mode), and facility survey through paper & pen version of questionnaire. The Annexure A gives state-wise details of sample size of households.

4.1.   Overall roles and responsibilities assigned to Field Agencies

4.1.1. The principal responsibility of the FA is to carry out the DLHS-4 survey fieldwork in the assigned States/UTs. The sample will be spread over rural and urban areas of the state. 4.1.2.   The involvement of FA will start from the time of signing the contract with IIPS and continue till the state reports have been finalized.

4.1.3 The FA must translate all questionnaires into the appropriate local language(s) according to survey procedure. After signing the contract, the soft copy of bilingual questionnaires should be provided to IIPS for approval, and uploading to the software in the prescribed time.

4.1.4. Field Agency will print sufficient number of questionnaires, manuals (both Household and Facility), for training and field practice. Each trainee must be provided an Interviewerøs Manual and each supervisor must additionally receive a Supervisorøs Manual. Of course, separate manuals will be given to houselisters and mappers.

4.1.5.   IIPS will supply the list of selected villages and UFS blocks. FA will obtain the maps of selected Urban Frame Survey (UFS)blocks from NSSO (FOD) offices. FA will also be responsible for any official payment to obtain map(s) of selected UFS.

4.1.6.   FA will be responsible for complete listing of all households in all the sampled villages/ UFSs and the selection of the required number of households from the listed HHs, as per the procedure given by IIPS. Segmentation will be allowed in very large enumeration areas so that only selected segments need to be listed.

4.1.7.   Field Agency must send three senior staff members including Health Coordinator for each state to the Training of Trainers (TOT) workshop to be organised by IIPS and NIHFW respectively. These same staff members will be responsible to conduct the training of interviewers, field supervisors and Health Investigators for the state(s) assigned to that organization. The field agency must ensure that the trained staff will stay for the entire duration of the survey. The scheduled training programmes are: 1. House Listing & Mapping Training, 2. Training of Trainers (TOT), 3. CAPI training, 4. CAB Training for Health Coordinators. Cost of travel and stay of the trainees from FA will be borne by IIPS.

4.1.8.   Field Agency will organize the training programmes for (1) Houselisters and Mappers (2) Field investigators, supervisors for household and facility survey, and health investigators. The FA must train extra field personnel to ensure that there are sufficient number of field staff to conduct the fieldwork, after accounting for attrition and the dismissal of personnel who are not found to meet the minimum requirements; Health coordinator of FA will be responsible for training and supervision of the CAB component. In addition to this, he/she will be responsible for coordinating the activities with IIPS, NIHFW and partner institutions with regard to CAB component.

4.1.9. Only those who successfully complete the TOT conducted by IIPS must train the field investigators and other staff for DLHS-4 in each state.

4.1.10. Interviewer training in each state will be for at least three weeks duration and each interviewer must complete at least five practice interviews during the training.

4.1.11. FA will plan all fieldwork including Mapping & Listing well in advance and inform the fieldwork schedule to IIPS/MoHFW along with details of teams. Field work should not be started before getting permission from IIPS.

4.1.12. After completion of data collection, each field agency has to send all the mapping & listing materials (House listing forms, location & sketch maps of the PSUs/village) to IIPS.

4.1.13. FA will ensure the minimum non-response for interviews and the quality of data collection to the satisfaction of IIPS, MoHFW and the timely completion of the survey work. There will be penalty clause(s) in the contract for any delay in completing the survey and poor quality of data.

4.1.14. FA is required to ensure that each interview is done only after the informed consent of the respective respondent is obtained, including for the CAB component.

4.1.15. FA will make sure that investigators keep all the information collected from each and every respondent strictly confidential.

4.1.16. FA is required to extend the necessary cooperation to the monitoring personnel from IIPS and other collaborating agencies.

4.1.17. A set of Field Check Tables will be produced by IIPS and will be given to the Field Agency. This will help the FA to monitor the work of each team.

4.1.18. FAs that are part of university, or government agency will be required to provide a letter (prior to signing the subcontract) from the parent organisation certifying that the FA will be allowed to set up a special bank account for DLHS-4, controlled directly by the Project Coordinator of the FA and that the FA will be allowed to follow special project arrangements for travel rules, duration of travel and per diem expenses, and other survey procedures.

4.1.19. For household survey, each team should be provided with a vehicle (7 members in each team). To ensure high quality of data and retention/continuation of the trained field staff, the FA should provide appropriate salary and DA to their field staff every month.

4.1.20. FAs are strictly debarred from extending any undue favors to any monitoring staff from IIPS or PRCs. Any such instance may be brought to the notice of IIPS/MoHFW.

4.1.21. Field Agency(s) should prepare electronic data files as per IIPS requirements and submit the clean data files for facility to IIPS in a timely manner as per the instruction from IIPS.

4.1.22. In order to carry out all these activities, FAs need to have office in the states where they undertake the fieldwork. Details of the field level offices should be informed to IIPS / MoHFW well in advance.

4.1.23. The head office of the FAs and state offices need to have all the basic modern communication facilities such as internet, fax, telephone (land line) & mobile phone for each field staff.

4.1.24. Field Agency(s) should have sufficient storage place in the office to securely store all the supplies (facility survey questionnaires, CAB consumables, instruments and stationeries, etc).

4.1.25. It is essential to have sufficient number of computers of required specification for timely completion of the data entry/editing/validation of facility survey.

4.1.26. Minimum of three days visit in a PSU is essential for household and eligible women survey.

4.1.27. Each FA needs to prepare and print State Fact sheet consisting of indicators for all districts (one thousand copies) and distribute as per the list provided by IIPS. Weekly progress reports should be sent to IIPS on every Friday, in a format prescribed by IIPS, to report the field level activities.

4.1.28. Each team supervisor should be given one pen drive of 4 GB capacity to facilitate the data transfer.

4.1.29. Arrangement of additional manpower and logistics for safely transferring of the DBS samples from the field to the designated Partner Institute is the responsibility of FA.

4.1.30. Each team supervisor should be responsible for ensuring safe disposal of biomedical wastage. This should be done scientifically and environment-friendly manner in the PSU itself.

4.1.31. Materials needed for disposal of bio-hazardous waste will be purchased by FAs.

4.1.32. The instruments and materials needed for CAB testing and measurements will be provided to FAs. This should be handled very carefully by survey teams, and should be returned after completion of the survey. In case of any loss/damage of instruments, FA will be responsible for meeting the cost.

4.1.33. The IIPS/MoHFW will be providing instructions/ suggestions from time to time during the survey. This needs to be followed by FAs for the smooth conduct of the survey.

4.1.34. In order to get proper response for the household survey from the public, FAs are required to publicize about the survey and its purpose, through local newspapers/electronic media in the state, before initiating the field work.

4.1.35. Contract agreement has to be signed between the Director of IIPS and the Executive Director/MD of selected Field Agency.

4.1.36. Roles and Responsibilities of Partner Institutes for CAB Component

 (See Annexure C)

4.1.37. Roles and Responsibilities of NIHFW for CAB Component (See Annexure D)

5.   IMPLEMENTATION SCHEDULE/TIME LINE FOR DATA COLLECTION

The DLHS-4 fieldwork would be completed in all districts within a period of six months followed by preparation of District fact sheet. The details of deliverables along with time line are given in the table below:-

Sr. No.	Deliverable/ Activities	Time line
1	Training for Mapping & Listing	1 week including field practice both in rural & urban areas.
2	Mapping & listing operation	It should be started immediately after the mapping & listing training and should be completed before one month of commencing of the actual field work. FA should provide one GPS instrument and mapping & listing manual to each team.
3	Survey materials for training	All the questionnaires with bilingual as well as all the manuals for reference with sufficient quantity before starting the training of main survey (at least 1 week before).
4	Main survey training & CAB training	The Field Agencies should provide the training to their investigators for a minimum of three weeks which includes the field practices. Minimum of 3 days training should be arranged separately for health investigators including field practice for CAB component. The Health Investigators will also join the main survey training to understand the whole process of the data collection.
5	Main field work including facility survey	After completion of 3 week training, the field agency should start field work immediately. Actual field work will be completed in **six months** period from the date of commencement of the field work. The number of teams will be equal to the number of districts assigned to FA. However FA should not start work more than four to five districts at a time. Agency should start field work simultaneously only in the adjoining districts. It is also important for every field agency to submit weekly progress report to the IIPS. After completion of each PSU, FA has to send the data to IIPS's FTP account immediately.
6	Data entry for facility survey	After completion of one district FA should send the final validated data to IIPS within one week of time.
7	Fact sheet generation	Each FA needs to prepare and print State Fact sheet carrying indicators for all districts (one thousand copies) and distribute as per the list provided by IIPS.

6. PAYMENT SCHEDULE

The payment plan for Field Agencies, DLHS-4 is provided in the table below:

		Verifiable indicator	% of the Amount to be released
	Total Budget		
1st Installment	**Disbursement Modality** 1. After Signing of the Agreement and furnishing Bank Guarantee from a nationalized bank and or recognized by the RBI equal to 20 % of the total cost of the work allotted. On giving details of the addresses of the state office, name of the state nodal officer (team leader), telephone/fax numbers/communication details of the field supervisors, email ids	On Physical receipt of the bank Guarantee in the IIPS and verification. On Physical receipt of the details from the head /MD	20%
2nd Installment	2. At the time of the beginning of the Field Work i.e. on: - Completion of Recruitment of all field staff - Completion of Training and - Completion of Printing of Questionnaires for facility survey - and on certification of FA appointed by IIPS and self certification by Head/MD of the Field Agency.	Letter from Head/MD of the FA giving details of recruitment and completion of training of field staff including mappers and listers etc. **And** Copy of the Printed questionnaires for Facility Survey received in the IIPS **And** Report of the Project officer/Project coordinator from IIPS/Monitoring agencies engaged by MoHFW **And** Completion of the financial requirements as per prescribed format provided by IIPS.	25%

3rd Installment	3. On the completion of the 50 percent targeted individual interviews/ PSUs in the state subject to verification by IIPS, a self certification by Head/MD of the Field Agency.	Letter from Head/MD of the FA giving details **And** Report of the Project officer/Project coordinator from IIPS/Monitoring agencies engaged by MoHFW **And** Completion of the financial requirements of previous releases	25%
4th Installment	4. On completion of 100% individual interviews/ PSUs in the state and validation of data.	Same as above **And** Completion of the financial requirements of previous releases	20%
5th Installment	5. On printing of Fact Sheets and acceptance of State Reports.	Same as above and on receipt of the fact sheets **And** Completion of the financial requirements of previous releases On returning of all Biomarker materials and equipments as per the instruction of IIPS. The Cost for transportation will be borne by the FA.	10%

7. GUIDELINES FOR SUBMITTING PROPOSAL

7.1. Technical Proposal

An organization can bid for maximum of 4 groups of states/UTs as per the grouping of States/UTs provided in Annexure A for the main survey including facility survey under DLHS-4 for non-AHS States. In addition FA can also bid for two more states from the AHS States for facility survey only. However, any FA will be assigned a maximum of two groups from non-AHS and one state from AHS for facility survey. FA is required to submit one comprehensive proposal consisting of a technical proposal and a cost proposal for each group of States/UTs. If the technical and financial proposals are found to be in proper order, the agencies belonging to the same state/UT will get preference over the agencies that are located outside the state/UT.

Items to be included in these proposals are as follows.

a. Organizational Profile

i. Name and address of the Organization.

ii. Year of establishment.

iii. Legal status of the Organization ó Whether Organization is registered under society Registration ACT or is an autonomous body or a Limited company or partnership firm, etc. and details there of (e.g. ó name(s) of partners, Managing Directors, Chief Executive Officers, key person,)

iv. Principal nature of activities undertaken.

  v. Organizational structure and names of personnel, their titles, and *curriculum vitae* including nature of appointment and duration with the organization of the key personnel proposed to be involved in the DLHS-4 project for each state, roles and responsibilities of the persons to be engaged for DLHS-4 project, where they propose to undertake the work. Please mention each key personøs specific role and time allocation for undertaking activities in DLHS-4;

  vi. Details of manpower as prescribed above.

  vii. Communication details of the organization: mailing address, telephone and fax numbers, email address, etc.

  viii. Signed consent of the organizationøs head and the identified Project Coordinator (State Level) to sign a MoU and agree to abide the terms & conditions set out in the project of conducting DLHS-4 field work.

b. Survey Experience

  i. Area of specialization of Field research/survey (enclose copy of the papers, letter of engagement, etc.)

  ii. Indicates the geographical location of surveys conducted jointly or alone

  iii. List of large scale demographic and/or health surveys conducted by the Organization (including DLHS, NFHS, AHS, CES, CE-NRHM, etc) with information on geographical area covered, number of officers and supervisors, investigators engaged and number of households covered in the last three years.

  iv. Name and addresses of sponsoring or funding agencies for whom the earlier surveys were conducted. (Indicate key personøs name and contact details of sponsoring / funding agencies).

  v. Were the surveys completed in time? If not, reasons thereof.

  vi. The cost of the each survey conducted should be submitted separately in a tabular form with documentary evidence.

  vii. Documentary evidence of experience of conducting large scale demographic and /or health surveys.

c. Financial Status of the Organization (For the last 3 years)

  i. Total revenue and expenditure of the organization.

  ii. Latest copy of the certified Audited Annual Accounts in support of the Financial Status.

  iii. The agency having an annual turnover of minimum Rs. 2 crores can only bid for DLHS-4.

  iv. The PRCs being fully funded by the grants-in-aid by MoHFW, Govt. of India, they are exempted from the turnover criteria in point iii.

d. Income Tax Details (Applicable to all bidders except for the PRCs)

  i. Whether the Organization is exempted from Income Tax? If yes, please furnish the exemption certificate number and date up to which exempted. A copy of exemption certificate is to be attached.

ii. If no, furnish PAN/TAN number, the copy of the latest Income Tax returns and assessment order.

For PRCs

PRCs affiliated to universities / research institutions are required to submit a letter from VC / Director / head of the institutions allowing them to open a separate bank account for DLHS-4 funds. An authority letter stating that the fund could be handled by the Project Coordinator, duly nominated by the VC / Director / head of the institution, is to be produced.

7.2. Financial Proposal

a. The financial quotes should cover the entire cost of household survey including CAB component and facility survey, data entry for facility survey, training their survey staff/data entry operators, travels & allowances, all resource cost, printing and distribution of fact sheet, manuals, questionnaires (facility) etc. The total cost converted in to per household cost should be given for non-AHS states.

b. The total cost quoted should be inclusive of all taxes.

c. The financial proposal will be evaluated only when a field agency is qualified with the technical proposal. In addition to it, even after clearing the technical proposal, those FAs which quote the survey cost per household less than 60% of the base price estimated by IIPS, will not be considered.

d. You may assume that the ratio of currently married women aged 15-49 and number of households in an area is 1:1 and the number of households per PSU is 25-30. The state wise sample size and coverage of facility details are given in Annexure A.

e. For CAB workload is given in Annexure A2.

f. The Unit Cost for Household and CAB component details are as below:

Unit Cost (INR) (Inclusive of all Taxes)										
Man Power	Training	Printing of Manual	Transportation for Field Staff (Hiring Vehicle)	D.A. & Salary for Field Staff	Monitoring & Supervision	Communication	Disposal of Bio Hazards materials of CAB	Miscellaneous Expenditure	Printing & distribution of Fact Sheet	Total Cost Per Unit

g. The Unit Cost for Facility Survey details are as below:

Unit Cost (INR) (Inclusive of all Taxes)								
Man Power	Training	Printing Questionnaire & Manual for Facility Survey	Transportation	D.A.& Salary for Field Staff	Monitoring & Supervision	Data Entry of Facility Questionnaire	Miscellaneous Expenditure	Total Cost Per Unit

7.3. SUBMISSION OF BIDS

É The bidder shall submit a sealed cover consisting of two (2) copies of all the bid documents. Both of the copies of the bids (Original and Duplicate) must

consist of the following:

    a. Pre Qualification Bid

       As per the Pre-qualification criteria given in Section 2 along with requisite EMD.

    b. Technical proposal, super scribing on the right hand side top of the cover as Technical Bid and the state/UT for which this technical bid is being submitted.

    c. Financial proposal super scribing on the right hand side top of the cover as Financial Bid and the state/ U T for which this financial bid is being submitted.

- The envelopes containing the Technical & Financial Proposal for a particular State/UT has to be enclosed in another envelope, clearly superscribing the original/duplicate copy, contents of the envelope, the state/UT of the enclosed proposals.

- Note: However for each State/UT separate sealed envelopes containing technical and financial proposal for that respective State/UT needs to be submitted.

É All the pages of the Financial Proposal shall be duly signed by the authorized signatory of the bidder before submission. Corrections, if any shall be counter signed.

7.4.   GENERAL INSTRUCTION AND TERMS & CONDITIONS

a) The proposal along with all the correspondence and documents exchanged by the Agency and IIPS shall be written in English language.

b) **Amendments to the tender:** IIPS reserves every right to amend any of the tender conditions or a part thereof before the last date for the receipt of the tender, if necessary. Amendments, if any, would be put on the web. The decision of extending the due date and time for the submission of tender documents on account of amendments will be the sole discretion of IIPS

c) IIPS reserves the right to cancel the IFP at any stage without assigning any reason.

d) **Earnest Money deposit**: The bidders should furnish an Earnest Money Deposit of Rs 1,00,000 for each of the non-AHS states and RS 50,000 for AHS state for which agency is bidding by means of Demand Draft / Banker Cheque drawn on any Nationalized Bank / Scheduled Bank payable in favour of the õ**Director, IIPS**ö. The Demand Draft/Banker Cheque for the earnest money shall be put in the envelope for the Prequalification Bid as the Technical and Financial Bid would be opened only in respect of those bidders who qualify the prequalification criteria. The Tenders received without the Earnest Money Deposit will be summarily rejected. The Earnest Money Deposit will be refunded after the completion of selection process. The amount remitted towards Earnest Money Deposit is liable to be forfeited in the case the bidder resoles from his offer after submission of the tender or after the acceptance of the offer by IIPS or fail to sign the contract or to remit the Security Deposit. No interest will be payable by the IIPS on the Earnest Money Deposited / remitted.

e) **Performance Bank Guarantee (PBG):** The successful bidder shall at his own expense deposit with IIPS, within fifteen (15) working days of the date of notice of award of the contract or prior to signing of the contract whichever is earlier, an unconditional and irrevocable Performance Bank Guarantee (PBG) from a Nationalized / Scheduled bank acceptable to IIPS, payable on demand, for the due performance and fulfillment of the contract by the bidder. This Performance Bank Guarantee (PBG) will be for an amount equivalent to 20% of the contract value which would be renewed every year. All incidental charges whatsoever such as premium; commission etc. with respect to the performance bank guarantee shall be borne by the bidder. The performance bank guarantee may be discharged/ returned by IIPS upon being satisfied that there has been due performance of the obligations of the bidder under the contract. However, no interest shall be payable on the performance bank guarantee.

f) No proposal shall be accepted unless it is properly sealed. Agency shall not be allowed to fill in or seal their proposal at the IIPS office. The documents should be sent by speed post/registered post/courier or hand delivered.

g) If the envelope is found to be open, not sealed and not marked as instructed above, IIPS will not be responsible for misplacement or premature opening of the proposal submitted. Any proposal opened prematurely due to this cause shall be rejected.

h) The bidder is advised to attach any additional information that is considered necessary in regard to establish the capabilities. No further information will be entertained after submission of application unless it is required by IIPS. The IIPS, however, reserves the right to call for additional information and clarification on information submitted by the bidders.

i) Proposals must be received by IIPS, at the address specified not later than the date and time specified in the Invitation of RFP. In case the specified date for the submission of proposal being declared holiday by the IIPS, the same will be received on next working day with the same specified time. Proposals received after the due date and time specified will automatically be rejected. on 31st October 2011

j) **Opening of tender:** Sealed tenders received up to 31st October 2011 by 5.00 PM will be taken up for opening. Tenders received after specified date and time will not be accepted. IIPS reserves the right to disqualify any of the tender in case it is not satisfied with the documents furnished or otherwise without assigning any reasons thereof. Any efforts by an agency to influence the IIPS personnel or representatives on matters relating to proposals under study in the process of examination, clarification, evaluation and comparison of proposal and in decision concerning award of contract, shall result in the rejection of the Agency's proposal and also lead to blacklisting of the organization.

k) Failing to execute the contract Agreement within the said period may result in termination of contract and award of the same to other agency/ agencies at the risk and cost of the Agency.

l) The person to sign the contract agreement shall be duly authorised.

m) The data, schedules, reports and other materials used by the agencies during the

conduction of the survey shall remain the property of the IIPS. The Agencies will not be allowed to use this information in any forum, national or international, without the explicit permission given in writing by the IIPS.

n) The RFP shall not bind the IIPS in any way whatsoever to offer any job to the applicant if it is decided to abandon the study.

o) **Arbitration:** Should any dispute arise, it may be referred to a sole arbitrator appointed on mutual consent.

p) The Field agency should invariably mention their order of preference for the States they are bidding for. The specified preference would be taken into consideration while allotting the States to the selected Field Agency. However the final decision on allotment of a particular State to the selected Field agency remains the sole prerogative of IIPS.

q) Continuance of the Core Team members for the entire project period is strongly desired in order to ensure effective execution of the project. However, to take care of unavoidable circumstances, the Field agency should have appropriate clause in their contract agreement to bind the outgoing member of the core team for at least one month to ensure proper handover, training and handholding to the newly appointed resource. This should invariably be done with the concurrence of the IIPS. In case of any attrition in the survey team, the agency would be required to ensure that the new staff is appropriately trained before putting them to the task. The training and handover is to be monitored by the team leader and the status of completion for the same is to be reported to the IIPS.

r) Cost of travel and stay of the officials from Field agencies for attending training other than TOT/meeting at PI / IIPS will be met by the Field Agency

s) Hard copy of the Prequalification, Technical and Financial proposals should be sent in separate envelopes placed in one large envelope marked as-

BID FOR DLHS-4, and addressed to
The Director,
International Institute for Population Sciences,
POST BOX NO. 8307
Govandi Station Road, Deonar, Mumbai-400 088
Tel: 91+22+42372400/42372463
Fax:91+22+2556 3257

The last date for submission of complete proposal with all supporting documents (by hand or by post) is 31st October 2011. Any proposal received after the prescribed time will not be entertained. IIPS will not be responsible for any loss or postal delay.

8. EVALUATION OF PROPOSAL FOR FAs

8.1.   An evaluation committee formed by IIPS & MoHFW would examine both the technical and financial bids based on the details provided in the Invitation for proposal for those agencies who are short listed as per the Prequalification criteria.

8.2.   Selection of FAs:

a.   FAs are required to score a minimum of 60 points out of 100 to be qualified in the technical proposal.

b.   Financial bid of FA will be opened only if the FA qualify in the technical evaluation (scoring of minimum of 60 points). Financial bids will be opened in the presence of all short listed FAs on the basis of technical proposal.

c.   For the final evaluation, the weightage for technical and financial proposals is in the ratio of 60:40 as per Quality and Cost Based Selection (QCBS) criteria.

d.   IIPS shall reserve the right to negotiate with the bidder (s) whose proposal has been ranked first by the committee on the basis of Joint Technical and Financial Evaluation.

e.   The proposal will be valid for 90 days from the date of submission; IIPS will make its best efforts to select the field agency within this period.

Technical Evaluation

Technical evaluation shall be carried out based on the following:

Sr. No.	Item	Responses
PART A (Organizational Profile)		
i.	Name and address of the Organization	**Mentioned (Y/N)**
ii.	Year of establishment.	**Mentioned (Y/N)** (a) More than 5 years (b) Less than 5 years
iii	Whether Organization is registered under Society Registration Act or is an autonomous body or a Limited company or partnership firm, etc	**Mentioned (Y/N)**
iv	Details there of (e.g. ó name(s) of partners, Managing Directors, Chief Executive officer, key person,	**Mentioned (Y/N)**
v	Principal nature of activities undertaken.	**Mentioned (Y/N)**
vi	Organizational structure and names of personnel, their titles	**Mentioned (Y/N)**
vii	Whether signed consent of all key participants enclosed?	**Y/N :**
viii	Whether Roles and responsibilities of the persons to be engaged for DLHS-4 Project is attached?	**Mentioned (Y/N)**

ix	*Curriculum vitae* including nature of appointment and duration with the organization of the key personnel	**Mentioned (Y/N)** **Nature of Appointment of Key person:** Permanent: Temporary/Contractual/Honorary:
x	Where they propose to undertake the work?	Mentioned (Y/N) (Whether properly given as per the state's Grouping? If not seek information)
xi	Communication details of the organization: mailing address, telephone and fax numbers, email address, etc.	Mentioned (Y/N) (If not seek information)
xii	Whether signed consent of the organization's head enclosed and the identified project officer agrees to sign a MoU to abide by the terms & Conditions set out in the Project of conducting DLHS-4?	Y/N (If No, seek clarification and if provided immediately, accept the bid. Else reject the entire bid.)
PART B : Survey Experience in last 3 years		
xiii	Area of specialization of Field research/surveys (enclose copy of the papers, letter of engagement, etc).	É Any Survey Work: É Any social sector Survey (other than Health): É Demographic/Health Surveys: É No experience in surveys: (Multiple responses: Multiple marking)
xiv	Geographical location of surveys conducted jointly or alone	É Studies carried out in the State/region proposed: É Elsewhere :
xv	List of large scale sample surveys conducted by the Organization with information on geographical area covered, number of officers and supervisors, investigators engaged and number of households covered.	Mentioned Y/N
xvi	Name and addresses of Sponsoring or funding agencies for which the earlier surveys were conducted. (Indicate key persons' name and contact details of sponsoring /funding agencies).	Mentioned Y/N
xvii	Whether earlier surveys completed on time?	Examine for last 3 years' activities and compare with the timeline É Completed: É Partially: É Else:

xviii	Cost of the surveys conducted in the last 3 years.	• At least 3 surveys of more than ` 50 lakhs each: • At least 3 surveys between ` 25-50 lakhs each: • At least 3 surveys less than `25 lakhs each:
xix	Whether documentary evidence of experience of conducting large scale demographic and/or health surveys provided.	Mentioned Y/N
PART C Financial Status of the Organization ((For the last 3 years)		
xx	Total revenue and expenditure of the Organization	Cumulative Turn Over in last three years ÉMore than ` 4 Crores**:** • *Between ` 2-3 Crores :* • *Between `1-2 Crores:* ÉLess than `1 Crore:
xxi	Latest copy of the certified Audited Annual Accounts in support of the Financial Status enclosed?	Mentioned Y/N
PART D Income Tax Details (Applicable to all bidders except for the PRCs under universities)		
xxii	É Whether the Organization is exempted from Income Tax? ÉWhether the exemption certificate number and date up to which exempted provided?	Y/N Y/N:
xxiii	É If not exempted, copy of the latest Income Tax returns and assessment order attached?	Y/N:
xxiv	PRCs affiliated to universities/research institutions are required to submit a letter from VC / Director / head of the institutions allowing them to open a separate bank account for DLHS-4 fund. And a authority letter that the fund could be handled by the project officer, duly nominated by the VC / Director / head of the institutions	Y/N:
PART E: DETAILS PERTAINING TO FIELDWORK FOR DLHS-4		
Operational Plan		
xxv	Name of the state(s), in which the Organization is proposing to undertake fieldwork. If, in more than one state, whether the names of the states are mentioned in order	Mention: Y/N Mention: Y/N

	of priority?	
xxvi	Whether details of the Operational Plan for each state enclosed?	Y/N: (Examine the quality of the operational plan)
xxvii	Whether the Agency has a local Office in the State proposed for undertaking the Fieldwork?	Yes/ No:
xxviii	Is it a permanent Establishment with Computers, Storage Space, communication facility etc/ or / Temporary?	Yes/No:
xxix	Availability of Staff in the State Office	ÉTeam leader of the State is located in the States: Yes/No: ÉTechnical/ Supervisory officers are located in the State office: Yes/No:
xxx	House listing/Mapping /fieldwork Plan enclosed	ÉIf Yes : If No : (Examine the quality of the operational plan)
xxxi	Whether the number of teams proposed confirm to estimated requirement?	ÉCompletely /Partially /Not at all: (Examine the quality of the operational plan)
xxxii	Training (Investigators, mappers, House listers, paramedics etc) Plan enclosed	ÉYes/No:
xxxiii	Whether Training Plan confirms to the plan conceptualized by IIPS?	ÉCompletely /Partially /Not at all: (Examine the quality of the operational plan)
xxxiv	Whether Data management Plan ensuring quality and timeliness (including data transportation) of data enclosed?	ÉYes/No: (Examine the quality of the operational plan)
xxxv	Whether Logistics arrangement like boarding, lodging plan for field staff enclosed.	ÉYes/No:
xxxvi	Whether Transportation Plan of the investigators among the PSUs and districts, enclosed? (Specially the number of vehicles required):	ÉYes/No:
Examination of CVs		
	Name of post	**General Qualifications/experience**
xxxvii	**Project Coordinator**	1. Ph D./Masters Degree in Mathematics/Statistics/Social Science included Demography 2. **Experience in large scale surveys** At least 5 years experience of handling large scale demographic/health survey as a team leader

xxxvii	**Statistician/Demographer**	1. Is there a Statistician/Demographer of the Agency associated with large scale surveys?
		2. **General Qualifications**
		  Ph D./M.Phil/ Masters Degree in the relevant field
		3. **Experience in large scale surveys**
		  a. 3 years of Experience for Ph.D./M. Phil
		  b. 5 years of Experience for Master Degree in handling Large Scale Demographic Survey data

xxxix	**IT Specialist**	1. Post Graduate degree/Diploma in any Computer Science Application 2. **5** years of Experience in handling Large Scale Demographic Survey data

xxxx	**Health Coordinator**	1. General Qualification
		  • MBBS/BAMS or any other medical degree
		2. Experience
		  • At least two years experience in Bio- Marker in Health survey

ANNEXURE A

Group-wise sample allocations of PSUs for non-AHS States

States		Number of PSUs per districts				Total no. of districts
		40	**50**	**60**	**70**	
Group 1	Jammu & Kashmir		14			**14**
Group 2	Himachal Pradesh	12				**12**
Group 3	Punjab		5	5	10	**20**
	Chandigarh		1			**1**
Group 4	Haryana		7	5	8	**20**
Group 5	Delhi		9			**9**
Group 6	West Bengal		15	3	1	**19**
Group 7	Gujarat		13	2	10	**25**
	Dadra & Nagar Haveli				1	**1**
	Daman & Diu		1		1	**2**
Group 8	Maharashtra		17	7	11	**35**
Group 9	Andhra Pradesh		12	2	9	**23**
	Andaman & Nicobar Islands	3				**3**
Group 10	Karnataka		9	5	13	**27**
	Goa		2			**2**
Group 11	Kerala		9	2	3	**14**
	Lakshadweep		1			**1**
Group 12	Tamil Nadu		18	6	6	**30**
	Puducherry		4			**4**
No. of Districts		15	137	37	73	262
No. of PSUs		600	6,850	2,220	5,110	14,780
North Eastern States						
Group 13	Sikkim	4				**4**
Group 14	Arunachal Pradesh	16				**16**
Group 15	Manipur	9				**9**
	Nagaland	11				**11**
Group 16	Mizoram	8				**8**
Group 17	Tripura	4				**4**
Group 18	Meghalaya	7				**7**
No. of Districts		59				59
No. of PSUs		2,360				17,140
		Total Number of Households				**4,28,500**

ANNEXURE A1

State-wise sample allocations of PSUs for AHS States
(As per 2001 Census)

State	No. of Districts	Sample Units (PSUs)	No. of Sample Units (PSUs) per District	No. of Households	No. of HHs per PSU	Sample Population Total	No. of Households per District
Assam	23	1,784	78	3,27,593	184	16,37,967	14,243
Bihar	37	2,356	64	4,39,268	186	21,96,340	11,872
Jharkhand	18	2,109	117	3,77,504	179	18,87,520	20,972
Madhya Pradesh	45	2,557	57	4,40,432	172	22,02,161	9,787
Chhattisgarh	16	1,255	78	2,25,188	179	11,25,940	14,074
Odisha	30	2,364	79	4,28,264	181	21,41,319	14,275
Rajasthan	32	1,841	58	3,24,342	176	16,21,710	10,136
Uttar Pradesh	70	3,927	56	6,93,893	177	34,69,464	9,913
Uttarakhand	13	2,059	158	3,68,934	179	18,44,670	28,380
Total	**284**	**20,252**	**71**	**36,25,418**	**179**	**1,81,27,089**	**12,766**

ANNEXURE A2
State-wise total number of Households and PSUs along with tentative workload for CAB Component and Designated Partner Institute

Household calculated = Number of PSUs in the State x No: of HHs (25) per PSU							
For Height and Weight measurement, all population aged one month and above in the sample will be covered. All Households in the sample will be covered for salt testing							
States	Districts	Total no: of PSUs	Total HHs in State	Total no: of HB	Total no: of BP/Sugar	Total no: of sample size	Partner Institution for Blood test
			PSU x HH (25)	PSU x HH (25) X 4.7	PSU x HH (25) X 3.5	10% extra	
J & K (Jammu)	10	500	12500	58750	43750	65000	Dr. R.P. Govt. Medical College, Tanda, Himachal Pradesh
Himachal Pradesh	12	480	12000	56400	42000	62100	
J & K (Kashmir & Ladakh)	12	600	15000	70500	52500	77600	Sher -E Kashmir Institute of Medical Sciences
Punjab	20	1250	31250	146875	109375	160000	PGIMER
Chandigarh	1	50	1250	5875	4375	6500	
Haryana	21	1210	30250	142175	105875	156000	
Delhi	9	450	11250	52875	39375	58200	NIHFW, DELHI
Gujarat	26	1510	37750	177425	132125	195000	NIOH, Gujarat
Daman & Diu	2	120	3000	14100	10500	15500	
Dadra & Nagar Haveli	1	70	1750	8225	6125	9000	
Maharashtra except vidharbha	16	920	23000	108100	80500	118900	NIRRH, Maharashtra
Maharashtra vidharbha only	19	1120	28000	131600	98000	144760	MGIMS, Sewagram
Sikkim	4	160	4000	18800	14400	20600	RMRC, Dibrugarh
Arunachal Pradesh	16	640	16000	75200	56000	80700	
Manipur	9	360	9000	42300	31500	46500	RIMS, Imphal
Mizoram	8	320	8000	37600	28000	41300	
Nagaland	11	440	11000	51700	38500	56870	
Tripura	4	160	4000	18800	14000	20700	Govt. Medical College, Agartala
Meghalaya	7	280	7000	32900	24500	36100	NEIGRIHMS, Shillong
Andhra Pradesh	23	1350	33750	158625	118125	174400	Gandhi Medical College, Hyderabad
North. Karnataka	15	920	23000	108100	80500	118900	JN Medical College, Manglore
South. Karnataka	15	920	23000	108100	80500	118900	Kasturba Medical college,Manglore
Goa	2	100	2500	11750	8750	12900	NIRRH, Maharashtra
West Bengal	19	1000	25000	117500	87500	129250	NICED
Lakshwadeep	1	50	1250	5875	4375	6500	Thiruvananthapuram Medical college
Kerala	14	780	19500	91650	68250	100800	
Tamil Nadu	32	1680	42000	197400	147000	217100	NIE Chennai
Puducherry	4	200	5000	23500	17500	25900	
Andaman & Nicobar	3	120	3000	14100	10500	15500	

ANNEXURE B

Equipments and materials for conducting CAB tests

The CAB equipments and consumables to be used for capturing various health indicators through CAB tests are mentioned in the table below:

'CAB Equipments and Consumable Set' No.	Test No.	Test Type	Test Name	Equipments	Consumables
CAB Equipments and Consumable Set - 1	Test-1	Anthropometric	Length	• Infantometer	NA (Not Applicable)
			Height	• Wall-Mounted Height Measuring Steel Tape	NA (Not Applicable)

CAB Equipments and Consumable Set - 2	Test-2	Anthropometric	Weight	• Electronic Weighing Machine	• Lithium Battery
					• Calibration Weights
					  o 2kgs
					  o 1 Kg
					  o 500 gms
					  o 100 gms
					  o All weights should be ISI certified

CAB Equipment and Consumable Set - 3	Test-3	Biochemical	Fasting Blood Glucose estimation	• Blood Glucose estimation by Glucometer	• Glucose Strips • Lithium Battery
CAB Equipment and Consumable Set - 4	Test-4	Clinical	Blood Pressure	• Digital BP Battery Apparatus	• Alkaline / Lithium Battery
CAB Equipment and Consumable Set - 5	Test-5	Biochemical	Hb estimation	• Colorimeter • Constant Voltage Stabilizer	• Filter Paper (Sets of 500 Big Sheets (46 cmx57 cm)) • Pipette • Lancet • Drabkinøs Solution • Solvent Ether • Distilled Water

'CAB Equipments and Consumable Set' No.	Test No.	Test Type	Test Name	Equipments	Consumables
					• Fixed volume automatic dispenser (Bottle Top) • 500 ml plastic bottle with screw-top • 100ml plastic bottle with screw-top • 10 ml plastic test tubes with screw-top. • 10 ml dropper plastic bottle. • Plastic self-sealing Envelope with printed label on it • Laminated Envelope with address printed on it • Cotton (Rolls of 1 Kg)
CAB Equipment and Consumable Set - 6	Test - 6	Biochemical	Salt Test	NA (Not Applicable)	• Salt Test Kits

ANNEXURE: C

Roles and Responsibilities of NIHFW for CAB Component

a) Instructions and Protocols

1. NIHFW will prepare Draft Instruction Manuals with the following details:
2. Procedure and Protocol for carrying out the CAB tests & instructions for filling up of CAB Schedule;
3. Detailing of Ethical guidelines (to be supplied by IIPS) as approved by the Ethics Committee that need to be adhered to for carrying out the CAB tests;
4. Quality control procedure for ensuring accuracy in measurement
5. Protocols for Hb estimation by Partner Institutes including the internal and external quality control mechanisms
6. Infection control and waste disposal practices to be followed for the field survey as well as by partner institutions while carrying out the lab Hb estimation test;
7. Besides, NIHFW will also assist IIPS in issuing necessary clarifications to the queries raised by the Field Agency(s) from time to time.

b) Training for CAB Component

Conduct of ‗Training of Trainers‗ of Partner Institutions for CAB component including preparation of the following:

1. protocols of tests measurements to be done in fields and collection of blood sample for Hb. Partner Institutes will be required to provide training on this to the Health Investigators and Supervisors of Field Agencies
2. Protocols to undertake the accuracy checking of CAB equipments which are to be handed over to the Health Investigators/Supervisors of Field Agency(s) by the respective Partner Institutions (including NIHFW) for the earmarked States after the training of the Health Investigators/Supervisors of Field Agency(s)
3. Protocols on Hb estimation to be done by Partner Institutes from the blood sample received from the Field Agency; This would include protocols for maintenance of the lab and quality checks.
4. Protocols for training of data entry operators about data entry, transmission of data and submission of reports etc.
5. Provide each Partner Institution with a customized training plan for undertaking training of Health Investigators/Supervisors for the earmarked States. The details of the training plan will be finalized by NIHFW in discussion with each partner institution and IIPS;
6. Provide training to Health Investigators/Supervisors for the States that are assigned to NIHFW;
7. To coordinate with the partner institutions for smooth and un-interrupted conduct of training programmes to Health Investigators / Supervisors of Field Agencies in batches of 15-20. In case of any interruption either due to inadequate batch size or due to any other reason, the same is to be communicated to IIPS & MoHFW along with possible remedial measures;

8. In order to take care of additional training requirements arising during the course of the survey due to attrition of field survey staff or otherwise, NIHFW in coordination with its partner institutions would impart training to the new incumbents or refresher training on any other account. The cost for the additional training shall be borne by the respective Field Agency(s).

9. On completion of the training of Health Investigators, NIHFW and its partner institutions will certify those Health Investigators/Supervisors who have successfully completed the training and has acquired the adequate skill set to conduct the CAB tests for the survey. In case a Health Investigator/Supervisor is not able to successfully complete the training even after additional training, NIHFW and its partner institutions under intimation to MoHFW & IIPS will communicate the same to the respective Field Agency for not engaging them for field work and replace with other staff after proper training.

c) Accuracy Checking of Instruments

1. Receive equipments / consumables for the field teams for the practice training and also for TOT.

2. Prior to training of health investigators of Field Agencies, NIHFW will ensure that all partner institutions complete the accuracy checking of the equipments in advance so that:

3. In case any equipment is found to be faulty, defective or inaccurate, the concerned institution will request for replacement of the equipment to the centralized procurement agency under intimation to IIPS. All such replacement requests should be carried out in such a manner so that the replacement is made in time and the overall timelines of training schedule is not affected;

4. The hands-on training to Health Investigators/Supervisors is to be imparted on same set of equipments. Thereafter, at the end of the training programme, these equipments will be handed over to the Field Agenciesø Health Investigators/Supervisors for carrying out the CAB tests in the field;

5. Instruments found to be faulty during the course of the survey would be repaired or replaced by the centralized procurement agency and NIHFW will coordinate with respective partner institutions to ensure that such replaced instruments are checked for accuracy before they are dispatched for usage by field survey team. Each institution will keep 10% extra number of tested equipment at their disposal;

6. NIHFW to ensure that all partner institutions shall maintain a detailed inventory for all kinds of equipments, consumables and other items. These records will have to be submitted to IIPS & MoHFW as and when demanded.

d) Quality Control

1. NIHFW and partner institutions will undertake requisite number of field inspections in order to resolve all technical problems in field including matching of the samples with individuals and their household, which may arise in the respective states and also to ensure that adequate quality control measures as prescribed for the purpose are

being adhered to by the Field Agency(s). In case of any exception, irregularity, non-adherence etc., the same should be rectified immediately and reported to IIPS and MoHFW immediately along with the remedial measures taken. The cost of travel and stay for these visits will be reimbursed as per the entitlement subject to actual;

2. In order to ensure that all the partner institutions are following the same protocols for Hb estimation, training and quality assurance during the Hb estimation of the sample collected in the survey, the senior staff from NIHFW will visit all partner institutions at least once for providing requisite technical assistance and handholding, as per the mandate.

3. If required, additional visits may also be undertaken in case any specific problem is being reported by the partner institution. During these visits a threadbare review on all aspects of work will be done and a report will be submitted to IIPS and MoHFW on the completion of visit. During such visits some field inspection may also be carried out The cost of travel and stay for these visits will also be reimbursed as per the entitlement subject to actual.

e) Hb Estimation

1. NIHFW and partner institutions will undertake Hb estimation in labs for the states assigned to them. The results of Hb estimation will be sent to NIHFW and IIPS in a prescribed format as per prescribed procedure and mode.

2. In order to ensure uniformity, NIHFW will provide the format (to be prepared by IIPS) to partner institution for reporting the Hb estimation lab test results to IIPS and NIHFW.

3. NIHFW will coordinate and ensure lab test guidelines and timelines for completion of lab tests are strictly adhered to by all the partner institutions for carrying out the Hb estimation test;

4. NIHFW will coordinate and ensure that all Partner Institutions report on repeated non-concordance of Hb values of duplicate samples originating from any of the field Investigators/Supervisors to the concerned Field Agency, IIPS and MOHFW, and suggest corrective action; and

5. NIHFW shall ensure that none of the partner institution undertaking Hb estimation test will reveal or utilize the results of the Hb test for any other purpose what so ever. These results are the sole property of MoHFW and further dissemination in any form will be done by MoHFW.

f) Report Writing

1. NIHFW will assist IIPS in the integration of the CAB component report with the main report.

2. Any publication/ research can be done only after release of National/State reports. Proper acknowledgement to be given to DLHS-4 and individual level confidentiality and privacy of data is to be maintained.

g) Administrative Activities

1. Designate a Nodal Officer for the activity to be carried out in DLHS-4 CAB component and put in place a core team of Officers for working as nodal agency.

2. NIHFW shall be single point of contact for IIPS and NHIFW would release funds to partner institutions and ensure submission of consolidated Statement of Expenditure, Utilization Certificates, etc;

3. NIHFW shall adhere to the financial protocol of Government of India while dealing with its partner institutions;

4. NIHFW shall submit quarterly consolidated Statement of Expenditures to IIPS and MoHFW;

5. NIHFW shall provide IIPS and MoHFW statement of final audited accounts and expenditure report within three months of the completion of the project;

6. In order to ensure the timely completion of activities, NIHFW shall deploy adequate manpower (technical as well as administrative) and maintain their records thereof. These records will have to be submitted to IIPS and MoHFW as and when demanded; and

7. NIHFW can plan subsequent release of funds to Partner Institutions by linking to the deliverables under four tranches of 40 %:30 %:15%:15%.

ANNEXURE D

Roles and Responsibilities of Partner Institutes for CAB Component

A) Overall Responsibilities

a. To undertake accuracy checking of equipment as per the protocols
b. To undertake training of Health Investigators and Supervisors of Field Agency on the CAB component
c. To carry out Hb estimation on the blood sample received from the Field Agency and communicate the results
d. To undertake field visits for trouble shooting and ensuring quality of work.

B) Administrative Activities

a. Designate a Nodal Officer for the activity to be carried out in DLHS-4 CAB component.
b. To recruit manpower, if required for undertaking training of health investigators and supervisors of the field agency, accuracy checking of equipments.
c. To recruit manpower for testing of Hb in the lab.
d. To establish the labs fully with equipments and manpower before launch of fieldwork
e. Send a team of 3-5 persons (regular staff as well as contractual) for undergoing TOT which would be organized by NIHFW at Delhi;
f. To send reports to NIHFW as prescribed by them

C) Accuracy Checking of Equipments

a. To receive equipment from supplier agency before commencement of the project;
b. Prior to commencement of training, all partner institutions will ensure that the accuracy checking of the equipments is completed in advance so that:
(i) In case any equipment is found to be faulty, defective or inaccurate, the concerned institution will request for replacement of the equipment to the centralized procurement agency under intimation to IIPS. All such replacement requests should be carried out in such a manner so that the replacement is made in time and the overall timelines of training schedule is not affected;
(ii) The hands-on training to Health Investigators/Supervisors is to be imparted on same set of equipments. Thereafter, at the end of the training programme, these equipments will be handed over to the Health Investigators/Supervisors for carrying out the CAB tests in the field;

c. To intimate about the requirement of consumables as well as maintenance or repair of equipment or replacement of faulty equipment or sub-standard consumables for the training and Hb estimation to the concerned supplier using the fastest mode of communication and seek the replacement on most urgent basis under intimation to, IIPS and while doing so, it is to be ensured that the work for the survey is not interrupted due to the reasons as stated above;

d. Instruments found to be faulty during the course of the survey would be got repaired or replaced by the centralized procurement agency. Respective partner institution will ensure that such replaced instruments are checked for accuracy before they are dispatched for usage by field survey team. Partner Institute to have 10% tested equipments with them;

e. All partner institutions shall maintain a detailed inventory for all kinds of equipments, consumables and other items. These records will have to be submitted to NIHFW, IIPS & MoHFW as and when demanded.

D) Training

a. To ensure, in the State(s) assigned, training of Health Investigators and Supervisors of Field Agency in batches of 15-20 in a schedule that ensures a smooth, uninterrupted flow of training, and to report forthwith to NIHFW of any interruption due to batch size or any other glitches in the implementation process, as training and field survey are inter-dependent and not mutually exclusive;

b. In order to take care of additional training requirements arising during the course of the survey due to attrition of field survey staff or otherwise, Partner Institute in coordination with NIHFW would impart training to the new incumbents or refresher training on any other account. The cost for the additional training shall be borne by the respective Field Agency(s); and

c. To conduct training of data entry operators about protocols for data entry, transmission of data and submission of reports etc.

d. Training for the CAB component are to be organized at the premise of the Partner Institute. Wherever the partner institutes have the requisite infrastructure and are willing to take up the responsibility, the training of the field staff for the main survey of DLHS-4 may also be held at the campus of the partner institute alongwith the CAB training. Partner Institutes can charge the amount for organizing the training from the Field Agency as the provision is made for this activity in the budget of the Field Agency.

E). Hb Estimation

a. To undertake estimation of haemoglobin (Hb) by cyanmethaemoglobin method from the filter paper containing the Dried Blood Spot (DBS) collected by the field agency from the households of State (s) assigned to it and delivered at the designated Partner Institute. The DBS is to be tested for Hb within a week from the date of receipt of sample by the Partner Institutes

b.   To enter the Hb values in the proforma (prescribed format to be provided by IIPS/NIHFW) and send the report of the Hb estimation values to NIHFW and IIPS within the stipulated time period of two weeks from receipt of samples;

c.   To ensure internal and external quality assurance in Hb estimation as per protocol to be provided by NIHFW;

d.   To report any inconsistency, non-concordance of Hb values for duplicate samples received from any field investigator(s) to the field agency concerned, NIHFW, IIPS, MOHFW and to undertake corrective measures;

e.   Recruitment of manpower and local procurement of some suggested equipment and consumables by the Partner Institutes. As there are differences in need based requirement of human resource and equipment between institutions (based on what they already have), the Partner Institute would have some flexibility in manpower and equipment depending on local need so long as performance laid down as per norms and quality assurance parameters are maintained;

F).   Quality Control

a.   To make field visits in the first week of survey and whenever required thereafter for maintaining quality assurance and to resolve technical problems, if any, during data collection for CAB component in the State (s) assigned

b.   Partner Institute will be required to do supervision and monitoring of the field work of the Field Agency for CAB as per the quality control protocols laid down in the MOU of NIHFW with Partner Institutes. This type of supervision for quality checks may be more required by the Partner Institutes only in initial stages. Accordingly, the Partner Institutes need to keep separate budget provision for the same.

c.   To follow all protocols of testing Hb in lab.

G).   Other Issues

a.   No data is to be used by any researcher before the National and State Reports are released. Further, individual level data can only be used by hiding identification particulars so that privacy and confidentiality is not compromised.

b.   To obtain requisite ethical clearance from respective Institutional Ethics Committee, if required, prior to the initiation of the survey (A centralized ethical clearance will be provided by NIHFW/IIPS) .

c.   To receive funds and submit Statement of Expenditure (SOE) quarterly and reporting of activities (monthly) on or before the 15th of the following month to NIHFW;

d.   In case of not achieving the benchmarks, a poor performance report will be sent to the Head of the Institution and the institute would have to bear the loss incurred. They would also be not paid Institution overheads and consultancy charges in such cases. The re-allotment of work would be decided at a later date after deciding the penalty amount on case to case basis.

Format A: Draft No-Conviction Certificate

[On the letterhead of the organisation]

No-Conviction Certificate

This is to certify that (Name of the organisation), having registered office at (Address of the registered office) has never been blacklisted or restricted to apply for any such activities by any Central/State Government Department or Court of law anywhere in the country.

Signature:

Name of the Authorised Signatory:

Designation:

Contact details (including E-mail):

Date:

Place:

ANNEXURE E

QUESTIONNAIRE ATTACHED

DISTRICT LEVEL HOUSEHOLD AND FACILITYSURVEY (DLHS - 4)

HOUSEHOLD QUESTIONNAIRE

**CONFIDENTIAL
(for research
purpose only)**

IDENTIFICATION

A. STATE _____

DISTRICT _____

TEHSIL/TALUK/COMMUNITY DEVELOPMENT BLOCK/MANDAL_____

TYPE OF LOCALITY :   **RURAL**. õ õ õ õ .õ .1   **URBAN**õ õ õ õ õ ...2

PSU (VILLAGE/URBAN WARD) _____

PSU POPULATION AS PER 2001 CENSUS/2007 NSSO FRAME _____

NO. OF SEGMENT CREATED IN VILLAGE / IN SELECTED UFS _____

NO OF SEGMENT(s) / UFS SELECTED_____

NAME OF HEAD OF THE HOUSEHOLD_____

ADDRESS _____

_____

SERIAL NUMBER OF THE VILLAGE QUESTIONNAIREõ õ õ õ ..õ ....õ õ õ õ õ õ õ õ õ õ õ ..

SERIAL NUMBER OF THE HOUSEHOLD QUESTIONNAIRE..õ õ õ ..õ õ õ õ ....õ õ õ õ õ õ õ õ ...

B.RESULT STATUS OF THE HOUSEHOLD QUESTIONNAIRE

COMPLETEDõ õ õ õ õ õ õ õ õ õ õ ......õ .	01	DWELLING VACANT/ADDRESS
PARTLY COMPLETEDõ õ õ õ õ õ õ õ õ	02	NOT A DWELLINGõ õ õ õ õ ......õ . 06
HOUSEHOLD PRESENT BUT NO		DWELLING DESTROYEDõ õ .....õ 07
COMPETENT RESP. AT HOMEõ õ õ ...õ õ õ .	03	DWELLING NOT FOUNDõ õ ...õ õ õ 08
HOUSEHOLD ABSENTõ õ õ õ õ õ õ ....õ .	04	OTHER_____ 96
REFUSEDõ õ õ õ õ õ õ õ õ õ õ õ õ .....õ .	**0**5	**(SPECIFY)**

INTERVIEW DATE

DATE	MONTH	YEAR

C. LINE NUMBER OF RESPONDENT IN HOUSEHOLD SCHEDULE

NUMBER OF VISITS MADE

1. INTRODUCTION AND INFORMED CONSENT

ANSWER ANY QUESTIONS AND ADDRESS RESPONDENT'S CONCERNS.

GIVE CARD WITH CONTACT INFORMATION.

Namaste, My name is ---------------------------- and I am working with (NAME OF ORGANISATION) We are conducting a District Level Household Survey about the health of women, men and children including information on household membership, living condition and use of health facilities. We would very much appreciate the participation of your household in this survey. I would like to ask you some questions about your household. The survey usually takes about 20 minutes to complete.
Whatever information you provide will be kept strictly confidential.

Participation in this survey is voluntary and you can choose not to answer any question or all of the questions. However, we hope that you will participate in this survey since your participation is important.

At this time, do you want to ask me anything about the survey?
ANSWER ANY QUESTIONS AND ADDRESS RESPONDENT'S CONCERNS.

In case you need more information about the survey, you may contact these persons.
GIVE CARD WITH CONTACT INFORMATION.

May I begin the interview now?

RESPONDENT AGREES TO BE INTERVIEWED .1   **RESPONDENT DOES NOT AGREE TO BE INTERVIEWED** ......2 ⟶ **END**

BEGIN INTERVIEW

Q01: RECORD THE TIME: HOUR ☐☐   **MINUTES** ☐☐

HOUSEHOLD SCHEDULE **(Respondent may consult to other family member of the household to give correct information about each member)**

Now I would like to have some information about the people who usually live in your household and the visitors who stayed last night in your household

Line No.	Name (Start with Head of the Household)	Sex Male=1 Female=2 Other=3	Whether Usual Resident Yes=1 No=2	Relation-ship to Head (code)	Date of birth							Age (In completed years)	Marital Status (code) (For age 10 and more years)	For age group 6-17 years		Highest educational qualification attained (aged 7 years and above) (code)	Completed Years of schooling	Occupation /Activity Status (for age 5 years. and above)
														Whether currently attending school Yes =1 No: attended before =2 Never attended = 3	If in Q10 no/never attended any school, main reason thereof (code)			
					D	D	M	M	Y	Y	Y	Y						
Q02	Q03	Q04	Q05	Q06	Q07							Q08	Q09	Q10	Q11	Q12	Q13	Q14
01				01														(SPECIFY)

CODE FOR Q6	
Item	Code
Head	1
Wife or Husband	2
Son or Daughter	3
Son-in-law or Daughter-in-law	4
Grandchild	5
Parent	6
Parent-in-law	7
Brother or Sister	8
Brother-in-law or Sister-in-law	9
Niece or Nephew	10
Other relatives	11
Adopted/foster child	12
Not related	13

CODE FOR Q9	
Item	Code
Never married	1
Married but, guana not performed	2
Marrieed and guana performed	3
Remarried	4
Widow / widower	5
Divorced	6
Seprated	7
Not Started	8

CODE FOR Q11	
Item	Code
School too far	01
Further education not considered necessary	02
Required for work in Household Activities/ Farm/ Family Business	03
Required for outside work	04
Not interested in studies	05
Cost too much	06
Repeated failures	07
Got married	08
Other	96

CODE FOR Q12	
Item	Code
Literate without formal education	01
Literate with formal education	
Below Primary	02
Primary	03
Middle	04
Secondray / Meatrics class-x	05
Hr. Secondry/ Sr. Secondry/ pre University (class xii)	06
Graduate / B.BA/ equivalent / B.Tech	07
Post graduate / M.B.A/ MCA equivalent or higher	08
Technical Diploma	09
Non-teechnical diploma or certificate not equilant to degree	10
Other	96
Illiterate	00

3

MORBIDITY DETAILS: (Respondent may consult to other family member of the household to give correct information about each member)

Line No.	(Start with Head of the HH)	AGE IF (LESS THAN 5 YEARS)		Whether having any form of Disability as on date of survey? (Code)	IF ANY INJURY (During last 1 Year) What type of treatment has (Name) taken for injury during last 1 year? (Code)	ACUTE ILLNESS (DURING LAST 15 DAYS)		CHRONIC ILLNESS (DURING LAST 1 YEAR)						(PERSONAL HABITS FOR AGE 15 YEARS AND ABOVE) DOES THE MEMBER OF THE HOUSEHOLD		
		Has (NAME),s Birth ever been registered with the civil authority? Y=1 N=2, DK=8	IF YES Does (NAME) Have a birth certificate? Yes =1 No = 2			What was the type of illness? (Code)	What was the main source of treatment ? (Code)	What was the main symptom(s) pertaining to illness persisting for more than 1 month ? (Code)	Whether sought medical care ? (Code) (Applicable for codes 01 to 9 & 96 in Q.21)	What was diagnosed ? (code)	What was the main source of diagnosis ? (code)	Whether getting regular treatment ? (code)	Not to be asked if code '00' in Q 24 If code 1 or 2 in Q25 What was source of treatment? (code)	Chew (code)	Smoke (Code)	Consume alcohol (code)
Q02	Q03	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	Q23	Q24	Q25	Q26	Q27	Q28	Q29
01																

CODE FOR Q17	
Item	Code
Mental	1
Visual	2
Hearing	3
Speech	4
Locomotor	5
Multiple	6
No disability	0

CODE FOR Q18	
Item	Code
Treated in intensive care unit for any time	1
Treated as in- patient with stay >2 weeks	2
Treated as in patient with stay 1 to 2 weeks	3
Treated as in patient with stay <1 weeks	4
Treated as out patient	5
Treated as traditional healers	6
Treated at home	7
No injury	0

CODE FOR Q19	
Item	code
Diarrhoea	01
Dysentery	02
Acute Respiratory Tract Infection	03
Jaundice with fever	04
Fever with chills/rigors malaria etc	05
Fever of short duration with rashes	06
Other types of fever	07
Reproductive tract infection (RTI)	08
Other	96
No illness	00

CODE FOR Q20,Q24,Q26	
Item	code
GOVERNMENT	
Sub centre	01
PHC	02
CHC	03
UHC/UHP/ UFWC	04
Dispensary/ clinic	05
Hospital	06
AYUSH Hospital/clinic	07
PRIVATE	
Dispensary/ clinic	08
Hospital	09
AYUSH Hospital/ clinic	10
NGO at trust hospital /clinic	11
DOTS Centre	12
At home	13
Other	96
No treatment	00

CODE FOR Q21	
Item	code
Disease of Respiratory system	01
Disease of Cardiovascular system	02
Disease of Central nervous system	03
Disease of musculoskeletal System	04
Disease of gastrointestinal system	05
Disease of genitourinary system	06
Skin diseases	07
Goitre	08
Elephantiasis	09
Asymptomatic	10
Other	96

4

	CODE FOR Q22	
	Item	Code
YES	Details of Diagnosis/ treatment not available	1
	Details of Diagnosis/ Treatment available	2
NO		3

CODE FOR Q23	
Item	Code
Diabetes	1
Hypertension	2
Chronic Heart Disease	3
Myocardial infection/ heart attack	4
Stroke cerebro vascular accident	5
Epilepsy	6
Asthma/ Chronic respiratory Failure	7
Goitre / Thyroid disorder	8
Tuberculosis	9
Leprosy	10
Cancer . Respiratory System	11
Cancer- Gastrointestinal system	12
Cancer- Genitourinary System	13
Cancer . Breast	14
Renal Stone	15
Chronic Renal Failure	16
Gall Stone/ Cholecystitis	17
Chronic Liver Failure	18
Rheumatoid Arthritis	19
Chronic skin Disease/ Psoriasis	20
Others hernia Hydrocele, Peptic ulcer, etc	21
Not Diagnosed	22

CODE FOR Q25	
Item	Code
Not regularly	1
Regularly	2
No	3

CODE FOR Q27	
Item	code
Pan with Tobacco	1
Pan without tobacco	2
Gutka/Pan masala with Tobacco	3
Gutka/Pan masala without tobacco	4
Tobacco only	5
Ex-chewer	6
Never chewed	7
Not known	8

CODE FOR Q28	
Item	code
Usual smoker	1
Occasional smoker	2
Ex-Smoker	3
Never Smoked	4
Not Known	8

CODE FOR Q29	
Item	code
Usual Drinker	1
Occasional Drinker	2
Ex-Drinker	3
Never Drunk	4
Not Known	8

5

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q30	What is the religion of the head of the household?	HINDU... 01 MUSLIM.. 02 CHRISTIAN... 03 SIKH.. 04 BUDDHIST/NEO-BUDDHIST............................. 05 JAIN.. 06 JEWISH... 07 PARSI/ZOROASTRIAN....................................... 08 NO RELIGION... 09 OTHER _____ 96 (SPECIFY)	
Q31A	What is the caste or tribe of the head of the household?	CASTE _____ 1 (SPECIFY) TRIBE _____ 2 (SPECIFY) NO CASTE/TRIBE.. 3 → **Q32** DON'T KNOW.. 8	→ **Q32**
Q31B	Is this a scheduled caste, a scheduled tribe, other backward class, or none of them? **(IF RESPONDENT NOT REPLIED, CHECK THE LIST OF CASTES/TRIBES AND CODE)**	SCHEDULED CASTE... 1 SCHEDULED TRIBE.. 2 OTHER BACKWARD CLASS............................... 3 NONE OF THEM / OTHER.................................. 6	
Q32	What is the main source of drinking water for members of your household?	PIPED WATER INTO DWELLING / YARD / PLOT.. 01 PUBLIC TAP / STANDPIPE.................................. 02 HAND PUMP.. 03 TUBE WELL OR BOREHOLE.............................. 04 PROTECTED DUG WELL...................................... 05 UNPROTECTED DUG WELL................................. 06 PROTECTED SPRING .... 07 UNPROTECTE SPRING....................................... 08 RAINWATER COLLECTION.................................. 09 TANKER / TRUCK .... 10 CART WITH SMALL TANK / DRUM..................... 11 SURFACE WATER (RIVER, DAM, LAKE, POND, STREAM, CANAL, IRRIGATIONCANAL).............. 12 PACKAGED / BOTTLED WATER......................... 13 OTHER SOURCE 96	
Q 33	Do you treat your water in any way to make it safer to drink?	YES... 1 NO... 2 DO NOT KNOW... 8	→ **Q 35**
Q 34	What do you usually do to the water to make it safer to drink? Anything else? **(RECORD ALL MENTIONED)**	YES NO A. BOIL .... 1 2 B. USE ALUM................................. 1 2 C. ADD BLEACH/CHLORINETABLETS.. 1 2 D. STRAIN THROUGH A CLOTH........ 1 2 E. USE WATER FILTER (CERAMIC/ SAND/COMPOSITE) ETC .... 1 2 F. USE ELECTRONIC PURIFIER....... 1 2 G. LET IT STAND AND SETTLE........ 1 2 H. OTHER_____ 1 2 (SPECIFY) I. DON'T KNOW............................... 1 2	

Q 35	What kind of toilet facility do members of your household mainly use?	**FLUSH OR POUR FLUSH TOILET**
		   FLUSH TO PIPED SEWER SYSTEM 11
		   FLUSH TO SEPTIC TANK............................. 12
		   FLUSH TO PIT LATRINE............................. 13
		   FLUSH TO SOMEWHERE ELSE.................... 14
		   FLUSH, DON'T KNOW WHERE..................... 15
		PIT LATRINE
		   PIT VENTILATED IMPROVED (VIP) BIO-GAS LATRINE... 21
		   PIT LATRINE WITH SLAB............................ 22
		   PIT LATRINE WITHOUT SLAB/OPEN PIT........ 23
		   TWIN PIT/COMPOSTING TOILET............................ 31
		   DRY/SERVICE LATRINE............................. 41
		   NO FACILITY/USES OPEN SPACE OR FIELD/ JUNGLE.. 51
		   OTHER _____ 96
		(SPECIFY)
			→ **Q37**

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES		SKIP TO
Q 36	Do you share this toilet facility with other households?	YES-COMMUNITY TOILET.................................	1	
		YES-SHARED TOILET.......................................	2	
		NO õ õ õ õ õ õ õ õ õ õ õ ...õ õ õ õ ..	3	
Q 37	If infants in the household, how is their faecal matter disposed?	PUT INTO TOILET OR LATRINE............................	01	
		LEFT IN THE OPEN...	02	
		PUT INTO DRAIN OR DITCH.................................	03	
		THROWN INTO GARBAGE....................................	04	
		BURIED...	05	
		RINSED..	06	
		OTHER _____	96	
		(SPECIFY)		
		DONõT KNOW...	98	
Q 38	How do you dispose either bath water or kitchen water?	LET OUT INTO DRAIN / SEWER	1	
		OPEN	2	
		DRAIN...		
		CLOSE	3	
		DRAIN..		
		REUSE FOR OTHER DOMESTIC PURPOSE.............	4	
		REUSE FOR GARDEN / FARMING...........................	5	
		OTHER..õ	6	
Q 39	What type of fuel does your household mainly use for cooking?	FIREWOOD..	01	
		CROP RESIDUE..	02	
		COW DUNG CAKE..	03	
		COAL/LIGNITE/CHARCOAL......................................	04	
		KEROSENE..	05	
		LPG/PNG..	06	
		ELECTRICITY..	07	
		BIOGAS..	08	
		NO COOKING..	09	
		OTHER..	96	
Q 40	Type of structure of house where the household is living? *(RECORD BY OBSERVATION)*	PUCCA..	1	
		SEMI-PUCCA..	2	
		KACHHA	3	
		OHTHER..	6	
Q 41	How many dwelling rooms are exclusively in possession of the household	ROOMSõ õ õ õ õ õ õ .... ☐☐		
Q 42	How many rooms in this household are used for sleeping?	NUMBER OF ROOMSõ õ .... ☐☐		
Q 43	What is the main source of lighting?	ELECTRICITY...	1	
		KEROSENE..	2	
		SOLAR..	3	
		OTHER OILS...	4	
		OTHER..	6	
		NO LIGHTING...	0	
Q 44	Do you have a separate room, which is used as kitchen?	**COOKING INSIDE HOUSE**	1	
		HAS KITCHEN...............		
		DOES NOT HAVE KITCHEN.......................................	2	
		COOKING OUTSIDE HOUSE	3	
		HAS KITCHEN............		
		DOES NOT HAVE KITCHEN......................................	4	
		NO COOKING..	5	
Q 45	Ownership status of the house where the Household is living.	OWNED..	1	
		RENTED..	2	
		OTHER..	6	

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q 46	Does your household have:		
		YES NO	
	A radio or transistor	A RADIO OR TRANSISTOR…… …………………… 1 2	
	A television	A TELEVISION… … … … …………… ………….… 1 2	
	A computer / laptop without internet	A COMPUTER / LAPTOP WITHOUT INTERNET 1 2	
	A computer / laptop with internet	A COMPUTER / LAPTOP WITH INTERNET........ 1 2	
	A telephone only	A TELEPHONE ONLY.. 1 2	
	A mobile phone only	A MOBILE PHONE ONLY.................................... 1 2	
	Both telephone & mobile phone	BOTH TELEPHONE & MOBILE PHONE............. 1 2	
	A washing machine	A WASHING MACHINE....................................... 1 2	
	A refrigerator	A REFRIGERATOR… … … ………….… 1 2	
	A sewing machine	A SEWING MACHINE………..… … … 1 2	
	A watch or clock	A WATCH OR CLOCK.. 1 2	
	A bicycle	A BICYCLE… … … ……..…… … … … 1 2	
	A motorcycle or scooter or moped	A MOTORCYCLE OR SCOOTER OR MOPED… 1 2	
	A car / jeep / van	A CAR / JEEP / VAN.. 1 2	
	A tractor	A TRACTOR… … ………..… … … … … 1 2	
	A water pump / tube well	A WATER PUMP / TUBE WELL.......................... 1 2	
	A car driven by animal	A CAR DRIVEN BY ANIMAL… … ..… 1 2	
	A cart driven by machine	A CART DRIVEN BY MACHINE........................... 1 2	
	Other cart	OTHER CART... 1 2	
	Cooler	COOLER.. .... 1 2	

Q 47	**A:** Does this household own any land?	YES... 1	
		NO... 2	
	B: How much agriculture land does this household own?		

ITEM	LOCAL UNIT (BIGHAS/ GUNTHAS)	ACRES
TOTAL LAND		
TOTAL AGRICULTURAL LAND		
TOTAL IRRIGATED LAND		

Q 48	Does this household have a Below Poverty Line (BPL) card? **(CARD COLOUR STATE-SPECIFIC)**	YES... 1 NO... 2 DON'T KNOW... 8	
Q 49	Is any usual member of this household covered by a health scheme or health insurance?	YES... 1 NO... 2 DON'T KNOW... 8	➔ **Q51**
Q 50	What type of health cover/ health scheme/ health insurance? Any other type? **(RECORD ALL MENTIONED)**	YES NO A. EMPLOYEES STATE INSURANCE SCHEME (ESIS)… … … .... 1 2 B. RASHTRIYA SWASTHYA BEEMA YOJANA(RSBY) 1 2 C. CENTRAL/STATE GOVERNMENT HEALTH SCHEME OTHER THAN RSBY… .... 1 2 D. MEDICAL REIMBURSEMENT FROM EMPLOYER 1 2 E. COMMUNITY HEALTH INSURANCE POGRAMME 1 2 F. MEDICLAIM… … … … … … … … … … … .... 1 2 G. OTHER PRIVATELY PURCHASED… .... 1 2 H. OTHER_____ 1 2 (SPECIFY)	

8

Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

Q 51.	When members of your household get sick, where do they mainly go for treatment?	**GOVERNMENT**
		SUB-CENTER 01
		PHC... 02
		CHC 03
		UHC/UHP/UFWC...................................... 04
		DISPENSARY/CLINIC............................... 05
		HOSPITAL.. 06
		AYUSH HOSPITAL/CLINIC........................ 07
		
		PRIVATE
		DISPENSARY/CLINIC 08
		HOSPITAL.. 09
		AYUSH HOSPITAL/CLINIC........................ 10
		NGO OR TRUST HOSP/CLINIC................ 11
		
		AT HOME.. 12
		CHEMIST / PHARMACY 13
		
		OTHER
		   NON MEDICAL SHOP............................. 14
		   HOME TREATMENT............................... 15
		   OTHER.. 96
		
		NO MEDICAL ATTENTION.......................... 00
			➤Q53

Q 52.	Why don't members of your household generally go to a government facility when they are sick? Any other reason? **(RECORD ALL MENTIONED)**	YES NO A. NO ADEQUATE INFRASTRUCTURE 1 2 B. NO FACILITY 1 2 C. NOT AWARE ABOUT ANY FACILITY 1 2 D. DOCTOR NOT AVAILABLE 1 2 E. FACILITY TIMING NOT CONVENIENT 1 2 F. HEALTH PERSONNEL OFTEN ABSENT 1 2 G. WAITING TIME TOO LONG 1 2 H. POOR QUALITY OF CARE 1 2 I. DRUG NOT AVAILABLE 1 2 J. NO TRUST ON GOVT. FACILITY 1 2 K. OTHER _____ 1 2 (SPECIFY)	
Q 53.	Was there any marriage performed for usual residents of this household since January 1, 2008?	YES... 1 NO... 2	➤**Q55**
Q 54.	(A) How many marriages were there? **(SPECIFY FOR BOYS AND GIRLS)** (B) What was the age of that person at the time of his/her marriage? (C) Date of marriage	**A.** BOYS [ ] GIRLS [ ] TOTAL [ ] Q54B Q54C Q54B Q54C Boy (age/date boxes) Girl (age/date boxes)	

MORTALITY DETAILS:

(Respondent may consult to other family members of the household to give correct information of each deceased in the household)

Q.55 Did any usual resident of this household including children died since January 1, 2007?   Yes...................1   Q55a. Number of death ☐

No...................2 ➝ End of Household Questionnaire

Serial No.	Name of the deceased	Sex of deceased **Male=1 Female=2**	Date of death									Age at death			What was main source of medical attention before death? (code)	Where did the death take place ? (code)	Registration of death		For Infant death (<1 year)		What was the main symp-toms leading to Death? (code)	Was the death asso-ciated with preg-nancy? **Yes=1 No=2**	For female deceased aged 15-49						
												Below 1 month (in days) How many days old when (Name) was deceased?	**1 to 11 months (In months)** How many months old when (Name) was deceased?	**One year and above (In year)** How many years old when (Name) was deceased?			Is the death registered ? **Yes=1 No=2 DK=8**	Whether Death certificate received? **Yes=1 No=2**	Line number of mother as in House-hold schedule)	Order of birth			If Yes in Q.70 ask the following						
																					What was period/ stage when the death occurred? (code)	If code 1,2,3 in Q.71 How many months was she pregnant at the time of death?	What were the top two factors contribu-ting to the death in order of priority? (code)		What was the main symp-toms leading to death? (code)	What was the time between onset of compli-cations and death? (code)	What was the distance from place of(where the deceased was staying) to nearest medical facility? (in km)
			D	D	M	M	Y	Y	Y	Y														P1	P2			
Q56	Q57	Q58	Q59									Q60	Q61	Q62	Q63	Q64	Q65	Q66	Q67	Q68	Q69	Q70	Q71	Q72	Q73	Q74	Q75	Q76

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CODE FOR Q63	
Item	Code
GOVERNMENT	
Sub center	01
PHC	02
CHC	03
UHC/UHP/UFWC	04
Dispensary/clinic	05
Hospital	06
AYUSH Hospital/ clinic	07
PRIVATE	
Dispensary/clinic	08
Hospital	09
AYUSH Hospital/ clinic	10
NGO or Trust Hosp/ clinic	11
At Home	12
Others	96
No Medical Attention	00

CODE FOR Q64	
Item	Code
At Home	1
In- transit	2
In health facility	3
Other places	6

CODE FOR Q69	
Item	Code
Asphyxia	01
Hypothermia	02
infections	03
Birth injuries	04
Convulsions soon after birth	05
Jaundice	06
Bleeding from umbilicus & elsewhere	07
Congenital/I birth defects	08
Preterm/ low birth weight baby not thriving	09
Respiratory infection	10
Diarrhoea/dysentery	11
Fever with rash	12
Fever with convulsions	13
Fever with jaundice	14
Others	96
Neonatal mortality (0-28 days) : Codes 1-9 &14	
Post neonatal mortality (29-365 days). Codes) 8-14	

CODE FOR Q71	
Item	code
During Ante Natal period	1
During Delivery	2
During Abortion	3
POST DELIVERY	
Within 42 days of delivery	4
After 42 days of delivery	5
POST ABOTRION	
Within 42 days of abortion	6
After 42 days of abortion	7

CODE FOR Q73	
Item	code
Delay in receiving health care at facility	01
Inadequate care at health facility	02
Lack of transport in shifting to facility	03
Lack of funds	04
Seriousness of the condition not realized	05
Seriousness of the condition realized but decision not made by family members	06
Others	96

CODE FOR Q75	
Item	Code
<2 Hours	1
2Hours to<24 hours	2
24 hours to 2 days	3
2 days to <7 days	4
7 days to <14 days	5
14 days or more	6

CODE FOR Q74	
Item	code
PV Excess bleeding	01
Sepsis	02
Pregnancy induced hypertension (PIH)	03
Prolonged labour/ obstructed labour	04
Injury to uterus other organs	05
Anemia	06
Jaundice	07
Malaria	08
Other medical conditions not related to pregnancy	96
Other conditions not related to pregnancy	00

CODE FOR Q76	
Item	Code
*if distance is less than 1 KM record	0

NOTE: Sometimes our seniors/supervisor may come to you for clarification of some question, so please cooperate with them.

THANK YOU FOR GIVING YOUR PRECIOUS TIME

D. RESULT STATUS OF THE WOMAN'S QUESTIONNAIRE

	1	2	3	4	5	6	7
D1. LINE NUMBER OF ELIGIBLE EVER MARRIED WOMAN							
D2. RESULT STATUS OF ELIGIBLE EVER MARRIED WOMAN'S QUESTIONNAIRE* (INTERVIEWED)							

*CODING CATEGORIES

COMPLETED.....õ õ õ ....õ õ õ õ õ õ .õ ..1   PARTLY COMPLETED õ õ õ .õ ..4
NOT AT HOME ....õ õ õ õ õ õ õ 2   OTHER_____6
REFUSED õ 3   (SPECIFY)

E1. ELIGIBLE EVER MARRIED WOMEN:	TOTAL		**E2.** INTERVIEWED	

G. TOTAL NUMBER OF CAB TESTED RESPONDENT		

_____   CODE [ ][ ][ ]   _____
NAME OF THE INVESTIGATOR / DATE

F1. TOTAL PERSONS IN HOUSEHOLD [ ][ ]

F2. TOTAL MALE [ ][ ]

F3. TOTAL FEMALE [ ][ ]

INFORMED CONSENT FOR ANAEMIA / DIABETES TESTING

As part of this survey, we are studying anemia among women, men in all age groups and children 6 months and above.

You may be assured that Anemia is a serious health problem that usually results from poor nutrition, infection, or chronic disease.

This information will assist the government to develop programmes to prevent and treat anemia.

We request that (you and (NAME OF RESPONDENT'S CHILD (REN)/CHILD (REN) IN RESPONDENT'S CARE) born in JANUARY 2007 or later)

participate in the anemia testing by giving a few drops of blood from a finger. The test uses disposable sterile instruments that are clean and completely safe.

The blood will be tested in new equipments at the center. The results will be kept confidential.

From the same finger prick we will take another one drop of blood for diabetes testing. The report of diabetes will be given to you within few minutes.

Would you like to ask anything, now?

ANSWER ANY QUESTIONS AND ADDRESS RESPONDENT'S/GUARDIAN'S CONCERNS.

May I now request that (you and NAME OF RESPONDENT'S CHILD (REN)/CHILD (REN) IN RESPONDENTøS CARE) participate in the anemia testing?

However, if you decide not to have the test(s) done, it is your right and we will respect your decision. Now please tell me if you agree to have the test done.

GO TO COLUMN 86, WRITE THE APPROPRIATE CODE,

IF RESPONDENT IS AGE IS 6 MONTH AND BELOW 18 YEARS AND NEVER MARRIED, ASK PARENT/GUARDIAN:

Now, will you tell me if you accept that (NAME OF YOUTH(S)) participate in the anemia testing?

GO TO COLUMN 87 AND WRITE THE LINE NUMBER OF THE PARENT/GUARDIAN. ASK FOR THEIR CONSENT.

IF THE PARENT/GUARDIAN REFUSES, WRITE CODE IN COLUMN 88.

IF THE PARENT/GUARDIAN AGREES, READ THE PRECEDING PARAGRAPHS TO THE YOUTH FOR HIS/HER CONSENT.

CLINICAL, ANTHROPOMETRIC AND BIOCHEMICAL (CAB) TESTS SCHEDULE

Parent/ Guardian agrees, read the preceding paragraphs to the youth for his/her consent; record the appropriate code in column 87, and write code 1 for Granted only if Both the Parent /Guardian and the youth agrees to the testing.

Line No. from HHS (Q2)	Sex M = 1 F = 2	Age (on the date of survey) from HHS (Q8)		(FOR AGE ≥10 YEARS)		FOR MEMBERS ONE MONTH AND ABOVE					For members SIX month & above
		D=1 M=2 Y=3 (Code)	AGE	MARITAL STATUS Married=1 Unmarried=2	PREGNANCY STATUS Pregnant=1 Lactating=2 Non-Pregnant=3 Non-Lactating=4	Weight (Kilograms)	Measured=1 Not Present=2 Refused=3 Other=6	Length/ Height L = 1 H = 2	Height/ Length (Centimetres)	RESULT Measured=1 Not Present=2 Refused=3 Other=6	Code No. of parent/ responsible adult. Record 00 if not listed in Household Schedule.
77	78	79		80	81	82	83	84	85	86	87
☐☐	☐	☐	AGE ☐☐	☐	☐	☐☐☐	☐	☐	☐☐☐	☐	☐☐
☐☐	☐	☐	AGE ☐☐	☐	☐	☐☐☐	☐	☐	☐☐☐	☐	☐☐
☐☐	☐	☐	AGE ☐☐	☐	☐	☐☐☐	☐	☐	☐☐☐	☐	☐☐
☐☐	☐	☐	AGE ☐☐	☐	☐	☐☐☐	☐	☐	☐☐☐	☐	☐☐
☐☐	☐	☐	AGE ☐☐	☐	☐	☐☐☐	☐	☐	☐☐☐	☐	☐☐

Note: 1.Childrens 1 month and above completed 5 months = only Height and weight
2. Children 6 month and above completed 17 years = Only Height, weight and Anemia
3. Eighteen years and above = Height, Weight, Anemia, Diabetes and Blood pressure.

A. In column 80 if respondent is unmarried then ask parent/guardian for consent.
B. In column 81 if respondent is pregnant then go to column 88

Code for column 79	CODE	Age
If less than one month	1 (Days)- D	In completed days
If age one month to 11 months	2 (Months)- M	In completed months
If age 1 year and above	3 (Years)-Y	In Completed years

14

Read Consent statement for Anaemia/Diabetes testing to women parent/ Responsible Adult Granted= 1 Refused=2 (code)	Haemoglobin Result (For all members 6 months & above) Measured=1 Not Present=2 Refused=3 Other=6	Bar code number	Blood Pressure measurement(For all members aged 18 years and above)				RESULT Measured=1 Not Present=2 Refused=3 Other=6	Fasting Blood Sugar level (For all members aged 18 years and above)	RESULT Measured=1 Not Present=2 Refused=3 Other=6
			Readings	Systolic	Diastolic	Pulse rate			
88	89	90		91	92	93	94	95	96
☐	☐		1	☐☐☐	☐☐☐	☐☐☐	☐	☐☐☐	☐
			2	☐☐☐	☐☐☐	☐☐☐			
☐	☐		1	☐☐☐	☐☐☐	☐☐☐	☐	☐☐☐	☐
			2	☐☐☐	☐☐☐	☐☐☐			
☐	☐		1	☐☐☐	☐☐☐	☐☐☐	☐	☐☐☐	☐
			2	☐☐☐	☐☐☐	☐☐☐			
☐	☐		1	☐☐☐	☐☐☐	☐☐☐	☐	☐☐☐	☐
			2	☐☐☐	☐☐☐	☐☐☐			
☐	☐		1	☐☐☐	☐☐☐	☐☐☐	☐	☐☐☐	☐
			2	☐☐☐	☐☐☐	☐☐☐			

97: **SALT TEST**	CODE
Ask respondent for a Teaspoonful of cooking salt currently used and Test Salt for iodine. RECORD PPM (parts per million)	Less than 15 PPM...1 More Than 15 PPM..2 NO Salt In Household...3 Salt Not tested _____6 **(Specify Reason)** 00 PPM (No Iodine)...0 RESULT OF SALT TEST...... ☐

15

DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY (DLHS -4)
EVER MARRIED WOMAN'S (15-49) QUESTIONNAIRE

**CONFIDENTIAL
(for research
purpose only)**

IDENTIFICATION

A. STATE _____

DISTRICT _____

TEHSIL/TALUK/COMMUNITY DEVELOPMENT BLOCK/MANDAL_____

TYPE OF LOCALITY   **RURAL**.õ õ õ õ .õ .1   **URBAN**õ õ õ õ õ ...2

PSU (VILLAGE/URBAN WARD) _____

PSU POPULATION AS PER 2001 CENSUS _____

NO. OF SEGMENT CREATED IN VILLAGE / UFS IN SELECTED WARD _____

NO OF SEGMENT/ UFS SELECTED_____

HEAD OF THE HOUSEHOLD

NAME _____

ADDRESS _____

_____

NAME AND LINE NUMBER OF THE ELIGIBLE WOMAN _____

SERIAL NUMBER OF THE VILLAGE QUESTIONNAIREõ õ õ õ õ ..õ õ õ õ õ õ õ õ õ õ .

SERIAL NUMBER OF THE HOUSEHOLD QUESTIONNAIRE..õ õ õ ..õ õ õ õ õ õ õ õ õ õ ..

SERIAL NUMBER OF EVER MARRIED WOMAN$ QUESTIONNAIREõ õ õ õ õ õ ..õ õ õ .

B. RESULT STATUS

COMPLETED.....õ õ õ ....õ õ õ õ õ õ .õ .1   PARTLY COMPLETED. õ õ õ õ .4
NOT AT HOME ....õ õ õ õ õ õ õ õ .õ 2   OTHER_____6
REFUSED õ õ õ õ ....õ õ õ õ õ .õ õ 3   **(SPECIFY)**

	DATE	MONTH	YEAR
INTERVIEW DATE			

NUMBER OF VISITS MADE

_____   CODE _____   _____
NAME OF THE INVESTIGATOR   SIGNATURE OF THE INVESTIGATOR

INTRODUCTION AND INFORMED CONSENT

ANSWER ANY QUESTIONS AND ADDRESS RESPONDENTS CONCERNS.

My name is _____and I am working with (NAME OF ORGANIZATION). We are conducting a District Level Household Survey about the health of women and children. We would very much appreciate your participation in this survey. Several different health-related topics will be discussed including use of health services, the quality of health care and infectious diseases. This information will help the government to assess health and information needs and to plan better health services. The survey usually takes around half an hour to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Participation in this survey is voluntary and if you choose to participate, you may withdraw at any time. However, we hope that you will take part in this survey since your participation is important.

At this time, do you want to ask me anything about the survey?
ANSWER ANY QUESTIONS AND ADDRESS RESPONDENTS CONCERNS.

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

May I begin the interview now?

Signature of interviewer _____   Date _____

RESPONDENT AGREES TO BE INTERVIEWED – 1   RESPONDENT DOES NOT AGREE TO BE INTERVIEWED– 2 ——▶ END
BEGIN INTERVIEW

↓

START/BEGAN

SECTION-I
WOMAN'S CHARACTERISTICS

Q NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q101	RECORD THE TIME	HOUR MINUTES	
Q102	LINE NUMBER OF THE WOMAN IN HOUSEHOLD QUESTIONNAIRE		
Q103	LINE NUMBER OF THE HUSBAND IN HOUSEHOLD QUESTIONNAIRE IF HE IS NOT LISTED IN THE HOUSEHOLD RECORD '00'		
Q104	How old are you?	AGE IN COMPLETED YEARS õ õ	
Q105	What is your date of birth?	D D M M Y Y Y Y	
Q106	What is your current marital status?	CURRENTLY MARRIED õ ....1 MARRIED BUT GAUNA NOT/PERFORMED.2 SEPARATED.. 3 DESERTED... 4 DIVORCED .... 5 WIDOWED 6	▸ Q113B ▸ Q113C
Q107	What was your age when you got married first?	AGE IN COMPLETED YEARS õ õ õ	
Q108	What was your date of marriage?	D D M M Y Y Y Y	
Q109	How old were you when you started living with your husband?	AGE IN COMPLETED YEARS õ õ õ õ	
Q 110	How old is your husband?	AGE IN COMPLETED YEARSõ DO NOT KNOW.....................................98	
Q111	**CHECK Q106:** **CURRENTLY MARRIED**	MARRIED BUT GAUNA NOT PERFORMED	▸ Q114
Q112	Are you living with your husband now, or is he staying elsewhere?	LIVING WITH HUSBAND ....1 STAYING ELSEWHERE 2	Q114 ▸ Q113A

3

Q NO	QUESTIONS AND FILTERS			CODING CATEGORIES	SKIP TO
Q113	**A.** CURRENTLY MARRIED Since how long have you and your husband not been living together? IF LESS THAN **1** MONTH RECORD DAYS IF LESS THAN **1** YEAR RECORD MONTHS OTHERWISE RECORD COMPLETED YEARS	**B**. SEPARATED / DESERTED/ DIVORCED Since how long you have not been living with your husband? IF LESS THAN **1** MONTH RECORD DAYS IF LESS THAN **1** YEAR RECORD MONTHS OTHERWISE RECORD COMPLETED YEARS	**C**. WIDOWED When did your husband die? IF LESS THAN **1** MONTH RECORD DAYS IF LESS THAN **1** YEAR RECORD MONTHS OTHERWISE RECORD COMPLETED YEARS	DAYS………........…....……. 1 ☐☐ MONTHS…….....…… ……….... 2 ☐☐ YEARS ……….…… .... 3 ☐☐	
Q114	Have/had your husband ever attended school?			YES.. 1 NO .... 2 DO NOT KNOW................................. 8	▶ **Q116**
Q115	What is/was the highest standard he completed?			STANDARD…….………. ☐☐ DO NOT KNOW................................. 98	
Q116	Have you ever attended school?			YES.. 1 NO.. 2	
Q117	What is the highest standard you have passed?			LITERATE WITHOUT FORMAL EDUCATION ….......................................01 **LITERATE WITH FORMAL EDUCATION** BELOW PRIMARY ....02 PRIMARY ....03 MIDDLE...04 SECONDRAY / MEATRICS CLASS-X..........05 HR. SECONDRY/ SR. SECONDRY/ PRE UNIVERSITY (CLASS XII)...........................06 GRADUATE / BBA/ EQUIVALENT / B.TECH...07 POST GRADUATE / M.B.A/ MCA EQUIVALENT OR HIGHER ....08 TECHNICAL DIPLOMA ....09 NON-TEECHNICAL DIPLOMA OR CERTIFICATE NOT EQUILANT TO DEGREE ....10 OTHER.. ....96 ILLITERATE 00	
Q118	Have you done any work in the last 12 months?			YES......................…...................1 NO...2	▶ **Q120**
Q119	What is/was your occupation/activity status, that is, what kind of work you mainly do? **(WRITE ACTUAL OCCUPATION. SUPERVISORFROM LIST.)**			_____ ☐☐ _____	
Q119A	**CHECK Q106** **ALL OTHER WOMEN** ☐		**MARRIED BUT GAUNA NOT PERFORMED** ☐		▶ **Q261**

Q NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q120	**NOW I WOULD LIKE TO ASK ABOUT ALL THE PREGANCIES THAT YOU HAVE HAD TILL NOW** Have you ever given live birth? **(INCLUDE ONLY BIOLOGICAL CHILDREN. CONSIDERED CHILDREN OF SURROGATE MOTHER, AS BIOLOGICAL CHILDREN)**	YES...1 NO..2	➤ **Q128**
Q121	How old were you at the time when your first child was born?	AGE IN COMPLETED YEARSõ õ õ ....õ	
Q122	Do you have any sons or daughters whom you have given birth to and are now living with you?	YES ....1 NO..2	➤ **Q124**
Q123	How many sons live with you? And how many daughters live with you?	SONS AT HOMEõ õ õ .. DAUGHTERS AT HOME **IF NONE, RECORD '00'**	
Q124	Do you have any sons or daughters to whom you have given birth to and are alive but do not live with you?	YES...1 NO 2	➤ **Q126**
Q125	How many sons are alive but do not live with you? And how many daughters are alive but do not live with you?	SONS ELSEWHERE................... DAUGHTERS ELSEWHERE....õ **IF NONE, RECORD '00'**	
Q126	Have you ever given birth to a boy or a girl who was born alive but later died? **(IF N0, PROBE: ANY BABY WHO CRIED OR SHOWED SIGNS OF LIFE BUT DID NOT SURVIVE?)**	YES...1 NO..2	➤ **Q128**
Q127	How many boys have died? And how many girls have died?	BOYS DEAD õ õ ....õ õ . GIRLS DEAD õ õ ....õ .õ **IF NONE, RECORD '00'**	
Q128	Did you have any pregnancy, which terminated in **still birth**? If yes, how many?	NO..0 YES, NUMBERõ õ õ õ ....õ	
Q129	Did any of your pregnancy terminate in **spontaneous** or **induced** abortion? If yes, how many?	NO..0 SPONTANEOUS ABORTION.............. INDUCED ABORTION...........................	➤ **Q136**
Q130	How many months pregnant were you when you had last induced abortion?	MONTHSõ õ õ õ õ õ õ õ õ õ ..õ **IF LESS THAN '1' MONTH RECORD ....'0'**	
Q131	At any time before (last) induced abortion did you have an **ultrasound test**?	YES...1 NO 2	
Q132	Who advised you for the (last) **induced abortion**? **(RECORD ALL MENTIONED)**	YES NO A. DOCTOR õ õ õ ....õ õ ..... 1 2 B. ANM/NURSE/LHVõ õ ....õ 1 2 C. MALE HEALTH WORKER 1 2 D. ASHA õ õ õ õ õ õ ....õ .. 1 2 E. DAI õ õ .õ õ õ õ õ .õ . 1 2 F. HUSBANDõ ..õ õ õ õ õ . 1 2 G. MOTHER-IN-LAW õ õ õ 1 2 H. MOTHER õ õ õ õ õ õ .. 1 2 I. RELATIVES õ õ õ õ 1 2 J. SELFõ õ õ õ õ õ ..õ õ .. 1 2 K. OTHER_____ 1 2 (SPECIFY)	

Q NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

Q133	Where was the last induced abortion performed/completed?	**GOVERNMENT**
		
		SUB-CENTRE 01
		PHC 02
		CHC..03
		UHC/UHP/UFWC............................04
		DISPENSARY/ CLINIC..........................05
		HOSPITAL 06
		AYUSH Hospital/ CLINIC.......................07
		
		PRIVATE
		DISPENSARY/ CLINIC..........................08
		HOSPITAL...09
		AYUSH Hospital/ CLINIC......................10
		NGO/TRUST HOSP. /CLINIC...............11
		HOME
		     SELF õ 12
		     ELSWHERE.................................13
		OTHER _____96
		             (SPECIFY)	

Q134	Who performed/completed the abortion?	DOCTORõ õ õ õ õ õ õ õ ..õ ......õ 01 NURSE / ANM / LHVõ õ õ õ õ õ õ ....02 TRAINED DAIõ õ õ õ õ õ õ õ .õ õ ..03 UNTRAINED DAI õ õ õ õ õ õ õ õ .õ ....04 FAMILY MEMBERS/RELATIVE/ FRIENDS õ ....05 NONE/SELFõ õ õ ..õ õ õ õ õ .õ õ ...06 OTHERõ õ õ õ õ õ õ õ õ .õ õ 96	
Q135	What was the reason for abortion?	UNPLANNED PREGNANCYõ õ ..õ ....õ 01 DUE TO CONTRACEPTIVE FAILURE.........02 COMPLICATION(S) IN PREGNANCY.........03 HEALTH DID NOT PERMITõ õ õ õ ....04 FEMALE FOETUS õ õ õ õ õ õ õ õ ....05 ECONOMIC REASON õ õ õ .õ õ õ ....06 LAST CHILD TOO YOUNGõ õ õ õ õ ....07 FOETUS HAD CONGENITAL ABNORMALITYõ ....08 OTHERõ õ õ õ õ õ õ õ õ ..õ 96	
Q136	**SUM ANSWERS TO Q123, Q125 AND Q127 ENTER TOTAL** **(IF NONE, RECORD '00')**	TOTAL LIVE BIRTHSõ ..õ .... ☐☐	
Q137	**SUM ANSWERS TO Q123, Q125, Q127, Q128 and Q129** **(IF NONE, RECORD '00')**	TOTAL PREGNANCIESõ õ .. ☐☐	

Q138A	**CHECK Q136 AND Q137:**
	
	Just to make sure that I have recorded correctly: you have had in TOTAL _____ births during your life. Is that correct?
	
	     YES ☐ NO ☐ → **PROBE AND CORRECT AS NECESSARY**
	                                           Q123, Q125, Q127, Q128, Q129, Q136 AND Q137	

Q138B	**CHECK Q106** **SEPARATED/ DESERTED/ DIVORCED/ WIDOW** ☐ **CURRENTLY MARRIED** ☐ **GAUNA NOT PERFORMED** ☐ **CHECK Q113** **GO TO Q139** **GO TO Q261** **0 - 4 YEARS** ☐ **MORE THAN 4 YEARS** ☐ **GO TO Q139** **GO TO Q261**	

Q139: Now I would like to ask you, about the number of times you were pregnant which resulted in live births, still births or abortions since January 1, 2007?

RECORD TOTAL NO. OF PREGNANCIES ---------- [ ]   If '0' GO TO **Q261**

START WITH THE LATEST PREGNANCY <u>EXCLUDING THE CURRENT PREGNANCY</u>. RECORD ALL PREGNANCIES IN 140. RECORD TWINS AND TRIPLETS ON SEPARATE LINES

Q140 Line number /Pregnancy number	Q140A Did you undergo Pregnancy confirmation test ?	Q141 What was the outcome of pregnancy? LIVE BIRTH STILL BIRTH INDUCED SPONTANEOUS	Q142 What name was given to your baby?	Q143 Was (his/her) a single or multiple births?	Q143A What is his/her birth order? **(ONLY FOR LIVE BIRTH)**	Q144 Is (NAME) a boy or a girl?	Q145 In which month and year you had live birth/ still birth/abortion? **Probe:** (In case of live birth, what is his/her birth date?)	Q146 What was your age at the time of (Name)s birth/still birth/abortion?
(1) Last pregnancy	Yes = 1 No = 2	LIVE BIRTH 1 STILL BIRTH 2 ➡ Q143 INDUCED 3 ➡ Q144 SPONT 4 ➡ Q145	_____ (NAME)	SINGLE 1 MULTIPLE 2	[ ][ ]	BOY = 1 GIRL = 2 DK = 8	MONTH [ ][ ] YEAR [ ][ ][ ]	AGE IN YEARS MONTH [ ][ ] YEAR [ ][ ][ ]
(2) Previous last pregnancy	Yes = 1 No = 2	LIVE BIRTH 1 STILL BIRTH 2 ➡ Q143 INDUCED 3 ➡ Q144 SPONT 4 ➡ Q145	_____ (NAME)	SINGLE 1 MULTIPLE 2	[ ][ ]	BOY = 1 GIRL = 2 DK = 8	MONTH [ ][ ] YEAR [ ][ ][ ]	AGE IN YEARS MONTH [ ][ ] YEAR [ ][ ][ ]
(3) Second from last pregnancy	Yes = 1 No = 2	LIVE BIRTH 1 STILL BIRTH 2 ➡ Q143 INDUCED 3 ➡ Q144 SPONT 4 ➡ Q145	_____ (NAME)	SINGLE 1 MULTIPLE 2	[ ][ ]	BOY = 1 GIRL = 2 DK = 8	MONTH [ ][ ] YEAR [ ][ ][ ]	AGE IN YEARS MONTH [ ][ ] YEAR [ ][ ][ ]
(4) Third from last pregnancy	Yes = 1 No = 2	LIVE BIRTH 1 STILL BIRTH 2 ➡ Q143 INDUCED 3 ➡ Q144 SPONT 4 ➡ Q145	_____ (NAME)	SINGLE 1 MULTIPLE 2	[ ][ ]	BOY = 1 GIRL = 2 DK = 8	MONTH [ ][ ] YEAR [ ][ ][ ]	AGE IN YEARS MONTH [ ][ ] YEAR [ ][ ][ ]

Q147 Did you receive any ANC? (Yes-1, No-2)	Q148 At what month of pregnancy did abortion happen?	Q149 Was ultrasound done? (Yes-1, No-2)	Q150 Where was the abortion performed / completed? (Code)	Q151 Who performed / completed the abortion? (Code)	IF LIVE BIRTH	
					Q152 Is (NAME) still alive?	Q153 If DEAD How old was (NAME) when he/she died? If "< 1 year", PROBE: How many months old was (NAME)? **RECORD DAYS IF LESS THAN 1 MONTH, MONTHS IF LESS THAN TWO YEARS, OR YEARS IF MORE THAN 2 YEARS**
☐	☐	☐	☐☐	☐	YES… ….1 GO TO NEXT ROW ← NO…2 →	DAYS… … … 1 ☐☐ / MONTHS… … .. 2 ☐☐ / YEARS… … … . 3 ☐☐
☐	☐	☐	☐☐	☐	YES… … …1 GO TO NEXT ROW ← NO…2 →	DAYS… … … 1 ☐☐ / MONTHS… … .. 2 ☐☐ / YEARS… … … . 3 ☐☐
☐	☐	☐	☐☐	☐	YES… … ….1 GO TO NEXT ROW ← NO… 2 →	DAYS… … … 1 ☐☐ / MONTHS… … .. 2 ☐☐ / YEARS… … … . 3 ☐☐
☐	☐	☐	☐☐	☐	YES… … …1 GO TO NEXT SEC. ← NO… 2 →	DAYS… … … 1 ☐☐ / MONTHS… … .. 2 ☐☐ / YEARS… … … . 3 ☐☐

Q154: CHECK Q141 AND Q152 AND ENTER THE NUMBER OF SURVIVING CHILDREN BORN AFTER 1ST January 2007 (IF NONE RECORD '0'). ☐
NOTE: IN Q144 'DK' (DO NOT KNOW) ONLY IN CASE OF INDUCED ABORTIONS.

Q 150					Q151	
Item	**code**	**Item**	**code**		**Item**	**code**
GOVERNMENT		**PRIVATE**			Doctor	01
Sub-Center	01	Dispensary / Clinic	08		Nurse / ANM / LHV	02
PHC	02	Hospital	09		Trained dai	03
CHC	03	AYUSH Hospital / Clinic	10		Untrained dai	04
UHC / UHP / UFWC	04	**NGO or Trust Hosp/Clinic**	11		Family members / Relative / Friends	05
Dispensary / Clinic	05	**At Home** Self	12		None / Self	06
Hospital	06	Elsewhere	13		Other	96
AYUSH Hospital / Clinic	07	Other	96			

Now I would like to ask you some questions about the Antenatal, Natal and Post-Natal care for your pregnancies since 1 January 2007.			
Q. NO	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP TO**
Q201	**CHECK Q139: ONE OR MORE PREGNANCIES IN 2007 OR LATER**	**NO PREGNANCY IN 2007 OR LATER**	**Q261**
Q201A	**CHECK Q141: LIVE BIRTH/STILL BIRTH LAST PREGNANCY**	**INDUCED/SPONTANEOUS ABORTION**	**Q261**
Q202	What is/was the date of birth of the baby? In case of still birth, record only month and year. D D M M Y Y Y Y D D M M Y Y Y Y		
Q203	During which month did you come to know about last pregnancy?	WITHIN ONE MONTH..................................1 WITHIN TWO MONTH.................................2 WITHIN THREE MONTH..............................3 MONTHS... (**Record actual month if 4 Month and above**)	
Q204	Did you undergo Pregnancy confirmation test (urine test) during the last pregnancy?	YES .... 1 NO 2	
Q205	Did you register your last pregnancy?	YES .... 1 NO 2	**Q207**
Q205A	When was the pregnancy registered?	WITHIN 12 WEEKS OF PREGNANCY........................ 1 AFTER 12 WEEKS OF PREGNANCY 2	
Q206	Pregnancy was registered with whom?	GOVT. DOCTOR õ õ õ õ õ ....õ .... 1 PRIVATE DOCTOR õ õ õ õ õ ....õ 2 ANM. õ õ õ õ õ õ õ õ õ õ ....õ ......õ 3 ANGANWADI WORKER õ õ .... 4 ASHA õ õ õ õ õ õ õ õ õ õ õ õ ....õ 5 OTHER _____ 6 (SPECIFY)	
Q207	When you were pregnant with (NAME/ THE STILL BIRTH), did you receive antenatal care?	YES .... 1 NO .... 2 (IF NO, PROBE)	**Q221**
Q208	After how many months of last pregnancy did you receive first antenatal care?	MONTHSõ õ õ õ õ õ õ ..õ õ õ .õ .. DONõT KNOW õ õ õ õ õ õ õ õ õ õ .98	
Q209	How many times you received antenatal check up during last pregnancy?	NUMBER OF TIMESõ õ ..õ DONõT KNOW õ õ õ õ õ õ õ õ õ õ ..õ õ .98	

Q.NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q210	Where did you receive antenatal care for last pregnancy? Any other place? IF UNABLE TO DETERMINE IF A HOSPITAL/ HEALTH CENTRE/ CLINIC IS GOVERNMENT OR PRIVATE MEDICAL SECTOR, WRITE THE NAME OF THE PLACE(S) _____ NAME OF THE PLACE(S) **(RECORD ALL MENTIONED)**	YES NO **GOVERNMENT** A. ANGANWADI/ICDS CENTRE............. 1 2 B. SUB-CENTRE.................................... 1 2 C. PHC.. 1 2 D. CHC... 1 2 E. UHC/UHP/UFWC............................. 1 2 F. DISPENSARY/CLINIC .... 1 2 G. HOSPITALõ õ .... 1 2 H. AYUSH HOSPITAL/CLINIC õ .... 1 2 I. MOBILE MEDICAL UNIT................... 1 2 **PRIVATE** J. DISPENSARY/CLINIC...................... 1 2 K. HOSPITAL.. 1 2 L. AYUSH/HOSPITAL/CLINIC............... 1 2 M. NGO/TRUST HOSP. /CLINICõ õ .... 1 2 **HOME** N. HOMEõ õ õ õ õ õ .... 1 2 O. PARENTS¬HOME.............................. 1 2 P. OTHER HOMEõ õ õ ....õ . 1 2 Q. **OTHER**_____ 1 2 (SPECIFY)	
Q210a	What was the main source of antenatal care for last pregnancy?	**GOVERNMENT** A. ANGANWADI/ICDS CENTRE .... 01 B. SUB-CENTRE.. 02 C. PHC õ õ õ õ õ ....õ õ 03 D. CHC... 04 E. UHC/UHP/UFWC õ õ õ ....õ .... 05 F. DISPENSARY/CLINIC.....õ õ .õ .... 06 G. HOSPITAL.. 07 H. AYUSH HOSPITAL/CLIN IC................ 08 I. MOBILE MEDICAL UNIT.................... 09 **PRIVATE** J. DISPENSARY/CLINIC........................ 10 K. HOSPITAL... 11 L. AYUSH HOSPITAL/CLINIC............... 12 M. NGO/TRUST HOSP. /CLINICõ ....õ 13 **HOME** N. HOMEõ õ õ õ õ õ .... 14 O. PARENTS¬HOME.............................. 15 P. OTHER HOME õ õ õ õ .... 16 Q. **OTHER** _____ 96 (SPECIFY)	

Q.NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

Q211	As part of your antenatal care during last pregnancy, were any of the following done at least once?
	
	A. Weight measured?
	B. Height measured?
	C. Blood pressure checked?
	D. Blood tested (Hb)?
	E. Blood tested (Blood Group)
	F. Blood tested (Other)
	G. Urine tested?
	H. Abdomen examined?
	I. Breast examined?
	J. Sonogram or Ultrasound done?
	K. Delivery date told?
	L. Delivery advice given?
	M. Nutrition advice given?
		Q211a.
		                     IF YES
		                     NO. OF
		           YES NO TIMES
		A. WEIGHT …………… . 1 2 ☐
		B. HEIGHT ……… .. 1 2
		C. BLOOD PRESSURE……….. 1 2 ☐
		D. BLOOD TESTED (Hb) … 1 2 ☐
		E. BLOOD TESTED (Blood Group) 1 2 ☐
		F. BLOOD TESTED (Other). 1 2 ☐
		G. URINE 1 2 ☐
		H. ABDOMEN………………… 1 2 ☐
		I. BREAST EXAMINED … …… 1 2 ☐
		J. SONOGRAM OR ULTRASOUND 1 2 ☐
		K. DELIVERY DATE ……… 1 2
		L. DELIVERY ADVICE …… .. 1 2
		M. NUTRITION ADVICE …… . 1 2	

Q212	During (any of) your antenatal care visit (s), did any one tell you about the following signs of pregnancy complications? A. Vaginal bleeding? B. Convulsions? C. Prolonged labour?	YES NO A. BLEEDING ……… ……. 1 2 B. CONVULSIONS ……… ……. 1 2 C. PROLONGED LABOUR …… …… 1 2	
Q213	Did any one tell you where to go (health facility) if you have any pregnancy complications?	YES……………………………………………………… 1 NO ……………………………………………………… 2	
Q214	During (any of) your antenatal visit (s), did you receive advice on the following at least once? A. Breastfeeding? B. Keeping the baby warm? C. The need for cleanliness at the time of delivery? D. Family planning for spacing? E. Family planning for limiting? F. Better nutrition for mother and child? G. Need for Institutional Delivery?	YES NO A. BREASTFEEDING …… …… . 1 2 B. KEEPING BABY WARM …… … 1 2 C. CLEANLINESS …… …… … .. 1 2 D. SPACING …… ……… .. …… . 1 2 E. LIMITING …… ……… …… . 1 2 F. NUTRITION …… …… . . …… ... 1 2 G. INSTITUTIONAL DELIVERY …… . 1 2	
Q215	How many IFA tablets/ bottles did you receive/ purchase during last pregnancy?	NUMBER OF TABLETS ☐☐☐ NUMBER OF BOTTLES ☐☐☐ IF NONE …… …… …… …… 000 ───────	► Q218

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Q.NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q216	From where did you get Iron Folic Acid (IFA) tablets/syrup? **(RECORD ALL MENTIONED)**	YES NO **GOVERNMENT** A. ANGANWADI/ICDS CENTRE.......... 1 2 B. SUB-CENTRE................................... 1 2 C. PHC... 1 2 D. CHC... 1 2 E. UHC/UHP/UFWC........................... 1 2 F. DISPENSARY/CLINIC .... 1 2 G. HOSPITAL .... 1 2 H. AYUSH HOSPITAL/CLINIC .... 1 2 I. MOBILE MEDICAL UNIT.................. 1 2 **PRIVATE** J. DISPENSARY/CLINIC...................... 1 2 K. HOSPITAL..................................... 1 2 L. AYUSH HOSPITAL/CLINIC............. 1 2 M. NGO/TRUST HOSP./CLINIC .... 1 2 N. DOCTOR.. 1 2 O. ANM/NURSE.................................. 1 2 P. CHEMIST/PHARMACY.................... 1 2 U. OTHER _____ 1 2 (SPECIFY)	
Q217	During the last pregnancy, for how many days and how much did you take the Iron Folic Acid (IFA) Tablets/Syrup bottles?	**A) IRON FOLIC ACID TABLETS** NUMBER OF DAYS NUMBER OF TABLETS ☐☐☐ ☐☐☐ DON'T KNOW ..998 DON'T KNOW ...998 **B) IRON FOLIC ACID SYRUP** NUMBER OF DAYS NUMBER OF BOTTLES ☐☐☐ ☐☐☐ DON'T KNOW .998 DON'T KNOW ..998	
Q218	Were you given an injection during last pregnancy to prevent Tetanus?	YES... 1 NO 2	►**Q220**
Q219	During last pregnancy, how many times did you get a Tetanus injection?	NUMBER OF TIMES .... ☐ DON'T KNOW 8	
Q220	Was the Antenatal check-up done with enough time, somewhat enough time or did hurriedly by health personnel?	ENOUGH TIME... 1 SOMEWHAT ENOUGH TIME .... 2 DID HURRIEDLY 3	►**Q222**
Q221	**(FOR THOSE WOMEN WHO SAID "NO" FOR Q207)** Why did you not go for an antenatal check-up? **(RECORD ALL MENTIONED)**	YES NO A. NOT NECESSARY .... 1 2 B. NOT CUSTOMARY .... 1 2 C. COST TOO MUCH .... 1 2 D. TOO FAR/NO TRANSPORT .... 1 2 E. POOR QUALITY SERVICE . 1 2 F. FAMILY DID NOT ALLOW ... 1 2 G. LACK OF KNOWLEDGE .. 1 2 H. NO TIME TO GO .... 1 2 I. OTHER _____ 1 2 **(SPECIFY)**	

Q.NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q221a	What was the main reason not going for ANC?	A. NOT NECESSARY .... 01 B. NOT CUSTOMARY .... 02 C. COST TOO MUCH .... 03 D. TOO FAR/NO TRANSPORT ... 04 E. POOR QUALITY SERVICE ...... 05 F. FAMILY DID NOT ALLOW .... 06 G. LACK OF KNOWLEDGE ...... 07 H. OTHER_____ 96 (SPECIFY) I. NO TIME TO GO 00	
Q222	Who facilitated or motivated you to avail antenatal care? (RECORD ALL MENTIONED)	YES NO A. DOCTOR .... 1 2 B. ANM .... 1 2 C. HEALTH WORKER .... 1 2 D. ANGANWADI WORKER .... 1 2 E. ASHA .... 1 2 F. NGO/CBO ..... 1 2 G. HUSBAND .... 1 2 H. MOTHER-IN-LAW ..... 1 2 I. MOTHER ..... 1 2 J. RELATIVES / FRIENDS .... 1 2 K. SELF ..... 1 2 L. OTHER_____ 1 2 (SPECIFY)	
Q222a	Who mainly facilitated or motivated you to avail antenatal care?	A. DOCTOR .... 01 B. ANM .... 02 C. HEALTH WORKER .... 03 D. ANGANWADI WORKER .... 04 E. ASHA .... 05 F. NGO/CBO ..... 06 G. HUSBAND .... 07 H. MOTHER-IN-LAW .... 08 I. MOTHER .... 09 J. RELATIVES / FRIENDS ..... 10 K. SELF .... 11 L. OTHER_____ 96 (SPECIFY)	
Q223	During your last pregnancy did you suffer from any of the following health problems? A. Swelling of hands, feet and Face B. Paleness/giddiness/weakness C. Visual disturbances D. Excessive fatigue E. Convulsions not from fever F. Weak or no movement of foetus G. Abnormal position of foetus H. Malaria I. Excessive vomiting J. Hypertension/ High BP K. Jaundice L. Excessive bleeding M. Vaginal Discharge N. Other _____ (SPECIFY)	YES NO A. SWELLING OF HANDS, FEET AND FACE 1 2 B. PALENESS / GIDDINESS/WEAKNESS.... 1 2 C. VISUAL DISTURBANCES .... 1 2 D. EXCESSIVE FATIGUE ...... 1 2 E. CONVULSIONS NOT FROM FEVER.... 1 2 F. WEAK OR NO MOVEMENT OF FOETUS 1 2 G. ABNORMAL POSITION OF FOETUS...... 1 2 H. MALARIA. ...... 1 2 I. EXCESSIVE VOMITING ..... 1 2 J. HYPERTENSION / HIGH BP ..... 1 2 K. JAUNDICE .... 1 2 L. EXCESSIVE BLEEDING ..... . 1 2 M. VAGINAL DISCHARGE ...... 1 2 N. OTHER_____ 1 2 (SPECIFY)	If 'NO' FOR ALL GO TO Q226
Q224	Did you seek treatment for any of these health problems?	YES...1 NO.. 2 ——→ Q226	

Q.NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q225	Where did you go for consultation or to seek treatment? **(RECORD ALL MENTIONED)**	**GOVERNMENT** YES NO A. ANGANWADI .... 1 2 B. SUB-CENTRE................................. 1 2 C. PHC... 1 2 D. CHC... 1 2 E. UHC/UHP/UFWC.......................... 1 2 F. DISPENSARY/CLINIC .... 1 2 G. HOSPITAL .... 1 2 H. AYUSH HOSPITAL/CLINIC .... 1 2 I. MOBILE MEDICAL UNIT............... 1 2 **PRIVATE** J. DISPENSARY/CLINIC. .... 1 2 K. HOSPITAL................................... 1 2 L. AYUSH HOSPITAL/CLINIC .... 1 2 M. NGO/TRUST HOSP. /CLINIC ..... 1 2 N. OTHER _____ 1 2 (SPECIFY)	
Q225a	Where did you go mainly for consultation or to seek treatment?	**GOVERNMENT** A. ANGANWADI.. 01 B. SUB-CENTRE..................................... 02 C. PHC .... 03 D. CHC... 04 E. UHC/UHP/UFWC.......................... 05 F. DISPENSARY/CLINIC .... 06 G. HOSPITAL .... 07 H. AYUSH HOSPITAL/CLINIC............... 08 I. MOBILE MEDICAL UNIT..................... 09 **PRIVATE** J. DISPENSARY/CLINIC .... 10 K. HOSPITAL...................................... 11 L. AYUSH HOSPITAL/CLINIC.................. 12 M. NGO/TRUST HOSP. /CLINIC .... 13 N. OTHER _____ 96 (SPECIFY)	
Q226	Did you receive any supplementary nutrition from the Anganwadi centre during last pregnancy?	YES... 1 NO 2	
Q227	Who facilitated or motivated you to go to health facility for delivery? **(RECORD ALL MENTIONED)**	YES NO A. DOCTOR . 1 2 B. ANM . 1 2 C. HEALTH WORKER .. 1 2 D. ANGANWADI WORKER ... 1 2 E. ASHA ... 1 2 F. NGO/CBO .. 1 2 G. HUSBAND .. 1 2 H. MOTHER-IN-LAW .. 1 2 I. MOTHER .... 1 2 J. RELATIVES/FRIENDS .. 1 2 K. SELF ... 1 2 L. OTHER_____ 1 2 **(SPECIFY)**	**If 'NO' FOR ALL GO TO Q229**
Q228	If yes, where did she /he advise you to go for delivery? **(RECORD ALL MENTIONED)**	**GOVERNMENT** YES NO A. ANGANWADI . 1 2 B. SUB CENTRE.. 1 2 C. PHC.. 1 2 D. CHC... 1 2 E. UHC/UHP/UFWC.................................. 1 2 F. DISPENSARY/CLINIC............................ 1 2 G. HOSPITAL. .... 1 2 H. AYUSH HOSPITAL/ CLINIC .... 1 2 **PRIVATE** I. DISPENSARY/ CLINIC . 1 2 J. AYUSH HOSPITAL/CLINIC .. 1 2 K. NGO/TRUST HOSPITAL/CLINIC . 1 2 L. OTHER _____ 1 2 **(SPECIFY)**	

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Q.NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

Q229	During delivery, did you experience any of the following problems?
	
	A. Did you experience premature labour?
	
	B. Did you experience excessive bleeding?
	
	C. Did you experience prolonged labour?
	
	D. Did you experience obstructed labour?
	
	E. Did you experience breech presentation?
	
	F. Did you experience Convulsion/High B.P?
	
	G. Any Other?
		YES NO
		
		A. PREMATURE LABOUR…………..… 1 2
		
		B. EXCESSIVE BLEEDING… … ..… .… . 1 2
		
		C. PROLONGED LABOUR
		  (More than 12 Hours) … … … … ..… … 1 2
		
		D. OBSTRUCTED LABOUR… … … .… .… 1 2
		
		E. BREECH PRESENTATION… … ….… 1 2
		
		F. CONVULSION/HIGH B.P…………… 1 2
		
		G. OTHER _____ 1 2
		         (SPECIFY)	

Q230	Was the delivery normal or caesarean or assisted?	NORMAL .... 1 CAESAREAN .... 2 BY INSTRUMENT OR ASSISTED…................. 3	
Q231	Where did your last delivery take place?	**GOVERNMENT** SUB CENTER...01 PHC..02 CHC..03 UHC/UHP/UFWC...04 DISPENSARY/CLINIC...................................05 HOSPITAL...06 AYUSH HOSPITAL/ CLINIC.....................................07 **PRIVATE** DISPENSARY/CLINIC... 09 AYUSH HOSPITAL/CLINIC.................................... 10 NGO/TRUST HOSPITAL/CLINIC .... 08 ON THE WAY TO HOSPITAL .... 11 AT HOME .... 12 AT PARENTS HOME .... 13 WORK PLACE .... 14 OTHER_____ 96 **(SPECIFY)**	➤ **Q235**
Q232	Who conducted your last delivery?	DOCTOR...1 ANM/NURSE/MIDWIFE/LHV ....2 TRAINED DAI ....3 UNTRAINED DAI...4 FAMILY MEMBER /RELATIVES/FRIENDS...........5 NONE 8	

Q.NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q233	At the time of last delivery were the following done? A. Was a Disposable Delivery Kit (Mamta Kit) used? B. Was the baby immediately wiped dry and then wrapped without being bathed? C. Was a new/sterilized blade used to cut the cord?	YES NO DK A. DDK/ MAMTA KIT USED… … … 1 2 3 B. WIPED AND WRAPPED..… ..… 1 2 3 C. NEW / STERLIZED BLADE 1 2 3	
Q234	What are the reasons for not going to health facility for delivery? **(RECORD ALL MENTIONED)**	YES NO A. COST TOO MUCH … .… … … … … 1 2 B. POOR QUALITY SERVICE.… … .. 1 2 C. TOO FAR/NO TRANSPORT.… … 1 2 D. NO TIME TO GO … … … … … … . 1 2 E. NOT NECESSARY… … ..… … … 1 2 F. NOT CUSTOMARY… … … … ..... 1 2 G. BETTER CARE AT HOME… … ..... 1 2 H. FAMILY DID NOT ALLOW … .… … 1 2 I. LACK OF KNOWLEDGE… … … . 1 2 J. OTHER _____ **(SPECIFY)** 1 2	
Q234a	What are the main reasons for not going to health facility for delivery?	A. COST TOO MUCH … .… … … … … 01 B. POOR QUALITY SERVICE.… … .. 02 C. TOO FAR/NO TRANSPORT.… … 03 D. NO TIME TO GO … … … … … … . 04 E. NOT NECESSARY… … ..… … … 05 F. NOT CUSTOMARY… … … … ..... 06 G. BETTER CARE AT HOME… … ..... 07 H. FAMILY DID NOT ALLOW … .… … 08 I. LACK OF KNOWLEDGE… … … . 09 J. OTHER _____ **(SPECIFY)** 96	**Q237**
Q235	What was the main mode of transportation used by you to reach the health facility for delivery?	AMBULANCE… … … … … … … … … … … … … … ......01 JEEP/CAR..… … … … … … … … … .… … … … ... 02 MOTORCYCLE/SCOOTER … … … … … … … … .... 03 BUS/TRAIN… … … … … … … … … … … … … … . 04 TEMPO/AUTO/TRACTOR… … … … … .… … … … .. 05 CART..… … … … .… … … … … … … … … ....06 ON FOOT ......… … … … … … … … … … … … … … 07 OTHER _____ 96 **(SPECIFY)**	►**Q237**
Q236	Who arranged the transportation to take you to the health facility for delivery? **(RECORD ALL MENTIONED)**	YES NO A. DOCTOR… … … … … … … … ....… … .. 1 2 B. ANM… … … … … … … … … … ....… .. 1 2 C. HEALTH WORKER … … … … … ....… … 1 2 D. ANGANWADI WORKER… … … ....… … 1 2 E. ASHA… … … … … … … … … … ....… . 1 2 F. NGO… … … … … … … … … … ....… . 1 2 G. CBO… … … … … … … … … … … .... 1 2 H. HUSBAND… … … … … … … … ....… … 1 2 I. MOTHER-IN-LAW… … … … … … ....… ... 1 2 J. MOTHER … … … … … … … … … .... 1 2 K. RELATIVES/FRIENDS… … … … .... 1 2 L. PRI MEMBER... 1 2 M. SELF … … … … … … … … … … … .... 1 2 N. OTHER_____ **(SPECIFY)** 1 2	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q236a	Who mainly arranged the transportation to take you to the health facility for delivery?	A. DOCTOR .... 01 B. ANM .... 02 C. HEALTH WORKER .... 03 D. ANGANWADI WORKER .... 04 E. ASHA .... 05 F. NGO .... 06 G. CBO .... 07 H. HUSBAND .... 08 I. MOTHER-IN-LAW .... 09 J. MOTHER .... 10 K. RELATIVES/FRIENDS .... 11 L. PRI MEMBER................ 12 M. SELF .... 13 N. OTHER_____ 96 **(SPECIFY)**	
Q237	In case of institutional delivery , how much it cost out of your pocket on following items during delivery	NO COST PAID .0000 DON'T KNOW.. 99998 **RUPEES** A. **TOTAL EXPENDITURE** B. ARRANGING TRANSPORTATION C. COST OF STAY IN HOSPITAL D. COST OF TESTS DONE E. COST OF MEDICINES F. OTHER EXPENDITURE DUE TO COMPLICATIONS	
Q238	In case of institutional delivery, how long did you stay in institution after delivery? (Record in Hours, if stay <= 48 hrs, in Days otherwise) UNIT / CODE HOURS / H DAYS / D	LAST BIRTH H/D NO. OF DAYS	
Q239	How out of pocket cost on delivery was met?	BORROWED FROM FRIENDS........ ....1 SELLING ROPERTY....... ...2 SELLING JEWELLERY... ...3 INSURANCE.................... ...4 OTHER..6	
Q240	Did you receive any financial assistance for delivery care?	YES ....1 NO................................ ...2	► Q241
Q240A	whether you received from ?	JANANI SURKSHA YOJANA (JSY) ....1 OTHER GOVERNMENT SCHEME (OTHER THAN JSY)......2	
Q240B	What was the total amount received by you during pregnancy and / or after delivery?	(AMOUNT IN RS.) JSY........................ OTHERGOVT.SCHEME	
Q240C	How many days after last delivery, did you receive the financial assistance?	DAYS	

Q.NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q241	Do you know the danger signs of new born? A. Breast feeding or drinking poorly.......... B. Fever or cold/ hot to touchõ .... C. Fast or difficult Breathingõ .... D. Blood in Stool....................................... E. Blue Tongue & Lips õ õ õ õ õ .... F. Develop yellow staining of Palm and Solesõ õ õ õ .... G. Abnormal movementõ õ õ .... H. Baby did not cry õ õ õ õ	YES NO A. BREAST FEEDING OR DRINKING POORLY.. 1 2 B. FEVER OR COLD/ HOT TO TOUCHõ .... 1 2 C. FAST OR DIFFICULT BREATHINGõ .... 1 2 D. BLOOD IN STOOL.. 1 2 E. BLUE TONGUE & LIPS õ õ õ õ õ ....õ . 1 2 F. DEVELOP YELLOW STAINING OF PALM AND SOLESõ õ õ õ õ õ õ .... 1 2 G. ABNORMAL MOVEMENTõ õ õ õ ....õ õ 1 2 H. BABY DID NOT CRY õ õ õ õ õ õ õ 1 2	
Q242	Did you have any check-up within 48 hours after delivery?	YES......................õ õ õ õ õ õ õ õ õ õ õ õ ....1 NO....................õ õ õ õ õ ..õ õ õ õ õ õ õ ...2	▶ **Q244**
Q243	How many days after delivery did the first check-up take place?	DAYS õ õ õ õ õ õ õ õ õ ......·................ CHECK UP NOT DONE AT ALLõ õ õ õ õ õ õ õ ...00 DONõT KNOW õ õ õ õ õ õ õ õ õ ....õ õ 98	▶ **Q246**
Q244	Where did the first check-up take place?	YES NO **GOVERNMENT** A. SUB-CENTRE................................. 1 2 B. PHC... 1 2 C. CHC... 1 2 D. UHC/UHP/UFWC............................ 1 2 E. DISPENSARY/CLINIC õ õ õ õ õ .. 1 2 F. HOSPITAL õ õ õ .... 1 2 G. AYUSH HOSPITAL/CLINICõ ..õ õ 1 2 H. MOBILE MEDICAL UNIT................ 1 2 **PRIVATE** I. DISPENSARY/CLINIC..õ õ õ .... 1 2 J. HOSPITAL..................................... 1 2 K. AYUSH HOSPITAL/CLINICõ ..õ õ 1 2 L. NGO/TRUST HOSP. /CLINICõ ...... 1 2 M. AT HOME....................................... 1 2 N. OTHER, _____ 1 2 (SPECIFY)	
Q245	Did any of the following happen when you had the check-up: A. Was your abdomen examined? B. Did you receive advice on breastfeeding? C. Did you receive advice on baby care? D. Did you receive advice on family planning? E. Any Other ?	YES NO A. ABDOMEN EXAMINEDõ õ .... 1 2 B. ADVICE ON BREASTFEEDINGõ .... 1 2 C. ADVICE ON BABY CAREõ õ ....õ õ .. 1 2 D. ADVICE ON FAMILY PLANNING...........õ 1 2 E. OTHER_____ 1 2 **(SPECIFY)**	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q246	During the first **6 weeks** after delivery did you experience any of the following health problems? A. Did you experience, **high fever**? B. Did you experience, **lower abdominal pain**? C. Did you experience, **foul smelling vaginal discharge**? D. Did you experience, **excessive bleeding**? E. Did you experience, **convulsions**? F. Did you experience, **severe headache**? G. Any other ?	YES NO A. HIGH FEVER õ õ õ õ ......õ õ ... 1 2 B. LOWER ABDOMINAL PAIN.......... 1 2 C. FOUL SMELLING VAGINAL DISCHARGE õ õ õ õ õ õ ......õ 1 2 D. EXCESSIVE BLEEDING õ ......õ . 1 2 E. CONVULSIONSõ õ õ õ õ õ ...õ 1 2 F. SEVERE HEADACHEõ õ õ õ õ 1 2 G. OTHER _____ 1 2 **(SPECIFY)**	**If 'NO'** **FOR** **ALL** **GO TO** **Q249**
Q247	Did you consult anyone or seek treatment for these health problems?	YES.......................õ õ õ õ õ õ õ õ õ õ 1 NO.......................õ õ õ õ õ õ õ õ õ õ 2	➤ **Q249**
Q248	Where did you go for consultation or treatment? **(RECORD ALL MENTIONED)**	YES NO **GOVERNMENT** A. SUB-CENTRE................................. 1 2 B. PHC... 1 2 C. CHC... 1 2 D. UHC/UHP/UFWC.......................... 1 2 E. DISPENSARY/CLINIC õ õ õ .õ õ .. 1 2 F. HOSPITAL õ õ õ .... 1 2 G. AYUSH HOSPITAL/CLINIC .õ ....õ 1 2 H. MOBILE MEDICAL UNIT................ 1 2 **PRIVATE** I. DISPENSARY/CLINIC Åõ õ õ .... 1 2 J. HOSPITAL...................................... 1 2 K. AYUSH HOSPITAL/CLINIC õ .õ õ 1 2 L. NGO/TRUST HOSP. /CLINICõ ...õ 1 2 M. OTHER _____ 1 2 (SPECIFY)	

Q249	**CHECK Q141: LIVE BIRTH**
	          LAST PREGNANCY ⬜ ⬇
		STILL BIRTH
		        LAST PREGNANCY ⬜
			GO TO
			Q261

Q250	Did your child have any check-up after delivery? (To be asked only in respect of live births)	WITHIN 24 HOURS õ õ õ õ õ õ .... 1 24 HOURS TO 72 HOURS ………………………………… 2 4 TO 7 DAYS õ õ ......õ õ õ ......õ õ .õ .... 3 AFTER 7 DAYSõ õ õ õ õ ......õ õ õ .... 4 NOT CHECKED UP... 5 CHILD DID NOT SURVIVEõ õ ....õ 6	➤ **Q255**
Q250A	Was birth weight of the baby taken?	YES. ....õ õ õ õ õ õ õ õ õ ....õ ......1 NO............................õ õ õ õ õ õ õ õ õ õ .õ ....2 Donq Know...õ õ ..õ 8	

Q250B	If code 1 in Q.250A, what was the birth weight of the baby?			

Birth Weight	Kg	Grams

Q251	How many check-ups take place within one week of his/her birth?	NO. OF TIMES. õ õ õ õ õ õ õ õ .... ☐ **(IF MORE THAN 5 RECORD 5)** CHECK UP NOT DONE AT ALL.õ ....0 CHILD NOT SURVIVED TILL ONE WEEKõ õ õ . õ õ 7 DONõT KNOW õ õ õ õ õ õ õ õ .õ 8	➤ **Q253**

Q252	Where did first check-up take place for your child?	**GOVERNMENT** A. ANGANWADI..................................... 01 B. SUB-CENTRE..................................... 02 C. PHC.. 03 D. CHC... 04 E. UHC/UHP/UFWC............................. 05 F. DISPENSARY/CLINIC....................... 06 G. HOSPITAL.. 07 H. AYUSH HOSPITAL/CLINIC............... 08 I. MOBILE MEDICAL UNIT.................. 09 **PRIVATE** J. DISPENSARY/CLINIC..................... 10 K. HOSPITAL..................................... 11 L. AYUSH HOSPITAL/CLINIC............ 12 M. NGO/TRUST HOSP. /CLINIC......õ 13 **HOME** N. DOCTORõ õ õ õ õ õ .... 14 O. ANM/NURSE.................................. 15 P. ASHA/AWW õ õ õ õ .... 16 Q. OTHER _____ 96 (SPECIFY)	

Q253	Did you feed milk %colostrum / khees+ (yellowish thick milk) secreted during the first few days after child birth?	YES...................õ õ õ õ õ õ õ õ õ õ õ .....õ ...õ õ õ 1 NO...................................õ õ õ õ õ õ õ õ õ õ õ õ õ õ 2	

Q253a	During the newborn period, did the child have any of the following?		YES	NO	IF NO FOR ALL GO TO 254
		BREASTFEEDING OR DRINKING POORLY...	1	2	
		FEVER OR COLD TO TOUCH............................	1	2	
		FAST OR DIFFICULT BREATHING....................	1	2	
		BLOOD IN STOOL...	1	2	
		NOTHING..	1	2	

Q253b	IF YES, What did you do?	SOUGHT CARE OUTSIDE HOME............................. 1 MANAGED AT HOME.. 2 NOTHING...3	➤ Q254

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Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q253c	Where do you seek care?	**GOVERNMENT** A. HOSPITAL.. 01 B. DISPENSARY/CLINIC........................ 02 C. UHC/UHP/UFWC õ õ õ õ õ .....õ 03 D. CHC/RUR. HOSP............................ 04 E. PHC õ õ õ õ .... 05 F. SUB-CENTRE õ õ õ .... 06 G. ANGANWADI/ICDS CENTRE....... 07 H. AYUSH HOSPITAL/CLINIC.......... 08 I. MOBILE MEDICAL UNIT............... 09 **PRIVATE** J. HOSP./MATERNITYHOME/CLINIC. 10 K. AYUSH HOSPITAL/CLINIC............. 11 L. DISPENSARY/OTHER PVT. SECT HEALTH FACILITY .... 12 M. NGO/TRUST HOSP. /CLINICõ ..õ 13 Q. OTHER _____ 96 (SPECIFY)	
Q254	When did you first breastfeed your child?	IMMEDIATELY / WITHIN ONE HOUR OF BIRTH........... 1 1 HOUR TO WITHIN 24 HOURS õ .... 2 2 TO 3 DAYS õ õ õ õ .õ õ õ õ .õ ....õ 3 AFTER 3 DAYSõ õ õ õ õ õ õ õ õ õ .... 4 NEVER BREASTFED.. 5	→ **Q259**
Q255	CHECK Q152: **LAST CHILD SURVIVING** ☐	**LAST CHILD NOT SURVIVING** ☐	→ **Q261**
Q256	Are you still breastfeeding the child?	YES...................õ õ õ õ õ õ õ õ õ õ ....õ 1 NO..............................õ õ õ õ .õ õ õ õ õ õ õ ...2	
Q257	How many days/ months did you exclusively breastfeed the child? **(NOTHING OTHER THAN MOTHER'S MILK)**	DAYSõ õ õ õ õ õ õ õ õ õ 1 ☐☐ (IF LESS THAN ONE MONTH WRITE DAYS) MONTHSõ õ õ õ õ õ õ õ õ 2 ☐☐ CONTINUING. õ õ õ õ õ õ õ õ õ 88	
Q258	Do/did you give water to the baby before completion of six months?	YES...................õ õ õ õ õ õ õ õ õ õ õ ....õ 1 NO................................õ õ õ õ õ õ õ õ õ õ õ õ ...2	
Q259	At what age/month you have started giving baby other **fluids, semisolid**, and **solid foods**? **(if Don't know record 98, if age less than 1 month record 99)**	MONTHS WATER... ☐☐ ANIMAL MILK/FORMULA MILK............................ ☐☐ OTHER FLUIDSõ õ õ ....õ . ☐☐ SEMISOLID FOODõ õ õ õ õ ....õ ☐☐ SOLID FOOD (ADILT FOOD)................................ ☐☐ VEGITABLES/FRUITS.. ☐☐ NOT GIVEN ANYTHING SO FAR........................... 96	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q260	Now I would like to ask you about liquids (NAME) drank yesterday, during the day or at night? Did (NAME) drink: A. Plain water? B. Commercially produced infant food? C. Any other milk such as tinned, powdered, or fresh animal milk? D. Fruit juice? E. Tea or coffee? F. Any other liquids? G. Not given so far	YES NO A. PLAIN WATER õ õ õ õ .õ õ .....õ .õ õ õ 1 2 B. INFANT FOOD õ õ õ õ .õ õ ....õ õ 1 2 C. TINNED, POWDERED OR FRESH ANIMAL MILK õ õ õ õ õ .õ õ õ .õ õ ....õ 1 2 D. FRUIT JUICE õ õ õ õ õ õ ...õ õ...õ õ 1 2 E. TEA/COFFEE õ õ õ õ õ .õ ....õ .õ õ 1 2 F. OTHER LIQUIDS õ õ õ õ õ õ ......õ õ õ 1 2 G. NOT GIVEN SO FAR õ õ õ õ ...õ .....õ õ 1 2	
Q261	Do you know what to do when child gets **Diarrhoea**? **(RECORD ALL MENTIONED)**	YES NO A. GIVE ORS SOLUTION.............................. 1 2 B. SALT AND SUGAR SOLUTION õ .... 1 2 C. GIVE PLENTY OF FLUIDS .... 1 2 D. CONTINUE NORMAL FOOD õ õ .õ õ . 1 2 E. CONTINUE BREASTFEEDING................. 1 2 F. OTHER _____ 1 2 **(SPECIFY)** G. DO NOT KNOW õ õ õ õ ....õ õ 1 2	
Q262	Do you know what are the danger signs of **Pneumonia**? (ACUTE RESPIRATORY INFECTION) **(RECORD ALL MENTIONED)**	**DANGER SIGNS** YES NO A. DIFFICULTY IN BREATHING....................... 1 2 B. NOT ABLE TO DRINK OR TAKE A FEED õ .. 1 2 C. EXCESSIVELY DROWSY AND DIFFICULT TO KEEP AWAKE õ õ ....õ . 1 2 D. PAIN IN CHEST AND PRODUCTIVE COUGH... 1 2 E. WHEEZING/WHISTLING.............................õ 1 2 F. RAPID BREATHING .... 1 2 G. RUNNING NOSE õ õ õ õ õ ....õ õ . 1 2 H. OTHER_____ 1 2 **(SPECIFY)** I. NOT AWARE õ õ õ õ õ ....õ õ 1 2	
Q263	**(IF THE RESPONSE IS "DO NOT KNOW" IN Q261 AND "NOT AWARE" IN Q262 THEN GO TO Q264)** Who told you about the Diarrhoea and danger signs of Pneumonia? **(RECORD ALL MENTIONED)**	YES NO A. DOCTOR õ õ õ õ õ õ õ õ õ õ . 1 2 B. ANM õ õ õ õ õ õ õ õ õ õ õ . 1 2 C. HEALTH WORKER õ õ õ õ õ õ .. 1 2 D. ANGANWADI WORKER õ õ õ õ ... 1 2 E. ASHA õ õ õ õ õ õ õ õ õ õ õ õ õ 1 2 F. NGO/CBO õ õ õ õ õ õ õ õ õ õ õ 1 2 G. HUSBAND õ õ õ õ õ õ õ õ õ .. 1 2 H. MOTHER-IN-LAW õ õ õ õ õ õ . 1 2 I. MOTHER õ õ õ õ õ õ õ õ õ õ . 1 2 J. RELATIVES/FRIENDS õ õ õ õ õ . 1 2 K. SELF õ õ õ õ õ õ õ õ õ õ õ .. 1 2 L. OTHER_____ 1 2 **(SPECIFY)**	

Q264	**CHECK Q154**:
	
	ONE OR MORE SURVIVING CHILDREN ☐
	
	               ↓
	    SECTION III
		NO SURVIVING CHILDREN/
		WOMEN MARRIED BUT GAUNA NOT PERFOMED/SEPERATED/DESERTED/DIVORCED/ WIDOWED FOR MORE THAN 4 YEARS ☐
			SEC IV

SECTION-III

IMMUNIZATION AND CHILD CARE

Q301	ENTER IN THE TABLE BELOW THE LINE NUMBER, NAME, AND SURVIVAL STATUS OF EACH BIRTH SINCE 2007 OR LATER. THEN ASK THE QUESTIONS ABOUT ALL OF THESE BIRTHS. BEGIN WITH THE LAST BIRTH. Now I would like to ask you some questions about the health of your last two surviving children. (Born since 1st January 2007). (**We will talk about each child separately**.)		
Q. NO	**QUESTIONS AND FILTERS**	**LAST SURVIVING CHILD**	**LAST BUT ONE SURVIVING CHILD**
Q302	LINE NUMBER OF CHILD IN PREGNANCY HISTORY FROM **Q140.** Name of the (index) child **Q142**	LINE NUMBER [ ][ ] NAME_____	LINE NUMBER [ ][ ] NAME_____
Q303	**CHECK Q 144:** Sex of the child.	BOY.......õ õ ..õ õ .õ õ õ õ õ õ ..1 GIRL.......õ õ õ õ õ õ õ õ ..õ ..2	BOY.......õ õ ..õ õ .õ õ õ õ õ ..1 GIRL.......õ õ õ õ õ õ õ õ ..õ ..2
Q304	**CHECK Q145:** Month and year of birth.	MONTHõ õ õ õ õ õ õ [ ][ ] YEAR	MONTH õ õ õ õ õ õ [ ][ ] YEAR
			2007 | 2008 | 2009 | 2010 | 2011	2007 | 2008 | 2009 | 2010 | 2011
Q305	Do you have a card where (Name's) vaccination details are written down? (IF YES, MAY I SEE IT, PLEASE?)	YES, SEEN......õ õ õ õ õ õ 1 [**SKIP TOQ307**] ↵ YES, NOT SEEN.õ õ õ õ 2 [**SKIP TOQ310**] ↵ NO CARD.........õ õ õ õ ...3	YES, SEEN......õ õ õ õ õ õ õ 1 [**SKIP TOQ307**] ↵ YES, NOT SEEN.õ õ õ õ 2 [**SKIP TOQ310**] ↵ NO CARD..........õ õ õ õ õ ...3
Q306	Did you ever have a vaccination card?	YES.....................õ õ ..1 NO.......................õ ...õ 2 → **SKIP TO Q310**	YES......................õ õ ..1 NO.........................õ õ 2 → **SKIP TO Q310**

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Q. NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD	LAST BUT ONE SURVIVING CHILD
Q307	(1) COPY VACCINATION DATES FOR EACH VACCINE FROM THE CARD. (2) WRITE '44' IN 'DAY' COLUMN IF CARD SHOWS VACCINATION IS GIVEN BUT NO DATE IS RECORDED (3) IF ONLY PART OF DATE IS SHOWN ON CARD, RECORD '98' OR '9998' FOR 'DON'T KNOW' IN THE COLUMN FOR WHICH INFORMATION IS NOT GIVEN. BCG POLIO 0 DPT 1 DPT 2 DPT 3 POLIO 1 POLIO 2 POLIO 3 MEASLES VITAMIN-A **(FIRST DOSE)** **(EXCLUDING PULSE POLIO)**	DAY MO YEAR BCG P0 D1 D2 D3 P1 P2 P3 MES VTA	DAY MO YEAR BCG P0 D1 D2 D3 P1 P2 P3 MES VTA
Q308	CHECK Q307:	'BCG' TO 'MEASLES' FILLED ☐ OTHER ☐ (SKIP TO Q314) ← ↓	'BCG' TO 'MEASLES' FILLED ☐ OTHER ☐ (SKIP TO Q314) ← ↓

Q309	Has (NAME) received any vaccinations that are not recorded on this card?
	
	RECORD **'YES'** ONLY IF RESPONDENT MENTIONS BCG, DPT 1-3, POLIO, 0-3 AND/OR MEASLES VACCINE (S).
		YES 1
		(PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN
		Q307 ⸺
		(SKIP TO Q314) ←
		
		NO .... 2 ⎤ **SKIP**
		                    TO
		DON'T KNOW .... 8 ⎦ **Q314**
			YES 1
			(PROBE FOR VACCINATIONS AND WRITE '66' IN THE CORRESPONDING DAY COLUMN IN
			Q307 ⸺
			(SKIP TO Q314) ←
			
			NO .... 2 ⎤ **SKIP**
			                    TO
			DON'T KNOW .... 8 ⎦ **Q314**

Q310	Did (NAME) ever receive any vaccinations to prevent him/her from getting disease, including vaccinations received in a Pulse Polio campaign?	YES 1
		
		NO .... 2 ⎤ **SKIP**
		                    TO
		DON'T KNOW .... 8 ⎦ **Q312**
			YES 1
			
			NO .... 2 ⎤ **SKIP**
			                    TO
			DON'T KNOW .... 8 ⎦ **Q312**

Q. NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD	LAST BUT ONE SURVIVING CHILD
Q311	Now please tell me if (NAME) has received any of the following vaccinations.		
Q311A	A **BCG vaccination** against tuberculosis, that is, an injection that usually causes a scar?	YES...................1 NO.....................2 DON'T KNOW........8	YES...................1 NO.....................2 DON'T KNOW........8
Q311B	Any **POLIO VACCINE**, that is, drops in the mouth, including vaccine received in a Pulse Polio campaign?	YES...................1 NO......................2 **SKIP TO Q311E** DON'T KNOW.............8	YES...................1 NO......................2 **SKIP TO Q311E** DON'T KNOW.............8
Q311C	Was the first **POLIO** VACCINE received in the first two weeks after birth or later?	FIRST 2 WEEKS.............................1 LATER.....................2 DON'T KNOW.............8	FIRST 2 WEEKS.............................1 LATER.....................2 DON'T KNOW.............8
Q311D	How many times Polio vaccine received? **(excluding Polio '0' and pulse polio) (IF 5 OR MORE TIMES RECORD 5)**	NUMBER................. [ ] DO NOT REMEMBER......8	NUMBER................. [ ] DO NOT REMEMBER......8
Q311E	A **DPT** vaccination against Diphtheria, Whooping Cough and Tetanus given to the child as an injection?	YES...................1 NO......................2 **SKIP TO Q311G** DON'T KNOW..........8	YES...................1 NO......................2 **SKIP TO Q311G** DON'T KNOW..........8
Q311F	How many **DPT injections** were given in thigh or buttocks, sometimes at the same time as polio drops?	NUMBER................. [ ] DO NOT REMEMBER......8	NUMBER................. [ ] DO NOT REMEMBER......8
Q311G	Was an injection against **MEASLES** given at right arm/shoulder?	YES...................1 NO......................2 DON'T KNOW...........8	YES...................1 NO......................2 DON'T KNOW...........8

Q. NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD	LAST BUT ONE SURVIVING CHILD
Q312	**CHECK Q307 AND Q310:** **ANY VACCINATIONS RECEIVED?**	NO ☐ YES ☐ ↓ **(SKIP TO Q314)** ←	NO ☐ YES ☐ ↓ **(SKIP TO Q314)** ←

Q313	Why (Name) was not given any vaccination?
	
	 (RECORD ALL MENTIONED)
		YES NO
		 A. CHILD TOO YOUNG FOR IMMUNIZATION................................ 1 2
		 B. UNAWARE OF NEED FOR IMMUNIZATION................................ 1 2
		 C. PLACE OF IMMUNIZATION UNKNOWN................................ 1 2
		 D. TIME OF IMMUNIZATION UNKNOWN.. 1 2
		 E. FEAR OF SIDE EFFECTS.................... 1 2
		 F. NO FAITH IN IMMUNIZATION.... õ õ 1 2
		 G. PLACE OF IMMUNIZATION TOO FAR TO GO................................ 1 2
		 H. TIME OF IMMUNIZATION INCONVENIENT................................ 1 2
		 I. ANM ABSENT................................ 1 2
		 J. VACCINE NOT AVAILABLE.....õ .õ õ 1 2
		 K. MOTHER TOO BUSY............................ 1 2
		 L. FAMILY PROBLEM, INCLUDING ILLNESS OF MOTHERõ …õ õ õ õ .. 1 2
		 M. CHILD ILL NOT BROUGHTõ õ ..õ õ 1 2
		 N. CHILD ILL BROUGHT BUT NOT GIVEN õ õ õ õ õ õ ....õ õ 1 2
		 O. LONG WAITING TIMEõ õ õ õ õ õ . 1 2
		 P. FINANCIAL PROBLEM.................õ . 1 2
		 Q. CHILD IS GIRL õ õ õ ....õ . 1 2
		 R. OTHER _____
		         (SPECIFY) 1 2
		
		 SKIP TO Q315
			YES NO
			 A. CHILD TOO YOUNG FOR IMMUNIZATION................................ 1 2
			 B. UNAWARE OF NEED FOR IMMUNIZATION................................ 1 2
			 C. PLACE OF IMMUNIZATION UNKNOWN................................ 1 2
			 D. TIME OF IMMUNIZATION UNKNOWN.. 1 2
			 E. FEAR OF SIDE EFFECTS.................... 1 2
			 F. NO FAITH IN IMMUNIZATION.... õ õ 1 2
			 G. PLACE OF IMMUNIZATION TOO FAR TO GO................................ 1 2
			 H. TIME OF IMMUNIZATION INCONVENIENT................................ 1 2
			 I. ANM ABSENT................................ 1 2
			 J. VACCINE NOT AVAILABLE.....õ .õ õ 1 2
			 K. MOTHER TOO BUSY............................ 1 2
			 L. FAMILY PROBLEM, INCLUDING ILLNESS OF MOTHERõ …õ õ õ õ .. 1 2
			 M. CHILD ILL NOT BROUGHTõ õ ..õ õ 1 2
			 N. CHILD ILL BROUGHT BUT NOT GIVEN õ õ õ õ õ õ ....õ õ 1 2
			 O. LONG WAITING TIMEõ õ õ õ õ õ . 1 2
			 P. FINANCIAL PROBLEM.................õ . 1 2
			 Q. CHILD IS GIRL õ õ õ ....õ . 1 2
			 R. OTHER _____
			         (SPECIFY) 1 2
			
			 SKIP TO Q315

Q. NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD			LAST BUT ONE SURVIVING CHILD		
			YES	NO		YES	NO
Q313a	What was main reason for (Name) not given any vaccination?	A. CHILD TOO YOUNG FOR IMMUNIZATION....................................	1	2	A. CHILD TOO YOUNG FOR IMMUNIZATION....................................	1	2
		B. UNAWARE OF NEED FOR IMMUNIZATION…................................	1	2	B. UNAWARE OF NEED FOR IMMUNIZATION…................................	1	2
		C. PLACE OF IMMUNIZATION UNKNOWN..	1	2	C. PLACE OF IMMUNIZATION UNKNOWN..	1	2
		D. TIME OF IMMUNIZATION UNKNOWN..	1	2	D. TIME OF IMMUNIZATION UNKNOWN..	1	2
		E. FEAR OF SIDE EFFECTS.....................	1	2	E. FEAR OF SIDE EFFECTS.....................	1	2
		F. NO FAITH IN IMMUNIZATION.... õ õ	1	2	F. NO FAITH IN IMMUNIZATION.... õ õ	1	2
		G. PLACE OF IMMUNIZATION TOO FAR TO GO…...	1	2	G. PLACE OF IMMUNIZATION TOO FAR TO GO…...	1	2
		H. TIME OF IMMUNIZATION INCONVENIENT...................................	1	2	H. TIME OF IMMUNIZATION INCONVENIENT...................................	1	2
		I. ANM ABSENT..	1	2	I. ANM ABSENT..	1	2
		J. VACCINE NOT AVAILABLE.....õ .õ õ	1	2	J. VACCINE NOT AVAILABLE.....õ .õ õ	1	2
		K. MOTHER TOO BUSY...........................	1	2	K. MOTHER TOO BUSY...........................	1	2
		L. FAMILY PROBLEM, INCLUDING ILLNESS OF MOTHERõ …õ õ õ õ ..	1	2	L. FAMILY PROBLEM, INCLUDING ILLNESS OF MOTHERõ …õ õ õ õ ..	1	2
		M. CHILD ILL NOT BROUGHTõ õ ..õ õ	1	2	M. CHILD ILL NOT BROUGHTõ õ ..õ õ	1	2
		N. CHILD ILL BROUGHT BUT NOT GIVEN õ õ õ õ õ õ ....õ õ	1	2	N. CHILD ILL BROUGHT BUT NOT GIVEN õ õ õ õ õ õ ....õ õ	1	2
		O. LONG WAITING TIMEõ õ õ õ õ õ .	1	2	O. LONG WAITING TIMEõ õ õ õ õ õ .	1	2
		P. FINANCIAL PROBLEM...................õ .	1	2	P. FINANCIAL PROBLEM...................õ .	1	2
		Q. CHILD IS GIRL õ õ õ ....õ .	1	2	Q. CHILD IS GIRL õ õ õ ....õ .	1	2
		R. OTHER _____ (SPECIFY)	1	2	R. OTHER _____ (SPECIFY)	1	2
		SKIP TO Q315			**SKIP TO Q315**		

Q.NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD			LAST BUT ONE SURVIVING CHILD		
			YES	NO		YES	NO
Q314	Where did (NAME) receive his/her vaccinations? IF UNABLE TO DETERMINE IF A HOSPITAL, HEALTH CENTRE, OR CLINIC IS PUBLIC OR PRIVATE MEDICAL SECTOR, WRITE THE NAME OF THE PLACE (S). NAME OF THE PLACE (S). **(RECORD ALL MENTIONED)**	**GOVERNMENT** A. ANGANWADI ....õ .... B. SUB-CENTRE...õ ....õ õ õ ..õ .õ C. PHCõ .õ ....õ ..õ õ . D. CHCõ õ õ ....õ .... E. UHC/UHP/UFWCõ õ õ õ õ õ õ ..... F. DISPENSARY / CLINIC..................... G. HOSPITALõ õ ....õ õ õ õ õ H. AYUSH HOSPITAL /CLINICõ .... I. MOBILE CLINIC...................õ õ ..õ . J. PULSE POLIOõ õ ....õ õ õ .õ **PRIVATE** K. DISPENSARY /CLINIC.................... L. HOSPITAL....................................... M. AYUSH HOSPITAL /CLINIC............ N. DOCTOR/CLINIC .... O. NGO/TRUST HOSP. /CLINICõ ....õ P. OTHER_____ (SPECIFY)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	**GOVERNMENT** K. ANGANWADI ....õ .... L. SUB-CENTRE...õ ....õ õ õ ..õ .õ M. PHCõ .õ ....õ ..õ õ . N. CHCõ õ õ ....õ .... O. UHC/UHP/UFWCõ õ õ õ õ õ õ ..... P. DISPENSARY / CLINIC..................... Q. HOSPITALõ õ ....õ õ õ õ õ R. AYUSH HOSPITAL /CLINICõ .... S. MOBILE CLINIC...................õ õ ..õ . T. PULSE POLIOõ õ ....õ õ õ .õ **PRIVATE** K. DISPENSARY /CLINIC.................... L. HOSPITAL....................................... M. AYUSH HOSPITAL /CLINIC............ N. DOCTOR/CLINIC .... O. NGO/TRUST HOSP. /CLINICõ ....õ P. OTHER_____ (SPECIFY)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Q315	Was **HEPATITIS-B** Injection given to the child?	YES...................õ õ õ õ õ õ õ ..1 NO...................õ õ ...õ õ õ õ õ 2 DONõT KNOW......... õ ..õ õ õ õ ...8			YES...................õ õ õ õ õ õ õ ..1 NO...................õ õ ...õ õ õ õ õ 2 DONõT KNOW......... ....õ õ õ ...8		
Q316	Has (NAME) ever received a **VITAMIN A** dose?	YES ....õ õ õ õ õ õ ..1 NO..................õ õ õ õ õ õ õ .. 2 DONõT KNOW.......õ õ õ õ õ 8	**SKIP TO Q318**		YES ....õ õ õ õ õ õ ..1 NO..................õ õ õ õ õ õ õ .. 2 DONõT KNOW.......õ õ õ õ õ 8	**SKIP TO Q318**	

Q. NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD	LAST BUT ONE SURVIVING CHILD
Q317	How many times was the **VITAMIN A** dose received? **(IF 5 OR MORE TIMES, RECORD '5')**	NUMBER OF TIMES…….. ☐	NUMBER OF TIMES…….. ☐
Q317a	How many times was the **PULSE POLIO** dose received? **(IF 9 OR MORE TIMES, RECORD '9')**	NUMBER OF TIMES…….. ☐	NUMBER OF TIMES…….. ☐

Q317b	**CHECK Q.304** Was IFA tablets/ syrup administered to your baby in the last three **month (ask only for the babies age above 6 month)**	YES TABLETS.................1
		        SYRUP....................2
		NO.......................................3
			YES TABLETS.................1
			        SYRUP....................2
			NO.......................................3

Q318	Has (NAME) taken any drug to get rid of intestinal worms in the past 6 months?	YES.................1 NO.................2 DON'T KNOW……..8	YES.................1 NO.................2 DON'T KNOW……..8

Q319	Who facilitated or motivated you to give vaccination to your child? **(RECORD ALL MENTIONED)**	YES NO
		A.DOCTOR 1 2
		B. ANM 1 2
		C. HEALTH WORKERS.. 1 2
		D. ANGANWADI WORKER 1 2
		E. ASHA 1 2
		F. NGO/CBO .. 1 2
		G. HUSBAND ... 1 2
		H. MOTHER-IN-LAW. 1 2
		I. MOTHER 1 2
		J. RELATIVES/FRIENDS 1 2
		K. SELF 1 2
		L. OTHER_____ 1 2
		        (SPECIFY)
			YES NO
			A.DOCTOR 1 2
			B. ANM 1 2
			C. HEALTH WORKERS.. 1 2
			D. ANGANWADI WORKER 1 2
			E. ASHA 1 2
			F. NGO/CBO .. 1 2
			G. HUSBAND ... 1 2
			H. MOTHER-IN-LAW. 1 2
			I. MOTHER 1 2
			J. RELATIVES/FRIENDS 1 2
			K. SELF 1 2
			L. OTHER_____ 1 2
			        (SPECIFY)

Q320	Has (NAME) had Diarrhoea in the last two weeks?	YES ....1 NO.................2 **SKIP TO** DON'T KNOW……… .8 → **Q325**	YES ....1 NO.................2 **SKIP TO** DON'T KNOW……… .8 → **Q325**

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Q. NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD	LAST BUT ONE SURVIVING CHILD
Q321	During the current (last) episode of diarrhoea have you given the following liquids to the child? Plain water / Salt and sugar solution / Fruit juice / Lime water / Gruel made from rice(other local grain) / Home remedy / Child on breast milk	YES NO A. PLAIN WATER… … 1 2 B. SALT AND SUGAR SOLUTION… 1 2 C.FRUIT JUICE … … … 1 2 D. LIME WATER … … … 1 2 E.GRUEL MADE FROM RICE (OTHER LOCAL GRAIN)… … 1 2 F.HOME REMEDY … 1 2 G.CHILD ON BREAST MILK… … 1 2	YES NO A. PLAIN WATER … … … 1 2 B. SALT AND SUGAR SOLUTION… 1 2 C.FRUIT JUICE … … … 1 2 D. LIME WATER … … … 1 2 E.GRUEL MADE FROM RICE (OTHER LOCAL GRAIN)… … 1 2 F.HOME REMEDY … 1 2 G.CHILD ON BREAST MILK… … 1 2
Q322	Did you give ORS solution to child during the diarrhoea?	YES...1 NO..2 CHILD ON BREAST MILK...................................3	YES...1 NO..2 CHILD ON BREAST MILK...................................3
Q322A	Did you administer HAF/ ORT/ORS/Zinc to the baby? 	ITEM	CODE
---	---
Yes	1
No	2			HAF	
ORT/ORS	
Zinc				HAF	
ORT/ORS	
Zinc		
Q322B	Whether normal feeding was continued during the diarrhoea?	YES......................… ....… 1 NO....................… … … ..… ..2	YES......................… ....… 1 NO....................… .… … ..… ..2
Q323	Did you seek advice or treatment for the diarrhoea from any source?	YES......................… ....… 1 **SKIP TO** NO...............… … … ...… … 2 ⟶ **Q325**	YES......................… ....… 1 **SKIP TO** NO...............… ..… … .… … 2 ⟶ **Q325**

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Q. NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD		LAST BUT ONE SURVIVING CHILD	
Q324	Where did you seek advice or treatment? Anywhere else? IF UNABLE TO DETERMINE A HOSPITAL, HEALTH CENTRE, OR CLINIC IS PUBLIC OR PRIVATE MEDICAL SECTOR, WRITE THE NAME OF THE PLACE (S). _____ NAME OF THE PLACE (S). **(RECORD ALL SOURCES MENTIONED)**	**GOVERNMENT** A. ANGANWADI............................ B. SUB-CENTRE....õ õ .õ .... C. PHC...õ õ õ õ õ õ .... D. CHCõ õ .... E. UHC/UHP/UFWCõ õ ....õ .... F. DISPENSARY/CLINICõ .õ ..... G. HOSPITALõ õ õ õ õ ....õ ...... H. AYUSH HOSPITAL/CLINIC..õ I. MOBILE HEALTH CLINIC........ J. ASHAõ õ õ õ õ õ õ õ õ .. **PRIVATE** K. DISPENSARY/CLINICõ õ ..õ L. HOSPITAL .õ õ õ õ õ .... M. AYUSH HOSPITAL/CLINICõ N. PHARMACY/DRUG STORE... **P.** NGO/TRUST HOSP. /CLINIC Q. OTHER_____ **(SPECIFY)**	YES NO 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	**GOVERNMENT** I. ANGANWADI............................ J. SUB-CENTRE....õ õ .õ .... K. PHC...õ õ õ õ õ õ .... L. CHCõ õ .... M. UHC/UHP/UFWCõ õ ....õ .... N. DISPENSARY/CLINICõ .õ ..... O. HOSPITALõ õ õ õ õ ....õ ...... P. AYUSH HOSPITAL/CLINIC..õ I. MOBILE HEALTH CLINIC........ J. ASHAõ õ õ õ õ õ õ õ õ .. **PRIVATE** K. DISPENSARY/CLINICõ õ ..õ L. HOSPITAL .õ õ õ õ õ .... M. AYUSH HOSPITAL/CLINICõ N. PHARMACY/DRUG STORE... **P.** NGO/TRUST HOSP. /CLINIC Q. OTHER_____ **(SPECIFY)**	YES NO 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2
Q325	Has (**NAME**) been ill with fever at any time in the last two weeks?	YES...........................õ ....õ 1 NO...................õ õ õ õ õ ..õ õ õ õ õ .õ õ 2 DONõT KNOW........õ õ õ õ õ õ õ õ õ .. 8		YES..........................õ ....õ 1 NO..................õ õ õ õ õ ..õ õ õ õ õ .õ õ 2 DONõT KNOW.........õ õ õ õ õ õ õ õ õ .. 8	
Q326	Has (**NAME**) been ill with cough at any time in the last two weeks?	YES.................õ .1 NO......................2 DONõT KNOW ....õ õ õ õ õ 8	**GO BACK TO Q302 IN NEXT COLUMN; OR, IF NOSURVIVING CHILD, GO TO SECTION IV**	YES..................õ õ .1 NO............................2 DONõT KNOW...... õ 8	**SKIP TO SEC IV**

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Q. NO	QUESTIONS AND FILTERS	LAST SURVIVING CHILD	LAST BUT ONE SURVIVING CHILD
Q327	When (NAME) had this illness with a cough, did he/she breath faster than usual with short, rapid breaths or have difficulty in breathing?	YES...........................õ ....õ 1 NO...................õ õ õ õ õ õ õ .õ õ ..õ õ 2 DON'T KNOW....... õ õ õ õ õ õ õ õ ..õ .. 8	YES...........................õ ....õ 1 NO....................õ õ õ õ õ õ õ õ õ ..õ ..õ 2 DON'T KNOW....... õ õ õ õ õ õ õ õ ..õ .. 8
Q328	Did you seek advice or treatment for the illness from any source?	YES.................õ õ 1 NO.................õ õ 2 ⟶ **GO BACK TO** **Q302 IN NEXT COLUMN;** **OR, IF NO SURVIVING CHILD,** **GO TO SECTION IV**	YES.................õ õ õ 1 NO................õ õ õ **2** ⟶ **GO TO** **SECTION IV**
Q329	Whether treatment with antibiotic was given?	YES...........................õ ....õ 1 NO...................õ õ õ õ õ õ õ ..õ õ .õ õ 2 DON'T KNOW õ õ õ õ õ õ ....õ ....õ .. 8	YES...........................õ ....õ 1 NO.................õ õ õ õ õ õ õ õ ..õ õ .õ õ 2 DON'T KNOW õ õ õ õ õ õ õ ....õ õ õ .. 8

Q330

Where did you seek advice or treatment?

Anywhere else?

IF UNABLE TO DETERMINE IF A HOSPITAL, HEALTH CENTRE, OR CLINIC IS PUBLIC OR PRIVATE MEDICAL SECTOR, WRITE THE NAME OF THE PLACE (S).

_____
NAME OF THE PLACE (S).

(RECORD ALL SOURCES MENTIONED)

LAST SURVIVING CHILD	YES	NO	LAST BUT ONE SURVIVING CHILD	YES	NO
GOVERNMENT			**GOVERNMENT**		
A. ANGANWADI...............................	1	2	Q. ANGANWADI............................	1	2
B. SUB-CENTRE....õ õ õ .õ õ õ .	1	2	R. SUB-CENTRE....õ õ õ .õ õ õ .	1	2
C. PHC...õ õ õ õ ....õ õ õ .	1	2	S. PHC...õ õ õ õ ....õ õ õ .	1	2
D. CHCõ ....õ õ	1	2	T. CHCõ ....õ õ	1	2
E. UHC/UHP/UFWCõ õ õ õ ..õ õ	1	2	U. UHC/UHP/UFWCõ õ õ õ ..õ õ	1	2
F. DISPENSARYõ õ õ õ õ ..õ ..õ .	1	2	V. DISPENSARYõ õ õ õ õ .õ ..õ .	1	2
G. HOSPITALõ õ õ õ ..õ õ .õ ..õ	1	2	W. HOSPITALõ õ õ õ ..õ õ .õ ..õ	1	2
H. AYUSH HOSPITAL/CLINICõ õ	1	2	X. AYUSH HOSPITAL/CLINICõ õ	1	2
I. MOBILE HEALTH CLINIC.........	1	2	Y. MOBILE HEALTH CLINIC.........	1	2
J. ASHAõ	1	2	Z. ASHAõ	1	2
PRIVATE			**PRIVATE**		
K. DISPENSARY/CLINIC	1	2	AA. DISPENSARY/CLINIC	1	2
L. HOSPITAL õ õ õ ....õ ...õ	1	2	BB. HOSPITAL õ õ õ ....õ ...õ	1	2
M. AYUSH HOSPITAL/CLINICõ õ	1	2	CC. AYUSH HOSPITAL/CLINICõ õ	1	2
N. PHARMACY/DRUG STORE..õ	1	2	DD. PHARMACY/DRUG STORE..õ	1	2
O. NGO/TRUST HOSP. /CLINICõ	1	2	EE. NGO/TRUST HOSP. /CLINICõ	1	2
P. OTHER_____	1	2	FF. OTHER_____	1	2
(SPECIFY)			**(SPECIFY)**		

Q. NO	LAST SURVIVING CHILD	LAST BUT ONE SURVIVING CHILD
Q331	**GO BACK TO** **Q302 IN NEXT COLUMN** **OR, IF NO SURVIVING CHILD,** **GO TO SECTION IV**	**GO TO SECTION IV**

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A. CONTRACEPTION		
Now I would like to talk about family planning . the various ways or methods that a couple can use to delay or avoid a pregnancy.		

Q. NO	QUESTIONS AND FILTERS	SKIP TO	CODING CATEGORIES
Q401A	Which ways or methods have you heard about? **CIRCLE CODE '1' IN Q401 A FOR EACH METHOD MENTIONED SPONTANEOUSLY** **FOR METHODS NOT MENTIONED SPONTANEOUSLY, ASK EACH METHOD SEPARATELY READING THE NAME AND DESCRIPTION.**		**CHECK Q106: Q401B IS NOT APPLICABLE TO WOMEN WHO ARE MARRIED BUT GAUNA NOT PERFORMED.** **ASK Q401B FOR EACH METHOD WITH CODE '1' CIRCLED IN Q401A.** Q401B Have you ever used (METHOD NAME)?
	MODERN		
01	**FEMALE STERILIZATION**- Women can have an operation to avoid having any more children.	YES õ õ .õ 1 NO õ õ õ ..2	Have you ever had an operation to avoid having any more children? YES õ õ .õ 1 NOõ õ õ ..2
02	**MALE STERILIZATION**- Men can have an operation to avoid having any more children.	YES õ õ ...1 NOõ õ õ ..2	Has your husband ever had an operation to avoid having any more children? YES õ õ .õ 1 NOõ õ õ ..2
03	**IUD** - Women can have device placed inside the uterus by a doctor or a nurse.	YESõ õ .õ 1 NOõ õ õ ..2	USED IUD YESõ õ .õ 1 NOõ õ õ ..2
04	**PILL**- Women can take a pill every day to avoid becoming pregnant.	YES õ õ ....1 NOõ õ õ ..2	USED PILLS YES õ õ .õ 1 NOõ õ õ ..2
05	**PILL**- Women can take a pill once a week to avoid becoming pregnant.	YES õ õ ..1 NOõ õ õ ..2	USED PILLS YES õ .õ 1 NOõ õ õ ..2
06	**EMERGENCY CONTRACEPTION**- Women can take pills within three days after unprotected sexual intercourse to avoid becoming pregnant.	YES õ õ ...1 NO õ õ ..2	USED EMERGENCY CONTRACEPTION YESõ õ .õ 1 NOõ õ õ ..2
07	**INJECTABLES**- Women can have an injection by health provider that stops them from becoming pregnant (for one or more months).	YES õ õ ....1 NOõ õ õ ..2	USED INJECTABLES YES õ .õ õ 1 NOõ õ õ ..2
08	**CONDOM OR NIRODH**- Men can put rubber sheath on their penis before sexual intercourse.	YES õ õ ..1 NOõ õ õ ..2	USED CONDOM/NIRODH YES õ õ .õ 1 NOõ õ õ ..2
09	*FEMALE CONDOM*- *Women* can place a sheath in their vagina before sexual intercourse.	YES õ õ .1 NOõ õ ..2	USED FEMALE CONDOM YES õ õ .õ 1 NOõ õ ..õ ..2

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Q. NO	QUESTIONS AND FILTERS	SKIP TO	CODING CATEGORIES
	TRADITIONAL		
10	**RHYTHM METHOD**- Every month that a woman is sexually active she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	YES õ õ ...1 NOõ õ õ ..2	USED RHYTHM METHOD YES õ õ ..1 NOõ õ õ ..2
11	**WITHDRAWAL**- Men can be careful and pull out before climax.	YESõ õ .õ 1 NOõ õ õ ..2	USED WITHDRAWAL YES õ õ ...1 NOõ õ õ ..2
12	Contraceptive herbs	YES õ õ .õ 1 NOõ õ ..2	USED CONTRACEPTIVE HERBS YESõ õ .õ 1 NOõ õ õ ..2
13	Lactational Amenorrhoea Method (LAM)	YES õ õ ..1 NOõ õ õ ..2	USED LACTATIONAL AMENORRHOEA METHOD (LAM) YES õ õ ..1 NOõ õ õ ..2
14	Have you heard of any **other ways** or methods that women or men can use to avoid pregnancy?	YES õ õ õ 1 _____ (SPECIFY) _____ (SPECIFY) NOõ õ õ ..2	USED ANY OTHER METHOD YESõ õ õ 1 NOõ õ õ ..2 YES õ õ õ 1 NOõ õ õ ..2

Q402	**CHECK Q106**: CURRENTLY MARRIED ☐	MARRIED BUT GAUNA NOT PERFORMED/ SEPARATED / DESERTED ☐ DIVORCED / WIDOWED	► **SEC V**
Q403	**CHECK Q401B**: WOMAN/MAN NOT STERILIZED ☐	WOMAN/MAN STERILIZED ☐	► **Q406A**

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q404	Are you currently pregnant?	YES ....1 ——► NO..2 UNSURE 3	**Q430**
Q405	Are you/your husband currently doing something or using any method to delay or avoid getting pregnant?	YES ....1 NO..2 ——►	**Q430**
Q406 Q406A	Which method are you/your husband using? **(CIRCLE ALL MENTIONED)** IF MORE THAN ONE METHOD MENTIONED, FOLLOW SKIP FOR HIGHEST METHOD ON LIST. CIRCLE ±1qFOR FEMALE STERILIZATION, CIRCLE ±2qFOR MALE STERILIZATION	FEMALE STERILIZATION ....01 MALE STERILIZATION ....02 IUD...03 DAILY PILLS ....04 WEEKLY PILLS...................................05 INJECTABLES ....06 CONDOM/NIRODH ....07 FEMALE CONDOM ....08 RHYTHM METHOD.............................09 WITHDRAWAL....................................10 OTHER _____ 96 **(SPECIFY)**	**Q412** **Q411** **Q415**
Q407	Have you/your husband ever faced difficulty in getting the method?	NO PROBLEM./õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .....1 NOT REGULARLY AVAIL. WITH PHC........................õ .2 NOT REGULARLY AVAIL. WITH AN õ õ õ õ õ õ õ õ 3 NOT REGULARLY AVAIL. WITH MEDICAL SHOPS/CHEMISTõ õ ....õ õ õ ....4 OTHER _____ 6 **(SPECIFY)**	
Q408	Do you know the brand name of (method) you/your husband are using? RECORD NAME OF BRAND. **(ASK SUPERVISOR FOR CODE LIST.)**	☐☐☐ BRAND NAME_____ **(SPECIFY)** DONqT KNOW. õ õ õ õ õ õ ....õ õ ..98	
Q409	Whether money was paid for getting pills condoms/injectables?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .1 NOõ .õ õ õ õ õ õ õ õ .....õ õ õ õ õ õ 2 DONqT KNOWõ õ õ õ õ ....õ õ õ õ .8	

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Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q410	Where did you obtain (CURRENT METHOD) the last time? IF UNABLE TO DETERMINE IT TO BE A HOSPITAL, HEALTH CENTER, OR CLINIC; IF IT IS GOVERNMENT OR PRIVATE, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	**GOVERNMENT** GOVT. MUNCIPAL HOSPITAL…………...11 GOVT.DISPENSARY………………… 12 UHC/UHP/UFWC……………………….. 13 CHC……………………………….……….. 14 PHC………………………………………. 15 SUB-CENTER………………………….. 16 AYUSH HOSPITAL/CLINIC……………..17 MOBILE CLINIC………………………… 18 ANGANWADI/ICDS CENTER…………. 19 ASHA/ANM……………………………… 20 OTHER COMMUNITY-BASED WORKER…………………………………21 OTHER PUBLIC MEDICAL SECTOR…..22 **PRIVATE** HOSPITAL/CLINIC……………………. 23 AYUSH HOSPITAL/CLINIC……………..24 NGO OR TRUST HOSPITAL/CLINIC….. 25 DOCTOR/CLINIC……………………….26 MOBILE CLINIC………………………… 27 TRADITIONAL HEALER………………. 28 PHARMACY/DRUG STORAGE.……….. 29 OTHER PRIVATE MEDICAL SECTOR…. 30 **OTHER SOURCE** SHOP……………………………………. 31 VENDING MACHINE……………………..32 HUSBAND……………………………….. 33 RELATIVES/FRIENDS……………………34 OTHER_____96 **(SPECIFY)** DON'T KNOW……………………….. 98	**Q415**
Q411	In what facility did the IUD insertion take place? IF UNABLE TO DETERMINE IT TO BE A HOSPITAL, HEALTH CENTER, OR CLINIC ; IT IS A GOVERNMENT OR PRIVATE, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	**GOVERNMENT** GOVT. MUNCIPAL HOSPITAL ………. 11 GOVT.DISPENSARY…………………… 12 UHC/UHP/UFWC……………………….. 13 CHC……………………………….……. 14 PHC…………………………………….. 15 SUB-CENTER……………………………16 AYUSH HOSPITAL/CLINIC……………..17 MOBILE CLINIC……………………… 18 **PRIVATE** HOSPITAL/CLINIC.………………… 19 AYUSH HOSPITAL/CLINIC NGO OR TRUST HOSPITAL/CLINIC…. 20 DOCTOR/CLINIC………………………. 21 MOBILE CLINIC……………………… 22 OTHER PRIVATE HEALTH FACILITY … 23 OTHER_____96 **(SPECIFY)** DON'T KNOW……………………….. 98	**Q415**
Q412	What type of sterilization procedure you/your husband have undergone?	**FEMALE** TUBECTOMY……………………………. 1 LAPAROSCOPY……………………….. 2 **MALE** VASECTOMY …………………………...3 NO-SCALPEL VASECTOMY (NSV) ……………………………….4	
Q413	Had you / your husband undergone sterilization just after child birth or abortion or any other time?	AFTER CHILD BIRTH……………………..1 AFTER ABORTION………………………2 ANY OTHER TIME……………………….6	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q414	In what facility did the sterilization take place? IF UNABLE TO DETERMINE IF A HOSPITAL, HEALTH CENTRE, OR CLINIC IS GOVERNMENT OR PRIVATE, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE)	**GOVERNMENT** GOVT. MUNCIPAL HOSPITAL õ õ . 11 GOVT.DISPENSARY.õ õ õ õ õ õ õ õ 12 UHC/UHP/UFWCõ õ õ õ õ õ õ õ .... 13 CHC.............................. õ õ õ õ õ .õ . 14 PHCõ õ õ õ õ õ õ õ õ õ õ õ .õ .. 15 AYUSH HOSPITAL/CLINIC..................... 16 MOBILE CLINICõ õ õ õ õ õ õ õ 17 **PRIVATE** HOSPITAL/CLINIC.õ ..õ õ õ õ õ õ .. 18 AYUSH HOSPITAL/CLINIC..................... 19 NGO OR TRUST HOSPITAL/CLINICõ … 20 DOCTOR/CLINICõ õ õ ..õ õ õ õ õ õ 21 MOBILE CLINICõ õ ..õ õ õ õ õ õ õ . 22 OTHER PRIVATE HEALTH FACILITY .. 23 OTHER_____ 96 **(SPECIFY)** DONõT KNOWõ õ õ õ õ õ õ õ õ õ 98	
Q414A	Did you/ your husband receive the compensation after sterilization?	YES õ õ õ õ õ õ õ õ õ õ õ õ õ õ 1 NO õ õ õ õ õ õ õ õ õ õ õ ..õ õ 2 ⟶	**Q415**
Q414B	When did you/your husband receive compensation for sterilization?	BEFORE / AT THE TIME OF DISCHARGE .....1 AT THE TIME OF FIRST FOLLOW-UP............2 AFTER SEVERAL VISITS.............õ õ õ .....õ 3	
Q414C	How much compensation did you/your husband receive for sterilization?	Rupees.........	
Q415	A). STERILIZED B). ALL OTHER METHODS How long ago did you/your husband undergo sterilization? For how long have you/ your husband been using (CURRENT METHOD) continuously (without stopping)?	**IF LESS THAN '1' MONTH RECORD… ………** 000 MONTHSõ õ õ õ õ õ õ õ õ õ 1 **(LESS THAN TWO YEARS)** YEARSõ õ õ õ õ õ õ õ õ õ 2 DO NOT REMEMBERõ õ õ .. 998	
Q416	Who facilitated or motivated you to use current family planning method? **(RECORD ALL MENTIONED)**	YES NO A. DOCTORõ õ õ õ ..õ õ õ õ 1 2 B. ANM õ õ õ õ õ õ õ .õ õ õ 1 2 C. HEALTH WORKER õ .õ õ .... 1 2 D. ANGANWADI WORKER õ ..õ 1 2 E. ASHA õ õ õ õ õ õ õ õ õ õ .. 1 2 F. NGO / CBO........................õ õ . 1 2 G. HUSBAND õ õ õ õ õ õ õ õ õ . 1 2 H. MOTHER-IN-LAWõ õ õ õ õ õ . 1 2 I. MOTHER õ õ õ õ õ õ õ õ õ ... 1 2 J. RELATIVES/FRIENDSõ õ õ õ . 1 2 K. DAI (TBA)õ õ õ õ õ õ õ õ õ õ 1 2 L. SELFõ õ õ õ õ õ õ õ õ õ õ õ 1 2 M. OTHER_____ 1 2 **(SPECIFY)**	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q417	When you/your husband started using (CURRENT METHOD), at that time, were you told about side effects or other problems?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ õ 1 NO õ õ .õ õ õ õ õ õ õ õ õ õ õ .....2 ⟶	**Q419**
Q418	Who told you/your husband about side effects or other problems/consequences that you might have due to usage of the method? **(RECORD ALL MENTIONED)**	YES NO A. DOCTORõ õ õ õ õ õ õ õ . 1 2 B. ANM õ õ õ õ õ õ õ õ õ õ 1 2 C. HEALTH WORKER õ ....õ 1 2 D. ANGANWADI WORKERõ õ .. 1 2 E. ASHA õ õ õ õ õ õ õ õ õ . 1 2 F. MOTHER-IN-LAWõ õ õ õ 1 2 G. MOTHER õ õ õ õ õ õ õ õ 1 2 H. RELATIVES/FRIENDSõ õ õ 1 2 I. OTHER_____ 1 2 **(SPECIFY)**	
Q419	**CHECK Q406/Q406A:** CIRCLE METHOD CODE: **(IF MORE THAN ONE METHOD CODE CIRCLES IN Q406/Q406A, CIRCLED CODE FOR HIGHEST METHOD IN LIST)**	NO CODE CIRCLED....................................00 ⟶ FEMALE STERILIZATION.........................01 MALE STERILIZATION ....02 IUD/ ....03 DAILY PILLS...04 WEEKLY PILLS ....05 INJECTABLES...06 CONDOM/NIRODH.....................................07 FEMALE CONDOM.....................................08 RHYTHM METHOD.....................................09 WITHDRAWAL 10 OTHER METHOD _____96 **(SPECIFY)** _____	**Q429** **Q422** **Q428**
Q420	How would you rate the care you received during and immediately after the sterilization/IUD insertion: very good, all right, not so good, or bad?	VERY GOOD ....1 ALL RIGHT ....2 NOT SO GOOD ....3 BAD 4	
Q421	After you adopted this method, did anyone visit you for enquiring about you/your husbands health within 48 hours? or Did you / your husband visit anyone for follow-up within 48 hours?	HEALTH PERSONNEL VISITED............................1 SELF/ HUSBAND VISITED HEALTHFACILITY.......2 NOT VISITED AT ALL...................................... 3	
Q422	At that time, when you/your husband started using current method, were you told by a health or family planning worker/ASHA about other methods of family planning that you could use? OR Were you/ your husband ever informed by a health or family planning worker/ASHA about other methods of family planning that you could use?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ 1 NO õ ......õ õ õ õ õ õ õ õ õ õ õ õ õ õ 2 DO NOT REMEMBERõ õ õ ....õ õ .õ õ õ .8 ⟶	**Q424**
Q423	What methods of contraception were informed? **(RECORD ALL MENTIONED)**	YES NO A. MALE STERILIZATIONõ õ õ ... 1 2 B. FEMALE STERILIZATIONõ õ .. 1 2 C. IUDõ õ õ õ õ õ õ õ õ õ õ .. 1 2 D. DAILY PILLSõ õ õ õ õ õ õ .. 1 2 E. WEEKLY PILLSõ õ õ õ õ õ 1 2 F. INJECTABLESõ õ õ õ õ õ .. 1 2 G. CONDOM/NIRODHõ õ õ õ . 1 2 H. FEMALE CONDOMõ õ õ õ . 1 2 I. OTHER_____ 1 2 **(SPECIFY)** J. DO NOT REMEMBERõ õ õ .. 1 2	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q424	Have you/your husband had any health problem after you/your husband started to use this (NAME) method?	YES õ ......õ õ õ õ õ õ ......õ õ õ õ õ õ 1 NOõ ....õ õ õ õ õ õ õ õ .2 ⟶	**Q428**

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q425	What health problem(s) did you/your husband has? **(RECORD ALL MENTIONED)**	YES NO A. WEAKNESS/INABILITY TO WORK .... 1 2 B. BODY ACHE/BACKACHE õ õ õ õ õ õ .. 1 2 C. ABDOMINAL PAINõ õ õ õ õ .... 1 2 D. WEIGHT GAINõ .... 1 2 E. DIZZINESS õ õ õ õ ....õ 1 2 F. NAUSEA/VOMITING......................... 1 2 G. FEVER...õ .. 1 2 H. BREAST TENDERNESSõ õ õ .õ õ . 1 2 I. IRREGULAR PERIODS .... 1 2 J. EXCESSIVE BLEEDING õ .... 1 2 K. SPOTTINGõ õ ....õ . 1 2 L. AMENORRHOEAõ õ õ õ õ õ õ õ õ õ 1 2 M. CRAMPS..õ õ õ õ õ N. SCROTUM SWELLINGO. DECREASED LIBIDO .... 1 2 P. RASHES/ALLERGY .... 1 2 Q INFECTIONõ õ õ õ õ ....õ 1 2 R. OTHER_____ **(SPECIFY)**	
Q426	Did you/your husband consult anybody or seek treatment for the health problem(s)?	YESõ ....õ õ õ õ õ õ õ õ õ õ .1 NO õ ....õ õ õ õ õ õ õ õ õ .2 ⟶	**Q428**

Q427	Where did you/your husband go for consultation or seek treatment?
	
	IF UNABLE TO DETERMINE WHETHER IT IS A HOSPITAL, HEALTH CENTRE, OR CLINIC ; IS A GOVERNMENT OR PRIVATE, WRITE THE NAME OF THE PLACE.
	
	_____
	       (NAME OF PLACE)
	
	(RECORD ALL MENTIONED)
		GOVERNMENT YES NO
		A. ANGANWADIõ õ õ õ 1 2
		B. SUB-CENTRE............................ 1 2
		C. PHCõ õ õ õ õ õ õ õ õ õ õ õ . 1 2
		D. CHC õ õ õ 1 2
		E. UHC/UHP/UFWCõ õ õ õ õ õ 1 2
		F. DISPENSARY/CLINICõ õ õ 1 2
		G. HOSPITALõ õ õ õ õ õ õ 1 2
		H. AYUSH HOSPITAL/CLINICõ õ .. 1 2
		I. MOBILE CLINICõ õ õ .õ õ õ õ 1 2
		PRIVATE
		J. DISPENSARY/ CLINICõ õ õ ..õ . 1 2
		K. HOSPITALõ õ õ õ ..õ õ .. 1 2
		L. AYUSH HOSPITAL/CLINICõ õ . 1 2
		M. NGO OR TRUSTHOSPITAL/CLINIC 1 2
		N. CHEMIST/MEDICAL SHOPõ õ ... 1 2
		O. OTHER_____ 1 2
		           (SPECIFY)	

Q428	To what extent are you/your husband satisfied with this method?	FULLY SATISFIEDõ õ õ õ õ ....1 PARTIALLY SATISFIEDõ .õ õ õ õ ....2 NOT SATISFIED õ õ õ õ .õ õ ..õ õ ....õ 3	

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B. FERTILITY PREFERENCES

Q429	**CHECK Q419: METHOD CODE** CODE ±1 qOR CODE ±2 qCIRCLED	
	ALL OTHER WOMEN ↓	☐ ───────────→ **SEC V**

Q 430	**CHECK Q404:** PREGNANT ☐ ↓	HAVE (A/ANOTHER) CHILD õ õ ..õ ..1	
	NOT PREGNANT OR UNSURE ☐ ↓	NO MORE/NONE õ õ õ õ ..õ õ .õ õ .2 ───→ **Q 433**	
	Now I have some questions about the future. Would you like to have (a/another) child, or would you prefer not to have any (more) children?	Now I have some questions about the future. **After the child you are expecting now, would you like to have another child, or would you prefer not to have any more children?**	SAYS SHE CANqT GET PREGNA...õ ....3 ───→ **SEC V** UNDECIDED/DONqT KNOW: a). AND PREGNANT.........................4 ───→ **Q 437** b). AND NOT PREGNANT OR UNSURE õ õ ....õ 5 ───→ **Q 434**

Q431	Would you prefer your next child to be a girl or a boy or it doesnq matter?	BOYõ ..õ ....õ õ õ õ õ 1 GIRL õ ..õ õ õ õ ..õ õ .õ ..2 DOESNqT MATTER õ õ .....3 UP TO GOD ......õ õ õ õ ...4

Q432	**CHECK Q404:** NOT PREGNANT OR UNSURE How long would you like to wait from now before the birth of (a/another) child?	PREGNANT After the birth of the child you are expecting now, how long would you like to wait before the birth of another child?	MONTHSõ .õ õ õ õ õ õ õ 1 ☐☐ YEARSõ õ õ õ õ õ õ õ .. 2 ☐☐ **(IF LESS THAN TWO YEARS, RECORD MONTHS, IF 2 YEARS OR MORE RECORD YEARS)** SOON/NOW/õ õ õ õ õ õ ....õ õ ..993 OTHER _____996 **(SPECIFY)** DONqT KNOWõ õ õ õ õ õ õ ....õ õ 998	→ **Q434**

Q432a	**CHECK Q404:** NOT PREGNANT OR UNSURE When you gave last time birth, did you want this child then, did you want later, did you not want to have any (more) children at all?	**PREGNANT** When you become pregnant this time, (i.e currently pregnant) did you want to become pregnant now, did you want until later, or did you not want to have any (more) children at all?	**(IF LESS THAN TWO YEARS, RECORD MONTHS, IF 2 YEARS OR MORE RECORD YEARS)** THEN õ ..õ ....õ õ õ ....1 LATER õ ..õ ....õ õ õ õ õ ....õ 2 DON'T WANT ANY MORE....................... 3 **(If Later ask duration)** MONTHSõ .õ .... 1 ☐☐ YEARSõ õ õ .... 2 ☐☐ DONqT KNOW................ 998	→ **Q434**

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Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q433	**CHECK Q404:** **NOT PREGNANT** ☐ **PREGNANT** ☐ **OR UNSURE** ↓		**Q437**
Q434	**CHECK Q405: USING A CONTRACEPTIVE METHOD?** **NOT USING** **CURRENTLY** **NOT ASKED** **CURRENTLY** ☐ **USING** ☐ → **Q440** **(STERILIZED)** ☐ ↓		**SEC V**

Q435	**CHECK Q432:**
	
	NOT ASKED **24 OR MORE MONTHS** **00-23 MONTHS**
	            OR 02 OR MORE YEARS OR OTHER/DK **OR LESS THAN 2 YEARS**
	(WANTS- ☐
	 NO MORE) ☐ ☐
	       ↓ **Q436** ↓ **Q436**
			Q437

Q436	**CHECK Q430:** **WANTS NO** **WANTS TO** **MORE/NONE** **HAVE A/ANOTHER** ☐ **CHILD** → ↓ You have said that you **do not want any (more) children**, but you are not using any method to avoid pregnancy. Can you tell me why you are not using any method? PROBE: Any other reason? (After 24 or more months) You have said that you **do not want (a/another) child soon**, but you are not using any method to avoid pregnancy. Can you tell me why you are not using any method? PROBE: Any other reason?	<table><tr><td></td><td>YES</td><td>NO</td></tr><tr><td>**FERTILITY-RELATED REASON**</td><td></td><td></td></tr><tr><td>A. NOT HAVING SEX.......................................</td><td>1</td><td>2</td></tr><tr><td>B. INFREQUENT SEX....................................</td><td>1</td><td>2</td></tr><tr><td>C. HUSBAND AWAYõ ....õ õ .õ õ õ</td><td>1</td><td>2</td></tr><tr><td>D. MENOPAUSE...</td><td>1</td><td>2</td></tr><tr><td>E. HYSTERECTOMY õ ....õ</td><td>1</td><td>2</td></tr><tr><td>F. SUBFECUND/INFECUNDõ õ ....õ õ</td><td>1</td><td>2</td></tr><tr><td>G. POSTPARTUM AMENORRHEIC............</td><td>1</td><td>2</td></tr><tr><td>H. BREASTFEEDING õ õ ....õ</td><td>1</td><td>2</td></tr><tr><td>I. UP TO GODõ õ õ õ ....õ õ</td><td>1</td><td>2</td></tr><tr><td>**OPPOSITION TO USE**</td><td></td><td></td></tr><tr><td>J. RESPONDENT OPPOSED......................</td><td>1</td><td>2</td></tr><tr><td>K. HUSBAND OPPOSEDõ õ ....õ</td><td>1</td><td>2</td></tr><tr><td>L. OTHERS OPPOSED..............................</td><td>1</td><td>2</td></tr><tr><td>M. RELIGIOUS PROHIBITION.......................</td><td>1</td><td>2</td></tr><tr><td>**LACK OF KNOWLEDGE**</td><td></td><td></td></tr><tr><td>N. KNOWS NO METHOD.............................</td><td>1</td><td>2</td></tr><tr><td>O. KNOWS NO SOURCE.............................</td><td>1</td><td>2</td></tr><tr><td>**METHOD-RELATED REASON**</td><td></td><td></td></tr><tr><td>P. HEALTH CONCERNSõ ....õ õ</td><td>1</td><td>2</td></tr><tr><td>Q. FEAR OF SIDE EFFECTS.........................</td><td>1</td><td>2</td></tr><tr><td>R. LACK OF ACCESS/TOO FAR....................</td><td>1</td><td>2</td></tr><tr><td>S. COSTS TOO MUCH õ ....õ õ õ ....õ</td><td>1</td><td>2</td></tr><tr><td>T. DIFFICULT/INCONVENIENT TO GET METHOD õ õ õ õ õ</td><td>1</td><td>2</td></tr><tr><td>U. INCONVENIENT TO USE.........................</td><td>1</td><td>2</td></tr><tr><td>V. INTERFERES WITH BODYõS NORMAL PROCESSES...</td><td>1</td><td>2</td></tr><tr><td>W. DO NOT LIKE EXISTING METHODSõ .</td><td>1</td><td>2</td></tr><tr><td>X. AFRAID OF STERILIZATION......................</td><td>1</td><td>2</td></tr><tr><td>Y. CAN NOT WORK AFTER STERILIZATION...</td><td>1</td><td>2</td></tr><tr><td>Z. OTHER_____</td><td>1</td><td>2</td></tr><tr><td>**(SPECIFY)**</td><td></td><td></td></tr><tr><td>AA. DONõT KNOW</td><td>1</td><td>2</td></tr></table>	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES				SKIP TO
Q437	CHECK Q401B, Q404 AND Q406/Q406A EVER USED BUT CURRENTLY NOT USING OR PREGNANT	EVER USED AND CURRENTLY USING (OTHER THAN STERILIZATION)	WOMAN / MAN STERILIZED	NEVER USED		
	↓ Q438	↓ Q440	↓ SEC V	↓ Q440		

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q438	What was the last method you/your husband used?	IUD.........õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .....õ õ 1 ORAL PILLS õ õ õ õ õ õ .õ õ õ õ õ ....õ .....õ .õ ..2 CONDOM/NIRODHõ õ õ õ õ õ õ õ õ õ õ .õ õ õ ....õ 3 RHYTHM/PERIODIC ABSTINENCEõ õ õ õ õ õ .....õ ..4 WITHDRAWAL..........õ õ õ õ õ õ õ õ õ õ õ õ õ õ ....5 OTHER MODERN METHOD_____6 (SPECIFY)) OTHER TRADITIONAL METHOD _____7 (SPECIFY)	
Q439	What was the main reason for discontinuing the use of that method?	**FERTILITY -RELATED REASON** WANTED CHILDõ õ .õ ....õ .õ .õ õ õ õ ...01 METHOD FAILED/BECAME PREGNANT.õ õ .02 **SIDE EFFECT- RELATED REASON** BREAST TENDERNESS.õ õ õ õ õ ....õ õ õ ..03 IRREGULAR PERIODS õ õ õ õ õ õ ....õ ..04 EXCESSIVE BLEEDING õ ...õ õ õ õ ....õ ..05 SPOTTING........õ õ õ õ õ õ õ õ õ õ õ ..õ ...06 WHITE DISCHARGE...õ õ õ õ õ õ õ õ õ õ ...07 WEAKNESS/INABILITY TO WORK ....õ õ 08 BODY ACHE/BACKACHE..õ õ õ õ õ ....õ ..09 CRAMPS...õ õ õ õ õ õ õ .õ õ õ õ õ ......õ ...10 WEIGHT GAIN....õ õ õ õ õ ..õ õ ..õ õ õ õ õ õ .11 DIZZINESS ....õ õ õ õ õ õ ..õ . õ õ õ õ õ ..12 NAUSEA/VOMITING.õ ..õ õ õ õ õ õ õ ...õ õ .13 **OTHER REASONS** SUPPLY NOT AVAILABLEõ õ õ ....õ .14 DIFFICULT TO GET METHODõ õ õ ....õ 15 LACK OF PLEASUREõ õ õ õ õ õ ....õ 16 METHOD WAS INCONVENIENTõ õ ....õ 17 COST TOO MUCH õ õ õ õ õ õ õ õ õ .õ õ õ .18 FAMILY/HUSBAND OPPOSED ....19 NOT HAVING SEXõ õ õ õ õ õ õ õ ......õ õ õ .20 INFREQUENT SEXõ õ õ ...õ ..õ õ ....õ õ 21 HUSBAND AWAY õ õ õ õ õ õ .õ õ ....õ õ ..22 OTHER _____96 (SPECIFY	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q440	**CHECK Q404: PREGNANCY STATUS** **NOT PREGNANT OR UNSURE** ☐ **PREGNANT** ☐		▶ **SEC V**
Q441	**CHECK Q405 AND Q406: USING A CONTRACEPTIVE METHOD** **CURRENTLY NOT USING** ☐ → **Q443** **RHYTHM METHOD WITHDRAWAL** ☐ → **Q442** **ALL OTHER METHODS** ☐		▶ **SEC V**
Q442	What is the main reason for currently not using any **modern** method of family planning?	**FERTILITY-RELATED REASON** NOT HAVING SEX………………….. 01 INFREQUENT SEX…………………. 02 HUSBAND AWAY………………… 03 MENOPAUSE………………………. 04 HYSTERECTOMY…………………. 05 SUBFECUND / INFECUND……….. 06 POSTPARTUM AMENORRHOEIC…… 07 BREASTFEEDING………………….. 08 UP TO GOD…………………………. 09 **OPPOSITION TO USE** RESPONDENT OPPOSED…………… 10 HUSBAND OPPOSED……………… 11 OTHERS OPPOSED………………... 12 RELIGIOUS PROHIBITION………… 13 **LACK OF KNOWLEDGE** KNOWS NO METHOD……………… 14 KNOWS NO SOURCE……………… 15 **METHOD-RELATED REASON** HEALTH CONCERNS………………. 16 FEAR OF SIDE EFFECTS…………... 17 LACK OF ACCESS/TOO FAR……… 18 COSTS TOO MUCH………………... 19 DIFFICULT/INCONVENIENT TO GET METHOD……………………….. 20 INCONVENIENT TO USE…………... 21 INTERFERES WITH BODY'S NORMAL PROCESSES…………… 22 DO NOT LIKE EXISTING METHODS. 23 AFRAID OF STERILIZATION……… 24 CAN NOT WORK AFTER STERILIZATION…………………... 25 OTHER_____ 96 **(SPECIFY)** DON'T KNOW…………………… 98	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q443	CURRENTLY NOT USING ⬒ RHYTHM METHOD AND WITHDRAWAL ⬒ Did anyone advise you/your husband to adopt any family planning method? Did anyone advise you/your husband to adopt any modern family planning method?	YES NO A. DOCTOR…………..……..……. 1 2 B. ANM …………………………..… 1 2 C. HEALTH WORKER …………… . 1 2 D. ANGANWADI WORKER ……….…… 1 2 E. ASHA ……………………………. 1 2 F. NGO/CBO…………………….. 1 2 G. HUSBAND/WIFE………………..… 1 2 H. MOTHER-IN-LAW……………… . 1 2 I. MOTHER…….………………… . 1 2 J. RELATIVE/FRIENDS…………… 1 2 K. OTHER_____ 1 2 **(SPECIFY)**	**IF 'NO' FOR ALL** **GO TO Q445**
Q444	What method did she/he advise you to use? **(RECORD ALL MENTIONED.)**	YES NO A. FEMALE STERILISATION..…… ..…… 1 2 B. MALE STERILISATION……....……… . 1 2 C. IUD……….……............……… 1 2 D. DAILY PILLS..............……………… ... 1 2 E. WEEKLY PILLS……………………….. 1 2 F. INJECTABLES…………………… 1 2 G. CONDOM/NIRODH..............……..…. 1 2 H. FEMALE CONDOM…………………… ... 1 2 I. RHYTHM/PERIODIC ABSTINENCE...… .. 1 2 J. WITHDRAWAL..................……………… .. 1 2 K. OTHER_____ 1 2 **(SPECIFY)**	
Q445	CURRENTLY NOT USING ⬒ RHYTHM METHOD AND WITHDRAWAL ⬒ Do you intend to use any method of family planning at any time in the future? Do you intend to use any modern method of family planning at any time in the future?	YES ....1 NO...2 NOT YET DECIDED.................................3 IN MENOPAUSE....................................4 HYSTERECTOMY 5	**SEC V**

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Q. NO	QUESTIONS AND FILTERS		CODING CATEGORIES	SKIP TO
Q446	When you want to use any family planning method?	When you want to use any modern family planning method?	WITHIN SIX MONTH...1 SIX MONTH TO LESS THAN ONE YEAR...................2 ONE TO LESS THAN TWO YEARS...........................3 TWO OR MORE YEARS..4 DON'T KNOW /UNDECIDEDõ õ õ õ õ õ õ õ õ ...5	
Q447	Which method would you prefer to use? **(CIRCLE ONLY THE MOST PREFERRED METHOD)**		FEMALE STERILIZATION ....01 MALE STERILIZATION..02 IUD/COPPER-T ....03 PILLS..04 INJECTABLES...05 CONDOM/NIRODH...06 FEMALE CONDOM..07 RHYTHM/PERIODIC ABSTINENCE ....08 WITHDRAWAL ....09 UNDECIDED..õ õ õ õ õ õ õ õ õ õ ....õ õ õ ...10 OTHER_____ 96 (**SPECIFY**)	

SECTION- V

REPRODUCTIVE HEALTH

A. MENSTRUATION RELATED PROBLEMS			
Q. NO	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP TO**
Q501	Are you currently menstruating?	YES...........õ õ õ õ õ õ ..õ õ õ õ .... 1 NO.........................õ õ õ õ õ õ õ õ õ õ ..õ 2 PREGNANT ....993 IN AMENORRHOEA ....994 IN MENOPAUSE ....995 HYSTERECTOMY ....996 NEVER MENSTRUATED 997	**Q505** **Q506**
Q502	During the last three months did you have any menstruation related problems?	YES...........õ õ õ õ õ õ ..õ õ õ õ .... 1 NO.........................õ õ õ õ õ õ õ õ õ õ ..õ 2	**Q505**
Q503	What are the problems you have/had? (**RECORD ALL MENTIONED**)	YES NO A. NO PERIODS...õ õ ....õ 1 2 B. PAINFUL PERIODS.......................... 1 2 C. FREQUENT OR SHORT PERIODS .... 1 2 D. IRREGULAR PERIODS .... 1 2 E. PROLONGED BLEEDING.... .... 1 2 F. SCANTY BLEEDING...................õ õ 1 2 G. INTER-MENSTRUAL BLEEDING........ 1 2 H. BLOOD CLOTS/EXCESSIVE BLEEDING 1 2	
Q504	Since how long do/did you have these problems?	MONTHSõ õ õ õ õ õ õ õ õ õ õ ☐☐ (**LESS THAN 1 MONTH RECORD ''00''**) 8 AND MORE YEARS õ õ õ õ . 96 DO NOT REMEMBER õ õ õ õ õ 98	
Q505	Women use different methods of protection during menstrual period to prevent bloodstains from becoming evident. What do you use for this? PROBE: Anything else?	YES NO A. USE CLOTH ...õ õ ....õ 1 2 B. LOCALLY PREPARED NAPKINS ... 1 2 C. USE SANITARY NAPKINS .... 1 2 D. USE NOTHINGõ ....õ 1 2 E. OTHER_____ 1 2 (**SPECIFY**)	

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	B. REPRODUCTIVE TRACT INFECTION (RTI) /SEXUALLY TRANSMITTED INFECTION (STI)		
Q. NO	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP TO**
Q506	Have you ever heard of an illness called Reproductive Tract Infection (RTI)/ Sexually Transmitted Infection (STI)?	YES õ õ õ õ õ õ õ õ ....õ õ õ .õ õ õ ...... 1 NO ....õ õ õ õ õ õ õ õ ..õ õ õ õ õ .. 2	► **Q509**

Q507	From which sources of information have you heard/read about RTI/STI?
	
	 Any other source?
	
	 (RECORD ALL MENTIONED)
		YES NO
		 A. RADIOõ .....õ õ õ õ ......õ õ õ õ õ 1 2
		 B. TELEVISION.........õ õ õ ..õ õ õ õ 1 2
		 C. CINEMAõ õ ......õ õ õ ..õ õ õ õ õ 1 2
		 D. NEWS PAPERS/BOOKS/
		      MAGAZINESõ õ õ õ õ õ õ õ õ 1 2
		 E. SLOGANS/PAMPHLETS/
		      POSTERS/ WALL HOARDINGSõ õ 1 2
		 F. DOCTORõ ....õ õ õ õ õ õ õ 1 2
		 G. HEALTH WORKERSõ ......õ õ õ õ . 1 2
		 H. ASHAõ õ õ õ õ õ õ õ õ õ õ õ 1 2
		 I. ADULT EDUC. PROGRAMMEõ õ 1 2
		 J. RELIGIOUS LEADERSõ .....õ õ õ 1 2
		 K. POLITICAL LEADERSõ ....õ õ õ õ 1 2
		 L. SCHOOL/ TEACHERSõ ......õ õ õ . 1 2
		 M. HUSBANDõ .....õ õ õ ..õ õ õ õ õ 1 2
		 N. COMMUNITY MEETINGSõ ....õ õ . 1 2
		 O. RELATIVES/FRIENDSõ ....õ õ õ . 1 2
		 P. WORK PLACEõ .....õ õ õ õ õ õ õ 1 2
		 Q. EXHIBITION/ MELAõ õ õ õ õ õ . 1 2
		 R. OTHER_____
		                (SPECIFY) 1 2	

Q508	How is RTI/STI transmitted?
	
	 (RECORD ALL MENTIONED)
		YES NO
		 A. UNSAFE DELIVERYõ ....õ 1 2
		 B. UNSAFE ABORTION 1 2
		 C. UNSAFE IUD INSERTION.............. 1 2
		 D. UNSAFE SEX WITH
		   HOMOSEXUALS 1 2
		 E. UNSAFE SEX WITH PERSONS
		   WHO HAVE MANY PARTNERS 1 2
		
		 F. UNSAFE SEX WITH SEX WORKERS 1 2
		 G. OTHER_____
		              (SPECIFY)) 1 2
		  H. DO NOT KNOW ....õ ....õ 1 2	

Q509	During the last three months did you have any abnormal vaginal discharge?	YES ..õ õ õ õ õ õ õ õ õ õ õ ....õ õ .1 NO ....õ õ õ õ õ õ õ õ õ õ õ õ .. 2	► **Q515**
Q510	Does/did it wet or stain your under clothes?	YES..............õ õ õ õ õ õ õ õ õ .õ ....õ õ õ ..1 NO....................õ õ õ õ õ .õ õ õ õ õ õ ... 2	
Q511	What is/was the colour of that discharge?	COLOURLESSõ õ õ ....õ .õ õ õ õ õ õ õ .1 WHITEõ ....õ ....õ õ õ õ õ õ õ õ õ 2 GREEN ......õ ....õ ..õ õ õ õ õ õ õ õ õ .3 YELLOWISHõ ....õ õ õ õ õ õ õ ... 4 BLOOD STAINEDõ ....õ õ õ õ õ õ 5 DON'T KNOW .... õ õ õ õ õ õ õ õ õ .õ õ .8	
Q512	What is/was the texture of that discharge?	STICKY MUCOIDõ õ õ ....õ õ õ .õ .... 1 FROTHY..................õ .õ õ õ õ õ õ .õ õ .... 2 CURDISHõ õ õ õ õ õ .õ ....õ õ .... 3 PUS LIKE (PURULENT) õ õ õ .....õ õ ....õ 4 DONT KNOWõ õ õ õ õ õ õ õ õ õ õ õ ....õ õ .8	
Q513	What is/was the odour of that discharge?	FOUL...............õ õ õ õ õ õ õ õ õ õ õ .... 1 NONE ....õ õ õ õ õ õ õ õ õ õ õ 2	

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Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q514	How long have you been having this problem?	WEEKS…………………………… [1] [ ][ ] MONTHS... [2] [ ][ ] YEARS……………………………………õ [3] [ ][ ] DO NOT REMEMBER õ õ õ õ õ .õ ..998 **(LESS THAN 1 MONTHS RECORD WEEKS IF LESS THAN 1 YEAR RECORD MONTHS, IF 2 OR MORE YEARS RECORD YEARS)**	
Q515	During the last three months did you have any of the following problems? A. Itching or irritation over vulvaõ B. Boils/ulcers/warts around vulva C. Pain in lower abdomen not related to menses D. Pain during urination or defecation E. Swelling in the groin F. Painful blister like lesions in and around vagina G. Low backache **(ASK ONLY TO CURRENTLY MARRIED WOMEN)** H. Pain during sexual intercourse I. Spotting after sexual intercourse	YES NO A. ITCHING OR IRRITATION OVER VULVAõ . 1 2 B. BOILS/ULCERS/WARTS AROUND VULVAõ 1 2 C. PAIN IN LOWER ABDOMEN NOT RELATED TO MENSESõ õ õ õ õ õ õ õ . 1 2 D. PAIN DURING URINATION OR DEFECATIONõ õ õ õ õ õ õ õ õ õ õ . õ 1 2 E. SWELLING IN THE GROINõ õ õ õ õ õ õ ..1 2 F. PAINFUL BLISTER LIKE LESIONS IN AND AROUND VAGINAõ õ õ õ õ õ õ õ õõ õ .. ..1 2 G. LOW BACKACHEõ õ õ õ õ õ õ õ õ õ .. õ 1 2 H. PAIN DURING SEXUAL INTERCOURSEõ õ 1 2 I. SPOTTING AFTER SEXUAL INTERCOURSEõ õ õ õ õ õ õ õ õ õ .. õ õ ..1 2	**IF "NO" FOR ALL IN** **Q 525** **&** **"NO"** **FOR Q515** **GO TO** **Q520**
Q516	Since how long do/did you have these problems?	WEEKSõ õ õ õ õ õ õ õ õ õ õ õ [1] [ ][ ] MONTHS... [2] [ ][ ] YEARS……………………………………õ [3] [ ][ ] DO NOT REMEMBER õ õ õ õ õ ... 998 **(LESS THAN 1 MONTHS RECORD WEEKS IF LESS THAN 2 YEAR RECORD MONTHS, IF 2 OR MORE YEARS RECORD YEARS)**	
Q517	Did you discuss about these problems with your husband/partner?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .1 NOõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ ..õ .2	
Q518	Did you consult anybody or seek treatment for these problems?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .1 NOõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ ...õ 2 ⟶	**Q520**

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

| Q519 | Where did you go for consultation or treatment for your problems?

(**RECORD ALL MENTIONED**) | **GOVERNMENT**   YES   NO
A. SUB CENTRE 1   2
B. PHC…………………………….. 1   2
C. CHC………………………………. 1   2
D. UHC/UHP/UFWC……………… 1   2
E. DISPENSARY/CLINIC…………… 1   2
F. HOSPITAL …………………… . 1   2
G. AYUSH HOSPITAL/CLINIC …… 1   2
H. VCTC/ICTC ……………………. .. 1   2
I. RTI/STI CLINIC……………… . 1   2
J. OTHER PUBLIC MEDICAL SECTOR.. 1   2
PRIVATE
K. DISPENSARY/ CLINIC. …… . … 1   2
L. HOSPITAL…………………….. 1   2
M. AYUSH HOSPITAL/CLINIC …… .. 1   2
N. NGO/TRUST HOSPITAL/CLINIC… 1   2
O. RTI/STI CLINIC……………… 1   2
P. OUT REACH/ MCP CAMP IN VILLAGE. 1   2
Q. CHEMIST/MEDICAL SHOP…… 1   2
R. HOME REMEDY…………… 1   2
S. TRADITIONAL HEALER……..… 1   2
T. OTHER_____ 1   2
(SPECIFY) | |

C. AWARENESS OF HUMAN IMMUNODEFICIENCY VIRUS (HIV)/ ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q520	Have you ever heard of Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS)?	YES………………………………. 1 NO……………………………… 2 ——→	**END**

Q521	From which sources of information have you heard/read about HIV/AIDS?
	
	Any other source?
	
	(**RECORD ALL MENTIONED**)
		YES NO
		A. RADIO.……………………… 1 2
		B. TELEVISION……………… . 1 2
		C. CINEMA ………………… . 1 2
		D. NEWS PAPERS/BOOKS/
		    MAGAZINES……………… 1 2
		E. SLOGANS/PAMPHLETS/
		    POSTERS/WALL HOARDINGS… 1 2
		F. DOCTOR……………………… 1 2
		G. HEALTH WORKERS………….. 1 2
		H. ASHA………………………. 1 2
		I. ADULT EDUC. PROGRAMME.… . 1 2
		J. RELIGIOUS LEADERS……… 1 2
		K. POLITICAL LEADERS……… 1 2
		L. SCHOOL/ TEACHERS……… 1 2
		M. HUSBAND………………… .. 1 2
		N. COMMUNITY MEETINGS……. 1 2
		O. RELATIVES/FRIENDS……… 1 2
		P. WORK PLACE……………… .. 1 2
		Q. EXHIBITION/ MELA………… .. 1 2
		R. OTHER_____ 1 2
		(SPECIFY)	

Q522	How is HIV/AIDS transmitted?
	
	(**RECORD ALL MENTIONED**)
		YES NO
		A. UNSAFE SEX WITH HOMOSEXUALS 1 2
		B. UNSAFE SEX WITH PERSONS WHO
		    HAVE MANY PARTNERS ……. 1 2
		C. UNSAFE SEX WITH SEX WORKERS 1 2
		D. UNPROTECTED SEX WITH HIV/AIDS
		    PERSON ………………… .. 1 2
		E. INFECTED MOTHER TO CHILD 1 2
		F. TRANSFUSION OF INFECTED BLOOD 1 2
		G. OTHER_____ 1 2
		(SPECIFY)
		H. DO NOT KNOW ….……… .. 1 2	

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q523	Do you think that one can get HIV /AIDS by SHAKING HAND with a person who has HIV /AIDS?	YES..1 NO ....2 DONөT KNOW 8	
Q524	Do you think that one can get HIV /AIDS by HUGGING with a person who has HIV /AIDS?	YES ....1 NO ....2 DONөT KNOW 8	
Q525	Do you think that one can get HIV /AIDS by KISSING with a person who has HIV /AIDS?	YES..1 NO ....2 DONөT KNOW 8	
Q526	Do you think that one can get HIV /AIDS by SHARING CLOTHES with a person who has HIV /AIDS?	YES..1 NO ....2 DONөT KNOW 8	
Q527	Do you think that one can get HIV /AIDS by SHARING FOOD with a person who has HIV /AIDS?	YES..1 NO ....2 DONөT KNOW 8	
Q528	Do you think that one can get HIV /AIDS by STEPPING ON URINE/STOOL OF SOMEONE who has HIV/AIDS?	YES..1 NO ....2 DONөT KNOW 8	
Q529	Do you think that one can get HIV/AIDS from Mosquito, Flea or Bedbug Bites?	YES..1 NO..2 DONөT KNOW 8	
Q530	Is there anything else a person can do to avoid or reduce the chances of getting HIV /AIDS? Any other? **(RECORD ALL MENTIONED)**		

Q530 coding categories:

	YES	NO
A. ABSTAIN FROM SEX ....ö ..	1	2
B. USING CONDOMS CORRECTLY DURING EACH SEXUAL INTERCOURSE	1	2
C. LIMIT SEX WITH ONE PARTNER/STAY FAITHFUL TO ONE PARTNER..............	1	2
D. LIMIT NUMBER OF SEXUAL PARTNERS	1	2
E. AVOID SEX WITH SEX WORKERS	1	2
F. AVOID SEX WITH PERSONS WHO HAVE MANY PARTNERS	1	2
G. AVOID SEX WITH HOMOSEXUALS	1	2
H. AVOID SEX WITH PERSONS WHO INJECT DRUGS	1	2
I. USE TESTED BLOOD	1	2
J. USE ONLY NEW/STERILIZED NEEDLES	1	2
K. AVOID IV DRIP	1	2
L. AVOID SHARING RAZORS/BLADES ...	1	2
M. AVOID PREGNANCY WHEN HAVING HIV / AIDS	1	2
N. OTHER _____ (SPECIFY	1	2
O. DONөT KNOW	1	2

Q. NO	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q531	Do you know a place where people can go to get tested for HIV /AIDS?	YES.................õ õ õ õ ..õ õ õ õ ..õ õ .õ õ õ õ ..1 NO.................õ õ õ õ õ õ õ ...õ õ ....õ õ õ õ ..2 ──────▶	**Q533**
Q532	Where is that? Any other place? IF UNABLE TO DETERMINE IF A HOSPITAL, HEALTH CENTRE, OR CLINIC IS PUBLIC OR PRIVATE MEDICAL SECTOR, WRITE THE NAME OF THE PLACE. _____ (NAME OF PLACE (S)) **(RECORD ALL MENTIONED)**	**GOVERNMENT** YES NO A. SUB CENTRE .... 1 2 B. PHCõ õ õ õ õ õ õ õ õ õ õ õ õ õ .. 1 2 C. CHC..................................õ õ õ õ õ . 1 2 D. UHC/UHP/UFWCõ õ õ .õ õ õ õ õ 1 2 E. DISPENSARY/CLINIC..............õ õ õ . 1 2 F. HOSPITAL õ õ õ õ õ õ õ õ õ õ õ . 1 2 G. AYUSH HOSPITAL/CLINIC õ õ õ õ õ 1 2 H. VCTC/ICTC õ õ õ õ õ õ õ õ õ õ õ .. 1 2 I. RTI/STI CLINICõ õ õ õ õ õ õ õ õ õ . 1 2 J. OTHER PUBLIC MEDICAL SECTOR.. 1 2 **PRIVATE** K. DISPENSARY/ CLINIC. õ õ õ õ . õ õ 1 2 L. HOSPITAL.. 1 2 M. AYUSH HOSPITAL/CLINIC õ õ õ õ .. 1 2 N. NGO/TRUST HOSPITAL/CLINICõ õ õ 1 2 O. RTI/STI CLINICõ õ õ õ õ õ õ õ õ õ 1 2 P. OUT REACH/ MCP CAMP IN VILLAGE. 1 2 Q. CHEMIST/MEDICAL SHOPõ õ õ õ õ 1 2 R. HOME REMEDYõ õ õ õ õ õ õ õ õ 1 2 S. TRADITIONAL HEALERõ õ õ ..õ õ 1 2 T. OTHER_____ 1 2 **(SPECIFY)**	
Q533	I donq want to know the results, but have you undergone HIV /AIDS test?	YES.. 1 NO... 2	
Q534	When was the last time you tested?	LESS THAN 12 MONTHS AGO..................................... 1 12-23 MONTHS AGO.. 2 2 OR MORE YEARS AGO... 3	

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DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY (DLHS - 4)

VILLAGE QUESTIONNAIRE

IDENTIFICATION

A. STATE _____

  DISTRICT _____

  TEHSIL/TALUK/COMMUNITY DEVELOPMENT BLOCK/MANDAL_____

  PSU (VILLAGE) _____

  PSU POPULATION AS PER 2001 CENSUS _____

  NO. OF SEGMENT CREATED IN VILLAGE _____

  NO OF SEGMENT SELECTED_____

RESPONDENT NAME: _____

1) VILLAGE PRADHAN/ UP PRADHAN 2) ANY OTHER PANCHAYAT MEMBER
3) TEACHER 4) GRAM SEVAK 5) ANGANWADI WORKER

  ADDRESS
  _____
  _____

(TO BE ENTERED AT OFFICE)

SERIAL NUMBER OF VILLAGE QUESTIONNAIREõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

SERIAL NUMBER OF SUB CENTRE QUESTIONNAIREõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

SERIAL NUMBER OF PHC QUESTIONNAIREõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

SERIAL NUMBER OF CHC QUESTIONNAIREõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

INTERVIEW DATE

	DATE		MONTH		YEAR		

GPS INFORMATION:

Number of Satellite signals received	Accuracy (signal in feet)	Longitude North - N South -S	Longitude East - E West -W	Way point circle one 1 = in front of household 2 = nearby landmark
No. = (Signals must be 3 or more)		Degree Minutes	Degree Minutes	

NAME OF THE INVESTIGATOR _____

_____
SIGNATURE OF THE INVESTIGATOR

CODE OF THE INVESTIGATOR

Q No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q101	Current population of the village:	CENSUS FIGURE… . ☐☐☐☐☐ **(Copy from the list)** CURRENT POPULATION ☐☐☐☐☐ **(Reported by respondent)**	
Q102	Total number of households in the village:	**(Copy from the list)** ☐☐☐☐	
Q103	Name the three major occupation groups in the village	1_____ ☐☐ 2_____ ☐☐ 3_____ ☐☐	
Q104	Main source of drinking water in the village	**PIPED WATER** PIPED INTO DWELLING… … … … … .… . . 11 PIPED TO YARD/PLOT...........… … … … . . 12 PUBLIC TAP/STANDPIPE… … … … … … ... 13 TUBE WELL OR BORE WELL… … .… … … . . 21 **DUG WELL** PROTECTED WELL… … … … … … … … ... 31 UN PROTECTED WELL… … … … … … … … 32 **WATER FROM SPRING** PROTECTED SPRING… … … … … … … .. 41 UNPROTECTED SPRING… … … … … … 42 RAINWATER… … … … … … … … … … . 51 TANKER TRUCK… … … … … … … … … 61 CART WITH SMALL TANK… … … ..… … 71 **SURFACE WATER (RIVER/DAM/ LAKE/POND/STREAM/CANAL/** IRRIGATION CHANNEL)… … … … … .... 81 BOTTLED WATER… … … … … … … ..… 91 HAND PUMP… … … … … … … … … .. 92 OTHER _____ ____96 (SPECIFY)	
Q105	Is the drainage facility available in the village?	YES… … … … … … … … … … … … .… … … .1 NO...… … … … … … … … … … … … … … … .2 ——▶	**Q107**
Q106	The type of drainage facility in the village: **(RECORD ALL MENTION)**	<table><tr><td></td><td>YES</td><td>NO</td></tr><tr><td>A. UNDERGROUND DRAINAGE… .</td><td>1</td><td>2</td></tr><tr><td>B. OPEN WITH OUTLET… … … .</td><td>1</td><td>2</td></tr><tr><td>C. OPEN WITHOUT OUTLET.… … .</td><td>1</td><td>2</td></tr></table>	
Q107	Village electrification: **(DOMESTIC PURPOSE)**	NOT ELECTRIFIED… … … … … … … … .… .1 LESS THEN 6 HOURS… … … … … … … … 2 MORE THEN 6 HOURS … … … … … … … .3	

Q No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q108	Main source of irrigation in the village:	TANK/POND.................... 01 STREAM/RIVER............... 02 CANAL............................ 03 WELL............................... 04 TUBE WELL...................... 05 OTHER (SPECIFY)_____ 96	
Q109	Major crops grown in the village:	1_____ ☐☐ 2_____ 3_____	
Q110	Distance to the nearest town (in kilometers):	NAME OF TOWN_____ ☐☐	
Q111	Distance to the district headquarters (in kilometers):	☐☐	
Q112	Distance to the nearest railway station (in kilometers):	☐☐☐	
Q113	Distance to the nearest bus station (in kilometers):	☐☐	
Q114	Whether village is connected by all-weather road to the health facility?		

		YES	NO
Q114	SUB CENTER...............	1	2
	PRIMARY HEALTH CENTER.	1	2
	BLOCK PHC...............	1	2
	COMMUNITY HEALTH CENTER/ RURAL HOSPITAL	1	2
	DISTRICT HOSPITAL......	1	2

Q115 Educational facilities available in the village:

	GOVT. YES	GOVT. NO	PVT. YES	PVT. NO
Primary School	1	2	1	2
Middle School	1	2	1	2
Secondary School	1	2	1	2
Higher Secondary School..	1	2	1	2
College......	1	2	1	2
Madarasa......	1	2	1	2
Non-formal education (Guruji scheme)	1	2	1	2

Education facilities:
If not in the village, distance to nearest govt. facility available

Primary School...........	☐☐	(KM)
Middle School............	☐☐	(KM)
Secondary School........	☐☐	(KM)
Higher Secondary School...	☐☐	(KM)
College...................	☐☐	(KM)
Madarasa.................	☐☐	(IKM)
Non-formal education (Guruji scheme).........	☐☐	(IKM)

Q No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO

Q116 Health facility available in the village:

Health facilities:
If not in the village, distance to nearest facility available

	YES	NO		Distance to nearest health facility in K.M.		Whether accessible throughout the year YES	NO
A) ICDS (Anganwadi)…….	1	2	A) ICDS (Anganwadi)…….			1	2
B) Sub-Centre………	1	2	B) Sub-Centre………			1	2
C) PHC…………….	1	2	C) PHC…………….			1	2
D) BLOCK PHC………	1	2	D) BLOCK PHC………			1	2
E) CHC/RH…………..	1	2	E) CHC/RH…………..			1	2
F) District/ Govt. Hospital…	1	2	F) District/ Govt. Hospital…			1	2
G) Govt. Dispensary………	1	2	G) Govt. Dispensary………			1	2
H) Private Clinic…………..	1	2	H) Private Clinic…………..			1	2
I) Private Hospital/ Nursing Home	1	2	I) Private Hospital……… Nursing Home			1	2
J) AYUSH Health Facility…	1	2	J) AYUSH Health Facility…			1	2

Q117 Availability of health provider in the Village (staying and/or visiting):

	YES	NO	IF YES, NUMBER
A). INTEGRATED CHILD DEVELOPMENT SCHEME / ANGANWADI WORKER ………			
B). VILLAGE HEALTH GUIDE (VHG)……	1	2	
C). ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)…………………….	1	2	
D). TRAINED BIRTH ATTENDANT (TBA)…	1	2	
E) .AUXILIARY NURSE MIDWIFE (ANM)…	1	2	
F). LADY DOCTOR ………	1	2	
G). PRIVATE DOCTOR ………	1	2	
H) .UNANI DOCTOR ………	1	2	
I) .AYURVEDIC DOCTOR ……	1	2	
J). HOMEOPATHIC DOCTOR ……	1	2	
K). SIDHA DOCTOR……………	1	2	
L). REGISTERED MEDICAL PRACTITIONER . ALTERNATIVE MEDICINES…………	1	2	
M). TRADITIONAL HEALER…………	1	2	
N). UNTRAINED DAI………	1	2	
O) .OTHER _____ (SPECIFY)	1	2	
	1	2	

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Q. No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q118	Availability of sonography /ultrasound facility in the village or within 5 kms:	YES………………….…...1 NO...…………………..2 DON'T KNOW…………..3	
Q119	Whether the village was covered by Mobile Health Clinic	YES………………...1 NO...…………………..2 ——► **Q121**	
Q120	Number of visits of Mobile Health Clinic in the last three months:	**IF NO PUT '0'**	
Q121	Number of health or family welfare camps in the last six months in and around the village:	NUMBER OF CAMPS **IF NO PUT '00'**	

Q122	Facilities available in the village:
	
	                      YES NO
	 A. Post / Telegraph office ……… 1 2
	 B. STD Booth……………… 1 2
	 C. Pharmacy/medical shop ……… 1 2
	 D. Bank………………… 1 2
	 E. Adult Education Center ……… 1 2
	 F. Youth Club ………………… 1 2
	 G. Mahila Mandal …………… 1 2
	 H. Self Help Groups ………… 1 2
	 I. Paan Shop…………… 1 2
	 J. Haat/Market………… 1 2
	 K. Kirana/ general provision shop… 1 2
	 L. Credit Cooperative Society …… 1 2
	 M. Agricultural Cooperative Society 1 2
	 N. Milk Cooperative Society …… 1 2
	 O. Fishermen's Cooperative Society 1 2
	 P. Computer Kiosk/ e-chaupal / …… 1 2
	 Q. Mills / Small Scale Industries …… 1 2
	 U. Community Television Set …… 1 2
	 R. Other_____ 1 2
	        (SPECIFY)
		Facilities: If not in a village, distance to nearest facility available
		
		 Post / Telegraph office …… (KM)
		
		 STD Booth……… (KM)
		
		 Pharmacy/medical shop… (KM)
		
		 Bank……………… (KM)	

Q123	Is there any Health & Sanitation Committee in your village?	YES……………………….1 NO...…………………… 2 ——► **Q126**	

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Q No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q124	**Role of Village Health and Sanitation committee**:	YES NO	
	Awareness about essential health programmesõ	1 2	
	Develop village health planõ õ õ õ õ õ õ õ ..	1 2	
	Village level nutritional awareness activitiesõ õ õ õ	1 2	
	Estimation of annual expenditure incurred for management of diseasesõ õ õ õ õ õ	1 2	
	Maintenance of village health register and health information board/calendarõ õ õ õ õ õ õ õ ..	1 2	
	Oversees the work of health and nutrition functionaries õ õ õ õ õ õ õ õ õ õ õ õ õ	1 2	
	Take into consideration of the problems of the community and suggest mechanisms to solve itõ õ ..	1 2	
	Discuss every maternal death or neonatal death that occurs in the villageõ õ õ õ õ õ õ õ õ õ õ	1 2	
	Suggest necessary action to prevent such deathõ	1 2	
	Get death registered at panchayatõ õ õ õ õ õ	1 2	
	Managing the village health fund	1 2	
Q125	During the last six months how many times cleaning, fogging drive was undertaken in the village?	CLEANING FOGGING	
Q126	Are you aware that Government provides ‰untied fund+of Rs.10, 000/- for improvement of health and sanitation facilities in the village?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ õ 1 NO...õ õ õ õ õ õ õ õ õ õ õ õ õ ..2	→ **Q128**
Q127	For what purpose ‰untied fund+was utilized in the last one year?	HIRING TRANSPORT FACILITYõ õ õ 1 CAMP ARRANGEMENTõ õ õ õ õ ..2 OTHER_____3 (SPECIFY)	
Q128	Has Rogi Kalyan Samiti been constituted in the PHC of your area? **(STATE SPECIFIC NAME)**	YESõ õ õ õ õ õ õ õ õ õ õ õ õ 1 NO...õ õ õ õ õ õ õ õ õ õ õ õ õ ..2 Donʼt knowõ õ õ õ õ õ õ õ õ .õ 99	
Q129	Have you seen any improvement in the health facilities i.e. Sub Center/ PHCs / CHCs in your area in the last one year?	VERY GOODõ õ õ õ õ õ õ õ õ ..1 GOODõ õ õ õ õ õ õ õ õ õ õ õ ..2 NO CHANGEõ õ õ õ õ õ õ õ õ ..3	
Q130	Whether PHCs located in your area provides health care services/treatment all the days round the clock?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ ..1 NO...õ õ õ õ õ õ õ õ õ õ õ õ õ .2	
Q131	Whether head of panchayat lives in the village?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ ..1 NOõ õ õ õ õ õ õ õ õ õ õ õ õ ...2	

Q No.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
Q132	Whether *gram sabha* met last year?	YES…………………..1 NO…………… 2 ⟶	**Q135**
Q133	If yes, number of meetings conducted last year?	NUMBER OF MEETINGS… ☐☐	
Q134	Whether any health related decisions taken in the *gram sabha* meetings?	YES……………….…1 NO……………….…2	

Q135

A. Have these programme implemented the village?

B. Are there any beneficiaries in the village from the following programme?

		A. PROGRAMMES IMPLEMENTED		B. BENEFICIARIES IN LAST 1 YEAR	
		YES	NO	YES	NO
A. Janani Suraksha Yojana	JSY…………… ..	1	2	1	2
B. Kishori Shakti Yojana	KSY………	1	2	1	2
C. Balika Samriddhi Yojana	BSY………	1	2	1	2
D. Mid-day Meal Programme	MMP…………….	1	2	1	2
E. Intergrated Child Development Scheme (ICDS)	ICDS…………….	1	2	1	2
F. Mahila Mandal Protsahan Yojana (MMPY)	MMPY……… .	1	2	1	2
G. National Food for work Programme (NFFWP)	NFFWP………	1	2	1	2
H. National Social Assistance Programme	NSAP…………	1	2	1	2
I. Sanitation Programme (SP)	SP……………… ..	1	2	1	2
J. Rajiv Gandhi National Drinking Water Mission	RGNDWM……… ..	1	2	1	2
K. Swarnjayanti Gram Swarozgar Yojana	SGSY……… .	1	2	1	2
M. Minimum Needs Programme (MNP)	MNP………… ..	1	2	1	2
N. National Rural Employment Programme	NREP………	1	2	1	2
O. Employee Guarantee Scheme (EGS)	EGS……… .	1	2	1	2
P. Prime Minister Rojgar Yojana (PMRY)	PMRY……… .	1	2	1	2
Q. Jawahar Rozgar Yojana (JRY)	JRY……… .	1	2	1	2
R. Indira Awas Yaojna (IAY)	IAY……… ..	1	2	1	2
S. Samagra Awas Yojana (SAY)	SAY………	1	2	1	2
T. Sanjay Gandhi Niradhar Yojana (SGNY)	SGNY……… .	1	2	1	2
U. Jawahar Gram Samridhi Yojana (JGSY)	JGSY……… ..	1	2	1	2
V. Other	OTHER………	1	2	1	2

_____
(SPECIFY)

Q No.	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP TO
			YES	NO	
Q136	Any epidemic/disease reported in the village during the last one year:	MALARIA…………….………………	1	2	
		CHOLERA……………………………	1	2	
		KALA-AZAR (BLACK FEVER)……… ..	1	2	
		DENGUE………………….….	1	2	
		CHICKEN POX/ CHIKUN GUINEA	1	2	
		PLAGUE………………………… ..	1	2	
		OTHER COMMUNICABLE DISEASES _____ (SPECIFY)	1	2	
			YES	NO	
Q137	Any natural calamity in the village during the last one year:	EARTHQUAKES…………………….	1	2	
		FLOODS……………………………	1	2	
		CYCLONE…………………………. ..	1	2	
		DROUGHT…………………………	1	2	
		LANDSLIDES……………………. ..	1	2	
		AVALANCHE………………………	1	2	
		OTHER _____ (SPECIFY)	1	2	

9

IDENTIFICATION

A. STATE _____

DISTRICT _____

TEHSIL/TALUK/COMMUNITY DEVELOPMENT BLOCK/MANDAL _____

SUB HEALTH- CENTRE _____

PRIMARY HEALTH CENTRE_____ _____

NUMBER OF VILLAGES CATERED BY THE SUB HEALTH - CENTRE _____

POPULATION COVERED BY THE SUB HEALTH-CENTRE (LATEST YEAR)_____ _____

DISTANCE (IN KM) BETWEEN PHC AND SUB HEALTH-CENTRE _____ _____

DISTANCE (IN KM) BETWEEN CHC AND SUB HEALTH-CENTRE _____ _____

TIME TAKEN TO REACH THE FARTHEST VILLAGE (IN MINUTES)_____ _____

WHETHER SUB HEALTH CENTRE IS LEVEL -1 MCH CENTRE: YES-1 NO-2

GPS information:

Number of Satellite signals received	Accuracy (signal in feet)	Longitude North - N South -S	Longitude East - E West -W	Way point circle one 1 = in front of household 2 = nearby landmark
No. = (Signals must be 3 or more)		Degree Minutes	Degree Minutes	

INTERVIEW DATE	DATE	MONTH	YEAR

B. DESIGNATION OF THE RESPONDENT

ANM /FEMALE HEALTH WORKER õ ..1
MALE HEALTH WORKER õ .2
OTHER_____3
**(SPECIFY*)*

PSU CODE (CATERED BY SUB HEALTH -CENTRE) õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ

(TO BE ENTERED AT OFFICE)

C1. SERIAL NUMBER OF SUB HEALTH - CENTRE QUESTIONNAIRE õ õ õ õ õ õ õ õ õ õ ....õ õ

C2. SERIAL NUMBER OF PHC QUESTIONNAIRE õ .

C3. SERIAL NUMBER OF CHC QUESTIONNAIRE õ

C4. SERIAL NUMBER OF DH QUESTIONNAIRE õ ..

D. NUMBER OF VISITS MADE TO HEALTH FACILITY

	E1. SPOT CHECKED BY	**E2.** FIELD EDITED BY	**E3.** OFFICE EDITED BY	**E4.** KEYED BY
NAME	_____	_____	_____	_____
DATE	_____	CODE	CODE	CODE

_____ NAME OF THE INVESTIGATOR	CODE INVESTIGATOR	_____ SIGNATURE OF THE INVESTIGATOR

I. AVAILABILITY OF HUMAN RESOURCES

Q. NO.	PERSONNEL	IN POSITION	IF NO, SINCE HOW LONG (SPECIFY DURATION IN MONTHS IF MORE THAN 99 MONTHS CODE 99)
1.1	ANM/ Female Health Worker	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	☐☐
1.2	Male Health Worker	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	☐☐
1.3	Additional ANM (Contractual)	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	
1.4	Any other _____ _____ _____ **(SPECIFY)**	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	

II. TRAINING RECEIVED DURING LAST FIVE YEARS/EVER (IF TRAINING NOT RECEIVED IN THE LAST FIVE YEARS ASK EVER RECEIVED THE TRAINING)

Q. NO.	TYPE OF TRAINING	CHECK Q 1.1 ANM/ FEMALE HEALTH WORKER		CHECK Q 1.2 MALE HEALTH WORKER	
		LAST 5 YEAR	EVER	LAST 5 YEAR	EVER
2.1	RTI/STI Training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.2	NSSK Training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.3	HBNC Training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.4	ASHA Training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.5	MDR (Maternal Death Review) Orientation	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.6	Vector Borne Disease Control Programme (VBDCP) training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.7	Directly Observed Treatment Short course (DOTS) training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.8	Immunization training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.9	Intra Uterine Device (IUD) Insertion training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2		
2.10	Integrated Management of Neonatal and Childhood Illnesses (IMNCI) training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.11	Skilled Birth Attendant training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
2.12	Any other training	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2	YESõ õ õ ..1 NOõ õ õ õ 2
		_____ _____ **(SPECIFY)**		_____ _____ **(SPECIFY)**	

IIIA.   DETAILS OF ALL VILLAGES COVERED BY THE SUB HEALTH-CENTRE

Q. No	VILLAGES UNDER SUB HEALTH-CENTRE								
	NAME OF THE VILLAGE (START FROM SUB HEALTH - CENTRE VILLAGE & CIRCLE THE PSU VILLAGE)	PSU NO.	CONNECTIVITY TO SUB- CENTRE						
3.1			DISTANCE FROM SUB-HEALTH CENTRE In.km	CONNECTED WITH PUCCA ROAD		BUS/PVT. VEHICLE AVAILABLE		ACCESSIBLE THROUGHOUT THEYEAR	
				YES	NO	YES	NO	YES	NO
1									
2				1	2	1	2	1	2
3				1	2	1	2	1	2
4				1	2	1	2	1	2
5				1	2	1	2	1	2
6				1	2	1	2	1	2
7				1	2	1	2	1	2
8				1	2	1	2	1	2
IF THERE ARE MORE THAN 8 VILLAGES COVERED BY SUB HEALTH- CENTRE ATTACH ONE MORE SHEET									

IIIB.   PHYSICAL INFRASTRUCTURE

Q.NO.	A. BUILDING	
3.2	Is a designated government building available for the Sub Health -Centre?	YESõ õ õ õ õ õ õ . 1 ⟶ **Skip to Q3.4** NOõ õ õ õ õ õ ..õ 2
3.3	If no, Where is Sub Health-Centre located?	RENTED BUILDING.....................................õ . 1 **RENT FREE/PANCHAYAT/VOLUNTARY** SOCIETY BUILDING.....................................õ .. 2 SCHOOL BUILDINGõ õ õ õ õ õ õ õ õ õ õ ..õ õ . 3 ANM HOUSE ....õ .. 4 OTHERS_____ 5 **(SPECIFY)**
3.4	Since when this Sub Health-Centre is functioning from this building?	YEARõ õ õ õ õ õ õ ☐☐☐☐
3.5	What is the type of Sub Health- Centre building? **(RECORD BY OBSERVATION)**	PUCCA õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ 1 SEMI-PUCCA õ õ õ õ õ õ õ õ õ õ õ õ õ . 2 KACHHAõ õ õ õ õ õ õ õ õ õ õ õ õ õ .. 3
3.6	What is the present condition of the existing building? **(RECORD BY OBSERVATION)**	GOODõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ . 1 SATISFACTORY ....õ 2 NEEDS REPAIR 3
3.7 (a)	Whether the cleanliness of Sub Health Centre/premises is Good / Fair / Poor? **(RECORD BY OBSERVATION)**	**I. IN SUB HEALTH-CENTRE BUILDING II. PREMISES** GOODõ õ õ õ .... 1 GOODõ ..õ õ 1 FAIRõ õ õ õ õ . 2 FAIRõ õ õ .õ 2 POOR.õ õ õ ..õ . 3 POOR.õ õ õ . 3
3.7 (b)	Is there a compound wall present around the facility? (**RECORD BY OBSERVATION)**	YES...1 NO 2

Q. No.	B. WATER SUPPLY	
3.8	What is the main source of water supply?	PIPED .... 1 BORE WELL/ TUBE WELL ....2 HANDPUMP .... 3 WELL .... 4 NO WATER SUPPLY... 5 OTHER (SPECIFY) _____6
Q. No.	**C. ELECTRICITY**	
3.9(a)	Is power supply available?	REGULAR POWER SUPPLY ....1 OCCASIONAL POWER SUPPLY....................................2 POWER CUT IN SUMMER ONLY..............................3 REGULAR POWER CUT ....4 NO ELECTRICITY CONNECTION 5
3.9(b)	Is there an inverter installed in this facility?	YES..1 NO 2
3.9(c)	Are there adequate funds available for maintaining the inverter?	YES..1 NO 2
Q. No.	**D. TOILET FACILITY**	
3.10	Is at least one functional toilet facility available?	YES..1 NO 2
	E. COMMUNICATION FACILITY	
3.11	Does Sub Health -Centre has Government provided Telephone /Mobile phone facility? **(IF YES, NOTE DOWN CONTACT NUMBER)**	YES..1 NO...2 PH. NO.– ☐☐☐☐☐☐☐☐☐☐☐
Q. No.	**F. QUARTERS**	

	CHECK Q 3.3 ALL OTHERS ☐	ANM HOUSE ☐ → **GO TO Q 3.17**

3.12	Is ANM quarter attached to the Sub Health-Centre?	YES– – – – – – – ....1 NO– – – – – – –.– 2 ————→ **Skip to Q3.15**
3.13	Is the ANM residing in the quarter?	YES– – – – – .– – – – 1 ————→ **Skip to Q3.17** NO– – – – – – – – ..2
3.14	Why ANM is not staying in Sub Health-Centre quarter? **(RECORD ALL MENTIONED)**	Yes No A) POOR CONDITION OF SUB HEALTH-CENTRE QUARTER 1 2 B) NO WATER FACILITY– – – – – – .– – – 1 2 C) NO ELECTRICITY FACILITY– – ..– – ..– . 1 2 D) LOCATION OF SUB HEALTH -CENTRE QUARTER IS OUTSIDE VILLAGE– – – – – – – – – ..– 1 2 E) HUSBAND STAYING IN ANOTHER PLACE 1 2 F) EDUCATION OF CHILDREN..– – – .– – .. 1 2 G) SECURITY– – – .– – – – – – .– – ..– 1 2 H) ANY OTHER_____ _____ 1 2 **(SPECIFY)**
3.15	Where ANM is staying?	WITHIN THE SUB HEALTH-CENTRE VILLAGE– – – – – – 1 OUT SIDE SUB HEALTH -CENTRE VILLAGE.– ..– – – – ..2
3.16	How far is the ANM¢s residence from Sub-Health Centre? **(RECORD IN KMS.)**	☐☐ IN KM.

Q. No.	G. LABOUR ROOM	
3.17	Whether the Sub Health-Centre is having labour room?	YES.................1 NO.................2 ——→ **Skip to 3.20**
3.18	Are deliveries being conducted in the labour room?	YES...1 NO 2
3.19	*Are the following services available, if facility a Level I MCH Centre as answered in section An on Identification?* *Physically verify and record*	
	(a). Labor table with McIntosh sheet	Yes, with McIntosh sheet........ 1 Yes, without McIntosh sheet..... 2 Not Available.......... 3
	(b). Suction machine	Yes, functional......... 1 Yes, but not functional....... 2 No............. 3
	(c). Autoclave/sterilizer	Yes, functional......... 1 Yes, but not functional....... 2 No............. 3
	(d).24 hr running water supply (may be from an overhead tank)	Yes, functional......... 1 Yes, but not functional....... 2 No............. 3
	(e). Attached toilet in the labor room	Yes, functional......... 1 Yes, but not functional....... 2 No............. 3
	(f). Condition of the toilet	GOOD.............. 1 FAIR.............. 2 POOR.............. 3
H	INVERTER	
	(a) Whether the inverter supply is connected to the Labour room.	YES............... 1 NO............... 2
	(b) If, yes, whether the inverter backup is assured at all times.	YES, AT ALL TIMES........ 1 YES, BUT NOT AT ALL TIMES.... 2 NOT AT ALL............. 3
J.	**Whether the following emergency drugs are available (emergency drug tray)? (Yes/No)**	
	(a).Oxytocin injection	YES............ 1 NO............ 2
	(b).Diazepam Injection	YES............ 1 NO............ 2
	(c).Magnesium Sulphate Injection	YES............ 1 NO............ 2
	(d).Lignocaine Hydrochloride Injection	YES............ 1 NO............ 2
	(e).Nifedipine Tablet	YES............ 1 NO............ 2

	(f).Tablet Misoprostol	YES .... 1 NO 2
	(g).Sterilized cotton and gauze	YES .... 1 NO 2
	(h).At least 2 pairs of gloves	YES .... 1 NO 2
	(i).Sterile I/V sets (at least 2)	YES .... 1 NO 2
	(J).Sterile syringes and needles (different sizes)	YES .... 1 NO 2
	(k).Oxygen cylinder with face mask, wrench & regulator	Yes, functional .... 1 Yes, but not functional ..... 2 No 3
K	**Observe and record the condition of the Labor Room** (Record Satisfactory-1, Unsatisfactory-2)	
	(a). Privacy in the labor room	Satisfactory .... 1 Unsatisfactory 2
	(b). Condition of the flooring in the Labor Room	Satisfactory .... 1 Unsatisfactory 2
	(c). Condition of walls in the Labor Room	Satisfactory .... 1 Unsatisfactory 2
	(d). Condition of ceiling in the Labor Room	Satisfactory .... 1 Unsatisfactory 2
	(e). Condition of lighting in the Labor Room	Satisfactory .... 1 Unsatisfactory 2
	(f). Overall condition of the Labor Room	Satisfactory .... 1 Unsatisfactory 2
L	**Ask and record (Yes-1 /No-2)**	
	(a).Normal delivery kits available in the facility?	YES .... 1 NO 2
	(b). Surgical set for Episiotomy and minor procedures available	YES .... 1 NO 2
M	**Whether the following items available in the labor room (Observe & Record)**	
	(a).Gloves	Yes, used one time .... 1 Yes, washed & used again ...... 2 NO 3
	(b).Sterilized cotton gauze	YES .... 1 NO 2
	(c).Sterile syringes and needles	YES .... 1 NO 2
	(d).Sterile drip sets	YES .... 1 NO 2
	(e).IV infusions like Dextrose 5%	YES .... 1 NO 2
	(f).Partographs being recorded for the recently delivered women or women in Labor at the facility	YES .... 1 NO 2
Q. No.	**L. WASTE DISPOSAL**	
3.20	Are colour coded waste bags available for segregated waste?	Yes .... 1 No 2

3.21	What is the mode of disposal of infectious/biological waste? **(RECORD ALL MENTIONED)**		YES	NO
		BURY IN A PIT……………..	1	2
		THROWN IN COMMON/PUBLIC DISPOSAL PIT……….	1	2
		THROWN OUTSIDE HOSPITAL COMPOUND………….	1	2
		THROWN INSIDE HOSPITAL COMPOUND…………….	1	2
		USE INCINERATOR…….	1	2
		OUT SOURCED………..	1	2
		OTHER…………………….	1	2

3.22	What is the mode of disposal of non-infectious waste? **(RECORD ALL MENTIONED)**		YES	NO
		BURY IN A PIT………..	1	2
		THROWN IN COMMON/PUBLIC DISPOSAL PIT….	1	2
		THROWN OUTSIDE HOSPITAL COMPOUND…	1	2
		THROWN INSIDE HOSPITAL COMPOUND…………..	1	2
		USE INCINERATOR…….	1	2
		OUT SOURCED………..	1	2
		OTHER……………….	1	2

3.23	**OBSERVE AND RECORD** Are any discarded/used sharps visible in the facility?	Yes ....1 No.......................................2

IV. AVAILABILITY OF SELECTED FURNITURE (RECORD FROM REGISTER AND ASK ABOUT FUNTIONALITY IF AVAILABLE)

Q. NO.	FURNITURE	AVAILABLE	FUNCTIONAL
4.1.	Examination Table	YES…………….... 1 NO……………... 2	YES…………….... 1 NO……………... 2
4.2.	Labour Table	YES…………….... 1 NO……………... 2	YES…………….... 1 NO……………... 2
4.3.	Foot Step	YES…………….... 1 NO……………... 2	YES…………….... 1 NO……………... 2
4.4.	Cupboard with lock and key	YES…………….... 1 NO……………... 2	YES…………….... 1 NO……………... 2
4.5.	Bedside Screen	YES…………….... 1 NO……………... 2	YES…………….... 1 NO……………... 2

V. AVAILABILITY OF EQUIPMENT (RECORD FROM REGISTER AND ASK ABOUT FUNCTIONALITY IF AVAILABLE)

Q. NO.	EQUIPMENTS	AVAILABLE	FUNCTIONAL
5.1.	Autoclave	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.2.	Auto Disposable (AD) Syringes	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.3.	Hub Cutter **(OBSERVE)**	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.4.	B.P. Instrument	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.5.	Stethoscope	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.6.	Weighing machine (adult)	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.7.	Weighing machine (infant)	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.8	Haemoglobinometer (Sahlis)	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.9	Foetoscope	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.10	SIMS Speculum	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.11	IUD Insertion Kit	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
5.12	Vaccine Carrier	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2

VI. AVAILABILITY OF ESSENTIAL DRUGS/ITEMS IN THE SUB HEALTH-CENTRE (RECORD FROM STOCK REGISTER)

Q. NO.	A.NAME OF THE ITEM/DRUG		
	ITEM/DRUG	AVAILABLE (ON THE DAY OF SURVEY)	OUT OF STOCK FOR MORE THAN 10 DAYS DURING LAST ONE MONTH
6.1.	Drug Kit -A	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
6.2.	Drug Kit -B	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
6.3.	IFA Tablets	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
6.4.	Vitamin A Solution	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
6.5.	Low Osmolarity ORS packets (and Zinc)	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
Q. NO.	B. ADDITIONAL DRUGS FOR INTRA NATAL CARE		
	DRUGS	AVAILABLE (ON THE DAY OF SURVEY)	OUT OF STOCK FOR MORE THAN 10 DAYS DURING LAST ONE MONTH
6.6.	Inj. Gentamycin	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
6.7.	Inj. Magnesium Sulphate	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
6.8.	Cap. Ampicillin	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
6.9.	Tab. Metronidazole	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
6.10.	Tab. Misoprostol	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2

Q. NO.	C. MEDICINES AND OTHER CONSUMABLES REQUIRED FOR CONTROL OF DIFFERENT DISEASES		
	DRUGS	**AVAILABLE** (ON THE DAY OF SURVEY)	OUT OF STOCK FOR MORE THAN 10 DAYS DURING LAST ONE MONTH
6.11.	Tab. or syrup Chloroquine Blister pack for treatment of Plasmodium Falcuparum (P.F.) cases	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.12.	Tab. Primaquine	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.13.	Tab. or syrup Paracetamol	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.14.	Tab. DEC (Di Ethyle Carbamazine)	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.15.	Anti Leprosy medicines (MDT)	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.16.	Anti-Tubercular drugs	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.17.	Diagnostic Kit for Malaria	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.18.	Testing strips for Glucose in Urine	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.19.	Testing strips for proteins in Urine	YES…… 1 NO…… 2	YES…… 1 NO…… 2
Q. NO.	D. CONTRACEPTIVE SUPPLY REQUIRED FOR FAMILY PLANNING		
6.20.	Nirodhs	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.21.	Daily Oral Pills	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.22.	Weekly Oral Pills	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.23.	Copper . T	YES…… 1 NO…… 2	YES…… 1 NO…… 2
6.24.	Emergency Contraceptive Pills	YES…… 1 NO…… 2	YES…… 1 NO…… 2

VII. SERVICES PROVIDED (DURING LAST ONE MONTH**) RECORD FROM REGISTER**

Q. NO	A. SERVICES PROVIDED	NUMBER OF CASES/TEST
7.1.	Number of pregnant women registered for ANC	
7.2.	Number of women registered in first trimester (Average per month) based :Last three month)	
7.3.	Number of Urine tests for pregnancy	
7.4.	Number of Pregnant women referred Reasons for referral a. Unavailability of SBA Trained Staff b. Unavailability of Blood Transfusion c. Others _____ (specify)_____ _____	
7.5.	Number of Hemoglobin estimation tests	

Q. NO.			
7.6.	Number of Urine test for presence of Protein and Sugar	**I. PROTEIN** ☐☐☐	**II. SUGAR** ☐☐☐
7.7.	A. Number of deliveries conducted at home	AT HOME… … … … . ☐☐	
	B. Number of deliveries conducted at Sub Health-Centre	AT SUB HEALTH-CENTRE..… … . ☐☐	
7.8.	Number of post-natal care contacts made	☐☐	
7.9.	Number of newborn care provided	☐☐	
7.10.	Number of children treated for Diarrhoea	☐☐	
	Number of Immunization sessions planned and conducted	PLANNED… … … … .. ☐☐	
		CONDUCTED… … … ☐☐	
7.11.	Total number of infants and children immunized	☐☐☐	
Q. NO.	**B. FAMILY PLANNING AND CONTRACEPTION/ OTHERS SERVICES**		
7.12.	Number of Oral Pills users	☐☐	
7.13.	Number of Condom users	☐☐	
7.14.	Number of women given EC Pills	☐☐	
7.15.	Number of IUD insertion cases	☐☐	
7.16.	Number of Sterilization cases accompanied	☐☐	
7.17.	Number of school health checkups organized	☐☐	
7.18.	Number of eligible couples	☐☐☐☐	
7.19.	Number of beneficiaries of Janani Suraksha Yojana registered	☐☐	
7.20.	Number of cases treated of minor ailments/first aid	☐☐	
7.21.	Number of TB cases referred	☐☐	
7.22.	No. of peripheral blood smear prepared for the detection of malarial parasite in case of fever **(IF FACILITY NOT AVAILBLE ENTER CODE '99')**	☐☐	

Q. NO.	C. MONITORING AND SUPERVISION ACTIVITIES	
8.1	Have you prepared the Sub Health-Centre plan for this year?	YES............. 1 NO.............. 2
8.2	When was the last Sub Health-Centre plan prepared?	MONTH... ☐☐ YEAR... ☐☐☐☐
8.3	Do you have the following materials in enough quantity?	YES NO A) REGISTERS .... 1 2 B) REPORTS .... 1 2 C) IMMUNIZATION CARD ... 1 2 D) ANC CARD .... 1 2 E) HB Testing Strips..... 1 2 F) ANY OTHER _____ 1 2 (SPECIFY)
8.4	Do you submit the reports in time?	YES............ 1 ⟶ **Skip to Q.8.6** NO............. 2
8.5	What are the main reasons for not submitting reports in time?	_____ _____
8.6.	Were you provided with any written feedback from the PHC?	YES............. 1 NO.............. 2
8.7.	During the last month has Medical Officer visited the Sub Health-Centre?	YES............. 1 NO.............. 2
8.8.	During the last month has LHV/Male health Assistant visited the Sub Health- Centre?	YES............ 1 NO............. 2
8.9.	Is Citizen's Charter displayed at Sub Health -Centre?	YES........... 1 NO............ 2
8.10	Do all the villages in your Sub Health-Centre area have Village Health and Sanitation Committee (VHSC) established?	YES; ALL..... 1 YES; SOME.. 2 NOT YET.... 3 ⟶ **Skip to Q.8.13**
8.11	Has the VHSC facilitated in carrying out your activities?	YES........... 1 NO............ 2
8.12	Does VHSC monitor your work regularly?	YES........... 1 NO............ 2
8.13	Do you observe any Village Health day?	YES........... 1 NO............ 2
8.14	How many Village Health Days or Nutrition days have been observed in the past six months?	☐☐☐☐
8.15	Number of ASHA's identified in your Sub Health-Centre villages and received Ist round of training?	**IF NONE............00** ☐☐
8.16	Have you received the untied fund for previous financial year?	YES........... 1 NO............ 2 ⟶ **Skip to Q.8.19**
8.17	Have you utilized the untied fund?	FULLY UTILISED.... 1 PARTIALLY UTILISED.. 2 NOT UTILISED.... 3
8.18	Did any woman from the Sub Health-Centre villages die during pregnancy, delivery or during six weeks after delivery since 1 Jan 2006?	YES........... 1 NO............ 2 ⟶ **Skip to Q.8.21**

Q. NO.		**NO.OF DEATHS**	**RECORD AVAILABLE**
8.19	Number of such maternal deaths, Since 1 Jan 2011?	☐☐	YES............ 1 NO............. 2
8.20	Number of Maternal Deaths Reviewed through MDR?	☐☐	YES............ 1 NO............. 2
8.21	Number of newborn deaths Since 1 Jan 2011?	☐☐	YES............ 1 NO............. 2
8.22	Number of infant deaths Since 1 Jan 2011?	☐☐	YES............ 1 NO............. 2

FACILITY SURVEY
DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY- 4
PRIMARY HEALTH CENTRE (PHC)

IDENTIFICATION	
A. STATE _____	⬚⬚
DISTRICT _____	
TEHSIL/TALUK/COMMUNITY DEVELOPMENT BLOCK/MANDAL_____	⬚⬚⬚
PRIMARY HEALTH CENTRE _____	
COMMUNITY HEALTH CENTRE_____	⬚⬚
LOCATION OF PHC: _____RURAL…1 URBAN………2	⬚
NUMBER OF SUB CENTERS CATERED BY THE PHC _____	⬚⬚
POPULATION COVERED BY THE PHC **(LATEST) YEAR**_____	⬚⬚⬚⬚⬚⬚
WHETHER PHC RUN BY NGO:_____ YESõ 1 NOõ 2	⬚
DISTANCE **(IN KM)** BETWEEN CHC AND PHC_____	⬚⬚⬚
NEAREST REFERRAL CENTER : DHõ 1 CHCõ 2 FRU...3	⬚

INTERVIEW DATE	DATE	MONTH	YEAR
	⬚⬚	⬚⬚	⬚⬚⬚⬚

GPS information:

Number of Satellite signals received	Accuracy (signal in feet)	Latitude North - N South -S	Longitude East - E West -W	Way point circle one 1 = in front of household 2 = nearby landmark
No. = (Signals must be 3 or more) ⬚	⬚	Degree ⬚ Minutes ⬚	Degree ⬚ Minutes ⬚	⬚

B. DESIGNATION OF THE RESPONDENT	
MEDICAL OFFICERõ õ õ õ õ õ õ õ õ õ õ õ 1	⬚
PHARMACISTõ õ õ õ õ õ õ õ õ õ õ õ õ õ 2	⬚
HEALTH ASSISTANT (MALE/FEMALE)õ õ õ õ õ 3	⬚
HEALTH WORKER (MALE/FEMALE)õ õ õ õ õ õ 4	⬚
OTHER_____ 5	⬚
SPECIFY	

(TO BE ENTERED AT OFFICE)	
C1. SERIAL NUMBER OF PHC QUESTIONNAIREõ õ	⬚⬚
C2. SERIAL NUMBER OF CHC QUESTIONNAIREõ õ	⬚⬚
C3. SERIAL NUMBER OF DH QUESTIONNAIREõ õ	

D. NUMBER OF VISITS MADE TO HEALTH FACILITY	⬚

E1. SPOT CHECKED BY	**E2.** FIELD EDITED BY _____	**E3.** OFFICE EDITED BY _____	**E4.** KEYED BY _____
NAME _____ DATE _____	CODE ⬚⬚⬚	CODE ⬚⬚⬚	CODE ⬚⬚⬚
_____ NAME OF THE INVESTIGATOR	CODE ⬚⬚⬚	_____ SIGNATURE OF THE INVESTIGATOR	

1

I. AVAILABILITY OF SERVICES

	ITEM	STATUS CODE	Skip/Remarks
1.1	Is this a functional 24x7 (functional round the clock) health facility?	**YES.........................** 1 **NO.........................** 2	**If 'NO' then Skip to 1.3**
1.2	Since when did this facility start functioning as a 24x7 facility?	**Year** ☐☐☐☐	**If 'NO' then Skip to 1.4**
1.3	Is it planned to be made a 24x7 functional facility by March 2012?	**YES.........................** 1 **NO.........................** 2	
1.4	Whether deliveries are conducted in this facility or not? If, yes, whether the deliveries are conducted 24x7?	**YES, 24 X 7 ....** 1 **YES, Only day Time….** 2 **No.................** 3	**If 'NO' then Skip to 1.7**
1.5	**Can you tell me whether the following services related to delivery are provided in this facility? If yes, ask 24x7 status**		
1.6	Normal Delivery	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.7	Assisted (forceps delivery/Vacuum)	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.8	Administration of parental oxytocics	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.9	Administration of parental antibiotics	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.10	Administration of Magnesium sulphate injection	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.11	Management of post-partum hemorrhages	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.12	Management of other delivery complications	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.13	Whether the following essential newborn care services are available?	YES............ 1 NO............ 2	**If 'NO' then skip to 1.15**
1.14	(a). Resuscitation Multiple coding possible. (b).Thermal protection (warmer/table lamp) Multiple coding possible	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.15	Whether the facility has the following services for the sick children? If, yes, 24x7 or not?		
	(a). Management of diarrhea	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
	(b). Management of ARI/Pneumonia	YES, 24 X 7 .... 1 YES, Only day Time…. 2 No.............. 3	
1.16	Whether antenatal care services provided in this facility?	YES............ 1 NO............ 2	**If 'NO' then skip to 1.19**
1.17	Whether the following services provided to the pregnant women?		
	(a). IFA tables	YES............ 1 NO............ 2	
	(b). Hemoglobin estimation in antenatal clinic	YES............ 1 NO............ 2	
	(c). TT injection	YES............ 1	

2

		NO.......... 2	
1.18	Whether manual vacuum aspiration is done in this facility for early abortion service?	YES............ 1 NO.......... 2	
1.19	Whether RTI/STI treatment and counseling provided in this facility? If, yes, both or only treatment or only counseling?	Yes, both...... 1 Yes, treatment only. 2 Yes, counseling only 3 No........ 4	
	ESSENTIAL LABORATORY SERVICES		
1.20	Whether laboratory services are available in this facility?	YES............ 1 NO.......... 2	**If 'NO' then skip to 1.22**
1.21	Are the laboratory services outsourced?	YES............ 1 NO.......... 2	
	AMBULANCE SERVICE		
1.22	How many ambulances are there in this facility? Of these, how many are functional	Available . ☐☐ Functional . ☐☐	**If '00' Skip to 1.25**
1.21	If ambulance available Do you have adequate funds available for operating the ambulances?	YES............ 1 NO.......... 2	
1.23	If there any mechanism to assure referral transport? If yes, is it available 24x7	YES, 24 X 7 .... 1 YES, Only day Time.. 2 No......... 3 ➝	**If 'NO' then skip to 1.25**
1.24	Whether government ambulances or is it out sourced?	YES............ 1 NO.......... 2	
1.25	Whether the facility has free diagnostic services for pregnant women?	YES............ 1 NO.......... 2	

II. AVAILABILITY OF HUMAN RESOURCES

Q. No.	PERSONNEL	IN POSTION	IF NO, SINCE HOW LONG (SPECIFY DURATION IN MONTHS) RECORD IN ACTUAL MONTHS IF MORE THAN 99 MONTHS CODE 99
2.1	Medical Officer	YES...... 1 NO...... 2	☐☐
2.2	Lady Medical Officer	YES...... 1 NO...... 2	☐☐
2.3	Ayush Medical Officer	YES...... 1 NO...... 2	☐☐
2.4	Medical Officer Contractual	YES...... 1 NO...... 2	☐☐
2.5	Staff Nurse	YES...... 1 NO...... 2	☐☐
2.6	Pharmacist	YES...... 1 NO...... 2	☐☐
2.7	LHV/Health Assistant	YES...... 1 NO...... 2	☐☐
2.8	Male Health Assistant	YES...... 1 NO...... 2	☐☐
2.9	Laboratory Technician	YES...... 1 NO...... 2	☐☐
2.10	ANM/ Female Health Worker	YES...... 1 NO...... 2	☐☐
2.11	Additional Staff Nurse/ANM (Contractual)	YES...... 1 NO...... 2	☐☐
2.12	Class IV Employee	YES...... 1 NO...... 2	☐☐
2.13	Any other_____ **(SPECIFY)**	YES...... 1 NO...... 2	

3

III. TRAINING

Q.NO.	(A) TRAINING ORGANIZED AT PHC			
3.1(a)	Whether any training programme was organized at PHC last year?	YESõ õ õ 1 NOõ õ õ 2		**Skip to Q3.2**
3.1(b)	**If YES,** What were the trainings organized?	TYPE OF TRAININGS A) PULSE POLIO TRAININGõ B) TRAINING OF ASHAõ õ õ C) TRAINING FOR ANM/MALE HEALTH WORKERõ õ õ D).ANY OTHER_____ (SPECIFY)	YES 1 1 1 1	NO 2 2 2 2

B. TRAINING RECEIVED BY ANY MEDICAL OFFICER DURING LAST FIVE YEARS/EVER (IF TRAINING NOT RECEIVED IN THE LAST FIVE YEARS ASK EVER RECEIVED THE TRAINING)			
	TYPE OF TRAINING	LAST 5 YEAR	EVER
3.2	MDR (Maternal Death Review) Orientation	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.3	Vector Born Disease Control Programme (VBDCP) training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.4	Directly Observed Treatment- Short Course (DOTS) training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.5	Immunization training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
	SPECIAL SKILL TRAINING		
3.6	NSV-Non Scalpel Vasectomy training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.6 (a)	F-IMNCI (Facility Based IMNCI) training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.6(b)	NSSK (Navjat Shishu Suraksha Karyakram) Training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.7	MTP-Medical Termination of Pregnancy training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.8	Minilap training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.8 (a)	IUD Insertion Training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.9	Reproductive Tract Infection/Sexually Transmitted Infection(RTI/STI) training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.10	SBA or Basic Emergency Obstetric Care training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.11	EMOC (Emergency Obstetric Care) training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.12	IMNCI- Integrated Management of Neonatal and Childhood Illnesses training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.12 (a)	Adolescent Reproductive Sexual Health (ARSH) Training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.12(b)	HMIS training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.12 (c)	Mother Child Tracking System	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.12(d)	Blood Banking/ Storage	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.13	Any other training _____ (SPECIFY) _____	YES...................1 NO....................2	YES 1 NO 2

III.C. TRAINING FOR PARA MEDICAL STAFF DURING LAST FIVE YEARS/EVER
      (IF TRAINING NOT RECEIVED IN THE LAST FIVE YEARS ASK EVER RECEIVED THE TRAINING)

	TYPE OF TRAINING	NUMBER OF PERSONS TRAINED	
		LAST 5 YEARS	**EVER**
3.14	Reproductive Tract Infection /Sexually Transmitted Infection (RTI/STI) training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.15 (a)	F-IMNCI (Facility Based IMNCI) training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.15 (b)	NSSK (Navjat Shishu Suraksha Karyakram) Training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.16	Integrated Management of Neonatal and Childhood Illnesses (IMNCI) training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.17	Skilled Birth Attendant training	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2
3.18	Any Other_____ **(SPECIFY**)	YESõ õ õ õ . 1 NOõ õ õ õ .. 2	YESõ 1 NOõ õ 2

IV.A.   DETAILS OF ALL SUB-CENTRE VILLAGES COVERED BY THE PHC

Q. No	SUB-CENTRES UNDER PHC							
4.1	**NAME OF THE SUB-CENTRE VILLAGES (CIRCLE THE SC VILLAGE COVERED)**	**DISTANCE TO PHC IN. KM**	CONNECTIVITY OF PHC					
			CONNECTED WITH PUCCA ROAD		**BUS/PVT. VEHICLE AVAILABLE**		**ACCESSIBLE THROUGHOUT THE YEAR**	
			YES	NO	YES	NO	YES	NO
1			1	2	1	2	1	2
2			1	2	1	2	1	2
3			1	2	1	2	1	2
4			1	2	1	2	1	2
5			1	2	1	2	1	2
6			1	2	1	2	1	2
7			1	2	1	2	1	2
8			1	2	1	2	1	2
9			1	2	1	2	1	2
10			1	2	1	2	1	2

IV.B.   PHYSICAL INFRASTRUCTURE

Q. No.	A. BUILDING	
4.2	Is a designated government building available for the PHC?	YESõ õ õ õ õ õ .... 1 ⟶ **Skip to Q4.4** NOõ õ õ õ õ õ ..õ 2
4.3	IF NO, where is PHC located?	RENTED BUILDING .... 1 **RENT FREE/PANCHAYAT/VOLUNTARY** SOCIETY BUILDING................................... 2 OTHERS_____ 3 **(SPECIFY)**
4.4	Since when this PHC is functioning from this building?	YEARõ õ õ õ õ . ☐☐☐☐
4.5	What is the type of PHC building? **(RECORD BY OBSERVATION)**	PUCCA õ õ õ õ õ õ õ õ 1 SEMI-PUCCA õ õ õ õ õ . 2 KACHHAõ õ õ õ õ õ õ 3

5

4.6	What is the present condition of the existing building? **(RECORD BY OBSERVATION)**	GOOD................. 1 SATISFACTORY.......... 2 NEEDS REPAIR....................... 3
	Is there a compound wall present around the facility? (RECORD by OBSERVATION)	ALL AROUND............... 1 PARTIAL.................... 2 NONE...................... 3
4.7	**RATE THE CLEANLINES (RECORD BY OBSERVATION)**	**CLEANLINESS**
i	Premises Cleanliness	GOOD----1 FAIR------2 POOR-----3
ii	Wards Cleanliness	GOOD----1 FAIR------2 POOR-----3
iii	OPD Cleanliness	GOOD----1 FAIR------2 POOR-----3
	B. WATER SUPPLY	
4.8	What is the main source of water supply?	PIPED .... 1 BORE WELL/TUBE WELL .... 2 HANDPUMP .... 3 WELL .... 4 NO WATER SUPPLY...................5 Skip to 4.10 OTHER (SPECIFY) _____6
4.9	Is there water supply for 24 hours in PHC?	YES..1 NO...2
	C. ELECTRICITY	
4.10	Is power supply available?	REGULAR POWER SUPPLY ....1 OCCASIONAL POWER SUPPLY.......2 POWER CUT IN SUMMER ONLY.......3 REGULAR POWER CUT ....4 NO ELECTRICITY CONNECTION.......5
4.11	Is standby facility of generator/inverter available in working condition? **(RECORED BY OBSERVATION)**	YES.....................1 NO........................2
(a)	What is the capacity of the generator?	KW ☐☐
(b)	Whether the generator supply is connected to the Labour room:	YES.............. 1 NO............. 2
(c)	Whether the generator backup is assured at all times in the Labour room	YES, AT ALL TIMES...... 1 YES, BUT NOT AT ALL TIMES. 2 NOT AT ALL.......... 3
(d)	Whether the generator supply is connected to the Ice lined Refrigerator (ILR)?	YES.............. 1 NO............. 2
(e)	Whether the generator backup is assured at all times in the Ice lined Refrigerator (ILR)?	YES, AT ALL TIMES..... 1 YES, BUT NOT AT ALL TIMES. 2 NOT AT ALL.......... 3
(f)	Whether the generator supply is connected to the Wards	YES.............. 1 NO............. 2
(g)	Do you have adequate funds available for operating the generator?	YES.............. 1 NO............. 2
	D.TOILET FACILITIES	
4.12	Is toilet facility available at PHC?	YES...... 1 NO...... 2 ⟶ **Q.4.14**
4.12 (a)	Whether it is in use?	YES.............. 1 NO............. 2
4.13	Is separate toilet facility available for males and females?	COMMON TOILET ...... 1 SEPARATE TOILET 2

	E. COMMUNICATION FACILITIES	
4.14	Is telephone facility available in the PHC? IF YES.NOTE CONTACT NO	YES…………… 1 NO………………… 2 ☐☐☐☐☐☐☐☐☐☐
4.15	Whether Personal Computer available or not?	YES……… 1 NO…… 2 ⟶ Q.4.18
4.16	Is connectivity to NIC terminal available at PHC?	YES…………… 1 NO………………… 2
4.17	Is asses to Internet facility available at PHC?	YES…………… 1 NO………………… 2
4.18	Are you outsourcing for data compilation and tabulation work?	YES…………… 1 NO………………… 2
4.19	Whether PHC has vehicle on road?	YES……… 1 ⟶ Q.4.21 NO…… 2
4.20	Does PHC has access to vehicle for transporting patients during emergencies?	YES…………… 1 NO………………… 2
4.21	Is there any complaint box/suggestion box kept at PHC?	YES…………… 1 NO………………… 2
	F. WASTE DISPOSAL	
4.22	Is biomedical waste segregated and treated before disposal?	YES…………… 1 NO………………… 2
4.23	Whether using different dustbins for biomedical waste?	YES…………… 1 NO………………… 2
(a)	Are colour coded waste bags available for segregated waste?	YES…………… 1 NO………………… 2

(b) What is the mode of disposal of infectious/biological waste? (RECORD ALL MENTIONED)

	YES	NO
BURY IN A PIT…………	1	2
THROWN IN COMMON/PUBLIC DISPOSAL PIT…………	1	2
THROWN OUTSIDE HOSPITAL COMPOUND…………	1	2
THROWN INSIDE HOSPITAL COMPOUND…………	1	2
USE INCINERATOR……… ..	1	2
OUT SOURCED……… ..	1	2
OTHER…………… .	1	2

(c) What is the mode of disposal of non-infectious waste? (RECORD ALL MENTIONED)

	YES	NO
BURY IN A PIT…………	1	2
THROWN IN COMMON/PUBLIC DISPOSAL PIT…………	1	2
THROWN OUTSIDE HOSPITAL COMPOUND…………	1	2
THROWN INSIDE HOSPITAL COMPOUND…………	1	2
USE INCINERATOR……… ..	1	2
OUT SOURCED……… ..	1	2
OTHER…………… .	1	2

(d)	**OBSERVE AND RECORD** Are any discarded/used sharps visible in the facility?	YES…………… 1 NO………………… 2
	SECURITY	
	Is one person available round the clock for security?	YES…………… 1 NO………………… 2

Q. No.	G. QUARTERS			
	A	B	C	D
4.24(a)	RESIDENTIAL QUARTER FOR PHC STAFF	AVAILABLE	WHETHER RESIDING	QUARTER IS AVAILABLE AND NOT RESIDING WHAT ARE THE REASONS:
	Medical Officer	YESõ . 1 NOõ .. 2 Skip to next row	YESõ . 1 Skip to next row NOõ .. 2	YES NO A) POOR CONDITION OF PHC QUARTERSõ õ õ 1 2 B) NO WATER SUPPLY õ 1 2 C) NO ELECTRICITY FACILITY 1 2 D) SPOUSE STAYING IN ANOTHER PLACEõ 1 2 E) LOCATION OF PHC QUARTER IS OUTSIDE VILLAGEõ 1 2 F) EDUCATION OF CHILDRENõ 1 2 G) SECURITYõ õ 1 2 H) ANY OTHER _____ 1 2 (SPECIFY)

Q. No.	QUARTERS			
4.24(b)	Pharmacist	YESõ . 1 NOõ .. 2 Skip to next row	YESõ . 1 Skip to next row NOõ .. 2	YES NO A) POOR CONDITION OF PHC QUARTERSõ õ õ 1 2 B) NO WATER SUPPLY õ 1 2 C) NO ELECTRICITY FACILITY 1 2 D) SPOUSE STAYING IN ANOTHER PLACEõ 1 2 E) LOCATION OF PHC QUARTER IS OUTSIDE VILLAGEõ 1 2 F) EDUCATION OF CHILDRENõ 1 2 G) SECURITYõ õ 1 2 H) ANY OTHER _____ 1 2 (SPECIFY)
4.24(c)	LHV	YESõ . 1 NOõ .. 2 Skip to next row	YESõ . 1 Skip to next row NOõ .. 2	YES NO A) POOR CONDITION OF PHC QUARTERSõ õ õ 1 2 B) NO WATER SUPPLY õ 1 2 C) NO ELECTRICITY FACILITY 1 2 D) SPOUSE STAYING IN ANOTHER PLACEõ 1 2 E) LOCATION OF PHC QUARTER IS OUTSIDE VILLAGEõ 1 2 F) EDUCATION OF CHILDRENõ 1 2 G) SECURITYõ õ 1 2 H) ANY OTHER _____ 1 2 (SPECIFY)

4.24(d)	Staff Nurse	YESõ . 1 NOõ .. 2 Skip to next row	YESõ . 1 Skip to next row NOõ .. 2		YES	NO
				A) POOR CONDITION OF PHC QUARTERSõ õ õ	1	2
				B) NO WATER SUPPLY õ	1	2
				C) NO ELECTRICITY FACILITY	1	2
				D) SPOUSE STAYING IN ANOTHER PLACEõ	1	2
				E) LOCATION OF PHC QUARTER IS OUTSIDE VILLAGEõ	1	2
				F) EDUCATION OF CHILDRENõ	1	2
				G) SECURITYõ õ	1	2
				H) ANY OTHER _____ (SPECIFY)	1	2

Q. No.	**H. LABOUR ROOM AND OPERATION THEATRE**

4.25(a)	Labour Room	YESõ . 1 NOõ .. 2 Skip to next row	YESõ . 1 Skip to next row NOõ .. 2		**YES**	**NO**
				A) NON-AVAILABILITY OF DOCTORS AND STAFFõ .	1	2
				B) LACK OF EQUIPMENTSõ	1	2
				C) POOR PHYSICAL STATE	1	2
				D) NO POWER SUPPLYõ õ	1	2
				E) ANY OTHER_____ **(SPECIFY)**	1	2

4.25(b)	Operation theater	YESõ . 1 NOõ .. 2 Skip to next row	YESõ . 1 Skip to next row NOõ .. 2		**YES**	**NO**
				A) NON-AVAILABILITY OF DOCTORS AND STAFFõ .	1	2
				B) LACK OF EQUIPMENTSõ	1	2
				C) POOR PHYSICAL STATE	1	2
				D) NO POWER SUPPLYõ õ	1	2
				E) ANY OTHER_____ **(SPECIFY)**	1	2

4.25(c)	Whether operation theater has Boyleõs apparatus and enough Anesthetic Medicines?	**i. BOYLES APPARATUS** YESõ õ .. 1 NOõ õ õ 2	**ii. ANESTHETIC MEDICINES** YESõ õ . 1 NOõ õ õ 2

	LABOUR ROOM

4.26	***Are the following services available, if facility a Level I MCH Centre as answered in section A on Identification.*** ***Physically verify and record***	
4.26(a)	Labor table with McIntosh sheet	Yes, with McIntosh sheetõ õ õ õ 1 Yes, without McIntosh sheetõ õ .. 2 Not Availableõ õ õ õ õ õ õ õ . 3
4.26(b)	Suction machine	Yes, functionalõ õ õ õ õ õ õ .. 1 Yes, but not functionalõ õ õ õ . 2 Noõ õ õ õ õ õ õ õ õ õ õ õ ... 3
4.26(c)	Autoclave/sterilizer	Yes, functionalõ õ õ õ õ õ õ .. 1 Yes, but not functionalõ õ õ õ . 2 Noõ õ õ õ õ õ õ õ õ õ õ õ ... 3
4.26(d)	24 hr running water supply (may be from an overhead tank)	YESõ õ õ õ õ õ .õ õ õ 1 NOõ õ õ õ õ õ õ õ õ õ 2

4.26(e)	Attached toilet in the labor room	Yes, functional	1
		Yes, but not functional	2
		No	3
4.26(f)	Condition of the toilet	GOOD	1
		FAIR	2
		POOR	3
4.26(g)	Whether the following emergency drugs are available (emergency drug tray)? (Yes/No)		
	a. Oxytocin injection	YES	1
		NO	2
	b. Diazepam Injection	YES	1
		NO	2
	c. Magnesium Sulphate Injection	YES	1
		NO	2
	d. Lignocaine Hydrochloride Injection	YES	1
		NO	2
	e. Nifedipine Tablet	YES	1
		NO	2
	f. Tablet Misoprostol	YES	1
		NO	2
	g. Sterilized cotton and gauze	YES	1
		NO	2
	h. At least 2 pairs of gloves	YES	1
		NO	2
	i. Sterile I/V sets (at least 2)	YES	1
		NO	2
	j. Sterile syringes and needles (different sizes)	YES	1
		NO	2
	k. Oxygen cylinder with face mask, wrench & regulator	Yes, functional	1
		Yes, but not functional	2
		No	3
4.26(h)	**Observe and record the condition of the Labor Room** (Record Satisfactory-1, Unsatisfactory-2)		
	Privacy in the labor room	Satisfactory	1
		Unsatisfactory	2
	Condition of the flooring in the Labor Room	Satisfactory	1
		Unsatisfactory	2
	Condition of walls in the Labor Room	Satisfactory	1
		Unsatisfactory	2
	Condition of ceiling in the Labor Room	Satisfactory	1
		Unsatisfactory	2
	Condition of lighting in the Labor Room	Satisfactory	1
		Unsatisfactory	2
	Overall condition of the Labor Room	Satisfactory	1
		Unsatisfactory	2
4.26(i)	*Ask and record (Yes-1 /No-2)*		
	Normal delivery kits available in the facility?	YES	1
		NO	2
	Surgical set for Episiotomy and minor procedures available	YES	1
		NO	2

4.26(j)	Whether the following items available in the labour room **(Observe & Record)**		
	a. Gloves	Yes, used one timeõ õ õ .	1
		Yes, washed & used againõ	2
		NOõ õ õ õ õ õ õ õ õ õ õ õ ..	3
	b. **Sterilized** cotton gauze	YESõ õ õ õ õ õ .õ õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ	2
	c. **Sterile** syringes and needles	YESõ õ õ õ õ õ .õ õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ	2
	d. **Sterile** drip sets	YESõ õ õ õ õ õ .õ õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ	2
	e. IV infusions like Dextrose 5%	YESõ õ õ õ õ õ .õ õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ	2
4.26(k)	Partographs being recorded for the recently delivered women or women in Labor at the facility	YESõ õ õ õ õ õ .õ õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ	2

Q. No.	PHYSICAL FACILITIES		
4.27	Total number of sanctioned and available Beds in the facility?	Sanctioned [ ][ ] Available [ ][ ]	
4.28	Whether PHC has separate room for drug storage?	YESõ õ õ õ õ õ 1 ⟶ **Q.4.30**	
		NOõ õ õ õ õ õ 2	
4.29	If NO, where are drugs stored?	_____ (Specify)	
4.30	Is there separate waiting area for the patients in the OPD of PHC?	YESõ õ õ õ õ õ .õ õ õ õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ õ õ õ ...õ	2
4.30(a)	Is there any Waiting area/room for relatives/attendants with the pregnant women coming for delivery?	YESõ õ õ õ õ õ .õ õ õ õ õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ õ õ õ õ ...õ	2
4.30(b)	Are there one or more designated ASHA rest rooms in the facility?	YESõ õ õ õ õ õ .õ õ õ õ õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ õ õ õ õ ...õ	2

IV. AVAILABILITY OF NEWBORN CARE EQUIPMENTS (*Physically verify and record (*Yes, functional-1; Yes, but not functional–2; No -3)

Q.NO.	ITEM	AVAILABILITY	FUNCTIONAL
4.31	Designated newborn baby corner	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.32	Ambu bag with mask	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.33	Radiant warmer	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.34	Any other mechanism available in the facility to keep the baby warm, like 200wt bulb at a height of 18 inches above newborn baby corner.	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.35	Suction catheter/canula	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.36	Pedal suction machine/mucus extractor	YESõ õ õ 1 NOõ õ õ 2	YESõ õ õ 1 NOõ õ õ ..2
4.37	Baby weighing machine of any type	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.38	Designated newborn baby corner	YESõ õ õ 1 NOõ õ õ 2	YESõ õ õ 1 NOõ õ õ ..2
4.39	Separate drug tray	YESõ õ õ 1 NOõ õ õ 2	YESõ õ õ 1 NOõ õ õ ..2

IV(A). AVAILABILITY OF OTHER EQUIPMENT (RECORD FROM REGISTER AND ASK ABOUT FUNCTIONALITY IF AVAILABLE

4.40	Instrument trolley	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.41	Instrument cabinet	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.42	Blood / Saline stand	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.43	Stretcher on trolley	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.44	Stool for patients.	YESõ õ õ 1 NOõ õ õ õ 2	YESõ õ õ 1 NOõ õ õ ..2
4.45	Wheel chair	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.46	Almirah/Cupboard with lock and key	YESõ õ õ 1 NOõ õ õ õ 2	YESõ õ õ 1 NOõ õ õ ..2
4.47	Separate dustbin for biomedical waste	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.48	Autoclave	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.49	Auto Disposable (AD) Syringes	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.50	Hub Cutter **(OBSERVE)**	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.51	B.P. Instrument	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.52	Stethoscope	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.53	Weighing machine (adult)	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.54	Weighing machine (infant)	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.55	Haemoglobinometer (Sahlis)	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.56	Foetoscope	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
4.57	SIMS Speculum	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2

V. AVAILABILITY OF EQUIPMENT (RECORD FROM REGISTER AND ASK ABOUT FUNCTIONALITY IF AVAILABLE)

Q. NO.	A.EQUIPMENT	AVAILABILITY		FUNCTIONAL	
5.1	IUD Insertion Kit	YESõ õ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.2	Minilap Kit	YESõ õ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.3	NSV Kit	YESõ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.4	Laparoscopes	YESõ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ ...õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.5	Normal Delivery Kit	YESõ õ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.6	Equipment for assisted vacuum delivery	YESõ õ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.7	Equipment for assisted forceps delivery	YESõ õ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õõ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.8	Equipment for New Born Care and Neonatal Resuscitation	YESõ õ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.9	Standard Surgical Set (for minor procedures like episiotomies stitching)	YESõ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
5.10	Equipment for Manual Vacuum Aspiration	YESõ õ õ õ õ õ .õ õ õ	1	YESõ õ õ õ õ õ .õ õ õ	1
		NOõ õ õ õ õ õ õ õ õ ....õ	2	NOõ õ õ õ õ õ õ õ õ ....õ	2
	B. COLD CHAIN EQUIPMENT (Response as per old format)				
5.11	Ice Lined Refrigerator (Large)	Yes, functionalõ õ õ õ õ õ õ ..	1	Yes, functionalõ õ õ õ õ õ õ ..	1
		Yes but not functionalõ õ õ õ .	2	Yes but not functionalõ õ õ õ .	2
		Noõ õ õ õ õ õ õ õ õ õ õ ...	3	Noõ õ õ õ õ õ õ õ õ õ õ ...	3
5.12	Ice Lined Refrigerator (Small)	Yes, functionalõ õ õ õ õ õ õ ..	1	Yes, functionalõ õ õ õ õ õ õ ..	1
		Yes but not functionalõ õ õ õ .	2	Yes but not functionalõ õ õ õ .	2
		Noõ õ õ õ õ õ õ õ õ õ õ ...	3	Noõ õ õ õ õ õ õ õ õ õ õ ...	3
5.13	Deep Freezer Large	Yes, functionalõ õ õ õ õ õ õ ..	1	Yes, functionalõ õ õ õ õ õ õ ..	1
		Yes but not functionalõ õ õ õ .	2	Yes but not functionalõ õ õ õ .	2
		Noõ õ õ õ õ õ õ õ õ õ õ ...	3	Noõ õ õ õ õ õ õ õ õ õ õ ...	3
5.14	Deep Freezer Small	Yes, functionalõ õ õ õ õ õ õ ..	1	Yes, functionalõ õ õ õ õ õ õ ..	1
		Yes but not functionalõ õ õ õ .	2	Yes but not functionalõ õ õ õ .	2
		Noõ õ õ õ õ õ õ õ õ õ õ ...	3	Noõ õ õ õ õ õ õ õ õ õ õ ...	3

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5.15	Cold Box	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
5.16	Vaccine Carrier	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
C. REQUIREMENTS OF THE LAB			
5.17	Chemical for Hb estimation	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
5.18	Reagent strips for urine albumin and urine sugar analysis	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
5.19	Rapid Plasma Reagin (RPR) test kits for syphilis	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
5.20	Reagents for peripheral blood smear examination for MP	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
5.21	Residual chlorine in drinking water testing strips	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
5.22	Centrifuge	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
5.23	Light Microscope	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2
5.24	Binocular Microscope	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2	YESõ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2

VI. AVAILABILITY OF ESSENTIAL DRUGS IN THE PHC (RECORD FROM REGISTER)

Q. NO.	ESSENTIAL DRUGS	AVAILABLE ON THE DAY OF SURVEY	OUT OF STOCK FOR MORE THAN TEN DAYS DURING LAST ONE MONTH
6.1	Antiallergics and drugs used in Anaphylaxis	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.2	Anti Hypertensives	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.3	Anti Diabetics	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.4	Anti Anginal	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.5	Anti Tubercular	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.6	Anti Leprosy	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.7	Anti Filarials	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.8	Anti Bacterials	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.9	Anti Helminthic	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.10	Anti Protozoal	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.11	Antidots (Antisnake Venom etc.)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	Anti Rabies	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.12	Low Osmolarity ORS packets (and Zinc)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.13	Essential Obstetric Care drugs.	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(i)	Emergency Contraceptive Pills	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(li)	Normal Saline	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(iii)	Dextrose 5 %	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(iv)	Condoms	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(v)	Oral Contraceptive Pills	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(vi)	MVA Syringes	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(vii)	Tab Misoprostol	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2

Q. No.	Item	Option 1	Option 2
(viii)	IFA tablets	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(ix)	Reagents for cross matching of blood	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
6.14	**RTI/STI DRUGS**		
(i)	**Tab Azithromycin (1 g)**	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(ii)	Doxycycline Hydrochloride Capsules	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(iii)	Benzathine Penicillin Injection	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(iv)	Tab Metronidozale	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(v)	Tab Fluconazale	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(vi)	Tab Cefixime (200mg and 400mg)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(vii)	Tab Secnidazole (500 mg)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(viii)	Tab Erythromycin (500 mg) base/stearate	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(ix)	Tab Acyclovir (400 mg)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(x)	Cap Amoxicillin 500 mg	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(xi)	Clotrimazole Vaginal pessary (500 mg)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(xii)	Podophyllin tincture 20 %	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(xiii)	Permethrin cream (5%) and (1%)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
(xiv)	Gamma Benzene Hexachloride 1 % lotion or cream	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2

VII. ESSENTIAL LABORATORY TEST (DURING LAST ONE MONTH)
   (IF FACILITY FOR TEST IS NOT THERE IN PHC RECORD '999')

Q. NO.	SERVICES	NUMBER OF TEST DONE
7.1.	Blood grouping	
7.2.	Haemogram (TLC/DLC)	
7.3.	Diagnosis of RTIs/STDs with wet mounting, grams stain, etc.	
7.4.	Sputum testing for TB	
7.5.	Blood smear examination for Malaria Parasite	
7.6.	Urine (Routine culture/sensitivity/Microscopy)	
7.7.	Rapid tests for pregnancy	
7.8.	Rapid Plasma Reagin (RPR) test for Syphilis	
7.9.	Others _____ **(Specify)**	

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VIII. SERVICES (DURING LAST ONE MONTH) RECORD FROM REGISTER

Q. NO.	A. ESSENTIAL SERVICES PROVIDED	MALE	FEMALE
8.1.	OPD Patients		
8.2.	In-patient Admissions		
8.3.	Number of cases referred for serious ailments from PHC to Higher centre.		

Q. NO.	B. SERVICES PROVIDED	NUMBER OF CASES
8.4.	Number of cases provided with antenatal care services	
8.5.	Number of Pregnant women registered in 1st trimester	
8.6.	Number of pregnant women referred	
8.7.	Number of Deliveries performed	
8.8.	If deliveries performed, how many were beneficiaries of Janani Suraksha Yojana?	
8.9.	Number of complicated pregnancies/ delivery cases referred?	
8.10.	Number of women provided with postnatal care services	
8.11.	Number of newborn care provided	
8.12.	Number of children treated for Diarrhoea	
8.13.	Number of children treated for Acute Respiratory Tract Infection (ARI)	
8.14.	Number of infants and children immunized	
8.15.	Number of MTPs performed	
8.16.	No. of Manual Vacuum Aspirations done	

Q. No.	C. FAMILY PLANNING AND CONTRACEPTION/OTER SERVICES	
8.17.	No. of oral pills users	
8.18.	No. of condom users	
8.19.	No. of women given EC pills	
8.20.	**No. of IUD insertion conducted**	
8.21.	**Number of Sterilization operations performed**	MALE…………..1 FEMALE………..2
8.22.	Number of RTI/STI cases provided services	
8.23.	Number of school health check-ups organized	
8.24.	Number of eligible couples	

Q. No.	D. AVAILABILITY OF SPECIFIC SERVICES			
8.25.	Is there a fixed immunization day?	YESõ õ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2		
8.26.	How vaccines are distributed to Sub Centers?	**DISTRIBUTION OF VACCINE**	**YES**	**NO**
		A).PHC STAFF DELIVERS VACCINES TO Sub-Centreõ õ õ õ õ õ	1	2
		B).THE SAME IS OUTSOURCED IN THE FORM OF COURIER õ õ õ	1	2
		C).ANMs COLLECT VACCINES FROM THE PHC ON THEIR OWNõ õ õ	1	2
		D). ANY OTHER_____ **(SPECIFY)**	1	2
8.27.	Has any outbreak of Diarrhea, Diphtheria, Measles, jaundice and fever taken place during last three month? **(RECORD ALL MENTIONED)**	**OUTBREAK**	**YES**	**NO**
		A).DIARRHOEAõ õ õ õ õ õ õ	1	2
		B).DIPTHERIAõ õ õ õ õ õ õ	1	2
		C).MEASLESõ õ õ õ õ õ õ	1	2
		D).JAUNDICEõ õ õ õ õ õ õ õ	1	2
		E).FEVERõ õ õ õ õ õ õ õ	1	2
8.28.	Does the PHC collects and reports vital events?	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ 2		
Q. No.	E. MONITORING AND SUPERVISION ACTIVITIES			
8.29.	Have you prepared the PHC Plan for this year?	YESõ õ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2		
8.30.	When was the last PHC Plan prepared?	MONTH YEAR ☐☐ ☐☐☐☐		
8.31.	Do you have enough printed reports and registers?	**A. REGISTERS** **B. REPORTS** YESõ õ õ õ 1 YESõ õ õ ..1 NOõ õ õ õ .2 NOõ õ õ ..2		
8.32.	Do you submit the reports in time?	YESõ õ õ õ õ õ õ 1 ——→ **Q.8.33** NOõ õ õ õ õ õ 2		
8.33.	What are the main reasons for not submitting reports on time?	_____		
8.34.	Were you provided with any written feedback from the CHC or supervisory officers?	YESõ õ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2		
8.35.	During last month has any supervisory officer visited the PHC?	YESõ õ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2		
8.36.	During last month has any supervisory officer from this facility visited the Sub-centre?	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ 2 ——→ **Q.8.38**		
8.37.	How many Sub Centers were covered during the last month?	NUMBER OF SUBCENTERS..õ õ õ õ ☐		
8.38.	Is Citizens Charter displayed at PHC?	YESõ õ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2		
8.39.	Has Rogi Kalyan Semite (RKS) been constituted?	YESõ õ õ õ õ õ õ .õ õ õ .... 1 NOõ õ õ õ õ õ õ õ õ ....õ 2		

8.40.	Has Rogi Kalyan Samitei (RKS) been registered?	YES…………….…….	1
		NO……………………....…	2
8.41.	Does RKS conduct monthly meetings?	YES…………….…….	1
		NO……………………....…	2
8.42.	Has any RKS fund been utilized for patient welfare?	YES…………….…….	1
		NO……………………....…	2
8.43.	Have you received the untied fund for previous financial year?	YES…………….…….	1
		NO……………………....…	2
8.44.	Have you utilized the untied fund?	FULLY UTILISED……………..	1
		PARTIALLY UTILISED…….….	2
		NOT UTILISED………….……..	3

THANKS FOR GIVING YOUR PRECIOUS TIME

17

DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY- 4
COMMUNITY HEALTH CENTRE (CHC)

CONFIDENTIAL
(For research
purpose only)

IDENTIFICATION

A. STATE_____

DISTRICT _____

NAME OF TEHSIL/ TALUK/ BLOCK /MANDAL_____

CHC/RURAL HOSPITAL_____

DISTRICT HOSPITAL_____

LOCATION OF CHC: _____RURALõ õ õ 1   URBANõ õ õ 2

NUMBER OF PHCs CATERED BY THIS CHC _____

SERIAL NO PHCs CATERED BY CHC

POPULATION COVERED BY THE CHC **(LATEST) YEAR**_____

DISTANCE *(IN KM)* BETWEEN DH AND CHC/RH _____

DISTANCE OF CHC FROM THE FARTHEST SC VILLAGE_____

GPS information:

Number of Satellite signals received	Accuracy (signal in feet)	Latitude North -N South -S		Longitude East -E West - W		Way point circle one 1 = in front of household 2 = nearby landmark
No. = (Signals must be 3 or more)		Degree Minutes		Degree Minutes		

INTERVIEW DATE	DATE	MONTH	YEAR

B. DESIGNATION OF THE RESPONDENT

MEDICAL SUPERINTENDENT	õ õ õ õ õ 1
DOCTOR/SPECIALIST /OBCTETRICIAN/GYNAECOLOGIST	õ õ õ õ õ 2
ADMINISTRATIVE PERSONNEL	õ õ õ õ õ 3
ANM/ MALE HEALTH WORKER	õ õ õ õ õ 4
OTHER_____ (SPECIFY)	õ õ õ õ õ 5

(TO BE ENTERED AT OFFICE)
C1. SERIAL NUMBER OF CHC QUESTIONNAIREõ õ õ õ õ
C2. SERIAL NUMBER OF DH QUESTIONNAIREõ õ õ õ õ õ õ

D. NUMBER OF VISITS MADE TO HEALTH FACILITY

	E1.SPOT CHECKED BY	**E2.** FIELD EDITED BY	**E3.**OFFICE EDITED BY	**E4.**KEYED BY
NAME DATE _____ _____		CODE	CODE	CODE

_____
NAME OF THE INVESTIGATOR

CODE OF INVESTIGATOR

_____
SIGNATURE OF THE INVESTIGATOR

I AVAILABILITY OF SERVICES

	Item	STATUS CODE	
1	Is this a functional FRU	YES……………….…… 1 NO……………….…… 2 ⟶	**If 'NO' then Skip to III**
1.2	Since when did this facility start functioning as a 24x7 facility?	**Year** [| | |] ⟶	**If 'NO' then Skip to IV**
1.3	Is it planned to be made a 24x7 functional facility by March 2012?	YES……………….…… 1 NO……………….…… 2	
1.4	Whether deliveries are conducted in this facility or not? If, yes, whether the deliveries are conducted 24x7?	YES, 24 X 7 ……………. 1 YES, Only day Time……. 2 No…………… 3 ⟶	**If 'NO' then Skip to VI**
1.5	**Can you tell me whether the following services related to delivery are provided in this facility? If yes, ask 24x7 status**		
	(a). Normal Delivery	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(b). Assisted (forceps delivery/Vacuum)	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(c). Administration of parental oxytocics	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(d). Administration of parental antibiotics	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(e). Administration of Magnesium sulphate injection	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(f). Management of post-partum hemorrhages	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(g). Management of other delivery complications	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(h). Caesarian section	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
1.6	I there a blood bank available in this facility? If yes, is it functional 24x7	YES, 24 X 7 õ õ õ õ …. 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3 ⟶	**If 'NO' then Skip to 1.8**
1.7	Is there a blood storage facility available in this facility?	YES……………….…… 1 NO……………….…… 2	
1.8	Do you have license for the blood bank/approval for the blood storage centre? If, yes, can you show the license/approval?	YES, License/approval seenõ õ õ …. 1 YES, but not seenõ õ . 2 Not available.õ õ õ ..õ . 3 ⟶	**If 'NO' then Skip to 1.9**
1.9	CHECK A6 7 A7 : if A6 = 3 or A7 =2 What are the reasons for non-availability of blood bank/blood storage facility? Multiple coding possible	No equipment/refrigerator 1 Noreagentsõ õ õ õ …. 2 No licenceõ õ õ õ 3 No power backupõ õ 4 No manpowerõ õ 5 Other (specify_____) 6	
1.10	Whether the following essential newborn care services are available? If, yes, is it available		

	in the labour room and ward?		
	a. Resuscitation Multiple coding possible	YES, in labor room… 1 YES, in Ward… … . 2 Not Available.… … … ..… . 3	
	b. Thermal protection (warmer/table lamp) Multiple coding possible	YES, in labor room… 1 YES, in Ward… … . 2 Not Available.… … … ..… . 3	
1.11	Whether the following safe abortion services are available in this facility?		
	a. Manual Vacuum Aspiration (MVA)	**YES**………………….... **1** **NO**………………….... **2**	
	b. Electric Vacuum Aspiration (EVS)	**YES**………………….... **1** **NO**………………….... **2**	
	c. Dilatation & Curettage (D&C)	**YES**………………….... **1** **NO**………………….... **2**	
	d. Others (specify_____)	**YES**………………….... **1** **NO**………………….... **2**	
1.12	Whether RTI/STI treatment and counseling provided in this facility? If, yes both or only treatment or only counseling?	Yes, both… … … … … .. 1 Yes, treatment only… . 2 Yes, counseling only… 3 No… … … … … … … … 4	
	ESSENTIAL LABORATORY SERVICES		
1.13	Whether laboratory services are available in this facility?	**YES**………………….... 1 **NO**………………….... 2	**If 'NO' then skip to 1.15**
1.14	Are the laboratory services outsourced?	**YES**………………….... **1** **NO**………………….... **2**	
	AMBULANCE SERVICES		
1.15	How many ambulances are there in this facility? change the question as in PHC Of these, how many are functional?	Available… . [ ][ ] Functional… . [ ][ ]	**If '00' Skip to 1.17**
1.16	If ambulance available Do you have adequate funds available for operating the ambulances?	**YES**………………….... **1** **NO**………………….... **2**	
1.17	Is there any mechanism to assure referral transport? If yes, is it available 24x7	YES, 24 X 7 … … … .... 1 YES, Only day Time… … . 2 No.… … … ..… . 3	**If 'NO' then Skip to 1.19**
1.18	Whether government ambulances are used for referral transport or is it outsourced?	**Government**………………….... **1** **Out Sourced**………………….... **2**	
1.19	Whether the facility has free diagnostic services for pregnant women?	**YES**………………….... **1** **NO**………………….... **2**	
1.20	Whether the facility has free referral services?	**YES**………………….... **1** **NO**………………….... **2**	

I. CLINICAL HUMAN RESOURCE (IF NO RECORD O)

Q.NO	PERSONNEL	IN POSITION	ON CONTRACT	IF NOT FILLED, SINCE HOW LONG SPECIFY DURATION IN MONTHS AND IF MORE THAN 99 MONTHS CODE 99)
1.21	General Surgeon	☐	☐	☐ ☐
1.22	Physician	☐	☐	☐ ☐
1.23	Obstetrician /Gynecologist	☐	☐	☐ ☐
1.24	Pediatrician	☐	☐	☐ ☐
1.25	Anesthetist/ trained MO	☐	☐	☐ ☐
1.26	Public Health Programme Manager	☐	☐	☐ ☐
1.27	Eye surgeon	☐	☐	☐ ☐
1.28	General Medical Officer	☐	☐	☐ ☐
1.29	Other specialist _____ _____ (SPECIFY)	☐	☐	

II. SUPPORT HUMAN RESOURCE

Q. NO.	PERSONNEL	IN POSITION	ON CONTRACT	IF NOT FILLED, SINCE HOW LONG (SPECIFY DURATION IN MONTHS AND IF MORE THAN 99 MONTHS CODE 99)
2.1	Public Health Nurse (PHN)	☐	☐	☐ ☐
2.2	Auxiliary Nurse Midwife (ANM)	☐	☐	☐ ☐
2.3	Staff Nurse	☐	☐	☐ ☐
2.4	Nurse/ Midwife	☐	☐	☐ ☐
2.5	Dresser	☐	☐	☐ ☐
2.6	Pharmacist/ Compounder	☐	☐	☐ ☐
2.7	Lab. Technician	☐	☐	☐ ☐
2.8	Radiographer	☐	☐	☐ ☐
2.9	Ophthalmic Assistant	☐	☐	☐ ☐
2.10	OPD Attendant	☐	☐	☐ ☐
2.11	Statistical Assistant/Data Entry Operator	☐	☐	☐ ☐
2.12	OT Attendant	☐	☐	☐ ☐
2.13	Registration Clerk	☐	☐	☐ ☐
2.14	Class IV Employee	☐	☐	☐ ☐
2.15	Any other _____ _____ (SPECIFY)	☐ ☐	☐ ☐	
2.16	Is at least one staff nurse/LHV/ANM at CHC available round the clock?	YESõ õ õ õ õ õ .1	NOõ õ õ õ õ õ ..2	

4

2.17	Are Gynecologist and Anesthetist /Trained Anesthetist available on call in case of emergency?	**A. GYNAECOLOGIST** YES õ õ õ õ õ õ .1 NO õ õ õ õ õ õ ...2	**B. ANAESTHETIST** YES õ õ õ õ õ õ .1 NOõ õ õ õ õ õ õ 2

III.A. TRAINING FOR MEDICAL OFFICER (MO) DURING LAST FIVE YEARS/EVER
(IF TRAINING NOT RECEIVED IN THE LAST FIVE YEARS ASK EVER RECEIVED THE TRAINING)

Q. NO.	TYPE OF TRAINING	NUMBER OF MO TRAINED	
		LAST 5 YEARS	**EVER**
3.1.	**MDR (Maternal Death Review) Orientation**	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.2	Non Scalpel Vasectomy(NSV) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.3	Vector Born Disease Control Programme (VBDCP) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.4	Directly Observed Treatment- Short Course (DOTS) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.5	Immunization training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.6	NSV . Non Scalpel Vasectomy training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.7	Reproductive Tract Infection/Sexually Transmitted Infection(RTI/STI) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.8	Adolescent Reproductive Sexual Health (ARSH) Training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.9	**MDR (Maternal Death Review) Orientation**	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.10	**F-IMNCI (Facility Based IMNCI) training**	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.11	**NSSK (Navjat Shishu Suraksha Karyakram) Training**	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.12	Minilaprotomy training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.13	IUD insertion training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.14	HIV/AIDS Prevention, Care and Support training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.15	Emergency Obstetric Care(including C-Section) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.16	Newborn Care training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.17	SBA or Basic Emergency Obstetric Care training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.18	Integrated Management of Neonatal and Childhood Illnesses training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.19	Medical Termination Of Pregnancy (MTP) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2

Q.NO		LAST 5 YEARS	EVER
3.20	Mother Child tracking system	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.21	HMIS Training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.22	Any Other training_____ (**SPECIFY**)	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2

III.B.TRAINING FOR PARA MEDICAL STAFF DURING LAST FIVE YEARS/EVER
(IF TRAINING NOT RECEIVED IN THE LAST FIVE YEARS ASK EVER RECEIVED THE TRAINING)

Q.NO	TYPE OF TRAINING	NUMBER OF PERSONS TRAINED	
		LAST 5 YEARS	**EVER**
3.23	Reproductive Tract Infection /Sexually Transmitted Infection (RTI/STI) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.24	**F-IMNCI (Facility Based IMNCI) training**	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ...õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.25	**NSSK (Navjat Shishu Suraksha Karyakram) Training**	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.26	Blood grouping and cross matching training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.27	Integrated Management of Neonatal and Childhood Illnesses (IMNCI) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.28	Skilled Birth Attendant training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.29	Electro Cardiogram (ECG) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2

IV. INVESTIGATIVE FACILITY. (RECORD FROM REGISTER AND ASK ABOUT FUNCTIONALITY)

Q.NO.	FACILITY	AVAILABLE	FUNCTIONAL
4.1	ECG facility	YESõ õ õ õ 1 NOõ õ õ 2	YESõ õ õ õ 1 NOõ õ õ 2
4.2	X- Ray facility	YESõ õ õ õ 1 NOõ õ õ 2	YESõ õ õ õ 1 NOõ õ õ 2
4.3	Ultrasound facility	YESõ õ õ õ 1 NOõ õ õ 2	YESõ õ õ õ 1 NOõ õ õ 2

V. PHYSICAL INFRASTRUCTURE

Q. NO.	A. LOCATION	
5.1	Where is the CHC located?	WITHIN THE BLOCK HEAD QUARTERõ õ õ .1 ⟶ **Skip to Q5.3** FAR FROM THE BLOCK HEAD QUARTERõ õ 2
5.2	What is the distance of CHC from Block Head Quarter?	KMsõ õ õ õ . ☐ ☐ ☐
	B. BUILDING	
5.3	Is a designated government building available for the CHC?	YESõ õ 1 ⟶ **Skip to Q5.5** NOõ õ .2
5.4	If NO, then where is the CHC located?	RENTED PREMISESõ õ õ õ õ õ õ 1 OTHER GOVERNMENT BUILDINGõ ..2 ANY OTHER_____6 (SPECIFY)
5.5	Since when this CHC is functioning from this building?	YEARõ ☐ ☐ ☐ ☐
5.6	Compound Wall / Fencing	ALL AROUNDõ õ õ .õ õ õ õ õ õ õ 1 PARTIALõ õ õ õ õ . õ õ õ õ õ õ 2 NONEõ õ õ õ õ õ õ õ õ õ õ õ ...3
5.7	**RATE THE CLEANLINESS (RECORD BY OBSERVATION)**	**CLEANLINESS**
	(a)OPD cleanliness	GOOD õ õ ...1 FAIR õ õ õ 2 POOR õ 3
	(b)Rooms cleanliness	GOOD õ õ ...1 FAIR õ õ õ 2 POOR õ 3
	(c)Wards cleanliness	GOOD õ õ ...1 FAIR õ õ õ 2 POOR õ 3
	(d)Premises (compound) cleanliness	GOOD õ õ ...1 FAIR õ õ õ 2 POOR õ 3
	C. WATER SUPPLY	
5.8	What is the main source of water supply?	PIPEDõ õ õ õ õ õ õ õ õ õ 1 BOREWELL/ TUBEWELLõ õ ...2 HANDPUMPõ õ õ õ õ õ õ ..3 WELLõ õ õ õ õ õ õ õ õ ..4 OTHERõ õ õ õ ..õ õ õ õ .5 NO WATER SUPPLYõ õ õ õ 6 **Skip to Q 5.12**
5.9	Is water supply available for 24 hours at CHC?	YESõ õ õ ..1 NOõ õ õ õ 2 **Skip to Q5.12**
5.10	Is regular water supply in OT?	YESõ õ õ .1 NOõ õ õ õ õ ..2
5.11	Is regular water supply in labor room?	YESõ õ õ .1 NOõ õ õ õ õ ..2

	D. ELECTRICITY	
5.12	Is there power supply in all parts of the CHC?	IN ALL PARTSõ õ 1 IN SOME PARTSõ 2 NONEõ õ õ õ õ õ 3 ⟶ **Skip to Q 5.15**
5.13	Is three phase connection available?	YESõ õ õ õ õ õ .õ õ õ õ 1 NOõ õ õ õ õ õ õ õ õ õ 2
5.14	Is power supply available?	REGULAR POWER SUPPLY õ õ õ õ õ ...1 OCCASIONAL POWER SUPPLYõ õ õ õ õ .2 POWER CUT IN SUMMER ONLYõ õ õ õ õ 3 REGULAR POWER CUT õ õ õ õ õ õ õ õ ..4 NO ELECTRICITY CONNECTIONõ õ õ õ õ 5
5.15	Is standby facility of generator/inverter available in working condition? **(RECORED BY OBSERVATION)**	YESõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .1 NOõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ ...2
	(a).What is the capacity of the generator?	KW [ ][ ]
	(b).Whether the generator supply is connected to the Labour room:	YESõ õ õ õ õ õ õ .õ õ õ õ 1 NOõ õ õ õ õ õ õ õ õ õ 2
	(c).Whether the generator backup is assured at all times in the Labour room	YES, AT ALL TIMESõ õ õ õ õ 1 YES, BUT NOT AT ALL TIMES. 2 NOT AT ALLõ õ õ õ õ õ õ . 3
	(d).Whether the generator supply is connected to the Ice lined Refrigerator (ILR)?	YESõ õ õ õ õ õ .õ õ õ õ 1 NOõ õ õ õ õ õ õ õ õ õ 2
	(e).Whether the generator backup is assured at all times in the Ice lined Refrigerator (ILR)?	YES, AT ALL TIMESõ õ õ õ õ 1 YES, BUT NOT AT ALL TIMES. 2 NOT AT ALLõ õ õ õ õ õ õ . 3
	(f).Whether the generator supply is connected to the Wards	YESõ õ õ õ õ õ .õ õ õ õ 1 NOõ õ õ õ õ õ õ õ õ õ 2
	(g).Do you have adequate funds available for operating the generator?	YESõ õ õ õ õ õ .õ õ õ õ 1 NOõ õ õ õ õ õ õ õ õ õ 2
	E.TOILET FACILITIES	
5.16	Is functional toilet facility available?	YESõ õ õ õ õ õ .1 NOõ õ õ õ õ õ õ 2 ⟶ **Skip to Q5.18**
5.17	Is there separate toilet facility for males and females?	COMMON TOILETõ õ õ õ õ õ õ õ õ õ õ .1 SEPARATE TOILETõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ .2
	F. LAUNDRY FACILITIES	
5.18	Is laundry facility available at CHC?	YESõ õ õ õ .1 ⟶ **Skip to Q5.20** NOõ õ õ õ õ 2
5.19	If no, is it outsourced?	YESõ õ õ .1 NOõ õ õ õ õ ..2
	G. COMMUNICATION FACILITIES	
5.20	Is telephone facility available in the CHC? **(IF 'YES' NOTE DOWN CONTACT NUMBER)**	YESõ 1 NOõ 2 ⟶ **Skip to Q5.22** [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

5.21	Whether CHC has intercom facility?	YES......1 NO......2
5.22	Whether CHC has Personal Computer?	YES...1 NO...2 ⟶ **Skip toQ.5.25A**
5.23	Is NIC Terminal available at CHC?	YES......1 NO......2
5.24	Is access to internet facility available at CHC?	YES......1 NO......2
5.25	If Computer is not there, are you outsourcing for data compilation and tabulation work?	YES......1 NO......2
	F. WASTE DISPOSAL	

5.26	Is biomedical waste segregated and treated before disposal?	YES................... 1 NO................... 2
5.27	Whether using different dustbins for biomedical waste?	YES................... 1 NO................... 2

	(a). Are color coded waste bags available for segregated waste?	YES................... 1 NO................... 2		

	(b).What is the mode of disposal of infectious/biological waste? **(RECORD ALL MENTIONED)**		YES	NO
		BURY IN A PIT......	1	2
		THROWN IN COMMON/PUBLIC DISPOSAL PIT	1	2
		THROWN OUTSIDE HOSPITAL COMPOUND......	1	2
		THROWN INSIDE HOSPITAL COMPOUND......	1	2
		USE INCINERATOR......	1	2
		OUT SOURCED......	1	2
		OTHER......	1	2

	(c).What is the mode of disposal of non-infectious waste? **(RECORD ALL MENTIONED)**		YES	NO
		BURY IN A PIT......... .	1	2
		THROWN IN COMMON/PUBLIC DISPOSAL PIT......... .	1	2
		THROWN OUTSIDE HOSPITAL COMPOUND......... .	1	2
		THROWN INSIDE HOSPITAL COMPOUND.........	1	2
		USE INCINERATOR...... ..	1	2
		OUT SOURCED......... ..	1	2
		OTHER........... .	1	2

	(d).**OBSERVE AND RECORD** Are any discarded/used sharps visible in the facility?	YES................... 1 NO................... 2		
	SECURITY			
5.28	Is one person available round the clock for security?	YES................... 1 NO................... 2		

	H. VEHICLES		
5.29		**NO. OF VEHICLES**	
		AVAILABLE	**ON ROAD**
	1. Ambulance	☐☐	☐☐
	2. Jeep	☐☐	☐☐ **Skip to Q5.28**
	3. Car	☐☐	☐☐

5.30	Why vehicles are not on road? 1.Driver not available 2. Money for POL not available 3. Money for repair not available					YES	NO
				DRIVER NOT AVAILABLEõ õ õ		1	2
				NO MONEY FOR POL..õ õ õ õ õ .		1	2
				C). NO MONEY FOR REPAIRõ õ õ õ õ ..		1	2

5.31	Does the CHC have access to vehicle for transporting patients during emergency?	YESõ õ õ õ õ .1 NOõ õ õ õ õ ..2

I. RESIDENTIAL FACILITY FOR THE MEDICAL STAFF

Q. NO.	PERSONNEL	AVAILABILE	WHETHER STAYING IN QUARTER
5.32	General Surgeon	YESõ .1 NOõ õ 2	YESõ .1 NOõ õ 2
5.33	Physician	YESõ .1 NOõ õ 2	YESõ .1 NOõ õ 2
5.34	Obstetrician /Gynecologist	YESõ .1 NOõ õ 2	YESõ .1 NOõ õ 2
5.35	Pediatrician	YESõ .1 NOõ õ 2	YESõ .1 NOõ õ 2
5.36	Anesthetist	YESõ .1 NOõ õ 2	YESõ .1 NOõ õ 2
5.37	Staff Nurse	YESõ .1 NOõ õ 2	YESõ .1 NOõ õ 2

5.38	**CHECK.Q.NO1.3 & .5.31** If quarter is available for Obstetrician /Gynecologist and he/she is not staying in the quarters then: Why Obstetrician /Gynecologist is not staying in quarter?			YES	NO
		A). POOR CONDITION OF QUARTERõ õ õ õ		1	2
		B). NO WATER SUPPLYõ õ õ õ õ õ õ õ õ		1	2
		C). NO ELECTRICITY FACILITYõ õ õ õ õ õ õ		1	2
		D).LOCATION OF QUARTER IS OUT SIDE VILLAGEõ õ õ õ õ õ õ õ õ õ õ õ õ		1	2
		E).SPOUSE STAYING IN ANOTHER PLACEõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ		1	2
		F). EDUCATION OF CHILDRENõ õ õ õ õ õ õ		1	2
		G). SECURITYõ õ õ õ õ õ õ õ õ õ õ ..		1	2
		H). ANY OTHER_____		1	2
		(SPECIFY)			

Q. NO.	**J. OPERATION THEATRE**

5.39	Is Operation Theatre available?	Yesõ õ õ 1 NOõ õ õ õ .2 ——————▶**Skip toQ5.45**
5.40	If yes, are surgeries carried out in the operation theatre?	YESõ õ õ ..1 ——————▶ **Skip toQ5.40** NOõ õ õ õ 2
5.41	Since how long surgeries are not carried out? **(RECORD MONTHS IF LESS THAN ONE YEAR)**	MONTHSõ õ õ õ . ☐☐ YEARSõ õ õ õ .. ☐☐

Q. NO.	OPERATION THEATRE			
5.42	What are the reasons for not conducting the surgeries? 1. Non-availability of doctors / staffõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ 2.Lack of equipment / poor physical state of the operation theatreõ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ 3.No power supply in the operation theatreõ õ õ õ õ õ .õ õ õ õ õ õ õ 4. Any other reason_____ **(SPECIFY)** **RECORD ALL MENTIONED**		YES	NO
		A). NON-AVAILABILITY OF DOCTORS /STAFFõ õ õ .	1	2
		B). LACK OF EQUIPMENT / POORõ õ õ õ õ õ õ .	1	2
		PHYSICAL STATE OF THE OPERATION THEATREõ õ õ õ õ õ õ	1	2
		C). NO POWER SUPPLY IN THE OPERATION THEATRE õ õ õ õ õ õ õ õ õ õ	1	2
		D). ANY OTHER REASONõ õ õ õ õ õ õ	1	2
5.43	Is Operation Theatre used for obstetrical / gynecological purpose?	Yesõ õ õ õ .1 Noõ õ ..õ õ 2		
5.44	Is OT fitted with air conditioner?	Yesõ õ õ õ .1 No..õ õ .õ õ 2 ──────▶ **Skip to Q5.43**		
5.45	Is air conditioner working?	Yesõ õ õ õ .1 Noõ õ õ ..õ 2		
5.46	Is back up facility for electricity cut-off available in OT?	Yesõ õ õ õ .1 Noõ õ õ ..õ 2		
5.47	Is fumigation done regularly? **Check Q.NO 5.37**	Yesõ õ õ õ .1 Noõ õ õ ..õ 2		
Q. NO.	**K. LABOUR ROOM**			
5.48	Is Labour room available?	Yesõ õ õ õ 1 Noõ õ õ õ .2 ──────▶ **Skip to Q5.51**		
5.49	If labor room is available, are deliveries carried out in the labor room?	Yesõ õ õ õ 1 ──────▶ **Skip to Q5.49** Noõ õ õ õ 2		
5.50	Since how long deliveries are not carried out? **(RECORD MONTHS IF LESS THAN ONE YEAR)**	MONTHSõ õ õ õ ..▢▢ YEARSõ õ õ õ .. ▢▢		
5.51	What are the reasons for not conducting the deliveries? 1. Non-availability of doctors/staffõ õ õ õ õ õ õ õ õ õ õ 2. Lack of equipment / poor physical state of the Labor Room õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ õ 3. No power supply in the Labor Roomõ õ õ õ õ õ õ õ .. 4. Any other reason_____ **(SPECIFY)** **(RECORD ALL MENTIONED)**		YES	NO
		A). NON-AVAILABILITY OF DOCTORS /STAFFõ õ õ .	1	2
		B). LACK OF EQUIPMENT / POORõ õ õ õ õ õ õ .	1	2
		PHYSICAL STATE OF THE OPERATION THEATREõ õ õ õ õ õ õ	1	2
		C). NO POWER SUPPLY IN THE OPERATION THEATRE õ õ õ õ õ õ õ õ õ õ	1	2
		D). ANY OTHER REASONõ õ õ õ õ õ õ	1	2
5.52	Whether area embarked as newborn care area is there in the labour room?	YESõ õ ..õ õ 1 NOõ õ õ õ ...2		
5.53	Whether emergency drug tray is there in the labour room?	YESõ õ õ õ ..1 NOõ õ õ õ .. 2		

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5.54	**Are the following services available, if facility a Level I MCH Centre as answered in section A on Identification.** **Physically verify and record**		
	(a)Labor table with McIntosh sheet	Yes, with McIntosh sheetõ . Yes, without McIntosh sheet.. Not Availableõ õ õ õ õ	1 2 3
	(b)Suction machine	Yes, functionalõ õ õ õ õ Yes, but not functionalõ õ Noõ õ õ õ õ õ õ õ õ	1 2 3
	(c)Autoclave/sterilizer	Yes, functionalõ õ õ õ Yes, but not functionalõ õ Noõ õ õ õ õ õ õ õ õ	1 2 3
	(d)24 hr running water supply (may be from an overhead tank)	Yes No	1 2
	(e)Attached toilet in the labor room	Yes, functionalõ õ õ õ Yes, but not functionalõ Noõ õ õ õ õ õ õ õ	1 2 3
	(f)Condition of the toilet	Yes, functionalõ õ õ õ Yes, but not functionalõ õ Noõ õ õ õ õ õ õ õ	1 2 3
5.56	Whether the following emergency drugs are available (emergency drug tray)? (Yes/No)		
	a. Oxytocin injection	Yes No	1 2
	b. Diazepam Injection	Yes No	1 2
	c. Magnesium Sulphate Injection	Yes No	1 2
	d. Lignocaine Hydrochloride Injection	Yes No	1 2
	e. Nifedipine Tablet	Yes No	1 2
	f. Tablet Misoprostol	Yes No	1 2
	g. Sterilized cotton and gauze	Yes No	1 2
	h. At least 2 pairs of gloves	Yes No	1 2
	i. Sterile I/V sets (at least 2)	Yes No	1 2
	j.Sterile syringes and needles (different sizes)	Yes No	1 2

	k.Oxygen cylinder with face mask, wrench & regulator	Yes, functional õ õ õ õ õ 1 Yes, but not functional õ õ 2 No õ õ õ õ õ õ õ ... 3
5.57	**Observe and record the condition of the Labor Room** (Record Satisfactory . 1, Unsatisfactory -2)	
	Privacy in the labor room	Satisfactory õ õ .õ õ .õ ....1 Unsatisfactory õ õ õ .....õ 2
	Condition of the flooring in the Labor Room	Satisfactory õ õ .õ õ .õ ....1 Unsatisfactory õ õ õ .....õ 2
	Condition of walls in the Labor Room	Satisfactory õ õ .õ õ .õ ....1 Unsatisfactory õ õ õ .....õ 2
	Condition of ceiling in the Labor Room	Satisfactory õ õ .õ õ .õ ....1 Unsatisfactory õ õ õ .....õ 2
	Condition of lighting in the Labor Room	Satisfactory õ õ .õ õ .õ ....1 Unsatisfactory õ õ õ .....õ 2
	Overall condition of the Labor Room	Satisfactory õ õ .õ õ .õ ....1 Unsatisfactory õ õ õ .....õ 2
5.58	*Ask and record (Yes-1 /No-2)*	
	Normal delivery kits available in the facility?	YES õ õ õ õ õ õ 1 NO õ õ õ õ õ õ 2
	Surgical set for Episiotomy and minor procedures available	YES õ õ õ õ õ õ 1 NO õ õ õ õ õ 2
	Whether the following items available in the labour room **(Observe & Record)**	
	a. Gloves	Yes, used one time õ õ õ 1 Yes, washed & used again. 2 NO õ õ õ õ õ õ õ õ õ 3
	b.**Sterilized** cotton gauze	Yes 1 No 2
	c.**Sterile** syringes and needles	Yes 1 No 2
	d.**Sterile** drip sets	Yes 1 No 2
	e.IV infusions like Dextrose 5%	Yes 1 No 2
5.59	Partographs being recorded for the recently delivered women or women in Labor at the facility	Yes 1 No 2

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Q. NO.	L. LABORATORY:	
5.60	Is there operational laboratory in the CHC?	YES õ õ õ .õ 1 NO õ õ õ . 2
5.61	Is Blood Storage Facility there in the CHC?	YES õ õ õ .1 NO õ õ õ ..2 ⟶ **Skip to Q 5.54**
5.62	Whether Blood Storage Facility is for 24-hour basis?	YES õ õ õ .1 NO õ õ õ . 2
	M. PHYSICAL FACILITY:	
5.63	Are there prominent display boards regarding service	Yes õ õ õ .1

	availability in local language at CHC? **(RECORD BY OBSERVATION)**	Noõ õ õ õ õ ..2
5.64	Is there separate registration counter in CHC? **(RECORD BY OBSERVATION)**	YESõ õ õ õ .1 NOõ õ õ õ õ õ .2
5.65	Is there pharmacy for drug dispensing and drug storage at CHC? **(RECORD BY OBSERVATION)**	YESõ õ õ õ .1 NOõ õ õ õ õ ..2
5.66	Is any suggestion / complaint box kept at CHC? **(RECORD BY OBSERVATION)**	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
5.67	Are there OPD rooms / cubicles at CHC? If YES, Give numberõ õ õ	YESõ õ õ õ .1 NOõ õ õ 2 ROOM [ ] CUBICLES [ ]
5.68	Is separate waiting area in OPD for patients at CHC?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
5.69	Is Minor OT in the CHC?	YESõ õ õ õ .1 NOõ õ õ õ .2
5.70	Is Injection Room and Dressing Room in the CHC?	YESõ õ õ õ .1 NOõ õ õ õ .2
5.71	Is Emergency Room / Casualty room in the CHC?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
5.72	Total Number of beds in CHC	NUMBERõ õ .. [ ][ ]
5.73	Are separate wards for males and females there in the CHC?	YESõ õ õ õ 1 NOõ õ õ õ 2 ⟶ **Skip toQ5.68**
5.74	Number of beds for Male	NUMBERõ ..õ .. [ ][ ]
5.75	Number of beds for Female	NUMBERõ ..õ .. [ ][ ]
5.76	Number of Pediatric beds	NUMBERõ ..õ .. [ ][ ]
5.77	Average days of inpatient stay in CHC	NUMBERõ .õ .. [ ][ ]

I AVAILABILITY OF NEWBORN CARE EQUIPMENTS (*Physically verify and record (*Yes, functional-1; Yes, No -2)

Q.NO.	ITEM	AVAILABILITY	FUNCTIONAL
5.78	Designated newborn baby corner	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
5.79	Ambu bag with mask	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
5.80	Radiant warmer	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
5.81	Any other mechanism available in the facility to keep the baby warm, like 200wt bulb at a height of 18 inches above newborn baby corner.	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
5.82	Suction catheter/canula	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
5.82	Pedal suction machine/mucus extractor	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
5.84	Baby weighing machine of any type	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
5.85	Designated newborn baby corner	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2

| 5.86 | Separate drug tray | YESõ õ õ õ õ õ 1
NOõ õ õ õ õ õ ..2 | YESõ õ õ õ õ õ õ 1
NOõ õ õ õ õ õ õ ..2 |

5.87 AVAILABILITY OF OTHER EQUIPMENT (RECORD FROM REGISTER AND ASK ABOUT FUNCTIONALITY IF AVAILABLE

	(a)Instrument trolley	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(b) Instrument cabinet	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(c) Blood / Saline stand	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(d) Stretcher on trolley	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(e) Stool for patients.	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(f) Wheel chair	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(g) Almirah/Cupboard with lock and key	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(h) Separate dustbin for biomedical waste	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(i)Autoclave	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(j) Auto Disposable (AD) Syringes	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(k) Hub Cutter **(OBSERVE)**	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(l) B.P. Instrument	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(m) Stethoscope	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(n) Weighing machine (adult)	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(o) Weighing machine (infant)	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(p) Haemoglobinometer (Sahlis)	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(q) Foetoscope	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2
	(r) SIMS Speculum	YESõ õ õ õ õ õ 1 NOõ õ õ õ õ õ ..2	YESõ õ õ õ õ õ õ 1 NOõ õ õ õ õ õ õ ..2

VI. FURNITURE/INSTRUMENT (RECORD FROM REGISTER ASK ABOUT FUNCTIONALITY IF ITEMS ARE AVAILABLE)

Q. NO.	ITEM	AVAILABLE	FUNCTIONAL
6.1	Examination Table	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.2	Delivery Table	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.3	Footstep	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.4	Bed Side Screen	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.5	Stool for patients	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.6	Saline stand	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.7	Wheel chair	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.8	Stretcher on trolley	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.9	Oxygen cylinder with regulator and Mask	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2

Q. NO.	ITEM	AVAILABLE	FUNCTIONAL
6.10	B P Instrument	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.11	Bed side locker	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.12	Dressing trolley	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.13	Instrument cabinet	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.14	Instrument trolley	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
6.15	Instrument tray	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2

VII. AVAILABILITY OF EQUIPMENTS AT CHC (RECORD FROM REGISTER ASK ABOUT FUNCTIONALITY IF EQUIPMENTS AVAILABLE)

Q. NO.	A. OPERATION THEATER EQUIPMENTS	AVAILABLE	FUNCTIONAL
7.1	Boyles Apparatus	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.2	Cardiac monitor	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.3	Ventilator	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.4	Horizontal high pressure sterilizer	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.5	Vertical high pressure sterilizer 2/3 drum capacity	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.6	Shadow less lamp ceiling track mounted	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.7	Shadow less lamp pedestal for minor OT	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.8	Oxygen Cylinder 660 Ltrs with regulator and Mask	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.9	Nitrous oxide cylinder 1780 Ltrs	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.10	Hydraulic operation table	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.11	Emergency drug tray	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
Q. NO.	**B. DIFFERENT SURGICAL EQUEPMENT**		
7.12	IUD Insertion Kit	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.13	Normal Delivery Kit	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.14	Equipment For Neo-Natal Resuscitation	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.15	Standard Surgical Set-I	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.16	Standard Surgical Set-II Instrument	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.17	CHC Standard Surgical Set III	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.18	Standard Surgical Set IV	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.19	Standard Surgical Set V	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.20	Standard Surgical Set VI	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.21	Equipments for Anesthesia	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.22	Equipments for laboratory test and blood transfusion.	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.23	Materials Kit for blood Transfusion	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.24	Equipment For Radiology	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2

Q. NO.	C. LABORATORY EQUIPMENT	AVAILABLE	FUNCTIONAL
7.25	Binocular microscope with oil immersion	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.26	Refrigerator	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.27	Stool transport carrier	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.28	Centrifuge	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.29	Rapid Diagnostic Kit for Typhoid	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.30	Rapid test kit for faecal contamination	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.31	Blood culture bottles with broth	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.32	Cold Box	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.33	Rapid Plasma Reagin(RPR) test kits for syphilis	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.34	Kits for ABO blood grouping	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.35	HIV test kits	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
	D. COLD CHAIN EQUIPMENT		
7.36	Walk in cooler	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.37	Walk in freezer	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.38	ILR Large	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.39	ILR Small	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.40	Deep freezer Large	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2
7.41	Deep freezer Small	YESõ õ õ 1 NOõ õ õ ...2	YESõ õ õ 1 NOõ õ õ ..2

VIII. AVAILABILITY OF ESSENTIAL DRUGS IN THE CHC(RECORD FROM REGISTER)

Q.NO.	DRUGS	AVAILABLE ON THE DAY OF SURVEY	OUT OF STOCK MORE THAN 10 DAYS DURING LAST MONTH
8.1	Antiallergics and drugs used in Anaphylaxis	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.2	Anti Hypertensive	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.3	Anti Diabetics	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.4	Anti Anginal	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.5	Anti Tubercular	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.6	Anti Leprosy	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.7	Anti Filarials	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.8	Anti Bacterials	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.9	Anti Helminthic	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.10	Anti Protozoal	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.11	Antidots (Antisnake Venom etc.)	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.12	Solutions correcting water and electrolyte imbalance	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
8.13	Essential Obstetric Care drugs.	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2

8.14	Emergency Obstetric Care Drug	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
	(a)Emergency Contraceptive Pills	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	(b) Normal Saline	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	(c) Dextrose 5 %	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	(d) Condoms	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	(e) Oral Contraceptive Pills	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	(f) MVA Syringes	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	(g) Tab Misoprostol	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	(h) IFA tablets	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	(i) Reagents for cross matching of blood	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
8.15	RTI/STI Drugs under RCH programme	YESõ õ õ õ 1 NOõ õ õ õ 2	YESõ õ õ õ 1 NOõ õ õ õ 2
	a) Tab Azithromycin (1 g)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	b) Doxycycline Hydrochloride Capsules	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	c) Benzathine Penicillin Injection	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	d) Tab Metronidozale	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	e) Tab Fluconazale	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	f) Tab Cefixime (200mg and 400mg)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	g) Tab Secnidazole (500 mg)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	h) Tab Erythromycin (500 mg) base/stearate	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	i) Tab Acyclovir (400 mg)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	j) Cap Amoxicillin 500 mg	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	k) Clotrimazole Vaginal pessary (500 mg)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	l) Podophyllin tincture 20 %	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	m) Permethrin cream (5%) and (1%)	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2
	n) Gamma Benzene Hexachloride 1 % lotion or cream	YESõ õ ...1 NOõ õ õ .2	YESõ õ ...1 NOõ õ õ .2

IX. ESSENTIAL SERVICES PROVIDED

I. LABORATORY SERVICES RECORDF ROM REGISTER (DURING LAST ONE MONTH)

Q. NO.	SERVICES PROVIDED	NUMBER OF TEST
9.1	Number of Blood grouping test	
9.2	Number of Haemogram (TLC/DLC)	
9.3	Number of test for diagnosis of RTIs/STDs with wet mounting, grams stain, etc.	
9.4	Number of Sputum test for TB	
9.5	Number of Blood smear examination for Malaria Parasite	
9.6	Number of Urine test (Routine culture/sensitivity/Microscopy)	
9.7	Number of Rapid test for pregnancy	
9.8	Number of Rapid Plasma Reagin (RPR) test for syphilis	
9.9	Number of test for HIV	
9.10	Others_____ _____ (**SPECIFY**)	

II. SERVICES PROVIDED RECORDF ROM REGISTER (DURING LAST ONE MONTH)

Q. No.	ESSENTIAL SERVICES PROVIDED	MALE	FEMALE
	A. SERVICE PROVIDED		
9.11	OPD Patients		
9.12	In patient admissions		
9.13	Number of cases referred for serious ailments to CHC		
9.14	Number of cases referred for serious ailments from CHC		
	B. PERFORMANCE		
9.15	Number of deliveries performed		
9.16	Number of Caesarean section deliveries performed		
9.17	Of the total deliveries how many were beneficiaries of **Janany Suraksha Yojana**		
9.18	Number of blood transfusion done		
9.19	Number of MTP performed		
9.20	Number of IUD insertion cases		

19

	PERFORMANCE		
9.21	Number of sterilization conducted	**MALE**	**FEMALE**
9.22	Number of cases provided with RTI/STI services		
9.23	Number of person completed treatment under DOTS		
9.24	Number of school health camp organized	NO OF SCHOOL	

X. AVAILABILITY OF SPECIFIC SERVICES

Q.NO.	QUESTIONS	CURRENT AVAILABILITY AT CHC
10.1	Is the facility for normal delivery available in the CHC for 24 hours?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
10.2	Is New born care for 24 hour basis.	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
10.3	Are the low birth weight babies managed at the CHC?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
10.4	Is CHC a microscopy centre?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
10.5	Is CHC having a Integrated Counseling and Testing Center (ICTC)?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
10.6	Are surgeries for cataract done in the CHC?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
10.7	Is the primary management of cases of poisoning /snake, insect or scorpion bite done at the CHC?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
10.8	Is the primary management of burns done at CHC?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2

XI. MONITORING AND SUPERVISORY ACTIVITIEs

Q. NO.	PARTICULAR	
11.1	Have you prepared the CHC plan for this year?	YESõ õ õ õ 1 NOõ õ 2
11.2	When was the last CHC plan prepared?	MONTH [ ][ ] YEAR [ ][ ][ ][ ]
11.3	Do you have enough printed registers and reports?	**A. REGISTERS** **B. REPORTS** YESõ õ õ õ 1 YESõ õ õ ..1 NOõ õ õ õ .2 NOõ õ õ ..2
11.4	Do you submit the report on time?	YESõ õ õ õ 1 ⟶ **Skip to Q11.6** NOõ õ õ õ ..2
11.5	What is the main reason for not submitting report in time?	_____
11.6	Were you provided with any written feedback on reports from the district or Supervisory Officer?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
11.7	During the last quarter has any Supervisory Officer visited CHC?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
11.8	Is Citizenş Charter displayed at CHC?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
11.9	Has the Rogi Kalyan Samiti (RKS) been established?	YESõ õ õ 1 NOõ 2 ⟶ **Skip to Q11.11**
11.10	Does Rogi Kalyan Samiti (RKS) monitor your work regularly?	YESõ õ õ õ .1 NOõ õ õ õ õ õ ..2
11.11	Have you received the untied fund for previous financial year?	YESõ õ õ õ õ õ ..1 NOõ õ õ õ õ õ 2 ⟶ **END**
11.12	Have you utilized the untied fund?	FULLY UTILISEDõ õ õ õ õ ..1 PARTIALLY UTILISEDõ õ õ .2 NOT UTILISEDõ õ õ õ õ ..3

DRAFT

**FACILITY SURVEY
DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY- 4
DISTRICT HOSPITAL/ SUB DIVISIONAL HOSPITAL**

IDENTIFICATION	
A. STATE_____ **DISTRICT** _____ **DISTRICT HOSPITAL**_____ **TOTAL NUMBER OF BEDS**_____ **SINCE WHEN IS THIS DH FUNCTIONING FROM THIS BUILDING? (YEAR)**_____ **POPULATION COVERED BY THE DH (LATEST) YEAR**_____ **NUMBER OF CHC CATERED BY DH**_____ **DISTANCE FROM THE FARTHEST CHC (IN K.M.)**_____ **TYPE OF HEALTH FACILITY: DH...................1 SDH...................2**	

GPS information:

Number of Satellite signals received	Accuracy (signal in feet)	Latitude North -N South -S	Longitude East -E West - W	Way point circle one 1 = in front of household 2 = nearby landmark
No. = (Signals must be 3 or more)		Degree Minutes	Degree Minutes	

INTERVIEW DATE	DATE	MONTH	YEAR

B. DESIGNATION OF THE RESPONDENT

    MEDICAL SUPERINTENDENT/PMO……………………… 1

    SPECIALIST/ OBSTETRICIAN/GYNAECOLOGIST………….……… ..2

    OTHER_____3
                     (SPECIFY)

C. SERIAL NUMBER OF DH QUESTIONNAIRE_____

D. NUMBER OF VISITS MADE TO HEALTH FACILITY

NAME DATE	**E1.**SPOT CHECKED BY _____ _____	**E1.**FIELD EDITED BY _____ CODE	**E1.**OFFICE EDITED BY _____ CODE	**E1.**KEYED BY _____
_____ NAME OF THE INVESTIGATOR	CODE OF INVESTIGATOR	_____ SIGNATURE OF THE INVESTIGATOR		

I   AVAILABILITY OF SERVICES

	Item	STATUS CODE	
1	Is this a functional FRU	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2 →	If ±NOqthen Skip to 1.3
1.2	Since when did this facility start functioning as a 24x7 facility?	Year	If ±NOqthen Skip to 1.4
1.3	Is it planned to be made a 24x7 functional facility by March 2012?	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	
1.4	Whether deliveries are conducted in this facility or not? If, yes, whether the deliveries are conducted 24x7?	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3 →	If ±NOqthen Skip to 1.6
1.5	Can you tell me whether the following services related to delivery are provided in this facility? If yes, ask 24x7 status		
	(a). Normal Delivery	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ...õ . 3	
	(b). Assisted (forceps delivery/Vacuum)	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(c). Administration of parental oxytocics	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(d). Administration of parental antibiotics	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(e). Administration of Magnesium sulphate injection	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(f). Management of post-partum hemorrhages	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(g). Management of other delivery complications	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
	(h). Caesarian section	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3	
1.6	I there a blood bank available in this facility? If yes, is it functional 24x7	YES, 24 X 7 õ õ õ õ .... 1 YES, Only day Timeõ õ . 2 No.õ õ õ ..õ . 3 →	If ±NOqthen Skip to 1.8
1.7	Is there a blood storage facility available in this facility?	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	
1.8	Do you have license for the blood bank/approval for the blood storage centre? If, yes, can you show the license/approval?	YES, License/approval seenõ õ õ .... 1 YES, but not seenõ õ . 2 Not available.õ õ õ ..õ . 3 →	If ±NOqthen Skip to 1.9
1.9	CHECK A6 7 A7 : if A6 = 3 or A7 =2 What are the reasons for non-availability of blood bank/blood storage facility? Multiple coding possible	No equipment/refrigerator 1 No reagentsõ õ õ õ ... 2 No licenseõ õ õ õ 3 No power backupõ õ 4 No manpowerõ õ õ 5 Other (specify_____) 6	
1.10	Whether the following essential newborn care services are available? If, yes, is it available in the labour room and ward?		
	a. Resuscitation Multiple coding possible	YES, in labor roomõ 1	

2

Q.NO.			
		YES, in Wardõ õ .	2
		Not Available.õ õ õ ..õ .	3
	b. Thermal protection (warmer/table lamp)	YES, in labor roomõ	1
		YES, in Wardõ õ .	2
	Multiple coding possible	Not Available.õ õ õ ..õ .	3
1.11	Whether the following safe abortion services are available in this facility?		
	a. Manual Vacuum Aspiration (MVA)	YESõ õ õ õ õ õ	1
		NOõ õ õ õ õ õ ..õ	2
	b. Electric Vacuum Aspiration (EVS)	YESõ õ õ õ õ õ	1
		NOõ õ õ õ õ õ ..õ	2
	c. Dilatation & Curettage (D&C)	YESõ õ õ õ õ õ	1
		NOõ õ õ õ õ õ ..õ	2
	d. Others (specify_____)	YESõ õ õ õ õ õ	1
		NOõ õ õ õ õ õ ..õ	2
1.12	Whether RTI/STI treatment and counseling provided in this facility? If, yes both or only treatment or only counseling?	Yes, bothõ õ õ õ ...	1
		Yes, treatment onlyõ .	2
		Yes, counseling onlyõ	3
		Noõ õ õ õ õ õ	4
	ESSENTIAL LABORATORY SERVICES		
1.13	Whether laboratory services are available in this facility?	YESõ õ õ õ õ õ	1	If "NO" then skip to 1.15
		NOõ õ õ õ õ õ ..õ	2
1.14	Are the laboratory services outsourced?	YESõ õ õ õ õ õ	1
		NOõ õ õ õ õ õ ..õ	2
	AMBULANCE SERVICES		
1.15	How many ambulances are there in this facility? change the question as in PHC Of these, how many are functional?	Availableõ . [ ]		If "0" Skip to 1.17
		Functionalõ . [ ]	
1.16	If ambulance available Do you have adequate funds available for operating the ambulances?	YESõ õ õ õ õ õ	1
		NOõ õ õ õ õ õ ..õ	2
1.17	Is there any mechanism to assure referral transport? If yes, is it available 24x7	YES, 24 X 7 õ õ õ õ	1
		YES, Only day Timeõ õ .	2
		No.õ õ õ ..õ.	3	If "NO" then Skip to 1.19
1.18	Whether government ambulances are used for referral transport or is it outsourced?	Governmentõ õ õ õ õ õ	1
		Out Sourcedõ õ õ õ õ õ ..	2
1.19	Whether the facility has free diagnostic services for pregnant women?	YESõ õ õ õ õ õ	1
		NOõ õ õ õ õ õ ..õ	2
1.20	Whether the facility has free referral services?	YESõ õ õ õ õ õ	1
		NOõ õ õ õ õ õ ..õ	2

I. AVAILABILITY OF HUMAN RESOURCES (CLINICAL)

Q. NO.	PERSONNEL	IN POSITION (A)	CONTRACTUAL (B)	IF NO, SINCE HOW LONG RECORD IN ACTUAL MONTHS & IF MORE THAN 99 MONTHS CODE 99 (C)
1.21	MEDICAL SUPERINTENDENT/PMO			
1.22	SPECIALIST (MEDICINE)			
1.23	SPECIALIST (SURGERY)			
1.24	OBSTETRICIAN /GYNEACOLOGIST			
1.25	PEDIATRICIAN			
1.26	ANESTHETIST			

Q. NO.	PERSONNEL			
1.27	PATHOLOGIST/ MICROBIOLOGIST	☐☐	☐☐	☐☐
1.28	RADIOLOGIST	☐☐	☐☐	☐☐
1.29	DERMATOLOGIST / VANEROLOGIST	☐☐	☐☐	☐☐
1.30	OPTHALMOLOGIST	☐☐	☐☐	☐☐
1.31	GENERAL DUTY DOCTOR	☐☐	☐☐	☐☐
1.32	AYUSH PHYSICIAN	☐☐	☐☐	☐☐
1.33	Other MOs or Specialist (Specify)_____	☐☐	☐☐	☐☐

II.   AVAILABILITY OF HUMAN RESOURCES (PARA MEDICAL)

Q. NO.	PERSONNEL	IN POSITION (A)	CONTRACTUAL (B)	IF NO, SINCE HOW LONG RECORD IN ACTUAL MONTHS & IF MORE THAN 99 MONTHS CODE 99 (C)
2.1	PUBLIC HEALTH NURSES	☐☐	☐☐	☐☐
2.2	NURSES WORKING IN OBS-GYNIC DEPARTMENT	☐☐	☐☐	☐☐
2.3	AUXILLARY NURSE MIDWIFE/ANM	☐☐	☐☐	☐☐
2.4	STAFF NURSE	☐☐	☐☐	☐☐
2.5	TECHNICIANS	☐☐	☐☐	☐☐
2.6	RADIOGRAPHER	☐☐	☐☐	☐☐
2.7	PHARMACIST	☐☐	☐☐	☐☐
2.8	PHYSIOTHERAPIST	☐☐	☐☐	☐☐
2.9	MEDICAL RECORD OFFICER	☐☐	☐☐	☐☐
2.10	COMPOUNDER	☐☐	☐☐	☐☐
2.11	DRESSER	☐☐	☐☐	☐☐
2.12	PUBLIC HEALTH PROGRAMME MANAGER	☐☐	☐☐	☐☐
2.13	LAB TECHNICIAN	☐☐	☐☐	☐☐
2.14	OPTHALMIC ASSISTANT	☐☐	☐☐	☐☐
2.15	OTHER STAFF (Specify)_____	☐☐	☐☐	☐☐

III.A. TRAINING FOR MEDICAL OFFICER (MO) DURING LAST FIVE YEARS/EVER
(IF TRAINING NOT RECEIVED IN THE LAST FIVE YEARS ASK EVER RECEIVED THE TRAINING)

Q. NO.	TYPE OF TRAINING	NUMBER OF MO TRAINED	
		LAST 5 YEARS	EVER
3.1.	MDR (Maternal Death Review) Orientation	YESõ õ õ õ õ õ .... 1 NO õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.2	Non Scalpel Vasectomy(NSV) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.3	Vector Born Disease Control Programme (VBDCP) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.4	Directly Observed Treatment- Short Course (DOTS) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.5	Immunization training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.6	NSV . Non Scalpel Vasectomy training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.7	Reproductive Tract Infection/Sexually Transmitted Infection(RTI/STI) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.8	Adolescent Reproductive Sexual Health (ARSH) Training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.9	MDR (Maternal Death Review) Orientation	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.10	F-IMNCI (Facility Based IMNCI) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.11	NSSK (Navjat Shishu Suraksha Karyakram) Training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.12	Minilaprotomy training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.13	IUD insertion training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.14	HIV/AIDS Prevention, Care and Support training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.15	Emergency Obstetric Care(including C-Section) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.16	Newborn Care training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.17	SBA or Basic Emergency Obstetric Care training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.18	Integrated Management of Neonatal and Childhood Illnesses training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2
3.19	Medical Termination Of Pregnancy (MTP) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2

Q.NO	TYPE OF TRAINING		
3.20	Mother Child tracking system	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2
3.21	HMIS Training	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2
3.22	Any Other training_____ (SPECIFY)	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2

III.B.TRAINING FOR PARA MEDICAL STAFF DURING LAST FIVE YEARS/EVER
(IF TRAINING NOT RECEIVED IN THE LAST FIVE YEARS ASK EVER RECEIVED THE TRAINING)

Q.NO	TYPE OF TRAINING	NUMBER OF PERSONS TRAINED	
		LAST 5 YEARS	**EVER**
3.23	Reproductive Tract Infection /Sexually Transmitted Infection (RTI/STI) training	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2
3.24	F-IMNCI (Facility Based IMNCI) training	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2
3.25	NSSK (Navjat Shishu Suraksha Karyakram) Training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2
3.26	Blood grouping and cross matching training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2
3.27	Integrated Management of Neonatal and Childhood Illnesses (IMNCI) training	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2
3.28	Skilled Birth Attendant training	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2
3.29	Electro Cardiogram (ECG) training	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2	YESõ õ õ õ õ õ õ .... 1 NOõ õ õ õ õ õ õ ..õ 2

III.C.INVESTAGATIVE AND LABORATORY SERVICES

A. LABORATORY SERVICES		
3.30	**CLINICAL PATHOLOGY**	
	(a).Hematology	YES.. 1 NO... 2
	(b).Urine analysis	YES.. 1 NO... 2
	(c).Stool analysis	YES.. 1 NO... 2
3.33	**PATHOLOGY**	
	(a).Pap smear	YES.. 1 NO... 2
	(b).Sputum	YES.. 1 NO... 2
	(c).Histopathology	YES.. 1 NO... 2
3.34	**MICROBIOLOGY**	
	(a).Diagnosis of RTIs/STDs with wet mounting, grams stain, etc.	YES.. 1 NO... 2
	(b).RPR for Syphilis	YES.. 1 NO... 2
3.35	**BIOCHEMISTRY**	
	(a).Blood sugar	YES.. 1 NO... 2
	(c).Blood urea,	YES.. 1 NO... 2

	(d).Blood creatinen	YES... 1 NO... 2
3.36	**SEROLOGY**	
	(a).Pregnancy test	YES... 1 NO... 2
	(b).Coombs test	YES... 1 NO... 2
	(c).Widal test	YES... 1 NO... 2
	(d).Elisa for hiv test	YES... 1 NO... 2
	(e).R A factor test	YES... 1 NO... 2
	(f).VDRL test	YES... 1 NO... 2
3.37	**INVESTIGATIVE**	
	(a).ECG	YES... 1 NO... 2
	(b).STRESS TEST(TMT)	YES... 1 NO... 2
	(c).2D-ECHO	YES... 1 NO... 2
3.38	**RADIOLOGY**	
	(a).X-RAY	YES... 1 NO... 2
	(b).ULTRASOUND	YES... 1 NO... 2
3.39	**BLOOD BANK**	
	FULLY OPERNATIONAL BLOOD BANK	YESõ õ õ õ õ õ .1 NOõ õ õ õ õ õ 2
3.40	**PHYSIOTHERAPY UNIT**	
	FULLY FUNCTIONAL PHYSIOTHERAPY UNIT	YES... 1 NO... 2

IV. INFRASTRUCTURE

A	WATER SUPPLY	
4.1	What is the main source of water supply?	PIPEDõ õ õ õ õ õ õ õ õ õ 1 BOREWELL/ TUBEWELLõ õ ...2 HANDPUMPõ õ õ õ õ õ õ ..3 WELLõ õ õ õ õ õ õ õ õ õ ..4 OTHERõ õ õ õ ..õ õ õ õ õ .5 NO WATER SUPPLYõ õ õ õ õ 6⌐ Skip to Q 4.5
4.2	Is water supply available for 24 hours at CHC?	YESõ õ õ ..1 NOõ õ õ õ 2 ⌐ Skip to Q 4.5
4.3	Is regular water supply in OT?	YESõ õ õ õ .1 NOõ õ õ õ õ ..2
4.4	Is regular water supply in labor room?	YESõ õ õ õ .1 NOõ õ õ õ õ ..2
B	ELECTRICITY	

4.5	Is there a three-phase connection?	YES…………….…..1 NO………..……. 2
4.6	Standby facility of generator/inverter available in working condition . (RECORD BY OBSERVATION)	YES…………….…..1 NO………..……. 2
4.7	What is the capacity of the generator?	KW ☐☐
4.8	Whether the generator supply is connected to the following areas:	
	a. Whether the generator supply is connected to Labor room?	Yes……………………..1 No………………… 2
	If, yes, whether the generator backup is assured at all times.	Yes, at all times............................ 1 Yes, but not at all times .... 2 No…………………………… 3
4.10	b. Whether the generator supply is connected to Ice lined Refrigerator (ILR)?	Yes …………………….1 No……………………… 2
	If, yes, whether the generator backup is assured at all times.	Yes, at all times............................ 1 Yes, but not at all times .... 2 No…………………………… 3
4.11	c. Wards	YES…………….…..1 NO……..……...2
4.12	Do you have adequate funds available for operating the generator?	YES…………….…..1 NO………..……...2
C	**TOILET FACILITY**	
4.13	Is functional toilet facility available?	YES………….…..1 NO……………. 2 ⟶ Skip to Q 4.16
4.15	Is there separate toilet facility for males and females?	COMMON TOILET…………………….1 SEPARATE TOILET……………………….2
D	**LAUNDRY FACILITY**	
4.16	Is laundry facility available at DH/ SDH?	YES……… .1⟶Skip to Q5.20 NO……… 2
4.17	If no, is it outsourced?	YES……… .1 NO……… ..2
E	**COMMUNICATION FACILITY**	
4.18	Telephone facility available in all the section of the hospital?	ALL SECTION............................ 1 SOME SECTION......................... 2 NOT AT ALL 3
4.19	Whether Personal computer available or not?	YES…………….…..1 NO……… ..…….2⟶**Skip to Q4.24**
4.20	Whether DH/SDH is using personal computer? (RECORD ALL MENTIONED)	YES NO A).OPD RECORD ………………… . 1 2 B).MAINTENANCE……… .... 1 2 C).ADMINISTRATIVE WORK……… .. 1 2 D).PRODUCING REPORTS …………… 1 2 E).ANY OTHER _____ 1 2 **(SPECIFY)** F).NOT AT ALL ………………………… 1 2
4.21	Is NIC Terminal available at DH /SDH?	YES…………….…..1 NO……… ..…….2

4.22	If access to Internet available at DH/SDH?	YESõ õ õ õ õ .õ õ .1 NOõ õ õ õ ..õ õ õ ..2	
4.23	Is DH/SDH outsourcing data compilation and tabulation work?	YESõ õ õ õ õ .õ õ .1 NOõ õ õ õ ..õ õ õ ..2	
F. VEHICLES		**AVAILABLE**	**ON ROAD**
	1. Ambulance	☐☐	☐☐
	2. Jeep	☐☐	☐☐
	3. Car	☐☐	☐☐
4.25	Whether CSSD (Central Sterile and Supply Department) is there at DH?	YESõ õ õ õ õ .õ õ .1 ⟶ Skip to Q. 4.30 NOõ õ õ ..õ õ ..õ 2	
4.26	Where instruments & items are sterilized?	_____ _____	
4.27	Whether DH/SDH has the facility for disposing of bio medical waste?	YESõ õ õ õ õ .õ õ .1 NOõ õ õ õ ..õ õ õ ..2 ⟶ Skip to Q.4.30	

			YES	NO
4.28	How waste is disposed? (RECORD ALL MENTIONED)	a). INCINERATORõ õ õ õ õ õ õ õ	1	2
		b).AUTOCLAVING/MICROWAVINGõ õ	1	2
		c).SHREDDER õ õ õ õ õ õ õ õ õ õ	1	2
		d).NEEDLE AND SYRING DESTROYERõ õ õ õ õ õ õ õ õ .	1	2
		e). ANY OTHER (SPECIFY)_____	1	2
4.29	Are Biomedical disposal services out sourced? (CHECK Q.4.13 IF YES DO NOT ASK)	YESõ õ õ õ .õ õ õ õ õ õ õ õ õ .1 NOõ õ õ ..õ õ õ õ õ õ õ õ õ õ ..2		
	(a). Are color coded waste bags available for segregated waste?	YESõ õ õ õ õ õ .õ õ õ 1 NOõ õ õ õ õ õ õ õ õ õ 2		

(b).What is the mode of disposal of infectious/biological waste?
(RECORD ALL MENTIONED)

	YES	NO
a) BURY IN A PITõ õ õ õ	1	2
b)THROWN IN c)COMMON/PUBLIC d)DISPOSAL PIT	1	2
e) THROWN OUTSIDE f) HOSPITAL COMPOUNDõ ...	1	2
g) THROWN INSIDE HOSPITAL COMPOUNDõ õ õ õ õ õ	1	2
h) USE INCINERATORõ õ õ	1	2
i) OUT SOURCEDõ õ õ õ	1	2
J) OTHERõ õ õ õ õ õ õ õ	1	2

(c).What is the mode of disposal of non-infectious waste?

(RECORD ALL MENTIONED)

	YES	NO
a) BURY IN A PITõ õ õ õ	1	2
b)THROWN IN c)COMMON/PUBLIC d)DISPOSAL PIT	1	2
e) THROWN OUTSIDE f) HOSPITAL COMPOUNDõ ...	1	2
g) THROWN INSIDE HOSPITAL COMPOUNDõ õ õ õ õ õ	1	2
h) USE INCINERATORõ õ õ	1	2
i) OUT SOURCEDõ õ õ õ	1	2
J) OTHERõ õ õ õ õ õ õ õ	1	2

(d).**OBSERVE AND RECORD**
Are any discarded/used sharps visible in the facility?

YESõ õ õ õ õ õ .õ õ õ 1
NOõ õ õ õ õ õ õ õ õ õ 2

	G.	SECURITY	
4.30	Is one person available round the clock for security?	YES…………..……… 1 NO………………… 2
4.31	Is Critical Care Area there at DH?	YES………..…………….1 NO……..……………..2
4.32	Is Integrated Counseling and Testing Centre (ICTC) there in DH,	YES……….…………….1 NO……..……………..2

V. RESIDENTIAL FACILITY FOR STAFF

Q. No.	QUARTERS			
	RESIDENTIAL QUARTER FOR DH STAFF	**(A)** **AVAILABLE**	**(B)** **WHETHER RESIDING**	**(C)** **IF NOT RESIDING, WHAT ARE THE REASONS?**
5.1	Medical Superintendent	YES… 1 NO…..2 → **SKIP TO NEXT ROW**	YES… 1 → **SKIP TO NEXT ROW** NO… .2	YES NO A).POOR CONDITION OF QUARTERS… 1 2 B). NO WATER SUPPLY ……… 1 2 C). NO ELECTRICITY FACILITY …… 1 2 D).SPOUSE STAYING IN ANOTHER PLACE.. 1 2 E).EDUCATION OF CHILDREN……… . 1 2 F). SECURITY………..……… 1 2 G). ANY OTHER **(SPECIFY)_____** 1 2
5.2	iii) Obstetrician /Gynecologist	YES… 1 NO… .2 → **SKIP TO NEXT ROW**	YES… 1 → **SKIP TO NEXT ROW** NO… .2	YES NO A).POOR CONDITION OF QUARTERS… 1 2 B). NO WATER SUPPLY ……… 1 2 C). NO ELECTRICITY FACILITY …… 1 2 D).SPOUSE STAYING IN ANOTHER PLACE.. 1 2 E).EDUCATION OF CHILDREN……… . 1 2 F). SECURITY……… ..……… 1 2 G). ANY OTHER **(SPECIFY)_____** 1 2
5.3	iii) Matron/Nurse In-Charge Obs&Gyne	YES… 1 NO… .2 → **SKIP TO Q 6.1**	YES… 1 → **SKIP TO Q6.1** NO… .2	YES NO A).POOR CONDITION OF QUARTERS… 1 2 B). NO WATER SUPPLY ……… 1 2 C). NO ELECTRICITY FACILITY …… 1 2 D).SPOUSE STAYING IN ANOTHER PLACE.. 1 2 E).EDUCATION OF CHILDREN……… . 1 2 F). SECURITY……… ..……… 1 2 G). ANY OTHER **(SPECIFY)_____** 1 2

## VI.	OTHER PHYSICAL FACILITIES

6.1	Are prominent display boards regarding service availability in local language displayed at District Hospital?	YESõ õ õ õ õ õ õ õ õ õ õ õ ..õ õ .1 NOõ ..õ õ õ õ õ õ õ õ õ õ õ ...õ õ õ 2
6.2	Are there separate registration counters in District Hospital?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ ..õ õ .1 NOõ ..õ õ õ õ õ õ õ õ õ õ õ ...õ õ õ 2
6.3	Are there any complaint box/ Suggestion box kept at District Hospital?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ õ ..õ õ .1 NOõ ..õ õ õ õ õ õ õ õ õ õ õ ...õ õ õ 2
6.4	Is there Pharmacy of drug storage and drug dispensing at district hospital?	YESõ õ õ õ õ õ õ õ õ õ õ õ õ ..õ õ .1 NOõ ..õ õ õ õ õ õ õ õ õ õ õ ...õ õ õ 2

WARDS AND BEDS

	WARD	AVAILABLE A	TOTAL NO OF BEDS B	MALE C	FEMALE D
6.5	General Medicine Ward	Yes--------------1 No--------------2	☐☐	☐☐	☐☐
6.6	General Surgery Ward	Yes--------------1 No--------------2	☐☐	☐☐	☐☐
6.7	Pediatric Ward	Yes--------------1 No--------------2	☐☐		
6.8	Intensive Medicine Care Unit	Yes--------------1 No--------------2	☐☐	☐☐	☐☐
6.9	Post Operation Ward	Yes--------------1 No--------------2	☐☐	☐☐	☐☐
6.10	Labour Room	Yes--------------1 No--------------2	☐☐		
6.11	ANC Ward	Yes--------------1 No--------------2	☐☐		
6.12	PNC Ward	Yes--------------1 No--------------2	☐☐		
6.13	Post Partum Ward	Yes--------------1 No--------------2	☐☐		
6.14	High Dependency Ward	Yes--------------1 No--------------2	☐☐		
6.15	Burn Ward	Yes--------------1 No--------------2	☐☐		

	OPERATION THEATRE		
Q. No.	OPERATION THEATER	Available	Currently Use
6.16	Elective OT-Major	Yesõ õ õ õ õ õ 1 Noõ õ õ õ õ õ 2	Yesõ õ õ õ õ 1 Noõ õ õ õ õ 2
6.17	Emergency OT/ Family Welfare OT	Yesõ õ õ õ õ ....1 Noõ õ õ õ õ õ 2	Yesõ õ õ õ õ 1 Noõ õ õ õ õ 2
6.18	Ophthalmology / ENT OT	Yesõ õ õ õ õ õ 1 Noõ õ õ õ õ õ .2	Yesõ õ õ õ õ 1 Noõ õ õ õ õ 2

	DELIVERY SUIT UNIT		
Q. No.	DELIVERY SUIT UNIT	Available A	CURRENTLY IN USE B
6.19	Labour room (aseptic & Clean)	Yesõ õ õ õ õ õ 1 Noõ õ õ õ õ .õ 2	Yesõ õ õ õ õ 1 Noõ õ õ õ .õ 2
6.20	Delivery room	Yesõ õ õ õ õ ....1 Noõ õ õ õ .õ õ 2	Yesõ õ õ õ õ 1 Noõ õ õ .õ õ 2
6.21	Neo-natal room	Yesõ õ õ õ õ õ 1 Noõ õ õ õ .õ õ .2	Yesõ õ õ õ õ 1 Noõ õ õ õ .õ 2

VII.	EMERGENCY OBSTETRIC CARE	Available
7.1	Whether obstetrician /gynecologist is available for 24 hrs?	Yesõ õ õ õ õ õ 1 Noõ õ õ õ .õ õ 2
7.2	Whether anesthetist is available for 24 hrs?	Yesõ õ õ õ õ õ 1 Noõ õ õ õ .õ õ 2
7.3	Whether Nurse in Obs/Gynae is available for 24 hrs?	Yesõ õ õ õ õ õ 1 Noõ õ õ õ .õ õ 2
7.4	Whether District Hospital provides for 24 hrs surgical interventions?	Yesõ õ õ õ õ õ 1 Noõ õ õ õ .õ õ 2

VIII. SERVICES (DURING LAST ONE MONTH) RECORD REFERENCE

Q. No.	A. Essential Services Provided Obs / Gynae department	Total Number
8.1	OPD Patients	
8.2	In-patient Admissions	
8.3	Average day of inpatients stay	
	B. Performance	
8.4	Total No. of surgeries done (Considered only RCH related surgeries ex. Delivery, Hysterectomy etc.)	
8.5	Total Number of Hysterectomy done	
8.6	Total No of D&C done	
8.7	Number of Deliveries performed	
8.8	Number of C-Section deliveries performed	PLANNED ELECTIVE Aí . Bí í
8.9	Of the total deliveries performed, how many were beneficiaries of Janani Suraksha Yojana	

8.10	Number of blood transfusion done	
8.11	Number of MTPs performed	
8.12	Number of Sterilizations Conducted	A. Male… B.Female… .
8.13	Number of cases provided with RTI/STI services	
8.14	**CHECK: Q4.15** Total Number of cases visited Integrated Counseling Testing Centre ICTC	STI A. HIV B.
8.15	Total Number of Pap smear prepared	

IX. OTHER ACTIVITIES

Q. No.	Particulars	
9.1	Is Citizen's charter displayed at DH?	Yes… … … … … … … … … … 1 No… … … … … … … … … … .2
9.2	Has the Rogi Kalyan Samiti (RKS) been constituted?	Yes… … … … … … … … … … ..1 No… … … … … … … … … … … 2 ⟶ Skip toQ9.4
9.3	Does RKS monitor your work regularly?	Yes… … … … … … … … … … 1 No… … … … … … … … … … ..2

CLEANLINESS (BY OBERVATION)		
9.4	Whether the Cleanliness of	**GOOD----1 FAIR------2 POOR-----3**
	A. OPD	GOOD.. … .1 FAIR… … ..2 POOR… … 3
	B. ROOMS	GOOD.. … .1 FAIR… … ..2 POOR… … 3
	C. WARDS	GOOD.. … .1 FAIR… … ..2 POOR… … 3
	D. PREMISES	GOOD ..… .1 FAIR… … ...2 POOR… … 3

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