

A18	Last child born (DD/MM/YYYY)	_ _ / _ _ / _ _ _ _
A19	What is your marital status? If the answer is " Married/union", please do answer A19.1	<input type="checkbox"/> Single <input type="checkbox"/> Married/union <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Other: _____
A19.1	Type of union?	<input type="checkbox"/> Monogamous <input type="checkbox"/> Poligamous
A20	Until which class did you study? <i>If university degree put 13</i>	_ _
A20.1	If you studied in the university please indicate the degree completed	<input type="checkbox"/> Licentiate <input type="checkbox"/> Master's degree <input type="checkbox"/> PhD
A21	What is your main occupation?	<input type="checkbox"/> Housewife <input type="checkbox"/> House maid <input type="checkbox"/> Agriculture <input type="checkbox"/> Small scale business <input type="checkbox"/> Employed/technician/manager <input type="checkbox"/> Student <input type="checkbox"/> Other: _____
A22	Do you have other income generating activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A23	To which ethnic group do you belong?	<input type="checkbox"/> Changana <input type="checkbox"/> Ronga <input type="checkbox"/> Chope <input type="checkbox"/> Chitswa <input type="checkbox"/> Other: _____
A24	To which religion do you belong?	<input type="checkbox"/> Catholic <input type="checkbox"/> Zionist <input type="checkbox"/> Jehovah's witness <input type="checkbox"/> Other Protestant <input type="checkbox"/> Muslim <input type="checkbox"/> Hindu <input type="checkbox"/> Animist/traditional <input type="checkbox"/> None <input type="checkbox"/> Other: _____

Section B - Module birth history		
<p><i>I would now like to ask you about your experience of pregnancy and childbirth. Some questions are about your experience in the health facility where you went. Please remember that nothing you tell us will be shared with the health facility and your responses will not negatively affect health care for you or your children in the future, There is no right or wrong answers to these questions. What is important is YOUR opinion. What we want to understand is YOUR experience.</i></p>		
B1	<p>Did any of your pregnancies result into a miscarriage? <i>Consider abortion as baby loss during the first 6 months of pregnancy, i.e. up to 27 weeks</i></p> <p><i>If No go to B3</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B2	If yes, How many miscarriages did you have?	_ _
B3	How many children did you give birth to?	_ _
B4	So, in total, how many pregnancies did you have?	_ _
B5	Have you ever delivered a baby by cesarean section?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B6	If yes, how many cesarean sections did you have?	_ _
B7	Have you ever delivered a baby which was born dead? <i>If no go to B9</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B8	If so, how many	_ _
B9	Have you ever delivered a child who had cried or showed some signs of being alive, but unfortunately died immediately afterwards? <i>If no go to B11</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B10	If so, how many	_ _
B11	Did any of you babies born alive died later? <i>If no go to B13</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B12	If so, how many	_ _
B13	Let me check again, it is right that you had _ _ pregnancies <i>If Yes go to B15</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B14	If B13 is not correct please clarify the number of pregnancies here. <i>(Please note that if you make correction to this question, return to the previous one and correct where it was not right)</i>	_ _
<p><i>Now, I am going to ask questions about your last delivery</i></p>		
B15	Where did you deliver your last baby? <i>If Health facility go to B16</i>	<input type="checkbox"/> Health facility <input type="checkbox"/> On the way <input type="checkbox"/> Home <input type="checkbox"/> Other _____

B15.1	In the case you delivered outside of health facility, did you immediately go to health center/hospital after the delivery? <i>If "No" go to B19</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	
B16	Please say the name of health post/health center/hospital where you delivered or had assistance after having delivered (chosed from listed facilities below)				
	Distrito de BILENE- MACIA			Distrito de CHIBUTO	
B16.1	<input type="checkbox"/>	Centro de Saúde de Chissano	B16.21	<input type="checkbox"/>	Centro de Saúde de Coca-Missava
B16.2	<input type="checkbox"/>	Centro de Saúde de Licilo	B16.22	<input type="checkbox"/>	Centro de Saúde de Malehice
B16.3	<input type="checkbox"/>	Centro de Saúde da Macia	B16.23	<input type="checkbox"/>	Centro de Saúde de Muavaquene
B16.4	<input type="checkbox"/>	Centro de Saúde Mamonho	B16.24	<input type="checkbox"/>	Centro de Saúde de Mucotuene
B16.5	<input type="checkbox"/>	Centro de Saúde de Mazivila	B16.25	<input type="checkbox"/>	Centro de Saúde de Txaimite
B16.6	<input type="checkbox"/>	Centro de Saúde de Messano	B16.26	<input type="checkbox"/>	Hospital Rural de Chibuto
B16.7	<input type="checkbox"/>	Centro de Saúde de Olombe		Distrito de MAGUDE	
	Distrito de CHÓKWÉ		B16.27	<input type="checkbox"/>	Centro de Saúde Chicutso
B16.8	<input type="checkbox"/>	Centro de Saúde de Hokwé	B16.28	<input type="checkbox"/>	Centro de saúde de Magude
B16.9	<input type="checkbox"/>	Centro de Saúde de Xilembene	B16.29	<input type="checkbox"/>	Centro de Saúde de Mahele
B16.10	<input type="checkbox"/>	Hospital Rural de Chókwé	B16.30	<input type="checkbox"/>	Centro de Saúde de Moine
	Distrito da MANHIÇA		B16.31	<input type="checkbox"/>	Centro de Saúde de Motaze
B16.11	<input type="checkbox"/>	Centro de Saúde da Maragra	B16.32	<input type="checkbox"/>	Centro de Saúde de Panjane
B16.12	<input type="checkbox"/>	Centro de Saúde de Munguine		Distrito de XAI-XAI	
B16.13	<input type="checkbox"/>	Centro de Saúde de Maluana	B16.33	<input type="checkbox"/>	Centro de Saúde de Chonguene
B16.14	<input type="checkbox"/>	Centro de Saúde de Calanga	B16.34	<input type="checkbox"/>	Centro de Saúde Siaia
B16.15	<input type="checkbox"/>	Centro de Saúde de Malavele	B16.35	<input type="checkbox"/>	Centro de Saúde Vlademir Lenine
B16.16	<input type="checkbox"/>	Centro de Saúde de Palmeira	B16.36	<input type="checkbox"/>	Hospital Provincial de Xai-Xai
B16.17	<input type="checkbox"/>	Centro de Saúde 3 de Fevereiro	B16.37	<input type="checkbox"/>	Hospital Rural de Chicumbane
B16.18	<input type="checkbox"/>	Centro de Saúde de Taninga		Outros	
B16.19	<input type="checkbox"/>	Centro de Saúde Ilha Josina	B16.38	<input type="checkbox"/>	Hospital Geral José Macamo
B16.20	<input type="checkbox"/>	Hospital Distrital de Manhiça	B16.39	<input type="checkbox"/>	Hospital Central de Maputo
B16.39	<input type="checkbox"/>	Hospital Rural de Xinavane	B16.40	<input type="checkbox"/>	Outros _____
B17	Where you transferred during the delivery or after the delivery? <i>If "No" go to B19</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	
B18	To what health center/hospital? (chosed from list of health facility below) (allow multiple answer in case the woman had subsequent referrals)				
	Distrito de BILENE- MACIA			Distrito de CHIBUTO	
B18.1	<input type="checkbox"/>	Centro de Saúde de Chissano	B18.21	<input type="checkbox"/>	Centro de Saúde de Coca-Missava
B18.2	<input type="checkbox"/>	Centro de Saúde de Licilo	B18.22	<input type="checkbox"/>	Centro de Saúde de Malehice
B18.3	<input type="checkbox"/>	Centro de Saúde da Macia	B18.23	<input type="checkbox"/>	Centro de Saúde de Muavaquene
B18.4	<input type="checkbox"/>	Centro de Saúde Mamonho	B18.24	<input type="checkbox"/>	Centro de Saúde de Mucotuene
B18.5	<input type="checkbox"/>	Centro de Saúde de Mazivila	B18.25	<input type="checkbox"/>	Centro de Saúde de Txaimite
B18.6	<input type="checkbox"/>	Centro de Saúde de Messano	B18.26	<input type="checkbox"/>	Hospital Rural de Chibuto

B18.7	<input type="checkbox"/>	Centro de Saúde de Olombe		Distrito de MAGUDE	
		Distrito de CHÓKWÉ	B18.27	<input type="checkbox"/>	Centro de Saúde Chicutso
B18.8	<input type="checkbox"/>	Centro de Saúde de Hokwé	B18.28	<input type="checkbox"/>	Centro de saúde de Magude
B18.9	<input type="checkbox"/>	Centro de Saúde de Xilembene	B18.29	<input type="checkbox"/>	Centro de Saúde de Mahele
B18.10	<input type="checkbox"/>	Hospital Rural de Chókwé	B18.30	<input type="checkbox"/>	Centro de Saúde de Moine
		Distrito da MANHIÇA	B18.31	<input type="checkbox"/>	Centro de Saúde de Motaze
B18.11	<input type="checkbox"/>	Centro de Saúde da Maragra	B18.32	<input type="checkbox"/>	Centro de Saúde de Panjane
B18.12	<input type="checkbox"/>	Centro de Saúde de Munguine		Distrito de XAI-XAI	
B18.13	<input type="checkbox"/>	Centro de Saúde de Maluana	B18.33	<input type="checkbox"/>	Centro de Saúde de Chonguene
B18.14	<input type="checkbox"/>	Centro de Saúde de Calanga	B18.34	<input type="checkbox"/>	Centro de Saúde Siaia
B18.15	<input type="checkbox"/>	Centro de Saúde de Malavele	B18.35	<input type="checkbox"/>	Centro de Saúde Vladimir Lenine
B18.16	<input type="checkbox"/>	Centro de Saúde de Palmeira	B18.36	<input type="checkbox"/>	Hospital Provincial de Xai-Xai
B18.17	<input type="checkbox"/>	Centro de Saúde 3 de Fevereiro	B18.37	<input type="checkbox"/>	Hospital Rural de Chicumbane
B18.18	<input type="checkbox"/>	Centro de Saúde de Taninga		Outros	
B18.19	<input type="checkbox"/>	Centro de Saúde Ilha Josina	B18.38	<input type="checkbox"/>	Hospital Geral José Macamo
B16.20	<input type="checkbox"/>	Hospital Distrital de Manhiça	B18.39	<input type="checkbox"/>	Hospital Central de Maputo
B16.39	<input type="checkbox"/>	Hospital Rural de Xinavane	B18.40	<input type="checkbox"/>	Outro _____
<i>I would like you to remember what happened on that time since the first symptoms of labour. I am going to use a timetable to help you to remember.</i>					
B19	At what time did you realize that labor started?		_____ h (round to full hours) <input type="checkbox"/> Don't know		
B20	How long did it take you to make the decision to go to the facility after labor started or you had a problem?		_____ h (round to full hours) <input type="checkbox"/> N/A because went to health facility BEFORE labour started. <i>Go to B 26</i> <input type="checkbox"/> N/A because didn't go to health facility. <i>Go to B 27</i>		
B21	Who took the decision to go to the health facility?		<input type="checkbox"/> Herself <input type="checkbox"/> Mother <input type="checkbox"/> Mother in law <input type="checkbox"/> Husband/partner <input type="checkbox"/> Other relative <input type="checkbox"/> Other: _____		
B22	How long did it take you to go out home, after having decided to go to the health facility?		_____ h (round to full hours)		
B23	How long did it take you to travel to the facility?		_____ h (round to full hours)		
B24	How long did they take to attend you at the health facility?		_____ h (round to full hours)		
B25	Did you receive any medication in the facility to speed up labour?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
B26	Did you take any herbal medicine to speed up labor?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
B27	When the baby was born?		_____ h (round to full hours)		
B28	[automatic calculation] <i>How long did the labor take in total, from the first moment the mother realized that birth started to the time the baby was born?</i>		_____ day _____ hours (round to full hours)		

B29	Was the baby delivered alone or with its twin? <i>If single go to B31</i>	<input type="checkbox"/> Single <input type="checkbox"/> Multiple
B30	If it were twins, how many?	_ _
B31	How did you deliver your last baby? <i>Give women the choices and probe for ventouse and breech delivery. Explain what is cesarean section, ask if her abdomen was open to deliver the baby</i> [answer for each twin if it is the case] <i>(skip to B35 if NOT a Caesarean section)</i>	<input type="checkbox"/> Spontaneous vertex (vaginally) <input type="checkbox"/> Breech vaginally <input type="checkbox"/> Ventouse <input type="checkbox"/> Caesarian section
B32	Have you had problem with wound dehiscence? <i>Did the wound open?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B33	Have you had problem with infection in the scar? <i>Probe...fever, antibiotic</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B34	Have you or have you had pain in the scar?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B35	Who supported you when delivering this child? Tick ALL that applies <i>Probe the type of the person who supported her, and list down each person.</i>	<input type="checkbox"/> Doctor <input type="checkbox"/> Clinical officer (Técnico de cirurgia) <input type="checkbox"/> Nurse/Midwife <input type="checkbox"/> Auxiliary Nurse/midwife <input type="checkbox"/> Traditional birth attendant <input type="checkbox"/> Relative <input type="checkbox"/> Other: _____ <input type="checkbox"/> None <input type="checkbox"/> Don't know
B36	Do you have a Caderneta de Saúde da Mulher, do you allow me to take some information from this care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B37	Was the height of the mother recorded as being below 150 cm?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Missing
B38	Could you check what the birth weight of the baby was? (info from <i>Caderneta de Saúde da Mulher</i>) [answer for each twin if it is the case]	_ _ _ grams <input type="checkbox"/> Not available from the caderneta
B38.1	If not available from the caderneta, do you know what the birth weight of the baby was? [answer for each twin if it is the case]	<input type="checkbox"/> Yes _ _ _ gram <input type="checkbox"/> No
B39	Could you check what the head circumference of the baby was? (info from <i>Caderneta de Saúde da Mulher</i> Recem nascido Perimetro cranenano) [answer for each twin if it is the case]	_ _ cm <input type="checkbox"/> Missing
B40.1	Could you check what the 1 st minute Apgar score of the baby was? (info from <i>Caderneta de Saúde da Mulher</i> Recem nascido Recem nascido Apgar (Check <i>Caderneta de Saúde da Mulher</i>) [answer for each twin if it is the case]	APGAR _ 1 min <input type="checkbox"/> Missing
B40.2	Could you check what the 5 th minute Apgar score of the baby was? (info from <i>Caderneta de Saúde da Mulher</i> Recem nascido Recem nascido Apgar (Check <i>Caderneta de Saúde da Mulher</i>) [answer for each twin if it is the case]	APGAR _ 5 min <input type="checkbox"/> Missing

B41	Have you been tested for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Missing
B42	What is the result (Check <i>Caderneta de Saúde da Mulher</i>)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Undetermined
B43	Have you been submitted to surgery up to 42 days after delivery? <i>if No jump to Section C Fistula module</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
B44	Does your uterus has been removed? <i>If Yes jump to Section C Fistula module</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
B45	If the uterus has not been removed in that surgery, do you know what kind of procedure has been done? <i>Check if you have any hospital document to complete the information provided (hospital card, letter of hospital discharge, referral letter, other...)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe the procedure: _____

Section C - Fistula module		
<i>Sometimes a woman can have a problem such that she experiences a constant leakage of urine or stool from her vagina during the day or night. It also can happen that a women has this problem only from time to time when coughed, laughed, sneezed etc.</i>		
C1	Do you know that constant leakage of urine or stool from your vagina can be a disastrous complication after birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C2	Have you heard about women's rights to get proper treatment in case of suffering from constant leakage of urine or stool from your vagina?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C3	Have you, BEFORE your last pregnancy, ever experienced a constant leakage of urine or stool from your vagina during the day and night?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
C4	Have you AFTER your last pregnancy ever experienced a constant leakage of urine or stool from your vagina during the day and night? <i>If No, go to Section D - Perceived health and pain</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
C5	How would you rate your last labor? Was it normal, or difficult or even very difficult?	<input type="checkbox"/> Normal <input type="checkbox"/> Difficult <input type="checkbox"/> Very difficult
C6	What kind of leakage do you experience?	<input type="checkbox"/> Urine only <input type="checkbox"/> Urine and stool <input type="checkbox"/> Stool only
C7	How many days after delivery did the leakage start?	_ _ _

C8	In the past 7 days, have you lost or leaked urine when you coughed, laughed, sneezed etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
C9	Has it been a big, little or no problem for you	<input type="checkbox"/> Big problem <input type="checkbox"/> Little problem <input type="checkbox"/> No problem
C10	Have you sought treatment for this condition? <i>If Yes go to C12</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
C11	If No, Why have you not sought treatment? <i>Tick ALL that applies</i> <i>Go to module perceived health and pain after answering this question</i>	<input type="checkbox"/> Did not know problem could be fixed <input type="checkbox"/> Do not know where to go <input type="checkbox"/> Too expensive <input type="checkbox"/> Too far to reach treatment facility <input type="checkbox"/> Poor quality of care at treatment facility <input type="checkbox"/> Could not get permission to go <input type="checkbox"/> Embarrassment <input type="checkbox"/> Other: _____
C12	If yes, where did you seek treatment?	<input type="checkbox"/> Health center <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____
C13	Have you been operated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C14	From whom did you last seek treatment?	<input type="checkbox"/> Doctor/ <input type="checkbox"/> Clinical officer (Técnico de Cirurgia) <input type="checkbox"/> Nurse/Midwife <input type="checkbox"/> Auxiliary nurse <input type="checkbox"/> Traditional healer <input type="checkbox"/> Traditional birth attendant <input type="checkbox"/> APE <input type="checkbox"/> Religious activist <input type="checkbox"/> Other: _____
<p>Section D - Perceived health and pain <i>I would now like to ask you about how you perceive your health now.</i> <i>For this section you might use the smiley</i></p>		
D1	How do you perceive your overall health now?	<input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Neither good or bad <input type="checkbox"/> Bad <input type="checkbox"/> Very bad
D2	Have you had any pain within the last 24 hours? <i>If No go to D7</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
D3	Where do you feel pain or have felt pain in the past 24 hours. <i>Tick ALL that applies</i>	<input type="checkbox"/> In your back <input type="checkbox"/> In your head <input type="checkbox"/> On the <i>outside</i> of your abdomen or front <input type="checkbox"/> <i>Deep inside</i> your abdomen or front <input type="checkbox"/> In your bottom or genital area <input type="checkbox"/> Other: _____

D4	How severe is the <i>worst</i> pain you have had in the last 24 hours? <i>Mark ONLY the answer that best describes the pain the woman explains</i>	<input type="checkbox"/> Almost no pain <input type="checkbox"/> Mild or a small amount of pain <input type="checkbox"/> Quite a lot of pain <input type="checkbox"/> Severe or excruciating <input type="checkbox"/> Terrible pain
D5	Have you taken any kind of tablets or medicine for the pain in the last 24 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D6	Have you taken any kind of traditional medicine for the pain in the last 24 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D7	If you have had sex since the birth of your baby, was it painful on the most recent occasion? <i>If No OR Have not had sex BUT delivered with caesarian section go to Section E</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Have not had sex
D8	How severe was the pain?	<input type="checkbox"/> Almost no pain <input type="checkbox"/> Mild or a small amount of pain <input type="checkbox"/> Quite a lot of pain <input type="checkbox"/> Severe or excruciating <input type="checkbox"/> Terrible pain

Section E - Health system delivery service responsiveness module (including perceived quality and satisfaction, experience of disrespect...)

Now I would like to ask you a few questions on your last delivery, how you felt about the service provided to you and how satisfied you were with your birth experience.

Some questions I have, relate to how you feel about you were taken care of at the facility where you went. For those questions you can use this "ruler" [present the smiley options showing the different alternatives to the woman]. I will let you know when this can be applied.

E1	Why did you chose the place where you had your delivery? (tick all that apply)	<input type="checkbox"/> Nearest facility <input type="checkbox"/> Best facility/clean environment/good services <input type="checkbox"/> Same facility used for ANC <input type="checkbox"/> To get services not available elsewhere <input type="checkbox"/> Hospital of choice for delivery <input type="checkbox"/> Affordable services <input type="checkbox"/> Recommended by relative/friend <input type="checkbox"/> Avoid congestion in other facilities <input type="checkbox"/> Referred from another facility <input type="checkbox"/> Well equipped facility with supplies <input type="checkbox"/> Only option <input type="checkbox"/> Facility offer specialized services <input type="checkbox"/> Because of complications <input type="checkbox"/> Providers treat clients well <input type="checkbox"/> Decision made by spouse <input type="checkbox"/> Like the facility <input type="checkbox"/> Other: _____
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E2	<p>How did you get to the place where you delivered?</p> <p><i>If N/A or delivered at home, skip to E7</i></p>	<input type="checkbox"/> Ambulance <input type="checkbox"/> Private car <input type="checkbox"/> Taxi motorcycle/Tutuk <input type="checkbox"/> Stretcher <input type="checkbox"/> Bicycle <input type="checkbox"/> Walked <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A (delivered at home)
E3	<p>Approximately how many hours did it take you to travel to the place where you had your delivery?</p>	<input type="checkbox"/> 0 - 30 minutes <input type="checkbox"/> up to 1 hour <input type="checkbox"/> 1 – 3 hours <input type="checkbox"/> more than 3 hours <input type="checkbox"/> Don't know <input type="checkbox"/> N/A (delivered at home)
E4	<p>Who accompanied you to the place where you gave birth?</p>	<input type="checkbox"/> No one <input type="checkbox"/> Mother <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Husband/partner <input type="checkbox"/> Other relative <input type="checkbox"/> Other: _____ <input type="checkbox"/> N/A (delivered at home)
E5	<p>How did you feel about the way you were welcomed at this health facility?</p>	<input type="checkbox"/> Very unhappy 😞 <input type="checkbox"/> Unhappy 😐 <input type="checkbox"/> Neither unhappy nor happy 😐 <input type="checkbox"/> Happy 😊 <input type="checkbox"/> Very happy 😄 <input type="checkbox"/> N/A (delivered at home)
E6	<p>How do you feel about the sanitation of the health facility? (How clean was it?) Pictures....</p>	<input type="checkbox"/> Very unhappy 😞 <input type="checkbox"/> Unhappy 😐 <input type="checkbox"/> Neither unhappy nor happy 😐 <input type="checkbox"/> Happy 😊 <input type="checkbox"/> Very happy 😄
E7	<p>Were you allowed to have someone accompanying you throughout your delivery? <i>If no, go to E9</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
E8	<p>If yes, who accompanied you throughout your delivery?</p>	<input type="checkbox"/> Mother <input type="checkbox"/> Mother-in-law <input type="checkbox"/> Husband/partner <input type="checkbox"/> Other relative <input type="checkbox"/> Friend/neighbor <input type="checkbox"/> Traditional birth attendant <input type="checkbox"/> Primary health care agent (APE) <input type="checkbox"/> Other: _____
E9	<p>During your delivery, how would you rate the experience of being respectfully treated? I mean being treated with care and attention</p>	<input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Neither good or bad <input type="checkbox"/> Bad <input type="checkbox"/> Very bad

E10	Did you feel abandoned when you needed help? <i>For example, did you ask for help and nobody come?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No, Go toE12
E11	When? <i>(DO NOT READ, Circle all that apply, prompt for any more)</i>	<input type="checkbox"/> While in labor <input type="checkbox"/> While delivering <input type="checkbox"/> While experiencing a complication <input type="checkbox"/> After delivery <input type="checkbox"/> Baby after delivery <input type="checkbox"/> Other _____
E12	How do you feel about the time taken to attend to you during your delivery?	<input type="checkbox"/> Very unhappy 😞 <input type="checkbox"/> Unhappy 😐 <input type="checkbox"/> Neither unhappy nor happy 😊 <input type="checkbox"/> Happy 😄 <input type="checkbox"/> Very happy 😁
E13	On a scale of 1-5 were you treated in a way that made you feel humiliated or disrespected? <i>A 5 means "I did not feel humiliated or disrespected". A 1 mean "I feel very humiliated or disrespected".</i>	<input type="checkbox"/> Very humiliated or disrespected 1 <input type="checkbox"/> Not very humiliated/disrespected 2 <input type="checkbox"/> Somewhat humiliated/disrespected 3 <input type="checkbox"/> A little humiliated/disrespected 4 <input type="checkbox"/> Not humiliated/disrespectfully treated5
E13B	Let me check again: did you deliver in a health facility? If you delivered at home or on the way, have you got assistance in a health unit after the delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No, <i>STOP the interview</i>
Question ONLY for women who delivered at HEALTH FACILITY		
E14	At any point during your stay for this delivery were you physically abused by any of the health care workers? For example physical abuse might include being hit or slapped.	<input type="checkbox"/> Yes <input type="checkbox"/> No, <i>GO to E17</i>
E15	What exactly happened? <i>(DO NOT READ, tick all that apply, prompt for any more)</i>	<input type="checkbox"/> Shouted <input type="checkbox"/> Kicked <input type="checkbox"/> Pinched <input type="checkbox"/> Slapped <input type="checkbox"/> Pushed <input type="checkbox"/> Beaten <input type="checkbox"/> Tied to the delivery bed/delivery coach <input type="checkbox"/> Other _____
E16	On a scale of 1 to 5 how bad did you feel/how much did you suffer as a result of being physically disrespected? <i>a 5 means "I did not feel bad or suffer at all." a 1means you felt the worst you could possibly feel/suffer</i>	<input type="checkbox"/> Felt very bad 1 <input type="checkbox"/> Not very bad 2 <input type="checkbox"/> Somewhat bad 3 <input type="checkbox"/> A little bad 4 <input type="checkbox"/> Not bad at all 5
E17	How would you rate the way privacy was respected during the physical examination?	<input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Neither good or bad <input type="checkbox"/> Bad <input type="checkbox"/> Very bad

E18	How would you rate the experience of how clearly the health providers explained things to you such as why something needed to be done?	<input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Neither good or bad <input type="checkbox"/> Bad <input type="checkbox"/> Very bad
E19	Did the health providers ask you for consent before doing any intervention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> N/A (no intervention done)
E20	How do you feel about the answers you received to your questions during your delivery?	<input type="checkbox"/> Very unhappy 😞 <input type="checkbox"/> Unhappy 😐 <input type="checkbox"/> Neither unhappy nor happy 😊 <input type="checkbox"/> Happy 😄 <input type="checkbox"/> Very happy 😁
E21	If you needed special medicines during the delivery were you able to get the medicines the health provider prescribed	<input type="checkbox"/> Yes, all were available <i>go to E23</i> <input type="checkbox"/> Most were available <input type="checkbox"/> Some were, some not <input type="checkbox"/> Very few were available <input type="checkbox"/> None of them was available <input type="checkbox"/> Did not need special medicines <i>go to E23</i>
E22	Which reasons explain why you were not able to get the medicines you were prescribed	<input type="checkbox"/> Could not afford <input type="checkbox"/> Were not available <input type="checkbox"/> Did not believe that all the medicines were needed <input type="checkbox"/> Started to feel better <input type="checkbox"/> Already had some medicines at home <input type="checkbox"/> Other: _____
E23	Did you pay officially to have access to the health unit for your delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E24	At any point during this facility did you feel/perceive or were asked by anyone for money other than the official costs of the service to access services or any favor?	<input type="checkbox"/> Yes <input type="checkbox"/> No (<i>go to question E26</i>)
E25	How much did you pay for the above?	_____ MT
E26	If you now reconsider your birth experience, would you recommend a family member to deliver in the health facility where you delivered?	<input type="checkbox"/> Yes, very much <input type="checkbox"/> Yes <input type="checkbox"/> Undecided <input type="checkbox"/> No <input type="checkbox"/> Not at all
E27	How would you rate the knowledge and competence of health workers at this facility for this delivery?	<input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Neither good or bad <input type="checkbox"/> Bad <input type="checkbox"/> Very bad
E28	Overall, taking everything into account, how are the services in the facility where you delivered your last baby?	<input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Neither good or bad <input type="checkbox"/> Bad <input type="checkbox"/> Very bad

Specific question for women who received a Caesarean section		
E29	What do you personally think: Do you feel that the Caesarean section was necessary?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Question ONLY for women who had a LIVE birth		
E30	How would you rate the experience of being helped by the health providers to feed your baby after your delivery?	<input type="checkbox"/> Very unhappy 😞 <input type="checkbox"/> Unhappy 😐 <input type="checkbox"/> Neither unhappy nor happy 😊 <input type="checkbox"/> Happy 😄 <input type="checkbox"/> Very happy 😁

Thank the women and end the interview

	Finishing time <i>hour /minute</i>	_ _ : _ _
	Signature (interviewer code)	