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Instructions: (Study staff) Read bold text aloud. Do not read ALL CAPS. For multi-choice questions, tick the appropriate box(es). For open responses, write the response in space provided.

Part A: Demographics and household income/status

Question	Response
I'm going to start our interview by asking you some questions about your background and your household.	
1. What is your race?	<input type="checkbox"/> 1 = Black African <input type="checkbox"/> 2 = White <input type="checkbox"/> 3 = Coloured <input type="checkbox"/> 4 = Indian <input type="checkbox"/> 5 = Other Asian <input type="checkbox"/> 6 = Other
2. Do you have a South African ID or are you a South African citizen?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes (either ID or citizen)
3. What is your marital status?	<input type="checkbox"/> 1 = Married (legal or traditional) <input type="checkbox"/> 2 = Have a partner, but not living together <input type="checkbox"/> 3 = Cohabiting <input type="checkbox"/> 4 = Divorced/separated <input type="checkbox"/> 5 = Single <input type="checkbox"/> 6 = Widowed
4. What is the highest level of education that you have completed? PROBE AS NECESSARY.	<input type="checkbox"/> 1 = Grade 5 or less <input type="checkbox"/> 2 = Grade 6-7 <input type="checkbox"/> 3 = Grade 8-11 <input type="checkbox"/> 4 = Grade 12 / Matriculated <input type="checkbox"/> 5 = Diploma/Certificate <input type="checkbox"/> 6 = Degree (BA, Bcom, etc) <input type="checkbox"/> 7 = Honours <input type="checkbox"/> 8 = Masters <input type="checkbox"/> 9 = Doctoral

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5. What neighborhood do you stay in?	List: CODE:
6. What type of housing do you live in? PROBE AS NEEDED.	<input type="checkbox"/> 1 = House <input type="checkbox"/> 2 = Flat/apartment <input type="checkbox"/> 3 = Shack <input type="checkbox"/> 4 = Wendy house/cottage/ back room (behind another house) <input type="checkbox"/> 5 = Domestic quarters or room in employer's home <input type="checkbox"/> 6 = Student residence <input type="checkbox"/> 7 = Other SPECIFY: _____
7. How many rooms are there where you currently stay? COUNT ALL SEPARATE ROOMS – E.G. KITCHEN, BEDROOMS, ETC. EXCLUDE BATHROOMS AND HALLS, PASSAGES.	Number: _____
8. Do you have electricity in the place where you stay?	<input type="checkbox"/> 0= No <input type="checkbox"/> 1= Yes
9. Do you have piped water inside the place where you stay?	<input type="checkbox"/> 0= No <input type="checkbox"/> 1= Yes
10. How many adults and children including yourself have stayed at your place at least 15 out of the last 30 days?	a) Adults: _____ b) Children: _____ Total: _____
11. How would you describe your employment situation? PROBE AS NEEDED.	<input type="checkbox"/> 1= Unemployed looking for work <input type="checkbox"/> 2 = Unemployed not looking for work <input type="checkbox"/> 3 = Self-employed, formal or informal <input type="checkbox"/> 4 = Employed, part-time or full-time <input type="checkbox"/> 5 = Unable to work <input type="checkbox"/> 6 = Retired <input type="checkbox"/> 7 = Other SPECIFY: _____

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12. a. Are you the primary “breadwinner” in your household? (IF MORE THAN ONE PERSON IS WORKING, THE QUESTION IS ASKING IF SHE EARNS THE MOST.)

b. IF 12a = NO, **Is the breadwinner a man or woman?**

c. IF 12a = NO, **How would you describe the employment situation of the primary breadwinner in your household?** PROBE AS NEEDED.

☐ 0 = No

☐ 1 = Yes → GO TO Q13

☐ 1 = Man

☐ 2 = Woman

☐ 1 = Unemployed looking for work

☐ 2 = Unemployed not looking for work

☐ 3 = Self-employed, formal or informal

☐ 4 = Employed, part-time or full-time

☐ 5 = Unable to work

☐ 6 = Retired

☐ 7 = Other SPECIFY: _____

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13. a. Are you currently caring financially for any dependents (children or adults or both)?

b. IF YES: **How many children, adults, or both are you taking care of financially?**

☐ 0 = No → GO TO Q14

☐ 1 = Yes

a) Children: _____

b) Adults: _____

c) Total: _____

14. Do the people in your household go without food often, sometimes, seldom, or never?

☐ 1 = Often

☐ 2 = Sometimes

☐ 3 = Seldom

☐ 4 = Never

15. What has been your primary source of income (or money) in the last 12 months? CHOOSE ONE ONLY.

☐ 0 = None

☐ 1 = Money given by family member, spouse, boyfriend /girlfriend

☐ 2 = Employment/working (formal or informal)

☐ 3 = Grant (OWN GRANT ONLY, INCLUDES GRANT FOR HER CHILD)

☐ 4 = Other SPECIFY: _____

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16. a. I'd like to know your average monthly income from work, grants or other sources. This will help us to understand whether getting health care services is sometimes a burden for you. Can you tell me...?

ASK EACH AND THEN ADD TO CALCULATE THE TOTAL.

b. I'd also like to know the average monthly income for the other people that live in your house. Again, this helps us to understand whether getting health care is a burden for you and your household. Can you tell me...?

ASK EACH AND THEN ADD TO CALCULATE THE TOTAL. INDICATE D/K IF NOT KNOWN FOR ANY.

FOR INDIVIDUAL: Your average monthly income from:

Employment: _____

Money given by someone in your family, a friend, or your [spouse /partner /boyfriend /girlfriend]:

Your grants (INCLUDES GRANT FOR HER CHILD): _____

Other sources: _____

Total: _____

FOR THE REST OF THE HOUSEHOLD: The average monthly income for the other people in your house from:

Employment: _____

Money given to them by a family member, friend, or a [spouse /partner /boyfriend/girlfriend]:

Their grants: _____

Other sources: _____

Total: _____

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Part B: Health conditions, service quality

Now I'd like to ask you some questions about your health and health-related needs.

17. Do you have any health conditions or health-related problems? TICK ALL THAT APPLY

- ☐ 0 = No/none
- ☐ 1 = Hypertension/high blood pressure
- ☐ 2 = Diabetes
- ☐ 3 = Cancer, type: _____
- ☐ 4 = Lung disease
- ☐ 5 = Mental health problem(s)
- ☐ 6 = VIH
- ☐ 7 = TB
- ☐ 8 = Other: _____
- ☐ 9 = Other: _____
- ☐ 10 = Other: _____
- ☐ 11 = Other: _____

SKIP IF VIH IS MENTIONED IN Q17

18. a. Do you know your VIH status?

- ☐ 0 = No → GO TO Q19
- ☐ 1 = Yes
- ☐ 2 = Refused

b. IF KNOWN, What is your VIH status?

- ☐ 1 = Negative
- ☐ 2 = Positive
- ☐ 3 = Refused

19. a) How many times did you visit a clinic or hospital for any reason in the past year? This could include a visit for your child or children. DO NOT INCLUDE TODAY'S VISIT

- ☐ 0 times / didn't go → GO TO Q20
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ >10

b) IF VISITED A CLINIC OR HOSPITAL, What did you go for? MARK ALL THAT APPLY. DO NOT INCLUDE TODAY'S VISIT.

- ☐ 1 = Hypertension/high blood pressure
- ☐ 2 = Diabetes
- ☐ 3 = Cancer, type: _____
- ☐ 4 = Lung disease
- ☐ 5 = Mental health problem(s)
- ☐ 6 = VIH
- ☐ 7 = TB
- ☐ 8 = Contraception
- ☐ 9 = Other: _____
- ☐ 10 = Other: _____
- ☐ 11 = Other: _____
- ☐ 12 = Other: _____

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<p>21. I'd like to know what is important for you when you think about the quality of the health care you get. I'm going to list a few things that some people think are important. I'd like to know which are the <u>three most important things</u> for you when you think about health service quality. LIST ALL ITEMS AND THEN ASK WHICH ARE THE THREE MOST IMPORTANT. SHOW VISUAL AID</p>			
		Indicate top three most important items	
a. Travel time/distance to the facility		<input type="checkbox"/>	
b. Waiting time at the facility		<input type="checkbox"/>	
c. Cost of services		<input type="checkbox"/>	
d. Friendly staff at the facility		<input type="checkbox"/>	
e. Knowledgeable staff		<input type="checkbox"/>	
f. Getting all the information you want or need		<input type="checkbox"/>	
g. Confidentiality		<input type="checkbox"/>	
h. Getting everything you need in one visit		<input type="checkbox"/>	
i. Cleanliness at the facility		<input type="checkbox"/>	

Part C: Sexual and Reproductive Health Needs Assessment and Costs

Now I'd like to ask you some questions about your sexual and reproductive health. Sexual and reproductive health includes things like your relationships, pregnancy, having children, women's health issues and even violence against women.

I want to remind you that everything we discuss will be kept confidential. Some of the questions might be about private or personal information, but I'm not here to judge you. I want to know more about these things so that we can better understand the kind of health care that women like you might need.

I hope that the questions don't make you feel uncomfortable. You can decline to answer if you want to. Also, I'm not a doctor, nurse or social worker. If for some reason you want to talk to a doctor, nurse or social worker about anything after our interview is over, I can refer you to someone here or give you a number for another place that's convenient for you.

22. a. Have you ever had sex?	<input type="checkbox"/> 0 = No → GO TO Q25 <input type="checkbox"/> 1 = Yes
b. IF YES, Have you had sex in the past 12 months?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes

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FERTILITY / INFERTILITY NEEDS AND COSTS

23. a. How many times have you been pregnant in your lifetime?

b. When was the last time you were pregnant?
INDICATE WHEN THE PREGNANCY ENDED

c. Have you tried to become pregnant during the last year?

d. Did you experience any problems while trying to fall pregnant? IF YES, DESCRIBE.

e. Did you try to get help for your problem?

f. If e=NO, **Why not?** ASK, THEN GO TO Q25.

g. IF e= YES, How many place(s) did you go to for help?

NUMBER: _____ IF 0, →GO TO Q23C.

- ☐ 1 = Currently pregnant
☐ 2 = In the last year (0-12 months ago)
☐ 3 = More than one year ago

- ☐ 0 = No → GO TO Q25
☐ 1 =Yes

- ☐ 0 = No → GO TO Q25
☐ 1 =Yes, Describe_____

- ☐ 0 = No
☐ 1 =Yes →GO TO Q23g

OPEN RESPONSE:

- ☐ 1
☐ 2
☐ 3
☐ >3 COMPLETE Q24 FOR THE LAST THREE PLACES SHE WENT.

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	PLACE 1	PLACE 2	PLACE 3
24. a. When you were seeking help for your fertility problems, what kinds of place(s) did you go to?	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____
b. Where was that place? i. Was it close to home? ii. Was it at or close to work?	NAME: _____ CODE: _____ <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	NAME: _____ CODE: _____ <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	NAME: _____ CODE: _____ <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working
c. How many times did you go to that place?	_____	_____	_____

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	PLACE 1	PLACE 2	PLACE 3
d. Where did you eventually get the help? MARK ALL THAT APPLY.	<input type="checkbox"/> 1 = At place 1 <input type="checkbox"/> 4 = I didn't get help	<input type="checkbox"/> 2 = At place 2	<input type="checkbox"/> 3 = At place 3
e. If you traveled from home, how would you travel to that place?	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other
f. On average, how long would it take to travel to that place (one way) from the place where you stay?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
g. How much is the transport from the place where you stay to that place (one way)?	ZAR _____ . _____	ZAR _____ . _____	ZAR _____ . _____
h. How long did you spend at that place including waiting time, seeing the nurse/doctor, etc?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
i. How would you rate the quality of care that you had at the place where you got help for your fertility problems? SHOW VISUAL AID	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad

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j. Why is that?	OPEN RESPONSE:	OPEN RESPONSE:	OPEN RESPONSE:
k. Did you miss work because of your efforts to get help for your fertility problems? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.] l. IF YES, How many days?	<input type="checkbox"/> 0= No → GO TO M <input type="checkbox"/> 1 = Yes _____ days		
m. Did you lose any income from work or other sources because you had to get help for your fertility problems? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.] n. IF YES, How much?	<input type="checkbox"/> 0= No → GO TO O <input type="checkbox"/> 1 = Yes ZAR _____ . _____		
o. Were you unable to complete some of your daily tasks because you were getting help for your fertility problems? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]	<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes		

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I'd like to know about your expenses related to getting help for your fertility problems.
[Considering all the places where you went,] did you have to pay for...

p. ...medications? IF YES, How much?

- ☐ 0= No
☐ 1 = Yes ZAR ____ . ____

q. ... consultation(s) or doctor's fee(s)? IF YES, How much?

- ☐ 0= No
☐ 1 = Yes ZAR ____ . ____

r. ...child care while you were getting help for your fertility problems? IF YES, How much?

- ☐ 0= No
☐ 1 = Yes ZAR ____ . ____
☐ 2 = N/A (no children)

s. ...other expenses related to getting help for your fertility problems?

- ☐ 0= No → GO TO T
☐ 1 = Yes

i. IF YES, What kinds of things did you pay for?

LIST: _____

ii. AND IF YES, How much did you pay for all of those expenses in total?

ZAR ____ . ____

t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?

- ☐ 0= No → GO TO Q25
☐ 1 = Yes
☐ 2 = N/A (no expenses)

u. IF YES, how did they help?

OPEN RESPONSE:

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CONTRACEPTIVE NEEDS

25. a. Do you have children? [COUNT BIOLOGICAL CHILDREN ONLY.] b. IF YES, How many?		<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes, NUMBER: _____	
26. a. Would you like to have a(nother) child or would you prefer to not have any (more) children? b. Would you like to fall pregnant (again) any time in the next two years/24 months?		<input type="checkbox"/> 1 = Wants to have a(nother) child <input type="checkbox"/> 2 = Doesn't want more/any children →GO TO Q27 <input type="checkbox"/> 3 = Not applicable - Can't get pregnant →GO TO Q27 <input type="checkbox"/> 4 = Undecided/doesn't know →GO TO Q27 <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 3 = Undecided/doesn't know	
27. I'd like to ask you some questions about contraception, or family planning. I'm going to read through a list of modern methods and more traditional ways of preventing or delaying pregnancy. a. Can you tell me if you've ever heard of...READ OPTION ALOUD. b. IF a=YES, And have you (or your partner or partners) <u>ever</u> used that method to delay or avoid getting pregnant? c. IF b=YES, And are you (or your partner) <u>currently</u> using that method to delay or avoid getting pregnant? TICK ALL THAT APPLY FOR A-C. N= No, Y = Yes.			
	a. Ever heard of...	b. Ever used...	c. Currently using
Modern methods: 1= Female sterilization	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
2= Male sterilization	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
3= IUD – Copper	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
4 = IUD – Mirena	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
5 = Injectable – Depot (3 month)	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A

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	a. Ever heard of...	b. Ever used...	c. Currently using
6 = Injectable – Nuristerate (2 month)	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
7 = Subdermal implant – Norplant, Jadelle	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
8 = Pills	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
9 = Contraceptive ring	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
10 = Contraceptive patch	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
11 = Male condoms	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
12 = Female condoms	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
13 = Emergency contraception	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
Traditional methods: 14 = Standard days / Rhythm method	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
15 = Lactational ammenorhea	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
16 = Withdrawal	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A
Other 17 = Any other method SPECIFY: _____	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A	<input type="checkbox"/> 0 = N <input type="checkbox"/> 1 = Y <input type="checkbox"/> 2 = N/A

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Q28 IS FOR WOMEN WHO ARE NOT USING A METHOD. SKIP Q28 IF SHE OR HER PARTNER IS CURRENTLY USING ANY METHOD.

28. a. You said you're not currently using any contraceptive method(s). Would you like to try using a contraceptive method in the future?

b. Why is that? (PROBE: IF a=YES, which method?)

c. Do you feel that you have enough information about all the methods so that you can request the one that is right for you?

- ☐ 0= No
☐ 1 = Yes
☐ 2 = Don't know

OPEN RESPONSE:

- ☐ 0= No
☐ 1 = Yes
☐ 2 = Don't know

Q29 IS FOR WOMEN WHO ARE CURRENTLY USING A METHOD. SKIP Q29 IF SHE OR HER PARTNER IS NOT CURRENTLY USING ANY METHOD.

29. a. Are you happy with your current contraceptive method(s)?

b. Why is that? PROBE WHY SHE IS OR IS NOT HAPPY WITH THE METHOD(S).

c. Would you like to try using a different method in the future?

d. Why is that? (PROBE: IF c=YES, which method?)

e. Do you feel that you have enough information about all the methods so that you can request the one that is right for you?

- ☐ 0= No
☐ 1 = Yes
☐ 2 = Don't know

OPEN RESPONSE:

- ☐ 0= No
☐ 1 = Yes
☐ 2 = Don't know

OPEN RESPONSE:

- ☐ 0= No
☐ 1 = Yes
☐ 2 = Don't know

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30. I'd like to know what is important for you when you think about the quality of contraceptive services. I'm going to list a few things that some people think are important. I'd like to know which are the three most important things for you when you think about health contraceptive service quality. LIST ALL ITEMS AND THEN ASK WHICH ARE THE THREE MOST IMPORTANT. SHOW VISUAL AID

	Indicate top three most important items
a. Travel time/distance to the facility	<input type="checkbox"/>
b. Waiting time at the facility	<input type="checkbox"/>
c. Cost of services	<input type="checkbox"/>
d. Friendly staff at the facility	<input type="checkbox"/>
e. Knowledgeable staff	<input type="checkbox"/>
f. Getting all the information you want or need	<input type="checkbox"/>
g. Confidentiality	<input type="checkbox"/>
h. Getting everything you need in one visit	<input type="checkbox"/>
i. Cleanliness at the facility	<input type="checkbox"/>
j. Having a choice of methods	<input type="checkbox"/>

CONTRACEPTIVE COSTS

SKIP Q31-32 IF SHE OR HER PARTNER IS NOT CURRENTLY USING ANY MODERN METHOD. ALSO, IF HER MAIN METHOD IS OBTAINED BY HER PARTNER (E.G. MALE CONDOMS OR VASECTOMY), SKIP Q31-32.

31. a. 1 When was the last time you got your [main] contraceptive method? IF SHE USES MORE THAN ONE NOW, ASK ABOUT HER MOST EFFECTIVE METHOD AND LIST THAT METHOD HERE:

a 2 How many times did you refill your method in the last year?

b. The last time you got your [main] current contraceptive method, how many place(s) did you go to?

- ☐ 1 = In the last year
☐ 2 = More than one year ago → GO TO Q33
☐ 3 = Can't remember → GO TO Q33

NUMBER: _____

- ☐ 1
☐ 2
☐ 3
☐ >3 COMPLETE Q32 FOR THE LAST THREE PLACES SHE WENT.

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	PLACE 1	PLACE 2	PLACE 3
32. a. The last time you got your [main] current contraceptive method, what kinds of place(s) did you go to?	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____
b. Where was that place?	NAME: _____ CODE: _____	NAME: _____ CODE: _____	NAME: _____ CODE: _____
i. Was it close to home?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes
ii. Was it at or close to work?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working
c. How many times did you go to that place?	_____	_____	_____
d. Where did you eventually get the method? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = At place 1 <input type="checkbox"/> 4 = I didn't get help	<input type="checkbox"/> 2 = At place 2	<input type="checkbox"/> 3 = At place 3
	PLACE 1	PLACE 2	PLACE 3

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<p>e. If you traveled from home, how would you travel to that place? MARK ALL THAT APPLY</p>	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other
<p>f. On average, how long would it take to travel to that place (one way) from the place where you stay?</p>	<p>_____ : _____ h h m m</p>	<p>_____ : _____ h h m m</p>	<p>_____ : _____ h h m m</p>
<p>g. How much is the transport from the place where you stay to that place (one way)?</p>	<p>ZAR _____ . _____</p>	<p>ZAR _____ . _____</p>	<p>ZAR _____ . _____</p>
<p>h. How long did you spend at that place including waiting time, [getting the method], etc?</p>	<p>_____ : _____ h h m m</p>	<p>_____ : _____ h h m m</p>	<p>_____ : _____ h h m m</p>
<p>i. How would you rate the quality of care that you had at the place(s) where you went for your method? SHOW VISUAL AID</p> <p>j. Why is that?</p>	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad OPEN RESPONSE:	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad OPEN RESPONSE:	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad OPEN RESPONSE:
<p>k. Did you miss work while you were getting your method? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p>			<input type="checkbox"/> 0= No → GO TO M <input type="checkbox"/> 1 = Yes

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I. IF YES, How many days?	_____ days
m. Did you lose any income from work or other sources because you had to get your method? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]	<input type="checkbox"/> 0= No → GO TO O <input type="checkbox"/> 1 = Yes
n. IF YES, How much?	ZAR _____ . _____
o. Were you unable to complete some of your daily tasks because you were getting your method? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]	<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes
I'd like to know about your expenses related to getting your method. [Considering all the places where you went,] did you have a pay for...	
p. ...the <u>method</u> ? IF YES, How much?	<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes ZAR _____ . _____
q. ... <u>consultation(s)</u> or doctor's fee(s)? IF YES, How much?	<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes ZAR _____ . _____
r. ... <u>child care</u> while you were getting the method? IF YES, How much?	<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes ZAR _____ . _____ <input type="checkbox"/> 2 = N/A (no children)
s. ... <u>other expenses</u> related to getting the method?	<input type="checkbox"/> 0= No → GO TO T <input type="checkbox"/> 1 = Yes

Provision of Contraceptive Services in South Africa

Semi-structured interview (SSI)

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<p>i. IF YES, What kinds of things did you pay for?</p> <p>ii. AND IF YES, How much did you pay for all of those expenses in total?</p>	<p>LIST: _____</p> <p>ZAR _____ . _____</p>
<p>t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?</p> <p>u. IF YES, how did they help?</p>	<p><input type="checkbox"/> 0= No → GO TO Q33</p> <p><input type="checkbox"/> 1 = Yes</p> <p><input type="checkbox"/> 2 = N/A (no expenses)</p> <p>OPEN RESPONSE:</p>

Do Not Circulate

MENSTRUATION NEEDS AND COSTS

<p>33. a. Have you experienced any menstrual problems in the past year?</p> <p>b. IF a=YES, Did you seek help for those problems?</p>	<p><input type="checkbox"/> 0= No → GO TO Q35</p> <p><input type="checkbox"/> 1 = Yes, DESCRIBE:</p> <p>_____</p> <p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes → GO TO Q33d</p> <p>OPEN RESPONSE</p>
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Provision of Contraceptive Services in South Africa

Semi-structured interview (SSI)

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<p>c. If b=NO, Why not? PROVIDE RESPONSE AND THEN GO TO Q35.</p>			
<p>d. IF b= YES, How many place(s) did you go to for help?</p>		<p> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3 COMPLETE Q34 FOR THE LAST THREE PLACES SHE WENT. </p>	
<p>34. a. When you were seeking help for your menstrual problems, what kinds of place(s) did you go to?</p>	<p>PLACE 1</p> <p> <input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____ </p>	<p>PLACE 2</p> <p> <input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____ </p>	<p>PLACE 3</p> <p> <input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____ </p>
	<p>b. Where was that place?</p> <p>NAME: _____</p> <p>CODE: _____</p>		
<p>i. Was it close to home?</p> <p> <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes </p>	<p> <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes </p>		
<p>ii. Was it at or close to work?</p> <p> <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working </p>	<p> <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working </p>		

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c. How many times did you go to that place?	_____	_____	_____
d. Where did you eventually get the help? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = At place 1 <input type="checkbox"/> 4 = I didn't get help	<input type="checkbox"/> 2 = At place 2	<input type="checkbox"/> 3 = At place 3
e. If you traveled from home, how would you travel to that place? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other
f. On average, how long would it take to travel to that place (one way) from the place where you stay?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
g. How much is the transport from the place where you stay to that place (one way)?	ZAR _____ . _____	ZAR _____ . _____	ZAR _____ . _____
h. How long did you spend at that place including waiting time, seeing the nurse/doctor, etc?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
i. How would you rate the quality of care that you had at the place(s) where you went for your menstrual problems? SHOW VISUAL AID	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad

Do Not Circulate

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j. Why is that?	OPEN RESPONSE:	OPEN RESPONSE:	OPEN RESPONSE:
k. Did you miss work because of your efforts to get help for your menstrual problems? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.] l. IF YES, How many days?		<input type="checkbox"/> 0= No → GO TO M <input type="checkbox"/> 1 = Yes _____ days	
m. Did you lose any income from work or other source because you had to get help for your menstrual problems? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.] n. IF YES, How much?		<input type="checkbox"/> 0= No → GO TO O <input type="checkbox"/> 1 = Yes ZAR _____ . _____	
o. Were you unable to complete some of your daily tasks because you were getting help for your menstrual problems? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]		<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes	
I'd like to know about your expenses related to getting help for your menstrual problems. [Considering all the places where you went,] did you have to pay for... p. ...<u>medications</u>? IF YES, How much? q. ... <u>consultation(s)</u> or doctor's fee(s)? IF YES, How much?		<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes ZAR _____ . _____ <input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes ZAR _____ . _____	

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r. ...child care while you were getting help for your menstrual problems? IF YES, How much?

- ☐ 0= No
☐ 1 = Yes ZAR ____ . ____
☐ 2 = N/A (no children)

s. ...other expenses related to getting help for your menstrual problems?

- ☐ 0= No → GO TO T
☐ 1 = Yes

i. IF YES, What kinds of things did you pay for?

LIST: _____

ii. AND IF YES, How much did you pay for all of these expenses in total?

ZAR ____ . ____

t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?

- ☐ 0= No → GO TO Q35
☐ 1 = Yes
☐ 2 = N/A (no expenses)

u. IF YES, how did they help?

OPEN RESPONSE:

Do Not Circulate

MENOPAUSE NEEDS AND COSTS

35. a. 1 Have you experienced any menopausal symptoms in the past year?

- ☐ 0 = No → GO TO Q37
☐ 1 = Yes
☐ 2 = Don't know, not sure → GO TO Q37

IF YES, TICK ALL THAT APPLY:

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a 2. IF YES, **What symptoms did you have?** TICK ALL THAT APPLY.

- ☐ 1 = Hot flashes
- ☐ 2 = Night sweats
- ☐ 3 = Irregular period
- ☐ 4 = Vaginal dryness
- ☐ 5 = Mood swings
- ☐ 6 = Loss of libido
- ☐ 7 = Memory Loss
- ☐ 8 = Other, specify: _____

b. IF a1=YES, **Did you seek help for those symptoms?**

- ☐ 0= No
- ☐ 1 = Yes → GO TO Q35d

c. If b=NO, **Why not?** PROVIDE RESPONSE AND THEN GO TO Q37

OPEN RESPONSE:

d. IF b= YES, **How many place(s) did you go to for help?**

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ >3 COMPLETE Q36 FOR THE LAST THREE PLACES SHE WENT TO.

Do Not Circulate

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	Place 1	Place 2	Place 3
36. a. When you were seeking help for your menopause symptoms, what kinds of place(s) did you go to?	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____
b. Where was that place?	NAME: _____	NAME: _____	NAME: _____
	CODE: _____	CODE: _____	CODE: _____
i. Was it close to home?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes
ii. Was it at or close to work?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working
c. How many times did you go to that place?	_____	_____	_____
d. Where did you eventually get the help? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = At place 1 <input type="checkbox"/> 4 = I didn't get help	<input type="checkbox"/> 2 = At place 2	<input type="checkbox"/> 3 = At place 3

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	Place 1	Place 2	Place 3
e. If you traveled from home, how would you travel to that place? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other
f. On average, how long would it take to travel to that place (one way) from the place where you stay?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
g. How much is the transport from the place where you stay to that place (one way)?	ZAR _____ . _____	ZAR _____ . _____	ZAR _____ . _____
h. How long did you spend at that place including waiting time, seeing the doctor/nurse, etc?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
i. How would you rate the quality of care that you had at the place(s) where you went for your menopause symptoms? SHOW VISUAL AID	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad
j. Why is that?	OPEN RESPONSE:	OPEN RESPONSE:	OPEN RESPONSE:

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<p>k. Did you miss work because of your efforts to get help for your menopause symptoms? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p> <p>l. IF YES, How many days?</p>	<p><input type="checkbox"/> 0= No → GO TO M</p> <p><input type="checkbox"/> 1 = Yes</p> <p>_____ days</p>
<p>m. Did you lose any income from work or other sources because you had to get help for your menopause symptoms? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p> <p>n. IF YES, How much?</p>	<p><input type="checkbox"/> 0= No → GO TO O</p> <p><input type="checkbox"/> 1 = Yes</p> <p>ZAR _____ . _____</p>
<p>o. Were you unable to complete some of your daily tasks because you were getting help for your menopause symptoms? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes</p>
<p>I'd like to know about your expenses related to getting help for your menopause symptoms. [Considering all the places where you went,] did you have to pay for...</p> <p>p. ... <u>medications</u>? IF YES, How much?</p> <p>q. ... <u>consultation(s)</u> or doctor's fee(s)? IF YES, How much?</p> <p>r. ...<u>child care</u> while you were getting help for your menopause symptoms? IF YES, How much?</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 2 = N/A (no children)</p>

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<p>s. ...<u>other expenses</u> related to getting help for your menopause symptoms?</p> <p>i. IF YES, What kinds of things did you pay for?</p> <p>ii. AND IF YES, How much did you pay for all of those expenses in total?</p>	<p><input type="checkbox"/> 0= No → GO TO T</p> <p><input type="checkbox"/> 1 = Yes</p> <p>LIST: _____</p> <p>ZAR _____ . _____</p>
<p>t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?</p> <p>u. IF YES, how did they help?</p>	<p><input type="checkbox"/> 0= No → GO TO Q37</p> <p><input type="checkbox"/> 1 = Yes</p> <p><input type="checkbox"/> 2 = N/A (no expenses)</p> <p>OPEN RESPONSE:</p>

Do Not Circulate

CERVICAL CANCER NEEDS AND COSTS

<p>37. a. Have you ever been screened for cervical cancer? Often that procedure is called a Pap smear.</p> <p>b. If a=NO, Why not? PROVIDE RESPONSE AND THEN GO TO Q39.</p> <p>c. IF a=YES, When was the last time you had a Pap? IF SHE HAS HAD MORE THAN ONE, ASK ABOUT THE LAST TIME.</p>	<p><input type="checkbox"/> 0 = No</p> <p><input type="checkbox"/> 1 = Yes → GO TO Q37c</p> <p>OPEN RESPONSE:</p> <p><input type="checkbox"/> 1 = In the last year</p> <p><input type="checkbox"/> 2 = More than one year ago → GO TO Q39</p> <p><input type="checkbox"/> 3 = Can't remember → GO TO Q39</p>
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d. How many place(s) did you go to while trying to get that Pap?		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3 COMPLETE Q38 FOR THE LAST THREE PLACES SHE WENT.		
38. a. When you were trying to get your Pap smear, what kinds of place(s) did you go to?	Place 1	Place 2	Place 3	
	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	
b. Where was that place?	NAME: _____	NAME: _____	NAME: _____	
i. Was it close to home?	CODE: _____	CODE: _____	CODE: _____	
ii. Was it at or close to work?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	
c. How many times did you go to that place?	_____	_____	_____	
d. Where did you eventually get the help? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = At place 1 <input type="checkbox"/> 4 = I didn't get help	<input type="checkbox"/> 2 = At place 2	<input type="checkbox"/> 3 = At place 3	

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	Place 1	Place 2	Place 3
e. If you traveled from home, how would you travel to that place? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other
f. On average, how long would it take to travel to that place (one way) from the place where you stay?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
g. How much is the transport from the place where you stay to that place (one way)?	ZAR _____	ZAR _____	ZAR _____ . _____
h. How long did you spend at that place including waiting time, seeing the doctor/nurse, etc?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
i. How would you rate the quality of care that you had at the place(s) where you went for your Pap smear? SHOW VISUAL AID	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad
j. Why is that?	OPEN RESPONSE:	OPEN RESPONSE:	OPEN RESPONSE:

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<p>k. Did you miss work because of your efforts to get a Pap smear? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p> <p>l. IF YES, How many days?</p>	<p><input type="checkbox"/> 0= No → GO TO M</p> <p><input type="checkbox"/> 1 = Yes</p> <p>_____ days</p>
<p>m. Did you lose any income from work or other sources because of your efforts to get a Pap smear? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p> <p>n. IF YES, How much?</p>	<p><input type="checkbox"/> 0= No → GO TO O</p> <p><input type="checkbox"/> 1 = Yes</p> <p>ZAR _____ . _____</p>
<p>o. Were you unable to complete some of your daily tasks because of your efforts to get a Pap smear? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes</p>
<p>I'd like to know about your expenses related to getting a Pap smear. [Considering all the places where you went,] did you have to pay for...</p> <p>p. ...<u>medications</u>? IF YES, How much?</p> <p>q. ... <u>consultation(s)</u> or doctor's fee(s)? IF YES, How much?</p> <p>r. ...<u>child</u> care while you were trying to get/getting the Pap smear? IF YES, How much?</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 2 = N/A (no children)</p>

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<p>s. ...<u>other</u> expenses related to getting your Pap smear?</p> <p>i. IF YES, What kinds of things did you pay for?</p> <p>ii. AND IF YES, How much did you pay for all of those expenses in total?</p>	<p><input type="checkbox"/> 0= No → GO TO T</p> <p><input type="checkbox"/> 1 = Yes</p> <p>LIST: _____</p> <p>ZAR _____ . _____</p>
<p>t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?</p> <p>u. IF YES, how did they help?</p>	<p><input type="checkbox"/> 0= No → GO TO Q39</p> <p><input type="checkbox"/> 1 = Yes</p> <p><input type="checkbox"/> 2 = N/A (no expenses)</p> <p>OPEN RESPONSE:</p>

Do Not Circulate

BREAST CARE NEEDS AND COSTS

<p>39. a. Have you ever been screened for breast cancer or other breast related problems?</p> <p>b. If a=NO, Why not? PROVIDE RESPONSE AND THEN GO TO Q41.</p> <p>c. IF YES, When was the last time? IF SHE HAS HAD MORE THAN ONE, ASK ABOUT THE LAST TIME.</p>	<p><input type="checkbox"/> 0 = No</p> <p><input type="checkbox"/> 1 = Yes → GO TO Q39c</p> <p>OPEN RESPONSE:</p> <p><input type="checkbox"/> 1 = In the last year</p> <p><input type="checkbox"/> 2 = More than one year ago → GO TO Q41</p>
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d. How many place(s) did you go to while trying to get screened?		<input type="checkbox"/> 3 = Can't remember → GO TO Q41 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3 COMPLETE Q40 FOR THE LAST THREE PLACES SHE WENT.	
	Place 1	Place 2	Place 3
40. a. When you were seeking your breast exam or help for your breast related problems, what kinds of place(s) did you go to?	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____
b. Where was that place? i. Was it close to home? ii. Was it at or close to work?	NAME: _____ CODE: _____ <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	NAME: _____ CODE: _____ <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	NAME: _____ CODE: _____ <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working
c. How many times did you go to that place?	_____	_____	_____

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	Place 1	Place 2	Place 3
d. Where did you eventually get the help? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = At place 1 <input type="checkbox"/> 4 = I didn't get help	<input type="checkbox"/> 2 = At place 2	<input type="checkbox"/> 3 = At place 3
e. If you traveled from home, how would you travel to that place? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other
f. On average, how long would it take to travel to that place (one way) from the place where you stay?	_____ : _____ h h : m m	_____ : _____ h h : m m	_____ : _____ h h : m m
g. How much is the transport from the place where you stay to that place (one way)?	ZAR _____ . _____	ZAR _____ . _____	ZAR _____ . _____
h. How long did you spend at that place including waiting time, seeing the doctor/nurse, etc?	_____ : _____ h h : m m	_____ : _____ h h : m m	_____ : _____ h h : m m

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<p>i. How would you rate the quality of care that you had at the place(s) where you went for to get breast screening or care? SHOW VISUAL AID</p> <p>j. Why is that?</p>	<p><input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad</p> <p>OPEN RESPONSE:</p>	<p><input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad</p> <p>OPEN RESPONSE:</p>	<p><input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad</p> <p>OPEN RESPONSE:</p>
<p>k. Did you miss work because of your efforts to get breast screening or care? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p> <p>l. IF YES, How many days?</p>	<p><input type="checkbox"/> 0= No → GO TO M <input type="checkbox"/> 1 = Yes</p> <p>_____ days</p>		
<p>m. Did you lose any income from work or other sources because of your efforts to get breast cancer screening or care? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p> <p>n. IF YES, How much?</p>	<p><input type="checkbox"/> 0= No → GO TO O <input type="checkbox"/> 1 = Yes</p> <p>ZAR _____ . _____</p>		
<p>o. Were you unable to complete some of your daily tasks because of your efforts to get breast cancer screening or care? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p>	<p><input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes</p>		

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I'd like to know about your expenses related to your efforts to get breast cancer screening or care. [Considering all the places where you went,] did you have to pay for...

p. ...the medications? IF YES, How much?

q. ... consultation(s) or doctor's fee(s)? IF YES, How much?

r. ...child care while you were trying to get/getting the screening or care? IF YES, How much?

s. ...other expenses related to getting the breast cancer screening or care?

i. IF YES, What kinds of things did you pay for?

ii. AND IF YES, How much did you pay for all of those expenses in total?

t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?

u. IF YES, how did they help?

☐ 0= No
☐ 1 = Yes ZAR ____ . ____

☐ 0= No
☐ 1 = Yes ZAR ____ . ____

☐ 0= No
☐ 1 = Yes ZAR ____ . ____
☐ 2 = N/A (no children)

☐ 0= No → GO TO T
☐ 1 = Yes

LIST: _____

ZAR ____ . ____

☐ 0= No → GO TO Q41
☐ 1 = Yes
☐ 2 = N/A (no expenses)

OPEN RESPONSE:

Do Not Circulate

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SEXUALLY TRANSMITTED INFECTION NEEDS AND COSTS

41. a. 1 Did you experience any symptoms that you think might be from a sexually transmitted infection, or "STI," in the past year?

a. 2 IF YES, **What symptoms did you have?** TICK ALL THAT APPLY.

b. IF a1=YES, **Did you seek help for those symptoms?**

c. If b=NO, **Why not?** PROVIDE RESPONSE AND THEN GO TO Q43.

d. **How many place(s) did you go to while trying to get care for your symptoms?**

- ☐ 0 = No → GO TO Q43
☐ 1 = Yes
☐ 2 = Not sure/don't know → GO TO Q43

IF YES, INDICATE ALL THAT APPLY:

- ☐ 1 = Vaginal itching
☐ 2 = Pain and or burning when urinating
☐ 3 = Vaginal discharge with odour
☐ 4 = Lower back or abdominal pain
☐ 5 = Pain during sex
☐ 6 = Irregular bleeding between periods
☐ 7 = Other, specify _____

- ☐ 0 = No
☐ 1 = Yes → GO TO Q41d

OPEN RESPONSE

- ☐ 1
☐ 2
☐ 3
☐ >3 COMPLETE Q42 FOR THE LAST THREE PLACES SHE WENT.

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	Place 1	Place 2	Place 3
42. a. When you were seeking help for your STI symptoms, what kinds of place(s) did you go to?	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____
b. Where was that place?	NAME: _____	NAME: _____	NAME: _____
	CODE: _____	CODE: _____	CODE: _____
i. Was it close to home?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes
ii. Was it at or close to work?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working
c. How many times did you go to that place?	_____	_____	_____
d. Where did you eventually get the help? TICK ALL THAT APPLY	<input type="checkbox"/> 1 = At place 1 <input type="checkbox"/> 4 = I didn't get help	<input type="checkbox"/> 2 = At place 2	<input type="checkbox"/> 3 = At place 3
e. If you traveled from home, how would you travel to that place? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other

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	Place 1	Place 2	Place 3
f. On average, how long would it take to travel to that place (one way) from the place where you stay?	$\frac{\quad}{h} \frac{\quad}{h} : \frac{\quad}{m} \frac{\quad}{m}$	$\frac{\quad}{h} \frac{\quad}{h} : \frac{\quad}{m} \frac{\quad}{m}$	$\frac{\quad}{h} \frac{\quad}{h} : \frac{\quad}{m} \frac{\quad}{m}$
g. How much is the transport from the place where you stay to that place (one way)?	ZAR $\frac{\quad}{\quad} . \frac{\quad}{\quad}$	ZAR $\frac{\quad}{\quad} . \frac{\quad}{\quad}$	ZAR $\frac{\quad}{\quad} . \frac{\quad}{\quad}$
h. How long did you spend at that place including waiting time, seeing the doctor/nurse, etc?	$\frac{\quad}{h} \frac{\quad}{h} : \frac{\quad}{m} \frac{\quad}{m}$	$\frac{\quad}{h} \frac{\quad}{h} : \frac{\quad}{m} \frac{\quad}{m}$	$\frac{\quad}{h} \frac{\quad}{h} : \frac{\quad}{m} \frac{\quad}{m}$
i. How would you rate the quality of care that you had at the place where you got help for your menstrual problems? SHOW VISUAL AID	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad
j. Why is that?	OPEN RESPONSE:	OPEN RESPONSE:	OPEN RESPONSE:
k. Did you miss work because of your efforts to get help for your STI symptoms? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]	<input type="checkbox"/> 0= No → GO TO M <input type="checkbox"/> 1 = Yes		
l. IF YES, How many days?	_____ days		

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<p>m. Did you lose any income from work or other sources because of your efforts to get help for your STI symptoms? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p> <p>n. IF YES, How much?</p>	<p><input type="checkbox"/> 0= No → GO TO O</p> <p><input type="checkbox"/> 1 = Yes</p> <p>ZAR _____ . _____</p>
<p>o. Were you unable to complete some of your daily tasks because of your efforts to get help for your STI symptoms? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes</p>
<p>I'd like to know about your expenses related to getting help for your STI symptoms. [Considering all the places where you went] did you have to pay for...</p>	
<p>p. ...<u>medications</u>? IF YES, How much?</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p>
<p>q. ... <u>consultation(s)</u> or doctor's fee(s)? IF YES, How much?</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p>
<p>r. ...<u>child care</u> while you were getting help for your STI symptoms? IF YES, How much?</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 2 = N/A (no children)</p>
<p>s. ...<u>other expenses</u> related to getting help for your STI symptoms?</p> <p>i. IF YES, What kinds of things did you pay for?</p> <p>ii. AND IF YES, How much did you pay for all of those expenses in total?</p>	<p><input type="checkbox"/> 0= No → GO TO T</p> <p><input type="checkbox"/> 1 = Yes</p> <p>LIST: _____</p> <p>ZAR _____ . _____</p>

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<p>t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?</p> <p>u. IF YES, how did they help?</p>	<p><input type="checkbox"/> 0= No → GO TO Q43</p> <p><input type="checkbox"/> 1 = Yes</p> <p><input type="checkbox"/> 2 = N/A (no expenses)</p> <p>OPEN RESPONSE:</p>
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TOP NEEDS AND COSTS

In South Africa a woman has a right to end her pregnancy for certain reasons. I know that this is a sensitive issue for some people. I want to ask about your experiences with this. I will keep your answer confidential (along with all the information I am collecting today).

43. a. Sometimes women have unplanned pregnancies that they do not want or cannot continue for lots of reasons. Did you have an unintended or unwanted pregnancy in last year?

b. Did you need to or decide that you wanted to have a termination of pregnancy, or TOP, at any time in the past year?

c. IF b=YES, Were you actually able to obtain a TOP in the past year?

- ☐ 0 = No
- ☐ 1 = Yes
- ☐ 2 = Declined to answer

- ☐ 0 = No → GO TO Q45
- ☐ 1 = Yes
- ☐ 2 = Declined to answer

- ☐ 0 = No
- ☐ 1 = Yes → GO TO Q43e
- ☐ 2 = Declined to answer

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d. IF c=NO, Why not?		OPEN RESPONSE	
e. IF c=YES, How many place(s) did you go to while trying to get your TOP?		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> >3 COMPLETE Q44 FOR THE LAST THREE PLACES SHE WENT.	
	Place 1	Place 2	Place 3
44. a. When you were trying to get your TOP, what kinds of place(s) did you go to?	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____
b. Where was that place?	NAME: _____ CODE: _____	NAME: _____ CODE: _____	NAME: _____ CODE: _____
i. Was it close to home?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes
ii. Was it at or close to work?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working

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c. How many times did you go to that place?	_____	_____	_____
d. Where did you eventually get the help? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = At place 1 <input type="checkbox"/> 4 = I didn't get help	<input type="checkbox"/> 2 = At place 2	<input type="checkbox"/> 3 = At place 3
e. If you traveled from home, how would you travel to that place? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other
f. On average, how long would it take to travel to that place (one way) from the place where you stay?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
g. How much is the transport from the place where you stay to that place (one way)?	ZAR _____ . _____	ZAR _____ . _____	ZAR _____ . _____
h. How long did you spend at that place including waiting time, getting the TOP, etc?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
i. How would you rate the quality of care that you had at the place(s) where you went for your TOP? SHOW VISUAL AID	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad

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j. Why is that?	OPEN RESPONSE:	OPEN RESPONSE:	OPEN RESPONSE:
k. Did you miss work because you were trying to get/getting a TOP? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]		<input type="checkbox"/> 0= No → GO TO M <input type="checkbox"/> 1 = Yes _____ days	
l. IF YES, How many days?			
m. Did you lose any income from work or other sources while you were trying to get/getting your TOP? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]		<input type="checkbox"/> 0= No → GO TO O <input type="checkbox"/> 1 = Yes ZAR _____ . _____	
n. IF YES, How much?			
o. Were you unable to complete some of your daily tasks because you were trying to get/getting your TOP? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]		<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes	
I'd like to know about your expenses related to getting your TOP. [Considering all the places where you went,] did you have to pay for...			
p. ... <u>medications</u> ? IF YES, How much?		<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes ZAR _____ . _____	
q. ... <u>consultation</u> (s) or doctor's fee(s)? IF YES, How much?		<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes ZAR _____ . _____	
r. ... <u>child care</u> while you were getting the TOP? IF YES, How much?		<input type="checkbox"/> 0= No <input type="checkbox"/> 1 = Yes ZAR _____ . _____ <input type="checkbox"/> 2 = N/A (no childcare)	

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<p>s. <u>...other expenses</u> related to getting the TOP?</p> <p>i. IF YES, What kinds of things did you pay for?</p> <p>ii. AND IF YES, How much did you pay for all of those expenses in total?</p>	<p><input type="checkbox"/> 0= No → GO TO T</p> <p><input type="checkbox"/> 1 = Yes</p> <p>LIST: _____</p> <p>ZAR _____ . _____</p>
<p>t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?</p> <p>u. IF YES, how did they help?</p>	<p><input type="checkbox"/> 0= No → GO TO Q45</p> <p><input type="checkbox"/> 1 = Yes</p> <p><input type="checkbox"/> 2 = N/A (no expenses)</p> <p>OPEN RESPONSE:</p>

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GENDER BASED VIOLENCE NEEDS AND COSTS

<p>Violence against women is a common problem in South Africa. I'd like to ask you some questions about your experience with this kind of violence. I'd like to know about your relationship with your main partner. This is another sensitive issue. If you are uncomfortable talking about this, I understand. I can also refer you to someone for help, if you need that.</p> <p>45. a. Did you experience any kind of violence from your main partner during the past year? This could mean that your partner kicked, hit or punched you, that your partner made you feel scared or threatened, or that your partner forced or pressured you to have sex when you did not want to at any time during the past year?</p>	<p><input type="checkbox"/> 0 = No → GO TO Q47</p> <p><input type="checkbox"/> 1 = Yes</p> <p><input type="checkbox"/> 2 = Declined to answer → GO TO Q47</p>
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b. IF a=YES, Did you seek help for any of those problems?

- ☐ 0 = No
☐ 1 = Yes → GO TO Q45d
☐ 2 = Declined to answer

c. If b=NO, Why not? PROVIDE RESPONSE AND THEN GO TO Q47.

OPEN RESPONSE

d. IF b=YES, How many place(s) did you go to while trying to get help?

- ☐ 1
☐ 2
☐ 3
☐ >3 COMPLETE Q46 FOR THE LAST THREE PLACES SHE WENT.

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	Place 1	Place 2	Place 3
46. a. When you were seeking help for your experiences with gender based violence, what kinds of place(s) did you go to?	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____ <input type="checkbox"/> 8 = Police station <input type="checkbox"/> 9 = Legal services provider <input type="checkbox"/> 10 = Counselling service	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____ <input type="checkbox"/> 8 = Police station <input type="checkbox"/> 9 = Legal services provider <input type="checkbox"/> 10 = Counselling service	<input type="checkbox"/> 1 = Public clinic/hospital <input type="checkbox"/> 2 = Private clinic/hospital <input type="checkbox"/> 3 = Pharmacy/chemist <input type="checkbox"/> 4 = Family/relative/friend <input type="checkbox"/> 5 = Partner <input type="checkbox"/> 6 = Traditional healer <input type="checkbox"/> 7 = Other, _____ <input type="checkbox"/> 8 = Police station <input type="checkbox"/> 9 = Legal services provider <input type="checkbox"/> 10 = Counselling service

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b. Where was that place?	NAME: _____ CODE: _____	NAME: _____ CODE: _____	NAME: _____ CODE: _____
i. Was it close to home?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes
ii. Was it at or close to work?	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = N/A, not working
c. How many times did you go to that place?	<div style="position: absolute; top: 50%; left: 50%; transform: translate(-50%, -50%); font-size: 100px; opacity: 0.5;">Do Not Circulate</div>		
d. Where did you eventually get the help? TICK ALL THAT APPLY			
e. If you traveled from home, how would you travel to that place? MARK ALL THAT APPLY	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other	<input type="checkbox"/> 1 = Walked <input type="checkbox"/> 2 = Public transport <input type="checkbox"/> 3 = Private taxi <input type="checkbox"/> 4 = Friend/family lift <input type="checkbox"/> 5 = Drove own car <input type="checkbox"/> 6 = Other
f. On average, how long would it take to travel to that place (one way) from the place where you stay?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m

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g. How much is the transport from the place where you stay to that place (one way)?	ZAR _____ . _____	ZAR _____ . _____	ZAR _____ . _____
h. How long did you spend at that place including waiting time, getting help, etc?	_____ : _____ h h m m	_____ : _____ h h m m	_____ : _____ h h m m
i. How would you rate the quality of care that you had at the place where you got help for your menstrual problems? SHOW VISUAL AID	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad	<input type="checkbox"/> 1 = Very good <input type="checkbox"/> 2 = Good <input type="checkbox"/> 3 = Neutral <input type="checkbox"/> 4 = Fair <input type="checkbox"/> 5 = Very bad
j. Why is that?	OPEN RESPONSE:	OPEN RESPONSE:	OPEN RESPONSE:
k. Did you miss work because of your efforts to get help for your experiences with gender based violence? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.] l. IF YES, How many days?			<input type="checkbox"/> 0= No → GO TO M <input type="checkbox"/> 1 = Yes _____ days

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<p>m. Did you lose any income from work or other sources because of your efforts to get help for your experiences with gender based violence? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p> <p>n. IF I=YES, How much?</p>	<p><input type="checkbox"/> 0= No → GO TO O</p> <p><input type="checkbox"/> 1 = Yes</p> <p>ZAR _____ . _____</p>
<p>o. Were you unable to complete some of your daily tasks because of your efforts to get help for your experiences with gender based violence? [IF MORE THAN ONE PLACE: This could be because of visits to any of the places you mentioned.]</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes</p>
<p>I'd like to know about your expenses related getting help for your experiences with gender based violence. [Considering all the places where you went,] did you have to pay for...</p>	
<p>p. ...<u>medications</u>? IF YES, How much?</p> <p>q. ... <u>consultation(s)</u> or doctor's fee(s)? IF YES, How much?</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p>
<p>r. ...<u>child care</u> while you were getting help for your experiences with gender based violence? IF YES, How much?</p> <p>s. ...<u>other expenses</u> related to getting help for your experiences with gender based violence?</p>	<p><input type="checkbox"/> 0= No</p> <p><input type="checkbox"/> 1 = Yes ZAR _____ . _____</p> <p><input type="checkbox"/> 2 = N/A (no children)</p> <p><input type="checkbox"/> 0= No → GO TO T</p> <p><input type="checkbox"/> 1 = Yes</p>

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Provision of Contraceptive Services in South Africa

Semi-structured interview (SSI)

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<p>i. IF YES, What kinds of things did you pay for?</p> <p>ii. AND IF YES, How much did you pay for all of those expenses in total?</p>	<p>LIST: _____</p> <p>ZAR _____ . _____</p>
<p>t. Did anyone help you to pay for your expenses (e.g. transport, fees, etc)?</p> <p>u. IF YES, how did they help?</p>	<p><input type="checkbox"/> 0= No → GO TO Q47</p> <p><input type="checkbox"/> 1 = Yes</p> <p><input type="checkbox"/> 2 = N/A (no expenses)</p> <p>OPEN RESPONSE:</p>

Do Not Circulate

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Part D: Service Quality / Integration

We're almost done. I have a few more questions about how you access health care, and where you would like to get different kinds of services. You can see from my questions that there are lots of different kinds of women's health services.				
47. Earlier you said you have some health problems or conditions. How many health facilities do you go to regularly to take care of those health conditions? CHECK RESPONSE AGAINST CONDITIONS REPORTED IN Q17. IF MORE THAN 3 PLACES, ASK FOR PLACES VISITED MOST FREQUENTLY.		<input type="checkbox"/> 0 = Doesn't regularly go to any health facility for chronic conditions → GO TO Q50 <input type="checkbox"/> 1 = 1 place <input type="checkbox"/> 2 = 2 places <input type="checkbox"/> 3 = 3 places <input type="checkbox"/> 4 = > 3 places <input type="checkbox"/> 5 = N/A (doesn't have any chronic conditions) → GO TO Q50		
		Place 1	Place 2	Place 3
48. What is the name and location of that facility / place?		NAME: _____ CODE: _____	NAME: _____ CODE: _____	NAME: _____ CODE: _____
49. a. Are you currently able to get contraception at that place?		<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes → GO TO Q49c <input type="checkbox"/> 2 = Don't know	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes → GO TO Q49c <input type="checkbox"/> 2 = Don't know	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes → GO TO Q49c <input type="checkbox"/> 2 = Don't know
b. IF 49a=NO OR DON'T KNOW, Would you like to be able to get contraception there?		<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = Don't know	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = Don't know	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = Don't know
c. Can you get other women's health services there?		<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = Don't know	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = Don't know	<input type="checkbox"/> 0 = No <input type="checkbox"/> 1 = Yes <input type="checkbox"/> 2 = Don't know

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SKIP Q50 IF SHE DOESN'T HAVE ANY CHILDREN.

50. a. Can you currently get women's health services in the places where you get health services for your children?

b. Would you like to be able to get women's health services in the places where you get health services for your children?

c. Why is that?

- ☐ 0= No
☐ 1 = Yes → GO TO Q51

- ☐ 0= No
☐ 1 = Yes

OPEN RESPONSE:

51. a. When you visit the doctor or nurse for other health conditions or problems, would you like him or her to spontaneously give you information about women's health issues – like when to get screening for cervical cancer, breast cancer, or information about contraceptive methods?

b. Why is that?

- ☐ 0= No
☐ 1 = Yes

OPEN RESPONSE:

52. We would like to follow up with some of the women who responded to this survey to talk to them more about women's health services and what they think could be done to improve services in public clinics and hospitals. If you are selected, could we contact you to ask if you would like to participate in another interview? It would be at a different location.

- ☐ 0 = No
☐ 1 = Yes

IF YES, ENTER CONTACT INFORMATION ON THE CONTACT PAGE.

Today's Date					
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***Interviewer initials
and date:***

Interviewer comments:

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IF COMPLETED, REMOVE THIS PAGE AND STORE WITH THE CONSENT FORMS.

CONTACT INFORMATION**PHONE NUMBER 1:****PHONE NUMBER 2:****PHONE NUMBER 3:**

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