



MINISTRY OF HEALTH REPUBLIC OF INDONESIA
HEALTH POLICY AGENCY



INDONESIAN HEALTH SURVEY 2023

INDIVIDUAL QUESTIONNAIRE

CONFIDENTIAL

Nomor Rekomendasi Survei Statistik Sektoral: V-23.0000.001

SKI23.IND

IX. PLACE IDENTIFICATION

Province	Regency / City	Sub-district	Village / Urban Village	D / K	Sample Code Number	Household member serial number

Quote from Block I PLACE RECOGNITION SKI23.RT

X. INDIVIDUAL INTERVIEWER DESCRIPTION

1	Date of initial visit	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - 2023	3	Name of Enumerator:	
2	Date of last visit	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - 2023	4	Signature of Enumerator:	

**XI. INDIVIDUAL DESCRIPTION
RESPONDENT IDENTIFICATION**

1	Write down the name and sequence number of Household Members (HMs)	Name	Sec. household member: <input type="checkbox"/> <input type="checkbox"/>	PUT THE STICKER HERE
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SEQUENCE NO. OF HMS FOR QUESTIONS P.2, P.3, P.4 IF NOT HMS IN THIS HOUSEHOLD FILL IN CODE '00'

2	Write down the name and sequence number of the biological father	Name	Sec. household member: <input type="checkbox"/> <input type="checkbox"/>
3	Write down the name and sequence number of the biological mothers	Name	Sec. household member: <input type="checkbox"/> <input type="checkbox"/>
4	For family members aged <15 years /sick condition / parents who need to be accompanied, write down the name and sequence number of the accompanying person	Name	Sec. household member: <input type="checkbox"/> <input type="checkbox"/>

A. COMMUNICABLE DISEASES

[NAME] in the questions below refers to the family member name that recorded in the question Block XI Q.1

DIARRHEA / DIARRHOEA [HMs OF ALL AGES]

A01	In the past 1 month, was [NAME] ever diagnosed with diarrhea by health officers?	1. Yes, ≤ past 2 weeks 2. Yes, > 2 weeks – 1 month	3. No → A.03 8. Unsure → A.03	<input type="checkbox"/>
A02	What type of health officers who diagnosed [NAME] with diarrhea? FILL IN THE ANSWER CODE: 1. YES OR 2. NO	a. Doctor <input type="checkbox"/>	b. Midwife <input type="checkbox"/>	c. Nurse <input type="checkbox"/>
A03	In the last 1 month, has [NAME] experienced: FILL IN CODE 1 IF "YES, ≤ LAST 2 WEEKS" CODE 2 IF "YES, > 2 WEEKS – 1 MONTH"	CODE 3 IF "NO" CODE 8 IF "UNSURE"		
	a. Defecate 3-6 times a day	<input type="checkbox"/>	c. Soft or loose stools / faeces	<input type="checkbox"/>
	b. Defecate > 6 times a day	<input type="checkbox"/>		

IF THE ANSWERS A.01 AND A.03 ARE ALL CODE "3" OR "8", GO TO A.05

A04	Does [NAME] take medicine for the disease/diarrhea complaint? FILL IN CODE 1 IF "YES", CODE 2 IF "NO", AND CODE 8 IF "UNSURE"			
	a. Oral Rehydration Solution	<input type="checkbox"/>	e. Antibiotics	<input type="checkbox"/>
	b. Salt-Sugar Solution	<input type="checkbox"/>	f. Herbal / traditional medicine	<input type="checkbox"/>
	c. Probiotics	<input type="checkbox"/>	g. Zinc tablet (especially for toddlers) SHOW DISPLAY CARD	<input type="checkbox"/>
	d. Anti-diarrhea drugs	<input type="checkbox"/>		

ACUTE RESPIRATORY INFECTION (ARI) [HMs OF ALL AGES]				
A05	In the past 1 month, was [NAME] ever diagnosed with ARI by health officers?		1. Yes 2. No → A.07	<input type="checkbox"/>
A06	Type of health officers who diagnosed [NAME] ARI? FILL IN THE ANSWER CODE: 1. YES OR 2. NO	a. Doctor <input type="checkbox"/>	b. Midwife <input type="checkbox"/>	c. Nurse <input type="checkbox"/>
GO TO A.09				
A07	In the last 1 month, was [NAME] experienced the following symptoms: FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Fever <input type="checkbox"/>	c. Cold / Nasal congestion <input type="checkbox"/>		
	b. Cough less than 2 weeks <input type="checkbox"/>	d. Sore throat <input type="checkbox"/>		
A08	If one of the answers to A.07a-d coded 1, is [NAME] confirmed for COVID-19 through antigen testing and/or PCR?	1. Yes 2. No 3. Did not check for COVID-19	<input type="checkbox"/>	
PNEUMONIA / LUNG INFLAMMATION [HMs OF ALL AGES]				
A09	In the last 1 year, was [NAME] ever diagnosed with pneumonia by a health workforce?	1. Yes, less than 1 month ago 2. Yes, 1 – 12 months ago	3. No → A.11 4. Unsure → A.11	<input type="checkbox"/>
A10	What type of health workforce diagnosed [NAME] with pneumonia? FILL IN THE ANSWER CODE: 1. YES OR 2. NO	a. Doctor <input type="checkbox"/>	b. Midwife <input type="checkbox"/>	c. Nurse <input type="checkbox"/>
A11	In the last 1 year, did [NAME] experience any symptoms? shortness of breath accompanied symptoms as follows: FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Fever <input type="checkbox"/>	b. Cough <input type="checkbox"/>	c. Difficulty breathing with or without chest pain <input type="checkbox"/>	
HMs AGED ≥ 5 YEARS OLD → GO TO A.12				
POINTS d, e, and f FOR HMs AGED 0 - 59 MONTHS OLD				
	d. Rapid breathing <input type="checkbox"/>	e. Nostrils breathing <input type="checkbox"/>	f. Indrawing of the lower chest wall (SHOW DISPLAY CARD) <input type="checkbox"/>	
PULMONARY TUBERCULOSIS (PULMONARY TBC) [HMs OF ALL AGES]				
A12	In the last 1 year, has [NAME] ever been diagnosed with Pulmonary TB / Spots lungs by the doctor?	1. Yes, within the last 6 months 2. Yes, more than 6 months	3. No → A.18	<input type="checkbox"/>
A13	What tests are used to make the diagnosis? FILL IN THE ANSWER CODE: 1. YES, 2. NO OR 7. NOT APPLICABLE			
	a. Tuberculin / Mantoux examination [SPECIALLY for HMs AGED < 15 YEARS OLD] <input type="checkbox"/>	c. Sputum examination [HMs OF ALL AGES] <input type="checkbox"/>		
	b. Blood test for TB (IGRA test) [SPECIALLY for HMs AGED < 15 YEARS OLD] <input type="checkbox"/>	d. Examination of chest photos / X-rays [HMs OF ALL AGES] <input type="checkbox"/>		
A14	What types of drugs are accepted? SHOW DISPLAY CARD. FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Fixed Dose Combination (FDC) TB Drugs <input type="checkbox"/>	d. Injectable TB drug <input type="checkbox"/>		
	b. Combipack TB drug regimen <input type="checkbox"/>	e. Other TB drugs, specify		
	c. Individual TB drugs regimen <input type="checkbox"/>			
A15	Was [NAME] diagnosed with Drug Resistant TB by a doctor?	1. Yes 2. No 3. Unsure	<input type="checkbox"/>	
A16	Is there a family member or other person on duty as a Drug Swallowing Supervisor (PMO)?	1. Yes 2. No	<input type="checkbox"/>	
A17	Are you still using pulmonary TBC medicine on a regular basis?	1. Yes, routine → A.22 2. Not routine 3. Heal → A.22	<input type="checkbox"/>	
A18	MAIN REASON for [NAME] not taking pulmonary TBC medicine regularly?	1. Felt healthy 2. Drugs are not available at health facilities (Hospitals / Public health centers / Pharmacies) 3. Cannot stand the side effects of the drug	4. Drink traditional medicine 5. Bored / lazy / often forget 6. Others, specify	<input type="checkbox"/>
GO TO A.22				
A19	In the past 1 year, has [NAME] ever been examined for pulmonary tuberculosis because there is another family members (HMs) who has pulmonary tuberculosis?	1. Yes 2. No → A.22	<input type="checkbox"/>	
A20	If yes, did [NAME] receive TBC prophylaxis / preventive medicine?	1. Yes → A.21 2. No	<input type="checkbox"/>	
A21	MAIN REASON for [NAME] not received TBC prophylaxis / preventive medicine?	1. Felt no symptoms / pain 2. Drugs are not available at health facilities (Hospitals / Public health center / Pharmacies)	3. Not given by health officers 4. Others, specify	<input type="checkbox"/>
HEPATITIS/ LIVER ILLNESS/ JAUNDICE [HMs OF ALL AGES]				
A22	In the last 1 year, was [NAME] ever diagnosed with hepatitis by a doctor?	1. Yes 2. No	<input type="checkbox"/>	
MALARIA [HMs OF ALL AGES]				
A23	In the last 1 year, has [NAME] ever been diagnosed with Malaria by a blood test by a doctor?	1. Yes, < last 1 month 2. Yes, 1 – 12 months	3. No → A.27	<input type="checkbox"/>

A24	Was [NAME] given malaria medication as follows? (SHOW DISPLAY CARD) FILL IN THE ANSWER CODE: 1. YES OR 2. NO		
	a. Artemisinin (ACT) 3 days + Primaquin 1 day	<input type="checkbox"/>	c. Other malaria drugs, please specify..... <input type="checkbox"/>
	b. Artemisinin (ACT) 3 days + Primaquin 14 days	<input type="checkbox"/>	
A25	Did [NAME] drink the malaria drug until finished?	1. Yes → A.29	2. No <input type="checkbox"/>
A26	MAIN reason for [NAME] not taking malaria medication until finished?	1. Felt healthy 2. Drugs are not available in health facilities (Hospital / Public Health Center / Pharmacy)	3. Take traditional medicine 4. Bored/lazy/often forgetting 5. Others, specify <input type="checkbox"/>

DENGUE HEMORRHAGIC FEVER [HMs OF ALL AGES]

A27	In the past 1 year, has [NAME] ever been diagnosed with dengue fever by a doctor?	1. Yes → A.28	2. No <input type="checkbox"/>
A28	In the past 1 year, has [NAME] ever had FEVER accompanied by the following signs and symptoms at the same time? FILL IN THE ANSWER CODE: 1. YES OR 2. NO		
	a. Headaches, especially the front of the head / dizziness	<input type="checkbox"/>	f. Limp <input type="checkbox"/>
	b. Pain around the eyeball	<input type="checkbox"/>	g. Cold feet / hands <input type="checkbox"/>
	c. Muscle pain / joint pain	<input type="checkbox"/>	h. Red spots under the skin <input type="checkbox"/>
	d. Pain in the groin / upper left abdomen	<input type="checkbox"/>	i. Nosebleed <input type="checkbox"/>
	e. Nausea / vomiting / no appetite	<input type="checkbox"/>	

FILARIASIS/ ELEPHANT FEET [HMs OF ALL AGES](CHECK DISPLAY CARD, CHECK THE REGIONAL GUIDELINES FOR RECIPIENTS RECEIVING POPM FILARIASIS)

A29	In the last 5 years, has [NAME] ever been given filariasis prevention drugs (diethylcarbamazine citrate and / or albendazole) by health officer (doctors / nurses / midwives) or cadres?	1. Yes 2. No → A.31	3. Not a priority area for Filariasis → A.32	<input type="checkbox"/>
A30	Are medicines taken in front of health officers (doctors / nurses / midwives) or cadres?	1. Yes, spent as directed → A.32 2. Yes, drink some	3. Not drunk at all 4. Do not drink in front of health officers / cadres → A.32	<input type="checkbox"/>
A31	MAIN REASON for [NAME] not taking medication pHMsially or completely	1. Feel no pain 2. Fear of drug side effects	3. Afraid because the medicine is big 4. Being sick	5. Forget 6. Others, specify: <input type="checkbox"/>

GO TO A.33

A32	MAIN REASON for [NAME] not receiving Mass Prevention Drug Administration?			<input type="checkbox"/>
	1. Pregnant 2. Not yet born	3. Not in place at the time of distribution 4. Only those who get positive elephantiasis / did not received	5. Unaware of the distribution 6. Afraid	7. Refused medication 8. Others, specify: <input type="checkbox"/>
A33	Has [NAME] ever been diagnosed with elephantiasis (filariasis) by a doctor?			<input type="checkbox"/>
	1. Yes, before and in 2021	2. Yes, in 2022	3. Yes, in 2023	4. Never <input type="checkbox"/>

B. NON-COMMUNICABLE DISEASES

ASTHMA / WHEEZING / COUGHING [HMs OF ALL AGES]

B01	Has [NAME] ever been diagnosed with asthma by a doctor?	1. Yes	2. No → B.04	<input type="checkbox"/>
B02	How old was [NAME] when he was first diagnosed with asthma? FILL IN "98" IF YOU DO NOT REMEMBER	..... year old		<input type="checkbox"/> <input type="checkbox"/>
B03	In the last 12 months, has [NAME]'s asthma ever recurred ?	1. Yes	2. No	<input type="checkbox"/>

CANCER [HMs OF ALL AGES]

B04	Has [NAME] ever been diagnosed with cancer by a doctor?	1. Yes	2. No → B.07	<input type="checkbox"/>
B05	How old was [NAME] when first diagnosed with cancer ? FILL IN "98" IF YOU DO NOT REMEMBER	..... year old		<input type="checkbox"/> <input type="checkbox"/>
B06	Has [NAME] been undergoing cancer treatment as below : FILL IN THE ANSWER CODE: 1.YES OR 2.NO			
	a. Surgery / dissection	<input type="checkbox"/>	c. Chemotherapy	<input type="checkbox"/>
	b. Radiation / irradiation	<input type="checkbox"/>	d. Others, Specify	<input type="checkbox"/>

DIABETES MELLITUS [HMs OF ALL AGES]

B07	a. Has [NAME] ever been diagnosed with diabetes mellitus (DM) by a doctor?	1. Yes	2. No → B.15	<input type="checkbox"/>
	b. What type of diabetes mellitus (DM) does [NAME] have?	1. Type 1 DM 2. Type 2 DM	3. DM with pregnancy 8. Unsure	<input type="checkbox"/>

B08	How old was [NAME] when first diagnosed with diabetes mellitus (DM)? FILL IN "98" IF YOU DO NOT REMEMBER	.....year	<input type="checkbox"/> <input type="checkbox"/>
B09	What type of treatment was received [NAME]? FILL IN THE ANSWER CODE: 1.YES OR 2.NO		
	a. Anti-DM drug from health officers	<input type="checkbox"/>	c. Individually purchased Anti-DM drugs
	b. Insulin injection	<input type="checkbox"/>	d. Not needed Anti-DM Drugs yet → B.12
B10	Did [NAME] take / inject anti-diabetic drugs according to the instructions doctor?	1. Yes, according to the doctor's instructions → B.12 2. Not according to doctor's instructions	
B11	MAIN REASON [NAME] did not drink / inject DM medication accordingly instruction doctor?	1. Felt healthy 2. Drugs are not available at the health facility (Hospital / Public health center / Pharmacy) 3. Can't stand the side effects of the drug 4. Drink traditional medicine 5. Bored / lazy / often forget 6. DM medication only drink during pregnancy / post labor 7. Others, specify	
B12	Did [NAME] re-examine (control) DM disease to a health care facility?	1. Yes, regularly 2. Yes, sometimes 3. No	
B13	Did [NAME] ever get information / explanation that DM medicine must be taken continuously / for life?	1. Yes 2. No	
B14	What did [NAME] do to control diabetes mellitus? FILL IN THE ANSWER CODE: 1. YES OR 2. NO		
	a. Meal arrangements	<input type="checkbox"/>	b. Exercise <input type="checkbox"/> c. Herbal alternatives <input type="checkbox"/>
GO TO B.16			
B15	In the last 1 month, has [NAME] experienced any these symptoms? (READ OUT POINT a-d TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES OR 2. NO		
	a. Frequent hunger	<input type="checkbox"/>	c. Frequent urination & large amounts <input type="checkbox"/>
	b. Frequent thirst	<input type="checkbox"/>	d. Weight loss <input type="checkbox"/>
HEART DISEASE [HMs OF ALL AGES]			
B16	Has [NAME] ever been diagnosed with heart disease by a doctor?	1. Yes 2.No → B.18	
B17	How old was [NAME] when first diagnosed with the heart disease? (FILL in "98" IF YOU DO NOT REMEMBER)	..... year	<input type="checkbox"/> <input type="checkbox"/>
HYPERTENSION [HMs AGED ≥ 15 YEARS OLD]			
B18	Has [NAME] ever been diagnosed with hypertension by a doctor?	1. Yes 2. No → B.24	
B19	How old was [NAME] when he was first diagnosed with hypertension ? (FILL in "98" IF YOU DO NOT REMEMBER)	.....year	<input type="checkbox"/> <input type="checkbox"/>
B20	Did [NAME] re-examine (control) hypertension experienced in health care facilities?	1. Yes, routinely 2. Yes, sometimes 3. No	
B21	Does [NAME] take anti-hypertension medication?	1. Yes, regularly → B.23 2. Not regularly 3. No medication	
B22	MAIN REASON [NAME] irregular take medicine every day?	1. Felt healthy 2. Drugs are not available at health facilities (Hospitals / Public health center / Pharmacies) 3. Can't stand the side effects of the drug 4. Drink traditional medicine 5. Bored / lazy / often forget 6. Others, specify	
B23	Did [NAME] ever get information / explanation that antihypertensive medication should be taken continuously / for life ?	1. Yes 2. No	
STROKE [HMs AGED ≥ 15 YEARS OLD]			
B24	Has [NAME] ever been diagnosed with a stroke by a doctor?	1. Yes 2. No → B.27	
B25	At what age was [NAME] first diagnosed with stroke? FILL IN "98" IF YOU DO NOT REMEMBER	.....year	<input type="checkbox"/> <input type="checkbox"/>
B26	Did [NAME] re-examine (control) stroke at a health care facility?	1. Yes, routinely 2. Yes, sometimes 3. No	
CHRONIC KIDNEY FAILURE DISEASE [HMS AGED ≥ 15 YEARS OLD]			
B27	Has [NAME] ever been diagnosed by a doctor as suffering from chronic kidney failure? (at least for 3 months in a row)?	1. Yes 2. No → BLOCK C	
B28	How old was [NAME] when first diagnosed with chronic kidney failure? FILL IN "98" IF YOU DO NOT REMEMBER	..... year	<input type="checkbox"/> <input type="checkbox"/>
B29	Has [NAME] ever / is undergoing dialysis (haemodialysis)?	1. Yes 2. No	

C. MENTAL HEALTH

HMs AGED ≥ 15 YEARS OLD AND "UNREPRESENTED"

DEPRESSION

C01	During the last 2 weeks, did [NAME] constantly feel sad, depressed or gloomy, almost all day, almost every day?	1. Yes	2. No	<input type="checkbox"/>
C02	During the last 2 weeks, was [NAME] less interested in many things or less able to enjoy the things that [NAME] usually enjoys?	1. Yes	2. No	<input type="checkbox"/>
C03	During the past 2 weeks, did [NAME] feel tired or low most of the time?	1. Yes	2. No	<input type="checkbox"/>
TOTAL ANSWERS CODE "1=YES" FOR QUESTIONS C01-C03				
.....				
C04	During the past 2 weeks, has [NAME]'s appetite changed markedly or has [NAME]'s weight increased or decreased without conscious effort?	1. Yes	2. No	<input type="checkbox"/>
C05	During the last 2 weeks, did [NAME] experience sleep disturbances almost every night (difficulty getting to sleep, waking up in the middle of the night, waking up early, oversleeping)?	1. Yes	2. No	<input type="checkbox"/>
C06	During the last 2 weeks, did [NAME] speak or move more slowly than usual, was restless, restless or had difficulty staying still?	1. Yes	2. No	<input type="checkbox"/>
C07	During the last 2 weeks, did [NAME] lose self-confidence, or did [NAME] feel worthless or even lower than other people?	1. Yes	2. No	<input type="checkbox"/>
C08	During the last 2 weeks, did [NAME] feel guilty or blame himself?	1. Yes	2. No	<input type="checkbox"/>
C09	During the last 2 weeks, did [NAME] have difficulty thinking or concentrating, or did he have difficulty making decisions?	1. Yes	2. No	<input type="checkbox"/>
C10	During the past 2 weeks, did [NAME] intend to hurt himself, wanted to kill himself or wished that [NAME] would die?	1. Yes	2. No	<input type="checkbox"/>
TOTAL ANSWERS CODE "1=YES" FOR QUESTIONS C04-C10				
.....				

IF ONE OF THE ANSWERS C.01 - C.10 CODE "1", CONTINUE TO C.11

IF THE ANSWERS C.01 - C.10 ALL CODE "2" NO, CONTINUE TO C.13

C11	For all the complaints mentioned above (C.01 to C.10), does [NAME] take medication or undergo medical treatment?	1. Yes	2. No → C.1	<input type="checkbox"/>
C12	Does [NAME] take medication regularly according to the doctor's recommendations?	1. Yes	2. No	<input type="checkbox"/>

MENTAL HEALTH PROBLEMS

We will read out 20 questions. If you don't understand, we will read it again, but we will not explain / discuss it. If you have any questions, we'll talk about it after we've finished answering the 20 questions.

C13	In the last 1 month, did [NAME] often suffer from headaches?	1. Yes	2. No	<input type="checkbox"/>
C14	In the last 1 month, has [NAME] had no appetite?	1. Yes	2. No	<input type="checkbox"/>
C15	In the last 1 month, did [NAME] have trouble sleeping?	1. Yes	2. No	<input type="checkbox"/>
C16	In the last 1 month, was [NAME] easily scared?	1. Yes	2. No	<input type="checkbox"/>
C17	In the last 1 month, did [NAME] feel tense, anxious or worried?	1. Yes	2. No	<input type="checkbox"/>
C18	In the last 1 month, did [NAME]'s hands shiver?	1. Yes	2. No	<input type="checkbox"/>
C19	In the past 1 month, was [NAME]'s digestion disturbed / poor?	1. Yes	2. No	<input type="checkbox"/>
C20	In the last 1 month, was it difficult for [NAME] to think clearly?	1. Yes	2. No	<input type="checkbox"/>
C21	In the last 1 month, did [NAME] feel unhappy?	1. Yes	2. No	<input type="checkbox"/>
C22	In the last 1 month, did [NAME] cry more often?	1. Yes	2. No	<input type="checkbox"/>
C23	In the last 1 month, did [NAME] find it difficult to enjoy daily activities?	1. Yes	2. No	<input type="checkbox"/>
C24	In the last 1 month, was it difficult for [NAME] to make a decision?	1. Yes	2. No	<input type="checkbox"/>
C25	In the last 1 month, did the job [NAME] bothered everyday?	1. Yes	2. No	<input type="checkbox"/>
C26	In the last 1 month, was [NAME] not able to do useful things in life?	1. Yes	2. No	<input type="checkbox"/>
C27	In the last 1 month, has [NAME] lost interest in things?	1. Yes	2. No	<input type="checkbox"/>
C28	In the last 1 month, did [NAME] feel worthless?	1. Yes	2. No	<input type="checkbox"/>
C29	In the last 1 month, did [NAME] have thoughts of ending his life?	1. Yes	2. No	<input type="checkbox"/>

C30	In the last 1 month, did [NAME] feel tired all the time?	1. Yes 2. No	<input type="checkbox"/>
C31	In the last 1 month, did [NAME] experience any discomfort in the stomach?	1. Yes 2. No	<input type="checkbox"/>
C32	In the last 1 month, did [NAME] tire easily?	1. Yes 2. No	<input type="checkbox"/>
TOTAL ANSWERS CODE "1=YES" FOR QUESTIONS C13-C32		.....

D. DISABILITY / INABILITY

D.1 DIFFICULTIES / BARRIERS TO FUNCTION IN HMs AGED ≥ 1 YEAR OLD

Now I will ask a few questions regarding the difficulties or obstacles that [NAME] might experience.

D01	Has [NAME] had difficulty seeing, at least in the last 6 months? (either wearing or not wearing device)	1. No trouble 2. Little difficulty	3. Very Hard 4. Not at all	<input type="checkbox"/>		
D02	Does [NAME] use visual aids (glasses, contact lenses, implants)?	1. Yes 2. No → D.04		<input type="checkbox"/>		
D03	When using visual aids, does [NAME] still have difficulty seeing?	1. No trouble 2. Little difficulty	3. Very Hard 4. Not at all	<input type="checkbox"/>		
D04	Does [NAME] have difficulty hearing (using or not using assistive devices), such as hearing the sound of other people's conversations or music for at least 6 months?	1. No trouble 2. Little difficulty	3. Very Hard 4. Not at all	<input type="checkbox"/>		
D05	Does [NAME] use a hearing aid?	1. Yes 2. No → D.07		<input type="checkbox"/>		
D06	When using a hearing aid, does [NAME] still have difficulty hearing, such as hearing other people's talk or music?	1. No trouble 2. Little difficulty	3. Very difficult 4. Not at all	<input type="checkbox"/>		
D07	Does [NAME] experienced difficulty walking, for at least the last 6 months? (Either using tools or the help of others or not at all)	1. No trouble 2. Little difficulty	3. Very difficult 4. Not at all	<input type="checkbox"/>		
D08	Does [NAME] use an assistive device or need help from another person to walk ?	1. Yes 2. No → D. 09c		<input type="checkbox"/>		
D09	a. When not using a walking aid or not being assisted by another person, does [NAME] have difficulty walking?	1. No trouble 2. Little difficulty	3. Very difficult 4. Not at all	<input type="checkbox"/>		
	b. By using a walking aid or assisted by other people, does [NAME] still have difficulty walking?	1. No trouble 2. Little difficulty	3. Very difficult 4. Not at all	<input type="checkbox"/>		
	c. Check Answers to Questions D01, D03, D04, D06, D07 <ul style="list-style-type: none"> • If one of the answers is "very difficult" or "not at all" → GO TO D.10a • If there is no answer "very difficult" or "not at all" → D11 					
D10	a. What was the cause for the inability?	1. Inherited abnormalities → D11 2. Accident / Injury / Violence → D11	3. Disease	<input type="checkbox"/>		
	b. If answer D10a is coded 3, then what kind of disease? FILL IN THE ANSWER CODE: 1. YES 2. NO					
	1. Strokes	<input type="checkbox"/>	3. Cancer	<input type="checkbox"/>	5. Cataracts	<input type="checkbox"/>
	2. Diabetes	<input type="checkbox"/>	4. Hypertension	<input type="checkbox"/>	6. others	<input type="checkbox"/>
D11	Has [NAME] been examined by a doctor and diagnosed with the following abnormality? FILL IN THE ANSWER CODE: 1. YES 2. NO					
	a. Lateness development general (global development delay)	<input type="checkbox"/>	d. ADD / ADHD / GPPH	<input type="checkbox"/>	g. Conduct Disorder	<input type="checkbox"/>
	b. Autism	<input type="checkbox"/>	e. Cerebral Palsy	<input type="checkbox"/>	h. Mental Retardation	<input type="checkbox"/>
	c. Asperger Syndrome	<input type="checkbox"/>	f. Dyslexia	<input type="checkbox"/>	i. Down Syndrome	<input type="checkbox"/>

IF HMs AGED 1-4 YEARS OLD → GO TO BLOCK G

IF HMs AGED 5-17 YEARS OLD → GO TO D.12

IF HMs AGED 18-59 YEARS OLD → GO TO D.21

IF HMs AGED ≥ 60 YEARS → GO TO D.34

D.2 DIFFICULTIES / BARRIERS TO FUNCTION IN HMs AGED 5-17 YEARS OLD

FOR QUESTIONS D12 – D20, READ OUT THE QUESTIONS & ALTERNATIVE ANSWERS TO RESPONDENT. FILL IN THE ANSWER CHOICE CODE:

1. NO DIFFICULTY 2. LITTLE DIFFICULTY 3. VERY DIFFICULTY 4. CANNOT BE DONE AT ALL

Repeat the four categories for each question if the HMS does not answer according to the category

D12	Does [NAME] experienced difficulty in daily activity such as eating or wearing their own clothes?	<input type="checkbox"/>
D13	Compared with child his age, when speaking, does [NAME] experienced difficulty to be understood by family members?	<input type="checkbox"/>
D14	Compared with child his age, when speaking, does [NAME] experienced difficulty to be understood by person other than family member?	<input type="checkbox"/>
D15	Compared with child his age, does [NAME] has difficulty to learn?	<input type="checkbox"/>

D16	Compared with child his age, does [NAME] has difficulty to remember ?	<input type="checkbox"/>
D17	Compared with child his age, does [NAME] has difficulty to concentrate on the activity that he is doing?	<input type="checkbox"/>
D18	Compared with child his age, is it? [NAME] has difficulty for accept changes to the routine ?	<input type="checkbox"/>
D19	Compared with child his age, is it? [NAME] has difficulty for control behavior ?	<input type="checkbox"/>
D20	Compared with child his age, is it? [NAME] has difficulty for intertwine friendship ?	<input type="checkbox"/>

GO TO BLOCK E

**D.3 PHYSICAL AND MENTAL INABILITY IN HMs AGED 18-59 YEARS
SPECIALLY FOR "UNREPRESENTED" HMs**

Now I will ask a few questions regarding the difficulties or obstacles that [NAME] might experience.

FOR QUESTIONS D20 – D31 , READ OUT THE QUESTIONS & ALTERNATIVE ANSWERS TO RESPONDENT.

FILL IN THE ANSWER CHOICE CODE:

1. None 2. LIGHT 3. MODERATE 4. SEVERE 5. VERY SEVERE

Repeat the five categories for each question if the HMS does not answer according to the category

D21	At least during the last 1 month , how difficult was it for [NAME] to stand up for ≥ 30 minutes ?	<input type="checkbox"/>
D22	At least during the last 1 month , how difficult was it for [NAME] to carry out or do the household activities that were his responsibility ?	<input type="checkbox"/>
D23	At least during the last 1 month , how difficult was it for [NAME] to learn / do new things , such as learn method going to a new place ?	<input type="checkbox"/>
D24	At least during the last 1 month , how difficult was it for [NAME] to be able to pHmsicipate in community activities (for example in sports activities, social gatherings, recitations, religion, or other activities)?	<input type="checkbox"/>
D25	At least during the last 1 month , how much has the health problem affected [NAME] 's emotional state ?	<input type="checkbox"/>
D26	At least during the last 1 month , how difficult was it for [NAME] to concentrate on doing something for 10 minutes ?	<input type="checkbox"/>
D27	At least during the last 1 month , how difficult was it for [NAME] to walk long distances, for example 1 kilometer ?	<input type="checkbox"/>
D28	At least during the last 1 month , how difficult was it for [NAME] to clean his whole body / shower ?	<input type="checkbox"/>
D29	At least during the last 1 month , how difficult was it for [NAME] to wear clothes ?	<input type="checkbox"/>
D30	At least during the last 1 month , how difficult was it for [NAME] to interact / associate with people you didn't know before ?	<input type="checkbox"/>
D31	At least during the last 1 month , how difficult was it for [NAME] to maintain friendship ?	<input type="checkbox"/>
D32	At least during the last 1 month , how difficult was it for [NAME] to do their daily work ?	<input type="checkbox"/>

**IF THERE IS ANY OF THE QUESTIONS ABOVE (D.21 - D.32) ANSWER "MODERATE", "SEVERE" OR "VERY SEVERE" →GO TO D.33
IF THE ANSWER IS "NO" OR "LIGHT" →GO TO BLOCK E**

D33	Health facility visited by [NAME] if experiencing one of the conditions above? 1. Public health center 3. Health officers' independent practice 5. Pharmacy 7. Not going to Health Facility 2. Hospital 4. Clinic 6. Traditional medicine	<input type="checkbox"/>
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GO TO BLOCK E

D.4 PHYSICAL AND MENTAL INABILITY IN HMs AGED ≥ 60 YEARS OLD

Now I will ask the circumstances health according to [NAME]'s own judgment .

Health in question here are physical and mental condition [NAME]

D34	In the past 1 month , was [NAME] able to control the urge to defecate?	1. Uncontrollable / irregular or need laxative (0) 2. Sometimes uncontrollable (1x / week) (+5) 3. Regularly controlled (+10)	<input type="checkbox"/>
D 35	In the past 1 month , was [NAME] able to control the urge to micturate / urinate?	1. Uncontrollable (using a disposable catheter or diaper) (0) 2. Sometimes uncontrollable (only 1x / 24 hours) (+5) 3. Regularly controlled (+10)	<input type="checkbox"/>
D36	In the last 1 month , was [NAME] able to clean himself (such as: washing face, combing hair, shaving mustache, brushing teeth)?	1. Need help from others (0) 2. Independent (+5)	<input type="checkbox"/>
D37	In the last 1 month , was [NAME] able to use the toilet alone (such as: going in and out of the toilet, taking off / putting on pants, washing, flushing)?	1. Depends on the help of others (0) 2. Needs help with some activities but can do others independently (+5) 3. Independent (+10)	<input type="checkbox"/>
D38	In the last 1 month , was [NAME] able to eat and drink alone? (if the meal must be in the form of pieces, it is considered assisted)	1. Unable (0) 2. Need help cutting food (+5) 3. Independent (+10)	<input type="checkbox"/>
D39	In the last 1 month , was [NAME] able to move from chair to bed and from bed to chair (including sitting on the bed)?	1. Unable / cannot sit on balance (lifted by two people) (0) 2. Need to be assisted by at least two people to be able to sit (+5)	<input type="checkbox"/>

		3. Requires light assistance, at least by one person (+10) 4. Independent (+15)	
D40	In the past 1 month, was [NAME] able to walk on level ground (for wheelchair users, able to walk in a wheelchair without assistance)?	1. Unable (0) 2. Able to (move) using a wheelchair (+5) 3. Walk with assisted by 1 person (physical or verbal assistance) (+10) 4. Independent (despite using a cane) (+15)	<input type="checkbox"/>
D41	In the last 1 month, was [NAME] able to dress themselves (including putting shoelaces, fastening the belt)?	1. Depends on others (0) 2. PHMsially assisted (eg: buttoning clothes) (+5) 3. Independent (+10)	<input type="checkbox"/>
D42	In the last 1 month, was [NAME] able to go up and down the stairs by himself?	1. Depends on others (0) 2. Need help (+5) 3. Independent (+10)	<input type="checkbox"/>
D43	In the past 1 month, was [NAME] able to bathe alone?	1. Depends on other people (0) 2. Needs help (+5)	<input type="checkbox"/>
TOTAL ANSWERS FOR QUESTIONS D34-D43			.....
IF THE SUMMARY OF ANSWERS D.34 to D.43 ≤ 40 THEN GO TO D.44 IF THE SCORE ≥ 40 GO TO BLOCK E			
D44	Who MAINLY takes care of [NAME] everyday?	1. Family closest (children, grandchildren, nephews, etc.) 2. Assistant Home Ladder	3. Trained personnel nurse elderly 4. Nurse 5. None

E. DENTAL AND ORAL HEALTH [HMs ≥ 3 YEARS OLD]

E01	In the last 1 year, did [NAME] have dental health problems? FILL IN THE ANSWER CODE: 1. YES OR 2. NO					
	a. Broken tooth, cavities or toothache	<input type="checkbox"/>	d. Loose tooth	<input type="checkbox"/>		
	b. Missing tooth due to self-extraction or naturally dislodged itself	<input type="checkbox"/>	e. Sensitive tooth	<input type="checkbox"/>		
	c. Tooth have been patched / filled due to cavity	<input type="checkbox"/>	f. Others, Specify	<input type="checkbox"/>		
E02	In the last 1 year, did [NAME] have oral problems? FILL IN THE ANSWER CODE: 1. YES OR 2. NO					
	a. Gum swelling and / or discharge boils (abscesses)	<input type="checkbox"/>	c. Ulcer repeated at least 4 times	<input type="checkbox"/>		
	b. Gum easily bleeds (e.g., during teeth brushing)	<input type="checkbox"/>	d. Canker sores persist and never heal for at least 1 month	<input type="checkbox"/>		
E03	In the last 1 year, has [NAME] ever received treatment from dental medical professional?			1. Yes 2. No → E.07	<input type="checkbox"/>	
E04	In the last 1 year, what type of action that [NAME] received from dental medical professionals to tackle the dental and oral problem? FILL IN THE ANSWER CODE: 1. YES OR 2. NO					
	a. Treatment / taking medication	<input type="checkbox"/>	f. Installation of dentures	<input type="checkbox"/>		
	b. Dental and oral hygiene and health care counseling	<input type="checkbox"/>	g. Insertion of implanted teeth (Implant denture)	<input type="checkbox"/>		
	c. Dental fillings	<input type="checkbox"/>	h. Orthodontic treatment (braces)	<input type="checkbox"/>		
	d. Tooth extraction	<input type="checkbox"/>	i. Cleaning tHMsar (scaling)	<input type="checkbox"/>		
	e. Mouth surgery	<input type="checkbox"/>	j. Gum care / periodontal treatment	<input type="checkbox"/>		
E05	In the last 1 year, where does [NAME] usually searches treatment or services to tackle the dental and oral health problems? FILL IN THE ANSWER CODE: 1. YES OR 2. NO					
	Profession (1)	Hospital (2)	Public health center (3)	Clinic (4)	Independent Practice (5)	Others (6)
	a. Specialist dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Dental therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Other general health practitioners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E06	In the last 1 year, how often does [NAME] seeks dental medical professionals' help?			1. 1- 2 times 2. >2 times	<input type="checkbox"/>	

GO TO E.08

E07	The reason why [NAME] never seeks dental medical professionals' help? FILL IN THE ANSWER CODE: 1. YES OR 2. NO (DO NOT READ OUT THE ANSWER TO RESPONDENT)				
	a. Never had a toothache	<input type="checkbox"/>	e. There is no dental and oral health service at the intended health facility	<input type="checkbox"/>	
	b. Felt unnecessary	<input type="checkbox"/>	f. Cannot afford the medical fees	<input type="checkbox"/>	

c. Afraid of going to the dentist	<input type="checkbox"/>	g. Cannot afford the transportation fees	<input type="checkbox"/>
d. Worried about exposure to COVID-19	<input type="checkbox"/>	h. Went to the dentist	<input type="checkbox"/>
e. Long waiting time	<input type="checkbox"/>	i. Self-treatment	<input type="checkbox"/>

THE IMPACT OF DENTAL AND ORAL DISEASES ON QUALITY OF LIFE

E08	In the last 1 year, has [NAME] been absent from school / work / couldn't do activities due to dental and oral health problems?	1. Yes 2. No	7. Not Applicable	<input type="checkbox"/>
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HYGIENIC BEHAVIOR

E09	Does [NAME] usually brush their teeth every day?	1. Yes	2. No → BLOCK F	7. Not Applicable → BLOCK F	<input type="checkbox"/>	
E10	If yes, how many times a day [NAME] do brush their teeth?	1. 1 time per day 2. 2 times per day 3. > 2 times per day			<input type="checkbox"/>	
E11	When does [NAME] usually brush their teeth? FILL IN THE ANSWER CODE: 1. YES OR 2. NO					
	a. Morning before breakfast	<input type="checkbox"/>	c. After lunch	<input type="checkbox"/>	e. Before sleeping at night	<input type="checkbox"/>
	b. Morning after breakfast	<input type="checkbox"/>	d. Evening bath	<input type="checkbox"/>		
E12	Is the toothbrush that [NAME] uses every day?	1. Own		2. Shared property	<input type="checkbox"/>	
E13	Does [NAME] use toothpaste?	1. Yes	2. Sometimes	3. No	<input type="checkbox"/>	

F. PHARMACY AND TRADITIONAL HEALTH SERVICES

RATIONAL DRUG USE [HMs AGED ≥ 15 YEARS OLD AND "UNREPRESENTED"]

If the respondent cannot answer the question themselves and need to be represented (check whether Block IV column 12 are coded 2 or 3), then proceed to Sub-block the Traditional Health Services (F10)

F01	In the last 1 year, has [NAME] ever bought / obtained medicine without a doctor's prescription or without visiting a Hospital / Public health center / Clinic / Health officers's practice?	1. Yes	2. No → F.06	<input type="checkbox"/>	
F02	Where did [NAME] buy / obtain the medicine? FILL IN THE ANSWER CODE: 1. YES OR 2. NO				
	a. Licensed pharmacy / drug store	<input type="checkbox"/>	c. Other people's gifts	<input type="checkbox"/>	
	b. Stalls / self-service shops	<input type="checkbox"/>	d. Purchase drugs online	<input type="checkbox"/>	
F03	Has [NAME] ever received information on drugs or asked information on drugs purchased/obtained from officers at the pharmacy or other health officers?	1. Yes	2. No → F.05	<input type="checkbox"/>	
F04	What type of drug information was obtained? (READ OUT POINT a-g TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES OR 2. NO				
	a. Name and drug content	<input type="checkbox"/>	e. Side effect	<input type="checkbox"/>	
	b. Indications / efficacy of the drug	<input type="checkbox"/>	f. Expiration time	<input type="checkbox"/>	
	c. Drug dosage	<input type="checkbox"/>	g. Drug's storage	<input type="checkbox"/>	
	d. How to use the drug	<input type="checkbox"/>			
F05	Does [NAME] know that the types of drugs purchased are classified as over-the-counter drugs (green circle), limited over-the-counter drugs (blue circle), or hard drugs (red circle with the letter 'K')?	1. Yes	2. No	<input type="checkbox"/>	
F06	a. In the last 1 year, has [NAME] used antibiotics that given orally, such as tablets, powders, or syrup (example: amoxicillin, cefadroxil, tetracycline)?	1. Yes	2. No → F.06d	8. Unsure → F.08	<input type="checkbox"/>
	b. How did [NAME] obtain the last antibiotic used?	1. With doctor's prescription 2. Without doctor's prescription		<input type="checkbox"/>	
	c. Where did [NAME] obtain the last antibiotic used?	1. Hospital/PHC/Clinic/Doctor's practice 4. Unlicensed drugstores 2. Midwife/Nurse practice 5. Gift from other people 3. Licensed pharmacies/drugstores 6. Purchase drugs online		<input type="checkbox"/>	
	d. In the last 1 year, has [NAME] ever bought antibiotics without a doctor's prescription to treat diarrhea/fever/skin infections/sore throats/aches/coughs/headaches/runny nose?	1. Yes	2. No	<input type="checkbox"/>	
F07	According to [NAME] how to use antibiotics? (READ OUT POINT a – f TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES 2. NO OR 8. UNSURE				
	a. Antibiotics must be used completely	<input type="checkbox"/>	d. Residual antibiotics can reused for self or others	<input type="checkbox"/>	
	b. Antibiotics are taken according to the schedule	<input type="checkbox"/>	e. If not used according to the rules, germs become immune (resistant)	<input type="checkbox"/>	
	c. Antibiotics can be purchased without a doctor's prescription	<input type="checkbox"/>	f. Antibiotics are only used for bacterial infections	<input type="checkbox"/>	
F08	According to [NAME], what are the characteristics of damaged drugs in tablets, syrups, ointments/creams, powders, capsules? (DO NOT READ POINT a-g TO RESPONDENT) FILL IN THE ANSWER CODE WITH 1. YES OR 2. NO				
	a. The medicine breaks, cracks, has holes, turns into powder	<input type="checkbox"/>	e. Capsules / pulverizers / tablets: moist, mushy, wet, sticky	<input type="checkbox"/>	

	b. Changes in color, smell, taste	<input type="checkbox"/>	f. Unreadable / torn etiquette	<input type="checkbox"/>	
	c. The container / packaging is damaged	<input type="checkbox"/>	g. Drug expired	<input type="checkbox"/>	
	d. Liquid / ointment / cream becomes cloudy, thickens, precipitates, separates, hardens, stains, spots, gas appear	<input type="checkbox"/>			
F09	What is [NAME] what to do with drugs that can no longer be used, damaged or expired drugs? DO NOT READ OUT THE ANSWERS FILL IN THE ANSWER CODE 1. YES OR 2. NO	a. Separate drug from packaging before thrown away	<input type="checkbox"/>	d. Drugs immediately disposed of into trash bin	<input type="checkbox"/>
		b. Destroy the drug before thrown away	<input type="checkbox"/>	e. Burnt / buried	<input type="checkbox"/>
		c. Drug is still kept	<input type="checkbox"/>	f. Entrusted to the pharmacy / 3rd party	<input type="checkbox"/>

TRADITIONAL HEALTH SERVICES [HMS OF ALL AGES AND CAN BE REPRESENTED]

F10	In the last 1 year, did [NAME] ever do traditional health efforts such as cupping, herbs, or massage?	1. Yes 2. Not at all → F.13	<input type="checkbox"/>	
F11	Who provides these traditional health services? FILL IN THE ANSWER CODE 1. YES OR 2. NO			
	a. Health officers or traditional health officers in hospitals, Hospital, clinic	<input type="checkbox"/>	d. Traditional healers	<input type="checkbox"/>
	b. Health officers's independent practice	<input type="checkbox"/>	e. Self-treatment	<input type="checkbox"/>
	c. Traditional health officers at Griya Sehat	<input type="checkbox"/>		

F12	What types of traditional health services are utilized? FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Finished potion	<input type="checkbox"/>	e. Manual Skills:	
	b. Homemade potions	<input type="checkbox"/>	e.1 Massage / acupressure	<input type="checkbox"/>
	c. Mindfulness / hypnotherapy skills	<input type="checkbox"/>	e.2 Fractures	<input type="checkbox"/>
	d. Internal energy / energy skills	<input type="checkbox"/>	e.3 Acupuncture/ needling	<input type="checkbox"/>
F13	In the last 1 year, has [NAME] used the Family Medicinal Plants?	1. Yes	2. No	<input type="checkbox"/>

G. KNOWLEDGE AND BEHAVIOR

PREVENTION OF DISEASES CAUSED BY MOSQUITO BITES [HMS OF ALL AGES]

G01	What does [NAME] do to avoid mosquito bites? (READ OUT POINT a-e TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Sleep using mosquito nets without insecticides	<input type="checkbox"/>	d. Using repellents / ingredients to prevent mosquito bites	<input type="checkbox"/>
	b. Sleep using mosquito nets with insecticides ≤ 3 years	<input type="checkbox"/>	e. Use anti-mosquito drugs (coils / spray / electric)	<input type="checkbox"/>
	c. Sleeping using mosquito nets with insecticides > 3 years	<input type="checkbox"/>		

IF HMS AGED < 3 YEARS OLD → ADVANCE TO BLOCK I

HYGIENIC BEHAVIOR [HMS AGED ≥ 3 YEARS OLD]

G02	Where does [NAME] usually defecate? (DO NOT READ THE ANSWER)	1. Toilet / WC 2. River / Lake / Ocean 3. Beach / Field / Garden / Yard	4. Ponds / Rice fields / Gutters 5. Ground pit	<input type="checkbox"/>
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IF HMs AGED 3-9 YEARS OLD → GO TO G.23

IF HMs AGED ≥ 10 YEARS OLD → GO TO G.03a

KNOWLEDGE ON STUNTING [HMS AGED ≥ 10 YEARS OLD] (G03-G06 ANSWERS DO NOT READ OUT TO RESPONDENT)

G03	a. Does [NAME] know about stunted child?	1. Yes	2. No → G.07	<input type="checkbox"/>
	b. According to [NAME], what is meant by stunting? FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	1) The bodyweight does not increase	<input type="checkbox"/>	4) Inappropriate bodyweight by length / height (malnourishment / wasting)	<input type="checkbox"/>
	2) Failed to grow	<input type="checkbox"/>	5) Inappropriate body length / height with age (short / stunted)	<input type="checkbox"/>
	3) Midget / Dwarf	<input type="checkbox"/>	6) Malnourished for a long time	<input type="checkbox"/>
			7) Inappropriate bodyweight with age (minimal bodyweight / underweight)	<input type="checkbox"/>
			8) Chronic lack of energy	<input type="checkbox"/>
			9) Anemia	<input type="checkbox"/>
G04	According to [NAME], what is the cause of stunting? FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Lack of nutritious food intake	<input type="checkbox"/>	d. Genetics	<input type="checkbox"/>
	b. Malnutrition before and during pregnancy	<input type="checkbox"/>	e. Frequently sick	<input type="checkbox"/>
	c. Lack of environmental cleanliness	<input type="checkbox"/>	f. Poverty	<input type="checkbox"/>
G05	According to [NAME], what is the impact of stunting on the child? FILL IN THE ANSWER CODE: 1. YES OR 2. NO			

	a. The risk of suffering from NCDs when in adult	<input type="checkbox"/>	d. Brain development hampered	<input type="checkbox"/>
	b. Reduced level of intelligence	<input type="checkbox"/>	e. Productivity level low	<input type="checkbox"/>
	c. Growth physical hampered	<input type="checkbox"/>	f. Not giving impact	<input type="checkbox"/>
G06	How to prevent stunting?			
	a. Infants / Children are exclusively breastfed	<input type="checkbox"/>	f. Pregnant women drink iron supplements tablet	<input type="checkbox"/>
	b. Infants / Children are breastfed for 2 years	<input type="checkbox"/>	g. Pregnant women regularly check at least do pregnancy check 6 times in health facilities	<input type="checkbox"/>
	c. Babies / Children are given complementary food for breastmilk (MP-ASI) according to the baby's nutritional needs	<input type="checkbox"/>	h. Pregnant women consuming animal protein corresponding to the pregnant mother's portion	<input type="checkbox"/>
	d. Infants / Children immunized	<input type="checkbox"/>	i. Others, Specify:	<input type="checkbox"/>
	e. Infants / Children monitor weight gain and height every month at integrated healthcare center / health facilities	<input type="checkbox"/>		

HAND WASHING BEHAVIOR [HMS AGED ≥ 10 YEARS OLD]

G07	Does [NAME] usually wash hands?	1. Yes 2. No → G. 11	<input type="checkbox"/>
G08	With what does [NAME] usually use to wash their hands?	1. Soap 3. Both 2. Hand sanitizers	<input type="checkbox"/>
G09	Does [NAME] always wash their hands using clean running water?	1. Yes 2. No	<input type="checkbox"/>
G10	When does [NAME] usually wash hands? (READ OUT ANSWERS TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES, 2. NO OR 7. NOT APPLICABLE		
	a. Before preparing food / before eating	<input type="checkbox"/>	d. After using pesticides / insecticides
	b. Whenever hands are dirty (handling money, animals, gardening)	<input type="checkbox"/>	e. After washing a toddler
	c. After defecation (BAB)	<input type="checkbox"/>	f. Before feeding the baby

SMOKING BEHAVIOR AND TOBACCO USE [HMS AGED ≥10 YEARS OLD]

G11	Has [NAME] ever smoked?	1. Yes, every day 3. Never smoked → G.20 2. Yes, not every day → G.13	<input type="checkbox"/>
G12	At what age did [NAME] starts smoking every day? FILL IN "98" IF YOU DO NOT REMEMBER	<input type="checkbox"/> <input type="checkbox"/> years	
G13	How old was [NAME] when he first started smoking? FILL IN "98" IF YOU DO NOT REMEMBER	<input type="checkbox"/> <input type="checkbox"/> years	
G14	Mention the types of cigarettes that [NAME] usually smokes: (READ OUT ANSWER TO RESPONDENT)		
	a. Clove cigarette	1. Yes 2. No <input type="checkbox"/>	e. Electric cigarette 1. Yes 2. No <input type="checkbox"/>
	b. White cigarette	1. Yes 2.No <input type="checkbox"/>	f. Shisha 1. Yes 2. No <input type="checkbox"/>
	c. Rolled cigarette	1. Yes 2. No <input type="checkbox"/>	

**IF G.14a =1 OR G. 14 b=1 OR G.14 c=1, CONTINUE TO G.15
IF G.14a =2 AND G. 14 b=2 AND G.14 c=2, CONTINUE TO G.16**

G15	IF G.11=1, G.15a FILLED IN CODE 1 AND G.15b FILL IN THE AVERAGE AMOUNT PER DAY IF G.11=2, G.15a FILLED IN CODE 2 AND G.15b FILL IN AVERAGE AMOUNT PER WEEK		
	On average, how many clove / white / rolled cigarettes does [NAME] smoke per day or per week?	a. Unit:	1. Stick per day 2. Stick per week <input type="checkbox"/>
		b. Amount: <input type="checkbox"/> <input type="checkbox"/>
		c. price per pack	..... Rp. <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
G16	Did [NAME] smoke in the last 1 month? (READ OUT ANSWERS TO RESPONDENT)	1. Yes, every day 3. Have quit smoking → G.19 2. Yes, not every day	<input type="checkbox"/>
G17	Does [NAME] usually smoke inside the building / room (public place, schools, workplaces, buildings / other spaces)	1. Yes 2. No	<input type="checkbox"/>
G18	Does [NAME] usually smoke in the house?	1. Yes 2. No	<input type="checkbox"/>

GO TO G.20

G19	How old was [NAME] when he quit / did not smoke at all? FILL IN "98" IF YOU DON'T REMEMBER	..... year	<input type="checkbox"/> <input type="checkbox"/>
G20	How often do other people smoke near [NAME] in closed spaces? (Including at home, workplace, and means of transportation)	1. Yes, every day 3. Never 2. Yes, not every day	<input type="checkbox"/>
G21	Has [NAME] CHEWED TOBACCO in the last 1 month?		

	1. Yes, every day 2. Yes, sometimes	3. No, but have chewed tobacco before 4. Never at all → G.23	<input type="checkbox"/>
G22	Did [NAME] ever chew tobacco every day?	1. Yes 2. No	<input type="checkbox"/>

RISK FOOD CONSUMPTION [HMs AGED ≥ 3 YEARS OLD]

Ask the frequency consumption of the following foods in one day. If not consumed every day, ask per week or per month

G23	In the past month, how many times did [NAME] usually eat the following foods: (READ OUT POINTS TO RESPONDENT)		
	ENTER THE CODE:	1. > 1 time per day 2. 1 time per day	3. 3 – 6 times per week 4. 1 – 2 times per week
			5. < 3 times per month 6. Never
	a. Sweet food	<input type="checkbox"/>	f. Processed meat / chicken / fish food with preservatives
	b. Sweet drink	<input type="checkbox"/>	g. Seasonings
	c. Salty food	<input type="checkbox"/>	h. Soft drinks or carbonated drinks
	d. Fatty / cholesterol / fried foods	<input type="checkbox"/>	i. Energy drink
	e. Grilled food	<input type="checkbox"/>	j. Instant noodles / other instant food
G 24	Reasons for consuming these foods: (READ OUT POINT a-e TO RESPONDENT) FILL IN THE CODE: 1. Yes 2. No		
	a. Great taste	<input type="checkbox"/>	d. Unsureing the dangers and risks
	b. Easy to get	<input type="checkbox"/>	e. Others, specify.....
	c. Cheaper	<input type="checkbox"/>	

CONSUMPTION OF FRUIT AND VEGETABLES (USE DISPLAY CARD) [HMs AGED ≥ 5 YEARS OLD]

G25	Usually in 1 week, how many days does [NAME] eat fresh fruit? IF NEVER, FILL IN 0 → CONTINUE TO G.27	.....day	<input type="checkbox"/>
G26	What is the average portion of [NAME] consuming fresh fruit in one day from those days?	..... portion	<input type="checkbox"/> . <input type="checkbox"/>

GO TO G.28

G27	Reasons why [NAME] does not eat fruit: FILL IN THE CODE: 1. YES OR 2. NO (READ OUT ANSWER TO RESPONDENT)		
	a. Dislike	<input type="checkbox"/>	d. Bored or Lazy
	b. Cannot afford fruit	<input type="checkbox"/>	e. No perceived benefit
	c. No fruit	<input type="checkbox"/>	f. Others, specify.....
G28	Usually in 1 week, how many days does [NAME] consume vegetables? IF NEVER, FILL IN 0 → CONTINUE TO G.30	.....day	<input type="checkbox"/>
G29	What is the average portion of [NAME] consuming vegetables in one day from those days?	.....portion	<input type="checkbox"/> . <input type="checkbox"/>

CONTINUE TO G.31

G30	Reasons why [NAME] does not consume vegetables: FILL IN THE CODE: 1. YES OR 2. NO (READ OUT ANSWERS TO RESPONDENT)		
	a. Dislike	<input type="checkbox"/>	d. Bored or Lazy
	b. Not used to cooking vegetables	<input type="checkbox"/>	e. No perceived benefit
	c. No vegetables (stock / availability / price)	<input type="checkbox"/>	f. Others, specify.....

FOOD CONSUMPTION PATTERN [HMS AGED ≥ 5 YEARS OLD, READ ANSWERS OUT TO RESPONDENT]

Ask the frequency in one day. If not consumed every day, ask per week or per month

G31	In the past month, how many times did [NAME] usually eat the following foods:		
	ENTER THE CODE:	1. > 1 time per day 2. 1 time per day	3. 3 – 6 times per week 4. 1 – 2 times per week
			5. < 3 times per month 6. Never
	a. Cereals and yields processed products (rice porridge / rice / bread / noodles / biscuits / vermicelli / sorgum / pasta)	<input type="checkbox"/>	g. Fish, shellfish, shrimp, and their processed products
	b. Starchy tubers and their processed products	<input type="checkbox"/>	h. Eggs (chicken eggs, eggs ducks, etc.)
	c. Nuts, seeds, tempeh, tofu, and their processed products	<input type="checkbox"/>	i. Milks and their processed products
	d. Vegetables and their processed products	<input type="checkbox"/>	j. Fats and oils
	e. Fruit and their processed products	<input type="checkbox"/>	k. Sugar, syrup, confectionery and their processed products
	f. Meat beef, chicken, beef poultry, offal, etc.	<input type="checkbox"/>	

IF HMs AGED ≥ 10 YEARS OLD → GO TO G.32

IF HMs AGED < 10 YEARS OLD → GO TO BLOCK I			
DRINKING ALCOHOLIC BEVERAGES BEHAVIOR [HMs AGED ≥10 YEARS OLD]			
G32	In the last 1 month, did [NAME] consume alcoholic beverages?	1. Yes 2. No → G.36	<input type="checkbox"/>
G33	In the past 1 month, what kind of alcoholic drinks did [NAME] usually drink at one time?		<input type="checkbox"/>
	1. Beer 2. Wine / Arrack 3. Whiskey 4. Traditional turbid drink 5. Clear traditional drink 6. Mixed drinks 7. Other, specify.....		
G34	During the last 1 month, how many days did [NAME] consume alcoholic beverages?		<input type="checkbox"/> <input type="checkbox"/>
G35	What is the average number of alcoholic drinks consumed per day		<input type="checkbox"/>
	a. Unit: 1. Beer glass (330ml) 2. Starfruit glass (200-250 ml) 3. Wine glass (200-250 ml) 4. Small bottle (250-300 ml) 5. Large bottle (750-800 ml) 6. Can (330 ml) 7. Small shot / glass (30-40 ml)		
	b. Average amount per day:		<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/>
PHYSICAL ACTIVITY [HMs AGED ≥10 YEARS OLD] (SHOW IMAGES FROM DISPLAY CARD ACCORDING TO THE TYPE OF PHYSICAL ACTIVITY ASKED)			
G36	Does [NAME] usually do heavy physical activity, which is done continuously for at least 10 minutes each time?	1. Yes 2. No → G.39	<input type="checkbox"/>
G37	How many days a week does [NAME] do heavy physical activity?	.....day	<input type="checkbox"/>
G38	Usually in a day, how long does [NAME] do those heavy physical activities?	a. Hour b. minute	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
G39	Does [NAME] usually do moderate physical activity, which is done continuously for at least 10 minutes each time?	1. Yes 2. No → G.42	<input type="checkbox"/>
G40	Usually how many days a week does [NAME] do this moderate physical activity?	.....day	<input type="checkbox"/>
G41	Usually in a day, how long does [NAME] do moderate physical activity?	a. Hour b. minute	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
CONTINUE TO G.43			
G42	Reasons why [NAME] does not carry out strenuous or moderate physical activity: (READ POINT a-e TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES OR 2. NO		
	a. No time	<input type="checkbox"/>	d. No partners
	b. Lazy	<input type="checkbox"/>	e. Others, Specify:
	c. Already elderly	<input type="checkbox"/>	
PRIVATE HEALTH CHECKS PERIOD [HMs AGED ≥ 15 YEARS OLD]			
G43	How many times does [NAME] usually carry out health checks both when healthy or sick: ENTER THE CODE: 1. At least once a month 2. At least once every 3 months 3. At least once every 6 months 4. At least once a year 5. More than 1 year 6. Never 7. Not applicable		
	a. Measuring / monitoring blood pressure	<input type="checkbox"/>	e. Check total cholesterol levels
	b. Measuring bodyweight	<input type="checkbox"/>	f. Measure blood sugar
	c. Measure height	<input type="checkbox"/>	g. Cervical Cancer Screening (Pap smear / VIA Test)
	d. Measuring abdominal circumference	<input type="checkbox"/>	h. Breast examination (SADARI / SADANIS)
G44	If one of the G43a-h answers is coded 1-5, where most frequently did [NAME] checking health status?	1. Hospitals 2. Public health center 3. Clinic 4. Health officers' independent practice 5. Integrated Healthcare Center /integrated coaching post 6. Health laboratory 7. Home 8. Others	<input type="checkbox"/>
TELEMEDICINE ACTIVITY BEHAVIOUR [HMs AGED ≥ 15 YEARS OLD]			
G45	In the last 1 year, has [NAME] used online health services (telemedicine)?	1. Yes, they had 2. Never → G.47a (SEE INSTRUCTION)	<input type="checkbox"/>
G46	Type of health online service initiated? (READ OUT POINTS a-d TO RESPONDENTS) FILL IN THE ANSWER CODE 1. YES OR 2. NO		
	a. Registration	<input type="checkbox"/>	c. Clinical consultation including pre-post vaccination
	b. Communication, Information and Education	<input type="checkbox"/>	d. Telepharmacy and preparation of lab and radiology examinations
G47a	<ul style="list-style-type: none"> IF FEMALES HMs AGED 10-19 YEARS OLD → G.47b IF FEMALES HMs AGED 20-54 YEARS OLD MARRIAGE / DIVORCED / WIDOW(ER) STATUS → BLOCK H IF FEMALES HMs AGED > 20 YEARS OLD IS NOT MARRIED OR FEMALES HMs > 54 YEARS OLD → BLOCK J IF MALES HMs → BLOCK J 		

ADMINISTRATION OF IRON TABLETS SUPPLEMENT FOR ADOLESCENT FEMALE [FEMALE HMs AGED 10-19 YEARS]

G47	Has [NAME] received period / menstruation?	1. Yes 2. No → G.49	<input type="checkbox"/>
G48	Since what age how much did [NAME] get period / menstruation?	..... year	<input type="checkbox"/> <input type="checkbox"/>

IF FEMALES HMs AGED 10-19 YEARS OLD AND CURRENTLY PREGNANT → BLOCK H

G49	Has [NAME] ever received / purchased iron tablets supplement? (SEE DISPLAY CARD)	1. Yes 2. No → G.52	<input type="checkbox"/>
G50	Has [NAME] ever received / purchased iron tablets supplement in the last 12 months? (SEE DISPLAY CARD)	1. Yes 2. No → BLOCK J	<input type="checkbox"/>

G51	Source of iron tablets supplement in the last 12 months	1. Yes 2. No → next line	Total TTD items obtained/purchased?	Amount consumed	MAIN REASON not drinking / not spending iron tablets supplement? [CODE]
	(1)	(2)	(3)	(4)	(5)
	a. Health facility	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	b. School	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	c. Self-initiative	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	d. Others, specify:	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
CODE 5. MAIN reason for not consuming / not finishing iron tablets supplement?		1. Felt unnecessary / useless 2. Only drink during period 3. Forget 4. Bad taste and smell	5. Side effect (nausea, constipation, dark-colored stool) 6. Assumed as drug 7. Not yet all finished 8. Bored	9. Other	

GO TO BLOCK H

G52	The reason for [NAME] not receiving / buying iron tablets supplement?	1. Not given by officers 2. TTD inventory is empty 3. Felt unnecessary / useless 4. Bad taste and smell	5. Side effect (nausea, constipation, dark-colored stool) 6. Assumed as drug 7. Cannot afford to buy	8. Unsure 9. Other	<input type="checkbox"/>
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H. MOTHER'S HEALTH
WOMEN'S HMs AGED 10-54 YEARS OLD WITH STATUS MARRIAGE / DIVORCED / WIDOW(ER)

REPRODUCTION PERIOD

H01	How old was [NAME] first became pregnant?	..... year	<input type="checkbox"/> <input type="checkbox"/>	
H02	How many times has [NAME] been pregnant, miscarried and given birth?				
	a. Gravida (pregnancy)	<input type="checkbox"/> <input type="checkbox"/>	b. Partus (giving birth)	<input type="checkbox"/> <input type="checkbox"/>	c. Abortion (miscarriage)	☐ ☐
H03	Has [NAME] ever given birth / miscarried in the period 1 January 2018 until data collection?	1. Yes 2. No	<input type="checkbox"/>		

• IF YOU HAVE A HISTORY OF PREGNANCY, DELIVERY AND THE POSTPARTUM PERIOD JANUARY 1, 2018 UNTIL DATA COLLECTION [ASKED FOR THE LAST BIRTH WHICH HAS ENDED] → GO TO H.04
 • IF BLOCK IV. Q.10 THE ANSWER CODE 1 "PREGNANT" AND HAS NO LAST BIRTH HISTORY THAT HAS BEEN ENDED → GO TO H.60

H04	a. Last child's name ? (If you haven't given name, write NN)		.....
	b. When did [NAME OF THE CHILD] born?		<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	c. Is it a single pregnancy or twins?	1. Single 2. Twin 3. Unknown	<input type="checkbox"/>
	d. How was the pregnancy outcome?	1. Born alive 2. Born dead 3. Born alive & born dead 4. Miscarriage	<input type="checkbox"/>
	e. When pregnant with [NAME OF THE CHILD], was the pregnancy desired at that time / desired after pregnancy / unwanted?		<input type="checkbox"/>
		1. Desired at that time 2. Desirable after pregnancy 3. Unwanted	

IF H.04d CODE 1 OR 3 → GO TO H.05
IF H.04d CODE 2 OR 4 → GO TO H.07

H05	Is [NAME OF THE CHILD] still alive?	1. Alive → H.07 2. Passed away	<input type="checkbox"/>
H06	Age when passed away	a. Unit:	1. Month 2. Day
	IF AGE < 30 DAYS FILL IN WITH DAY IF AGE ≥ 30 DAYS FILL IN WITH MONTH	b. Age	<input type="checkbox"/> <input type="checkbox"/>

PREGNANCY TIME

H07	Does [NAME] have a MCH book for pregnancy of the last child in the period January 1 2018 to the moment of interview?	1. Yes, can show 2. Yes, cannot show → H.09	<input type="checkbox"/>
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		3. Do not have → H.09						
H08	Risk factors for pregnancy in the mother (CHECK THE MCH BOOK) ANSWER CODE IF MORE THAN 1	1. Obesity 2. Anemia 4. Diabetes Mellitus 8. Hypertension	16. HeHMs Disease 32. Chronic Energy Deficiency (SEZ) 64. Other, specify	77. No risk factors 88. No notes				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
H09	Did [NAME] check pregnancy to health officers?	1. Yes 2. No →H.18						<input type="checkbox"/>
H10	How many months was [NAME]'s pregnancy when she checked for pregnancy for the first time?	..... Month						<input type="checkbox"/> <input type="checkbox"/>
H11	Pregnancy check and ultrasound examination							
	Personnel who carry out pregnancy examination (ANC) 1. Yes 2. No → next line	Gestational Age			Person doing ultrasound 1. Yes 2. No → next line	Gestational Age		
		0-3 months ANC frequency (min 1 time)	4-6 months ANC frequency (min 2 times)	7 months - give birth to ANC frequency (min 3 times)		0-3 months Ultrasound frequency (min 1 time)	4-6 months Ultrasound frequency	7 months - Give birth to Ultrasound frequency (min 1 time)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	a. Obstetricians	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	b. General practitioners	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	c. Midwife	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	d. Other health officers	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
H12	Where did [NAME] most often conduct pregnancy checks (ANC)?	1. Public Hospital / Private Hospital 2. Maternity home / Clinic 3. Public health center	4. Auxiliary Health Center 5. Doctor / Midwife's independent practice 6. Village maternity hut / Village Health Post	7. Integrated Healthcare Center 8. Home				<input type="checkbox"/>
H13	During [NAME OF THE CHILD]'s pregnancy, did [NAME] receive any examinations / services? FILL IN THE ANSWER CODE: 1. YES, 2. NO OR 3. UNSURE							
	a. First height measurement	<input type="checkbox"/>	h. Tetanus Toxoid (TT) Immunization	<input type="checkbox"/>	o. Blood Hb test	<input type="checkbox"/>		
	b. Bodyweight measurement	<input type="checkbox"/>	i. Given blood supplement tablets	<input type="checkbox"/>	p. Urine protein test	<input type="checkbox"/>		
	c. Blood pressure measurement	<input type="checkbox"/>	j. HIV test	<input type="checkbox"/>	q. Counseling	<input type="checkbox"/>		
	d. First measurement of upper arm circumference	<input type="checkbox"/>	k. Syphilis Test	<input type="checkbox"/>	r. Post contraceptive Counseling	<input type="checkbox"/>		
	e. Uterine fundal height examination	<input type="checkbox"/>	l. Hepatitis B test	<input type="checkbox"/>	s. Case management (Action)	<input type="checkbox"/>		
	f. Examination of the position of the fetus	<input type="checkbox"/>	m. Blood group test (fill in code 4 if you have already)	<input type="checkbox"/>				
	g. Fetal hearts rate calculation	<input type="checkbox"/>	n. Current blood sugar test					
H14	When [NAME] was pregnant, did she join the Pregnant Mother Class?	1. Yes → H.16 2. No						<input type="checkbox"/>
H15	MAIN REASON for [NAME] not attending the pregnant mother class?	1. COVID-19 pandemic 2. No information yet 3. Too far	4. Transportation is difficult 5. Forbidden 6. Not interested	7. Too long 8. Others, specify:				<input type="checkbox"/>
GO TO H.18								
H16	How many times has [NAME] attended the pregnant mother classes?	..... Time						<input type="checkbox"/> <input type="checkbox"/>
H17	Is there a husband / family who accompanies [NAME] in attending the pregnant mother class?	1. Yes 2. No						<input type="checkbox"/>
HISTORY OF TAKING IRON TABLET SUPPLEMENT IN THE LAST PREGNANCY								
H18	a. During [NAME OF THE CHILD]'s pregnancy, did [NAME] get / buy additional iron tablet supplement?	1. Yes 2. No → H.20						<input type="checkbox"/>
	b. Age of pregnancy during first time receiving / buying iron tablet supplement?	..... Week(s)						<input type="checkbox"/> <input type="checkbox"/>
H19	Source of iron tablet supplement?	1. Yes 2. No → next line	Total iron tablet supplement items	The amount of iron tablet supplement taken	MAIN reason for not drinking / not taking iron tablet supplement [CODE]			
	(1)	(2)	(3)	(4)	(5)			
	a. Given by health officers / cadres (Program)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> item(s)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> item(s)	<input type="checkbox"/> <input type="checkbox"/>			
	b. Individual purchase / Purchased from health officers (Besides Program)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> item(s)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> item(s)	<input type="checkbox"/> <input type="checkbox"/>			

Column 4: MAIN REASON for not drinking / not taking blood supplement tablets?			
1. Felt unnecessary / useless	4. Nausea / vomiting due to pregnancy	7. Not yet finished	
2. Forgot	5. Side effect (nausea, constipation, darkened stool)	8. Bored	
3. Bad taste and smell	6. Assumed it was a drug	9. Other	
GO TO H.21			
H20	The reason for [NAME] not getting / buying iron tablet supplement ?	1. Not given by the officer 2. Iron tablet supplement inventory was empty 3. Felt unnecessary / not useful	4. Bad taste and smell 5. Side effect (nausea, constipation, dark-colored stool) 6. Assume it was a drug
		7. Cannot afford it 8. Others	<input type="checkbox"/>
H21	The dangers of pregnancy that [NAME] know about? (DO NOT READ POINTS a-g TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES OR 2. NO		
	a. Hemorrhage	<input type="checkbox"/>	e. Amniotic fluid comes out prematurely <input type="checkbox"/>
	b. Swelling of the feet, hands or face and / or a headache	<input type="checkbox"/>	f. The baby in the womb has reduced movement or does not move <input type="checkbox"/>
	c. Fever or high fever	<input type="checkbox"/>	g. Constant vomiting or refusing to eat <input type="checkbox"/>
	d. Seizures	<input type="checkbox"/>	
H22	Did [NAME] experience the following problems / complications? (ANSWER COULD BE > 1, WRITE ANSWERS ON ALPHABETICAL ORDER)		
	A. Continuous vomiting or diarrhea B. High fever (3 days before giving birth) C. Hypertension D. Fetus does not move enough E. Hemorrhage profusely in the birth canal F. Premature release of amniotic fluid G. Pain when urinating	H. Long cough (> 2 weeks) I. Shortness of breath J. Hearts palpitations and chest pain K. Leg swelling L. Seizures M. Other , Please specify :.....	Z. No problems / disruptions → H.28
H23	Was [NAME] referred to a health facility regarding the problems experienced during the pregnancy?	1. Yes, as soon as possible 2. Yes, there is a gap in time 3. No → H.27	<input type="checkbox"/>
H24	How long does it take to refer to a health facility regarding the problems experienced during the pregnancy?	1. ≤ 30 minutes 2. 1-2 hours	3. 3-5 hours 4. ≥ 6 hours <input type="checkbox"/>
H25	To which health care facilities was [NAME] referred? ANSWER CAN BE > 1 WRITE THE ANSWER CODE BASED ON ALPHABETICAL ORDER		
	A. Healthcare practice B. Public health center	C. Clinic D. Maternity Hospital	E. Private Hospital F. Public Hospital
H26	Where are the referral funding sources from? (ANSWER COULD BE > 1, WRITE ANSWERS ON ALPHABETIC ORDER)		
	A. BPJS / JKN / KIS B. Private Health Insurance	C. Office expenses D. Other people 's expenses	E. Individual expenses F. Maternity assurance (Jampersal) G. Regional maternity insurance (Jamperda) H. Others, specify:
CONTINUE TO H.28			
H27	The reason for [NAME] not being referred to a health facility is related to the problems experienced during the pregnancy? SUM UP THE ANSWER CODE IF MORE THAN 1		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	1. Felt unnecessary 2. Not allowed by family 4. Lack of expenses	8. No transportation 16. Distance to health facilities were too far 32. Problem with abandoned family	64. Other, Specify:
LABOR HISTORY			
H28	Who helped [NAME OF THE MOTHER] during labor? (ANSWER COULD BE > 1, WRITE THE ANSWERS BASED ON THE HELP CHRONOLOGY)		
	A. Obstetrician B. General practitioners C. Midwife	D. Nurse E. 'Dukun' Witch doctor	F. Others, specify: Z. No help
H29	Where is the place delivery of [NAME OF THE CHILD]?		<input type="checkbox"/>
	1. Public Hospital 2. Private Hospital 3. Clinic	4. Health Center / Auxiliary Health Center / Mobile Health Center 5. Independent Clinic 6. Independent Midwife Practice	7. Village Health Post / Village Maternity Hut 8. Home → H.32 9. Other, specify : → H.32
H30	How many hours [NAME OF THE MOTHER] was treated at a health care facility (Fasyankes) after giving birth until she went home?	Hours	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
H31	What are the sources of financing for childbirth? (ANSWER COULD BE > 1 , WRITE ANSWERS ON ALPHABETICAL ORDER)		
	A. BPJS/KIS B. Insurance private	C. Office expenses D. Other people's expenses	E. Own expenses F. Jampersal G. Jamperda H. Other, please specify
H32	What was [NAME OF THE CHILD]'s birth method?	1. Normal 2. C-Section	3. Vacuum 4. Forceps (using tool) 5. Others, specify : <input type="checkbox"/>
H33	Did [NAME OF THE MOTHER] make use of the Birth Waiting Home (RTK) when she was about to give birth?	1. Yes → H.35 2. No	<input type="checkbox"/>

H34	The reason [NAME OF THE MOTHER] did not take advantage Birth Waiting Home?	1. Not available 2. Was not aware 3. Uncomfortable	4. Difficult transportation 5. Did not felt the need to 6. Others, specify :	<input type="checkbox"/>
H35	Did [NAME OF THE MOTHER] experience interruption / complication as following (ANSWER COULD BE > 1, WRITE ANSWERS ON ALPHABETICAL ORDER)			-----
	A. Transverse / Breech fetal position B. Hemorrhage C. Seizures D. Premature rupture of membranes E. Old PHMstition	F. Coiled umbilical cord G. Low lying placenta / Placenta Previa H. Placenta left behind	I. Hypertension J. Others, Specify: Z. No problems / Disruptions → H.41	
H36	Was [NAME OF THE MOTHER] referred to a health facility regarding the problems experienced during the labor?	1. Yes, as soon as possible 2. Yes, there is a gap in time	3. No → H.40	<input type="checkbox"/>
H37	How long did it take to refer [NAME OF THE MOTHER] to a health facility regarding the problems experienced during the labor?	1. ≤ 30 minutes 2. 1-2 hours	3. 3-5 hours 4. ≥ 6 hours	<input type="checkbox"/>
H38	To which health care facilities was [NAME OF THE MOTHER] referred? ANSWER CAN BE > 1 WRITE THE ANSWER CODE BASED ON THE ORDER OF REFERENCE			
	A. Healthcare Practice Hospital B. Public Health Center Hospital	C. Clinic D. Maternity Hospital	E. Private F. Public	-----
H39	Where are the sources of referral funding for [NAME OF THE MOTHER]? ANSWER CAN BE > 1, WRITE ANSWERS ON ALPHABETICAL ORDER			-----
	A. BPJS / JKN / KIS B. Private Insurance C. Office expenses	D. Other people's expenses E. Own expenses F. Jampersal	G. Jampersa H. Others, specify	
GO TO H.41				
H40	Why was [NAME OF THE MOTHER] not referred to a health facility related to the problems experienced during the labor? SUM UP THE ANSWER CODE IF MORE THAN 1			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	1. Felt unnecessary 2. Not allowed by family 4. Lack of expenses	8. No transportation 16. Distance to health facilities far 32. Problem abandoned family	64. Other, Specify:	
PUERPERIUM PERIOD HISTORY				
H41	After giving birth, was [NAME OF THE MOTHER]'s health checked by a health officers (visiting / visited by health officers)? FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Period 6 hours to 2 days after giving birth to [NAME OF THE CHILD]	<input type="checkbox"/>	c. Period 8 days up to 28 days after giving birth to [NAME OF THE CHILD]	<input type="checkbox"/>
	b. Period 3 days up to 7 days after giving birth to [NAME OF THE CHILD]	<input type="checkbox"/>	d. Period 29 days up to 42 days after giving birth to [NAME OF THE CHILD]	<input type="checkbox"/>
H42	Does [NAME OF THE MOTHER] know the danger signs of puerperium?	1. Yes	2. No → P.44	<input type="checkbox"/>
H43	Danger signs during the postpHMsum that [NAME OF THE MOTHER] knows? FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Bleeding through the birth canal	<input type="checkbox"/>	e. Fever or high fever for more than 2 days	<input type="checkbox"/>
	b. Foul-smelling discharge through the birth canal	<input type="checkbox"/>	f. Swollen, red breasts accompanied by pain	<input type="checkbox"/>
	c. Swelling of the face, feet and hands or headache	<input type="checkbox"/>	g. Mother looks sad, gloomy and crying for no reason (depression)	<input type="checkbox"/>
	d. Seizures	<input type="checkbox"/>		
H44	From the time immediately after giving birth to 42 days after giving birth, how many times did [NAME OF THE MOTHER] receive vitamin A capsules?	1. One time 2. Twice	3. More than twice 4. Never → H.46	<input type="checkbox"/>
H45	When did [NAME OF MOTHER] take vitamin A after giving birth? SUM UP THE ANSWER CODE IF MORE >1	1. Moment after giving birth 2. 24 hours after giving birth	4. More than 48 hours after giving birth	<input type="checkbox"/>
H46	During the puerperium period (0-42 days after giving birth) did [NAME OF MOTHER] experienced any of the following: (ANSWER COULD BE > 1, WRITE ANSWERS ON ALPHABETICAL ORDER)			-----
	A. Bleeding profusely in the birth canal B. Foul-smelling discharge from the birth canal C. Swelling of the face, hands and feet D. Headache E. Convulsions F. Fever for more than 2 days	G. Swollen, red breasts accompanied by pain H. Mother looks sad, depressed / crying for no reason (depression) I. Hypertension J. Other	Z. No problems / disruptions → H.52	
H47	Was [NAME OF THE MOTHER] referred to a health facility regarding the problems experienced during the puerperium period?	1. Yes, as soon as possible 2. Yes, there is a gap in time	3. No → H.51	<input type="checkbox"/>
H48	How long did it take to refer [NAME OF THE MOTHER] to a health facility regarding the problems experienced during the puerperium period?	1. ≤ 30 minutes 2. 1-2 hours	3. 3-5 hours 4. ≥ 6 hours	<input type="checkbox"/>
H49	To which health care facilities was [NAME OF THE MOTHER] referred? ANSWER CAN BE > 1 WRITE THE ANSWER CODE BASED ON THE ORDER OF REFERENCE			

	A. Healthcare practice B. Public Health Center	C. Clinic D. Maternity Hospital	E. Private Hospital F. Public Hospital	-----
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H50	Where are the sources of referral funding for [NAME OF THE MOTHER]? ANSWER COULD BE > 1, WRITE ANSWERS ON ALPHABETICAL ORDER) A. BPJS / JKN / KIS B. Private Insurance	-----
	C. Office expenses D. Other people's expenses	E. Own expenses F. Jampersal
	G. Jamperda H. Other, specify	

GO TO H.52

H51	Reasons for [NAME OF THE MOTHER] not being referred to a health facility related to the problem experienced during the postpartum period? SUM UP THE ANSWER CODE IF MORE THAN 1 1. Felt unnecessary 2. Not allowed by family 4. Lack of expenses	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
	8. No transportation 16. Distance to health facilities was too far 32. Problem with abandoned family	64. Other, Specify:

H52	Does [NAME OF MOTHER] have / know a companion and a vehicle that can accompany her in the event of an emergency pregnancy / labor / postpartum?	1. Yes 2. No	<input type="checkbox"/>
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H53	Does [NAME OF MOTHER] have / know blood donors in the event of an emergency pregnancy/labor/ childbirth?	1. Yes 2. No	<input type="checkbox"/>
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POSTPARTUM FAMILY PLANNING SERVICES

H54	After giving birth, did [NAME] / partner use modern tools / methods of contraception? 1. Female Sterilization 2. Male Sterilization 3. IUDs/AKDRs/Spirals	<input type="checkbox"/>
	4. 3-month Injection 5. 1-month Injection 6. KB Implants / Implants	7. Pill 8. Male Condom 9. Do not use → H.55b

H55a	When did [NAME] / partner use the contraception tool / method? 1. Simultaneously with the birth process 2. After labor is complete, but before returning from the Health Facility	<input type="checkbox"/>
	3. After returning from the health facility up to 42 days after labor 4. Above 42 days up to 1 year after labor	

GO TO H.56

H55b	Reason MAIN [NAME] / partner does not use tool contraception after giving birth?	1. Still in the puerperium 2. Not allowed husband / family	3. Unsure 4. Other, specify	<input type="checkbox"/>
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SUPPLEMENTARY FEEDING FOR PREGNANT WOMEN IN THE LAST PREGNANCY

H56	Did [NAME] get supplementary feeding during pregnancy?	1. Yes 2. No → H.60	<input type="checkbox"/>
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H57	How old was the pregnancy when [NAME] first received supplementary feeding ? month(s)	<input type="checkbox"/> <input type="checkbox"/>
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H58	Why do mothers get supplementary feeding during pregnancy? (DO NOT READ POINTS a-e TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Malnourished mother	<input type="checkbox"/>	e. Anemia	<input type="checkbox"/>
	b. Poor family	<input type="checkbox"/>	f. Unsure	<input type="checkbox"/>
	c. Pregnancy check at an Integrated Healthcare Center	<input type="checkbox"/>	g. Others, specify	<input type="checkbox"/>
	d. Bodyweight during pregnancy does not increase	<input type="checkbox"/>		

H59	Fill in the form and amount of supplementary feeding obtained during pregnancy, how much was spent and the main reason it was not spent				
	Form of supplementary feeding	Form of supplementary feeding obtained 1. Yes 2. No → to the next line	The total number of supplementary feeding obtained	Amount of additional food consumed	The main reason supplementary feeding was not fully consumed? [CODE]
	(1)	(2)	(3)	(4)	(5)
	a. Program biscuits	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Small pack(s)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Small pack(s)	<input type="checkbox"/>
	b. Local food	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Portions	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> Portions	<input type="checkbox"/>
	c. Other, Specify	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Portions / Packs	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> Portion / Packs	<input type="checkbox"/>
	Column 5. The main reason supplementary feeding is not fully consumed?	1. It does not taste good 2. The taste is less varied 3. Too sweet	4. Dislike the aroma / smell 5. There are side effects (nausea, allergies, etc.) 6. Forgot	7. Eaten by other HMs 8. Other, specify.....	

IF NOT PREGNANT → GO TO BLOCK J

ADMINISTRATION OF IRON TABLET SUPPLEMENT FOR PREGNANT WOMEN IN CURRENT PREGNANCY

H60	During pregnancy, did [NAME] ever get iron tablet supplement ?	1. Yes 2. No → H.63	<input type="checkbox"/>
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H61	At what gestational age did [NAME] start taking iron tablet supplement ? (CHECK WITH PREGNANCY AGE)		week(s)	<input type="checkbox"/> <input type="checkbox"/>
H62	Source of iron tablet supplement ?	1. Yes 2. No → next line	Total iron tablet supplement	The number of iron tablet supplement taken	MAIN reason for not drinking / not taking iron tablet supplement [CODE]
	(1)	(2)	(3)	(4)	(5)
	a. Given by health officers / cadres (Program)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Piece(s)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Piece(s)	<input type="checkbox"/> <input type="checkbox"/>
	b. Individual purchase / Purchased from Health officers (Besides Program)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Piece(s)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Piece(s)	<input type="checkbox"/> <input type="checkbox"/>
Column 4: MAIN reason for not drinking /not taking iron tablet supplement ?					
1. Felt unnecessary / Useless 4. Nausea / vomiting because pregnancy 7. Bored 2. Forgot 5. Side effect (nausea, constipation, black bowel movements) 8. Medicine not yet fully finished 3. Bad taste and smell 6. Assumed as drug					
CONTINUE TO H.64					

H63	The reason for [NAME] not getting / buying iron tablet supplement?	1. Not given by the officer 2. TTD inventory is empty 3. Felt unnecessary / not useful	4. Bad taste and smell 5. Effects side (nausea, constipation, dark-colored stool) 6. Assume as drug	7. No money 8. Others	<input type="checkbox"/>
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SUPPLEMENTARY FEEDING FOR PREGNANT WOMEN IN CURRENT PREGNANCY

H64	Did [NAME] get supplementary feeding during pregnancy?	1. Yes 2. No → BLOCK J	<input type="checkbox"/>		
H65	How old was the pregnancy when [NAME] first received supplementary feeding ?	..... month(s)	<input type="checkbox"/> <input type="checkbox"/>	
H66	Why do mothers get supplementary feeding during pregnancy? (DO NOT READ POINTS a-e TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES OR 2. NO				
	a. Malnourished mother	<input type="checkbox"/>	e. Anemia <input type="checkbox"/>		
	b. Poor family	<input type="checkbox"/>	f. Unsure <input type="checkbox"/>		
	c. Pregnancy check at Integrated Healthcare Center	<input type="checkbox"/>	g. Others, specify		
	d. Bodyweight during pregnancy does not increase	<input type="checkbox"/>			
H67	Fill in the form and amount of supplementary feeding obtained during pregnancy, how much was spent and the main reason it was not spent				
	Form of supplementary feeding	Form of supplementary feeding obtained 1. Yes 2. No → to the next line	The total number of supplementary feeding obtained	Amount of additional food which is consumed	The main reason supplementary feeding was not fully consumed? [CODE]
	(1)	(2)	(3)	(4)	(5)
	a. Program biscuits	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Small package(s)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Small package(s)	<input type="checkbox"/>
	b. Local food	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Portion(s)	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> Portion(s)	<input type="checkbox"/>
c. Other, Specify	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Portion(s) / Package(s)	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> Portion(s) / Package(s)	<input type="checkbox"/>	
Column 5. The main reason supplementary feeding is not fully consumed?		1. It doesn't taste good 4. Dislike the aroma / smell 7. Eaten by other HMSS 2. The taste is less varied 5. There are side effects (nausea, allergies, etc.) 8. Other, specify..... 3. Too sweet 6. Forgot			

I. INFANT AND TODDLER HEALTH

MCH BOOK [HMs aged 0-59 MONTHS OLD], CHECK THE MCH BOOK

I01	Does [NAME] have a MCH Handbook (Maternal and Child Health Book)?			<input type="checkbox"/>
	1. Yes, can show the 2020 model year KIA Ministry of Health book 4. Yes, showing the MCH Digital (m-KIA) book application → I.04 2. Yes, can show the KIA Kemenkes model before 2020 5. Yes, unable to show (kept by cadres / midwives / at Integrated Health Center) → I.03 3. government printed MCH book regional / private (non-Ministry of Health) 6. Had, but lost → I.03 7. Never have → I.04			
I02	Check the contents of the MCH book: FILL IN THE ANSWER CODE: 1. COMPLETELY FILLED 2. INCOMPLETELY FILLED, 3. NOT FILLED, OR 7. NOT APPLICABLE			
	a. Pregnancy history	<input type="checkbox"/>	d. Health check when sick	<input type="checkbox"/>
	b. Birth history	<input type="checkbox"/>	e. Growth monitoring	<input type="checkbox"/>
	c. Newborn history	<input type="checkbox"/>	f. Development monitoring	<input type="checkbox"/>

I03	Can the MCH Handbook be used as a source of information on child [NAME]'s health development?		1. Yes	2. No	<input type="checkbox"/>		
CONDITIONS AT BIRTH [HMS AGED 0–59 MONTHS OLD], CHECK THE MCH BOOK / OTHER DOCUMENTS IF THERE IS ANY							
I04	Gestational age when [NAME] was born FILL IN CODE '88' IF UNSURE THE GESTATIONAL AGE		..... week(s)	<input type="checkbox"/>	<input type="checkbox"/>	
I05	a. How much did [NAME] weigh at birth FILL IN THE CODE '8888' IF UNSURE BIRTH WEIGHT → CONTINUE TO I.07		..... grams	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Birth weight data source		1. MCH Handbook/ Other documents	2. Mother's Memories / Confessions	<input type="checkbox"/>		
IF BIRTH WEIGHT ≥ 2,500 GRAM CONTINUE TO I.07							
I06	If [NAME]'s birth weight was less than 2500 grams, what action should be taken at that time? 1. Nothing done 2. In incubator 3. Holding to the chest with the baby's skin touching the mother's skin and swaddled (kangaroo method) 4. Other 8. Unsure				<input type="checkbox"/>		
I07	How long was [NAME] when he was born? FILL IN THE CODE '8888' IF BODY LENGTH IS UNKNOWN → I.09		..... cm	<input type="checkbox"/>	<input type="checkbox"/>	
I08	Source of Body Length data at birth	1. MCH Handbook / Other documents	2. Mother's Memories / Confessions	<input type="checkbox"/>			
I09	Does [NAME] have a head circumference record / document?		1. Yes	2. No → I.11	<input type="checkbox"/>		
I10	Copy from [NAME]'s head circumference record / document		..... cm	<input type="checkbox"/>	<input type="checkbox"/>	
NEWBORN / NEONATE CARE [HMs aged 0 – 59 MONTH OLD] CHECK THE MCH BOOK / OTHER DOCUMENTS IF THERE]							
I11	Was [NAME] examined for newborns check by a health officers?		Exam location? [CODE]	Who conduct the exam? [CODE]			
	(1)	(2)	(3)	(4)			
	a. 6–48 hour after born	1. Yes 2. No → I.11b	7. Not applicable → I.13 8. Unsure → I.11b	<input type="checkbox"/>	<input type="checkbox"/>		
	b. 3–7 day after born	1. Yes 2. No → I.11c	7. Not applicable → I.12 8. Unsure → I.11c	<input type="checkbox"/>	<input type="checkbox"/>		
	c. 8–28 day after born	1. Yes 3. No → I.12	7. Not applicable → I.12 8. Unsure → I.12	<input type="checkbox"/>	<input type="checkbox"/>		
COLUMN CODE (3) PLACE OF EXAMINATION			COLUMN CODE (4) EXAMINATION PERSONNEL				
1. Public Hospital 2. Private Hospital			1. Medical specialist 2. General practitioner 3. Midwife				
3. Public Health Center / Mobile Health Center 4. Integrated Health Center / Village Health Post / Village Maternity Hut			4. Nurse / Other health officers 5. Other				
5. Clinic 6. Health Officers's Independent Practice 7. Home			8. Unsure				
IF I.11 point a, b or c on column (2) DOES NOT HAVE code "1", CONTINUE TO I.13							
I12	Did [NAME] get neonatal services from a health officers at 0-28 days? FILL IN THE ANSWER CODE: 1. YES, 2. NO OR 8. UNSURE, CHECK THE MCH MANUAL / DOCUMENT IF THERE IS ANY						
	(1)	(2)	(1)	(2)			
	a. Bodyweight measurement	<input type="checkbox"/>	g. Administration of eye ointment	<input type="checkbox"/>			
	b. Body length measurement	<input type="checkbox"/>	h. Inquire about health status	<input type="checkbox"/>			
	c. Body temperature measurement	<input type="checkbox"/>	i. Tells how to give good breastfeeding	<input type="checkbox"/>			
	d. Umbilical cord care	<input type="checkbox"/>	j. Ask about problems in breastfeeding	<input type="checkbox"/>			
	e. Hb-0 immunization	<input type="checkbox"/>	k. Inquired whether [NAME] had diarrhea or not	<input type="checkbox"/>			
f. Administration of Vitamin K	<input type="checkbox"/>	l. Inform about danger signs in infants	<input type="checkbox"/>				
I13	What was done in the care of the [NAME]'s umbilical cord when it was just born?				<input type="checkbox"/>		
	1. Not given anything and dry 2. Betadine / Alcohol 3. Topical drug (powder form) 4. Herbal / Traditional medicine 8. Unsure						
CONGENITAL HYPOTHYROID SCREENING [HMS AGED 0–59 MONTHS OLD], CHECK MCH BOOK / DOCUMENTS							
I14	a. Was [NAME] screened for congenital hypothyroidism (blood was taken from the heel)?		1. Yes, at 48-72 hours old 2. Yes, at age > 72 hours old 3. Not checked	7. Not applicable → I.15 8. Unsure → I.15	<input type="checkbox"/>		
	b. Data source		1. MCH Handbook	2. Others' documents	3. Respondent's confession	<input type="checkbox"/>	
CONDITIONAL DISORDERS [HMs AGED 0–59 MONTHS OLD]							
I15	Does [NAME] have a birth defect? SHOW DISPLAY CARD						
	a. Clubfoot	1. Yes	2. No	<input type="checkbox"/>	e. No anal canal	1. Yes	2. No	☐

b. Hydrocephalus	1. Yes 2. No	<input type="checkbox"/>	f. Down syndrome	1. Yes 2. No	<input type="checkbox"/>
c. Harelip	1. Yes 2. No	<input type="checkbox"/>	g. Congenital heHMs defects	1. Yes 2. No	<input type="checkbox"/>
d. Siamese twins	1. Yes 2. No	<input type="checkbox"/>	h. Thalassemia	1. Yes 2. No	<input type="checkbox"/>

IMMUNIZATION [AGED 0-59 MONTHS OLD]							
I16	Has [NAME] ever been immunized?			1. Yes	2.No → I.22	3. Unsure → I.23	<input type="checkbox"/>
I17	After receiving immunization, did [NAME] ever experience complaints of Adverse events following immunization (AEFI) as follows				1. Yes	2. No → I.19	<input type="checkbox"/>
	AEFI type	1. Yes 2. No → next line	Immunization site 1. Hospital 2. Independent practice of health officers 3. Public health center 4. Integrated Healthcare Center	AEFI type	1. Yes 2. No → next line	Immunization site 1. Hospital 2. Independent practice of health officers 3. Public health center 4. Integrated Healthcare Center	
	(1)	(2)	(3)	(1)	(2)	(3)	
	a. High fever	<input type="checkbox"/>	<input type="checkbox"/>	c. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Reactions around the injection site (itching, redness, pus)	<input type="checkbox"/>	<input type="checkbox"/>	d. Other, Please specify:	<input type="checkbox"/>	<input type="checkbox"/>	
I18	What was done when [NAME] experienced AEFI? FILL IN THE ANSWER CODE 1. YES OR 2. NO						
	a. Nothing done	<input type="checkbox"/>	d. Compress	<input type="checkbox"/>			
	b. Brought to the doctor	<input type="checkbox"/>	e. Other	<input type="checkbox"/>			
	c. Give febrifuge	<input type="checkbox"/>					
I19	Does [NAME] have a MCH Handbook or other records containing immunization records?	1. The MCH handbook and immunization record completely filled out 2. The MCH handbook for immunization records is incomplete	3. There is a health card or other immunization records filled in (complete/incomplete) 4. The MCH book/other records are not filled in or do not have the KIA book/other records				<input type="checkbox"/>

To answer questions I.20 and I.21 copy from the MCH book or immunization record, if immunizations are not recorded in the MCH book or other records, ask the respondent (based on memory), PAY ATTENTION TO THE AGE OF THE CHILD WITH THE APPROPRIATE AGE OF IMMUNIZATION GIVING

I20	COLUMN CODE (2)	1. Yes immunized, based on records → COLUMN 3 2. Yes immunized, based on memory → COLUMN 4 3. Not immunized → Next Line 7. The time has not yet been given → Next Line 8. Unknown → Next Line	COLUMN (3) FOR RECORDED IMMUNIZATION ONLY Write the number '8' in the date box if the date is not recorded	COLUMN (4) ONLY FILLED IN FOR IMMUNIZATION BASED ON MEMORY Write down the number "88" if the respondent does not know/does not remember the age at which the immunization was given
	Type immunization	[CODE]	Immunization date	Age at immunization (in month)
	(1)	(2)	(3)	(4)
a.	Hepatitis B 0 given shortly after the baby is born until the baby is 7 days old which is injected in the baby's thigh	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
b.	BCG given immediately after birth or as soon as possible before 1 month old and injected in the upper (right) arm (usually leaves a scar under the skin)	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
c.	DPT-HB-Hib 1 DPT-HB-Hib is usually injected in the thigh and started to be given when the child is 2 months old together with OPV 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
d.	DPT-HB Hib 2 starting to be given when the child is 3 months old together with OPV 3	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
e.	DPT-HB Hib 3 began to be given when the child was 4 months old together with OPV 4	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
f.	DPT-HB-Hib Advanced started when the child was 18 months old	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
g.	PCV 1 PCV is usually injected into the left thigh, usually starting to be given when the child is 2 months old along with DPT-HB-Hib 1 and OPV 2	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
h.	PCV 2 starting to be given when the child is 3 months old together with	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

DPT-HB-Hib 2 and OPV 3			
i. PCV 3 Start giving it when the child is 12 months old	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>
j. Campak-Rubella (MR) began to be given when he was 9 months old and injected in the thigh or upper left arm and was given once	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>
k. Campak-Rubella Advanced (MR/MMR) started at 18-24 months	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>

I21	COLUMN CODE (2)	4. Yes immunized, based on records → COLUMN 3 5. Yes immunized, based on memory → COLUMN 4 6. Not immunized → Next Line 9. The time has not yet been given → Next Line 7. Unknown → Next Line	COLUMN (3) FOR RECORDED IMMUNIZATION ONLY Write the number '8' in the date box if the date is not recorded	COLUMN (4) ONLY FILLED IN FOR IMMUNIZATION BASED ON MEMORY Write down the number "88" if the respondent does not know/does not remember the age at which the immunization was given	COLUMN CODE (5) 1. Oral polio vaccine (OPV) 2. Polio vaccine injection (IPV)
	Type immunization	[CODE]	Immunization date	Age at immunization (in month)	Vaccine type
	(1)	(2)	(3)	(4)	(5)
	a. Polio 1 OPV is a vaccine that is dripped into the mouth which is usually given immediately after birth and/or starting at 1 month of age, IPV is a polio vaccine that is injected and given from 2 months of age	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	b. Polio 2 OPV 2 begins to be given from 2 months of age, while IPV is given from 3 months	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	c. Polio 3 OPV 3 begins to be given from 3 months of age, while IPV is given from 4 months	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	d. Oral polio vaccine (OPV) 4 Start giving it from 4 months of age	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	e. Supplemental polio injection 1 This additional IPV is intended to complement OPV, so this point is answered in children who have been given OPV immunization, starting from the age of 4 months	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
f. Supplemental polio injection 2 Start programmed in 2023, starting at the age of 9 months	<input type="checkbox"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="checkbox"/>	

I22	IF QUESTIONS IN I.16 ARE CODE "2", QUESTIONS I.20 AND I.21 ARE CODE "2" Reasons for not carrying out immunizations / incomplete immunizations?			
a. Forgot / unsure immunization's timetable	<input type="checkbox"/>	g. Does not feel that immunization is important	<input type="checkbox"/>	
b. Difficulty in reaching facilities (places) for immunization	<input type="checkbox"/>	h. Religious issues (e.g., halal issue)	<input type="checkbox"/>	
c. Vaccines are not available	<input type="checkbox"/>	i. Not enough time / money to go to the place of immunization	<input type="checkbox"/>	
d. Children are often sick when they are going to be immunized	<input type="checkbox"/>	j. Expensive vaccines	<input type="checkbox"/>	
e. Worried about the side effect of immunization (fever, fussiness, etc.)	<input type="checkbox"/>	k. Delayed due to COVID-19	<input type="checkbox"/>	
f. Not allowed by family	<input type="checkbox"/>	l. Do not know the place of immunization services	<input type="checkbox"/>	

GROWTH MONITORING [HMS AGED 0-59 MONTH(S) OLD]

I23	Has [NAME]'s weight been measured in the last 12 months?	1. Yes 2. No → I.25 8. Unsure → I.26	<input type="checkbox"/>
I24	In the last 12 months, how many times was [NAME] weighed? IF "UNSURE", FILL IN CODE "88"	.....time(s)	<input type="text"/>

GO TO I.26

I25	MAIN REASON in the last 12 months [NAME] has never been weighed: 1. Child was already big (≥1 year old) 4. Forgot / Did not know the schedule 7. Busy / Troublesome 2. Child already finished immunization 5. No place for weight measurement 8. Lazy 3. Child did not want to be weighed 6. The place was too distant 9. Weighing equipment was not available	<input type="checkbox"/>	
I26	Has [NAME]'s length / height been measured in the last 12 months?	1. Yes 2.No → I.28 8. Unsure → I.29	<input type="checkbox"/>
I27	In the last 12 month, how many times had [NAME]'s length / height was measured? IF "UNSURE", FILL IN CODE "88"	..... time(s)	<input type="text"/>

CONTINUE TO I.29

128	Reason main in 12 month final [NAME] no once be measured long/ tall body? 1. Child was already big (≥1 year old) 4. Forgot / Did not know the schedule 7. Busy / Troublesome 2. Child already finished immunization 5. There is no measurement activity 8. Lazy 3. Child did not want to be measured 6. The place was too distant 9. Height measurement tool was not available	<input type="checkbox"/>
129	In the last 12 months , did [NAME] ever get vitamin A capsules (show display card picture) 1. Yes, 1 time 3. Never 2. Yes, 2 times 4. Not old enough (age < 6 months old)	<input type="checkbox"/>

MONITORING OF CHILDREN'S DEVELOPMENT [HMS AGED 1-59 MONTHS OLD]

130	Was [NAME] monitored for development according to age group? (SEE AGE COLUMN), CHECK THE MCH BOOK / DOCUMENTS FILL IN THE ANSWER CODE: 1. YES 2. NO 3. CANNOT SHOW / DOES NOT HAVE MCH BOOK 7. NOT APPLICABLE					
	Age	Answer [Code]	Age	Answer [Code]	Age	Answer [Code]
	(1)	(2)	(1)	(2)	(1)	(2)
	a. 29 days - 3 months old	<input type="checkbox"/>	d. 9 – 12 months old	<input type="checkbox"/>	g. 23 years old	<input type="checkbox"/>
	b. 3 – 6 months old	<input type="checkbox"/>	e. 12 – 18 months old	<input type="checkbox"/>	h. 3 – 4 years old	<input type="checkbox"/>
	c. 6 – 9 months old	<input type="checkbox"/>	f. 18 – 24 months old	<input type="checkbox"/>	i. 4 – 5 years old	<input type="checkbox"/>

IF HMS IS 24-59 MONTHS OLD → I.47

BREAST MILK and COMPLEMENTARY FOODS FOR BREAST MILK [HMS AGED 0-23 MONTHS OLD]

131	a. Was [NAME] immediately after birth placed directly on the mother's chest / stomach with the mother's skin attached to the baby's skin?	1. Yes 2. No → I.32 3. Unsure → I.32	<input type="checkbox"/>
	b. When did [NAME OF THE CHILD] begin to be placed on the mother's chest / stomach after birth?	..... minute(s)	<input type="checkbox"/> <input type="checkbox"/>
	c. How long does it take for the baby to attach to the mother's chest / stomach after birth?	1. < 1 hour 2. ≥ 1 hour	<input type="checkbox"/>
132	When did the mother start breastfeeding for the first time, after the child was born? IF LESS THAN 1 HOUR, WRITE '00' IF LESS THAN 24 HOURS, WRITE 'HOUR' IF MORE THAN 24 HOURS, WRITE 'DAY'	a. Units: 1. Hour 2. Day b. Amount (hour or day)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
133	What does the mother do with colostrum (the first milk that comes out, usually thin, clear and / or yellowish in color)? 1. All given to the baby 3. Thrown all away 8. Unsure 2. Discarded pHMsially 4. Breast milk has not come out		<input type="checkbox"/> <input type="checkbox"/>
134	Mother's reason for taking the following action? (BASED ON I.33 ANSWER)	1. Habit 3. Did not understand 2. Was told what to do 4. Others, Specify:	<input type="checkbox"/>
135	Has [NAME] ever been breastfed or given ASI (breast milk)?	1. Been breastfed → I.37 3. Never 2. Have not yet been breastfed	<input type="checkbox"/>
136	If you have not / never been breastfed, what are the main reasons? 1. Breast milk does not / has not come out 3. Mother's medical reason 5. Child's medical reason 7. Mother died 9. Others 2. Child does not want to be breastfed 4. Was treated separately 6. Separated from mother 8. Cultural/Norm/religious reasons		<input type="checkbox"/>

IF ANSWER I.35 CODED 2 → GO TO I.38
IF ANSWER I.35 CODED 3 → GO TO I.42

137	Is [NAME] currently still being breastfed / breastfeeding?	1. Yes → I.39 2. No	<input type="checkbox"/>			
138	At what age was [NAME] weaned?	..... month(s)	<input type="checkbox"/> <input type="checkbox"/>		
139	In the last 24 hours, was [NAME] given any drink (liquid) or food other than breast milk?	1. Yes 2. No	<input type="checkbox"/>			
140	Was [NAME] given any drink (liquid) or food other than breast milk before the first breastfeeding?	1. Yes 8. Unsure → I.43 2. No → I.43	<input type="checkbox"/>			
141	What is the MAIN reason for giving drinks (liquids) or food other than breast milk? 1. Breast milk is not / has not come out 4. Was treated separately 7. Mother died 2. The child does not want to be breastfeed 5. Child's medical reasons 8. Cultural / Religious / Norm reasons 3. Mother's medical reasons 6. Child separated from mother 9. Other		<input type="checkbox"/>			
142	What types of drinks / food were given to [NAME] before stHMSing to breastfeed or before the milk came out / smoothly? FILL IN THE ANSWER CODE: 1. YES OR 2. NO					
	a. Formula milk	<input type="checkbox"/>	e. Starch water	<input type="checkbox"/>	i. Flour porridge / Strained porridge	<input type="checkbox"/>
	b. Non-formula milk	<input type="checkbox"/>	f. Coconut water	<input type="checkbox"/>	j. Mashed bananas	<input type="checkbox"/>
	c. Honey / honey + water	<input type="checkbox"/>	g. Sweet tea	<input type="checkbox"/>	k. Mashed rice	<input type="checkbox"/>
	d. Sugar water	<input type="checkbox"/>	h. Water	<input type="checkbox"/>	l. Other,	<input type="checkbox"/>
143	At what age did [NAME] mother stHMSed to INTRODUCE food or drink (liquid) other than breast milk?					

	a. 0–7 days d. 2 months g. 5 months j. 8 months m. 11 Months p. Not Applicable → I.45 b. 8–29 days e. 3 months h. 6 months k. 9 months n. ≥ 12 Months c. 1 month old f. 4 months i. 7 months l. 10 months o. Unsure → I.45	<input type="checkbox"/>
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I44	What foods / drinks (liquids) other than breast milk, WERE INTRODUCED to [NAME] at that age? FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Formula milk	<input type="checkbox"/>	f. Starch water	<input type="checkbox"/>
	b. Non-formula milk	<input type="checkbox"/>	g. Pureed fruit (banana, etc.)	<input type="checkbox"/>
	c. Formula porridge	<input type="checkbox"/>	h. Pureed rice/team rice/rice/side dishes	<input type="checkbox"/>
	d. Biscuits	<input type="checkbox"/>	i. Juice	<input type="checkbox"/>
	e. Flour porridge / Strained porridge	<input type="checkbox"/>	j. Others, Specify:	<input type="checkbox"/>

I45	At what age was [NAME OF CHILD] STHMSED ROUTINELY BEING GIVEN food or drink (liquid) other than breast milk? a. 0–7 days d. 2 months g. 5 months j. 8 months m. 11 Months p. Not Applicable → I.47 b. 8–29 days e. 3 months h. 6 months k. 9 months n. ≥ 12 months c. 1 month f. 4 months i. 7 months l. 10 months o. Unsure → I.47	<input type="checkbox"/>	<input type="checkbox"/>
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I46	What foods/drinks (liquids) other than breast milk, WHICH STHMSED ROUTINELY being given to [NAME] at that age? FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Formula milk	<input type="checkbox"/>	f. Starch water	<input type="checkbox"/>
	b. Non-formula milk	<input type="checkbox"/>	g. Pureed fruit (banana, etc.)	<input type="checkbox"/>
	c. Formula porridge	<input type="checkbox"/>	h. Pureed rice / Nasi Tim / Rice / Mashed side dishes	<input type="checkbox"/>
	d. Biscuits	<input type="checkbox"/>	i. Juice	<input type="checkbox"/>
	e. Flour porridge / Strained porridge	<input type="checkbox"/>	j. Others, specify:	<input type="checkbox"/>

IF HMs AGED 0-5 MONTHS OLD → CONTINUE TO BLOCK J

SUPPLEMENTARY FEEDING IN CHILDREN [HMs AGED 6-59 MONTHS OLD]

I47	During the last 12 months , did [NAME] receive supplementary feeding Program assistance?	1. Yes 2. No → I.50	<input type="checkbox"/>
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I48	Fill in the form and amount of supplementary feeding earned by [NAME], how much was spent and the main reason it was not spent				
	Form of supplementary feeding	Form of supplementary feeding obtained 1. Yes 2. No → next line	The total number of supplementary feeding obtained	Amount of supplementary food consumed	The main reason supplementary feeding was fully consumed? [CODE]
	(1)	(2)	(3)	(4)	(5)
	a. Program biscuits	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Small pack(s)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Small pack(s)	<input type="checkbox"/>
	b. Local supplementary feeding	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Portion(s)	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> Portion(s)	<input type="checkbox"/>
c. Others, please specify:.....	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Portion(s) / Pack(s)	<input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/> Portion(s) / Pack(s)	<input type="checkbox"/>	
COLUMN 5. The main reason supplementary feeding was not fully consumed?	1. It does not taste good 2. The taste is less varied 3. Too sweet	4. Dislike the aroma/ smell 5. There are side effects (nausea, allergies, etc.) 6. Forgot	7. Eaten by other HMs 8. Mother forgot to give 9. The child does not want	10. Others, please specify:	

I49	Reason for [NAME] getting supplementary feeding? (DO NOT READ POINTS a-g TO RESPONDENT) FILL IN THE ANSWER CODE: 1. YES OR 2. NO			
	a. Malnutrition	<input type="checkbox"/>	e. Sickly	<input type="checkbox"/>
	b. Undernutrition / Under the red line	<input type="checkbox"/>	f. Took part in the weighing at Integrated Health Center	<input type="checkbox"/>
	c. Skinny	<input type="checkbox"/>	g. Poor family	<input type="checkbox"/>
	d. Body weight does not increase 2 times	<input type="checkbox"/>	h. Others, specify:	<input type="checkbox"/>

AGED 6-23 MONTHS OLD

FOR QUESTION I.50 PLEASE USE THE 24-HOUR RECALL METHOD (USE THE HELP SHEET)

In the last 24 hours (starting from waking up yesterday morning until this morning), what food did [NAME] eat?
Date, name of toddler, census block (CB), name of enumerator

I50	Food Group	Fill in the Code:		Amount drank
		1. Yes 2. No	8. Unsure	
	(1)	(2)		(3)
	a. Breastmilk	<input type="checkbox"/>		
	If yes, how many times did [NAME] breastfeed? If 7 times or more, record '7'			<input type="checkbox"/>
	b. Water	<input type="checkbox"/>		
	c. Juice or fruit extract	<input type="checkbox"/>		
	d. Broth (such as chicken broth, meat broth, or fish stock)	<input type="checkbox"/>		
	e. Infant / toddler formula milk	<input type="checkbox"/>		
	If Yes, how many times did [Name] drink milk? If 7 times or more, write '7'			<input type="checkbox"/>
	f. Other milk, such as: powdered milk, or fresh milk	<input type="checkbox"/>		
	If Yes, how many times did [Name] drink milk? If 7 times or more, write '7'			<input type="checkbox"/>
	g. Other drinks / liquids (such as sugar water, condensed milk, tea, starch water, soy milk, etc.)	<input type="checkbox"/>		
	h. Yogurt? (excluding Yakult, vitacarm etc.)	<input type="checkbox"/>		
	If Yes, how many times did [Name] drink yogurt? If 7 times or more, write '7'			<input type="checkbox"/>
	i. Branded baby food, e.g., Sun, Milna, Cerelac etc.	<input type="checkbox"/>		
	j. Rice, bread, noodles, porridge, corn, sago or other foods made from grains such as rice, wheat, sorghum, etc.	<input type="checkbox"/>		
	k. Pumpkin, carrot, or sweet potato that has a yellow or orange-colored inside	<input type="checkbox"/>		
	l. Potatoes, cassava, taro, and other foods made from roots or tubers	<input type="checkbox"/>		
	m. Green vegetables (spinach, kale, katuk, cassava leaves, pumpkin leaves etc.)	<input type="checkbox"/>		
	n. Ripe fruits rich in vitamin A, such as mango, papaya, jackfruit, chempedak, persimmon, yellow melon	<input type="checkbox"/>		
	o. Other fruits or vegetables (such as apples, avocados, peas, eggplants, Chinese okra etc.)	<input type="checkbox"/>		
	p. Liver, gizzard, kidney, heHMs, or other offal	<input type="checkbox"/>		
	q. Meat: chicken, beef, goat, pork or duck	<input type="checkbox"/>		
	r. Egg	<input type="checkbox"/>		
	s. Fresh or salted fish / shellfish	<input type="checkbox"/>		
	t. Foods made from legumes (soybeans, red beans, black-eyed peas, kidney beans, green beans, velvet beans, peanuts, tofu, tempeh, etc.)	<input type="checkbox"/>		
	u. Cheese or other foods made from milk	<input type="checkbox"/>		
	v. Other solid, semi-solid, mashed foods including pastries such as banana cake, cucur cake, pancong cake, candy	<input type="checkbox"/>		
I51	Did [NAME] eat solid, semi-solid or pureed food in the previous day (from waking up yesterday morning until this morning)?	1. Yes	2. No → J.01	<input type="checkbox"/>
I52	How many times did [NAME] eat solid, semi-solid or mashed food during the previous day (stHMsd from waking up yesterday morning until this morning)? IF 7 TIMES OR MORE, FILL IN CODE "7", IF UNSURE FILL IN CODE "88"	.....time(s)		<input type="checkbox"/> <input type="checkbox"/>

J. MEASUREMENT				
BODYWEIGHT [HMs OF ALL AGES]				
J01	a. Was [NAME] weighed?	1. Yes	2. No → J.02	<input type="checkbox"/>
	b. FOR TODDLERS , Health condition during measurement?	1. Healthy 2. Mild pain	3. Severe/chronic illness 4. Diarrhea	5. Edema <input type="checkbox"/>
	c. Weight (kg)	.....,..... kg		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/> <input type="checkbox"/>
BODY HEIGHT / LENGTH [HMs OF ALL AGES]				

J02	a. Was [NAME] measured for Height / Length?	1. Yes	2. No → J.03	<input type="checkbox"/>
	b. Height / Length (cm)	.....,..... cm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/>
	c. SPECIALLY FOR TODDLERS , (Height / Length measurement position)	1. Standing up	2. Lying flat on the back	<input type="checkbox"/>
	d. The condition of [NAME] when measured	1. Can stand upright / straight back 2. Unable to stand straight / straight back		<input type="checkbox"/>

ABDOMINAL CIRCUMFERENCE [HMs AGED ≥ 15 YEARS OLD, EXCEPT FOR PREGNANT WOMEN]

J03	a. Was [NAME] measured for abdominal circumference?	1. Yes	2. No → J.04	<input type="checkbox"/>
	b. Abdominal Circumference (cm)	.....,..... cm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/>

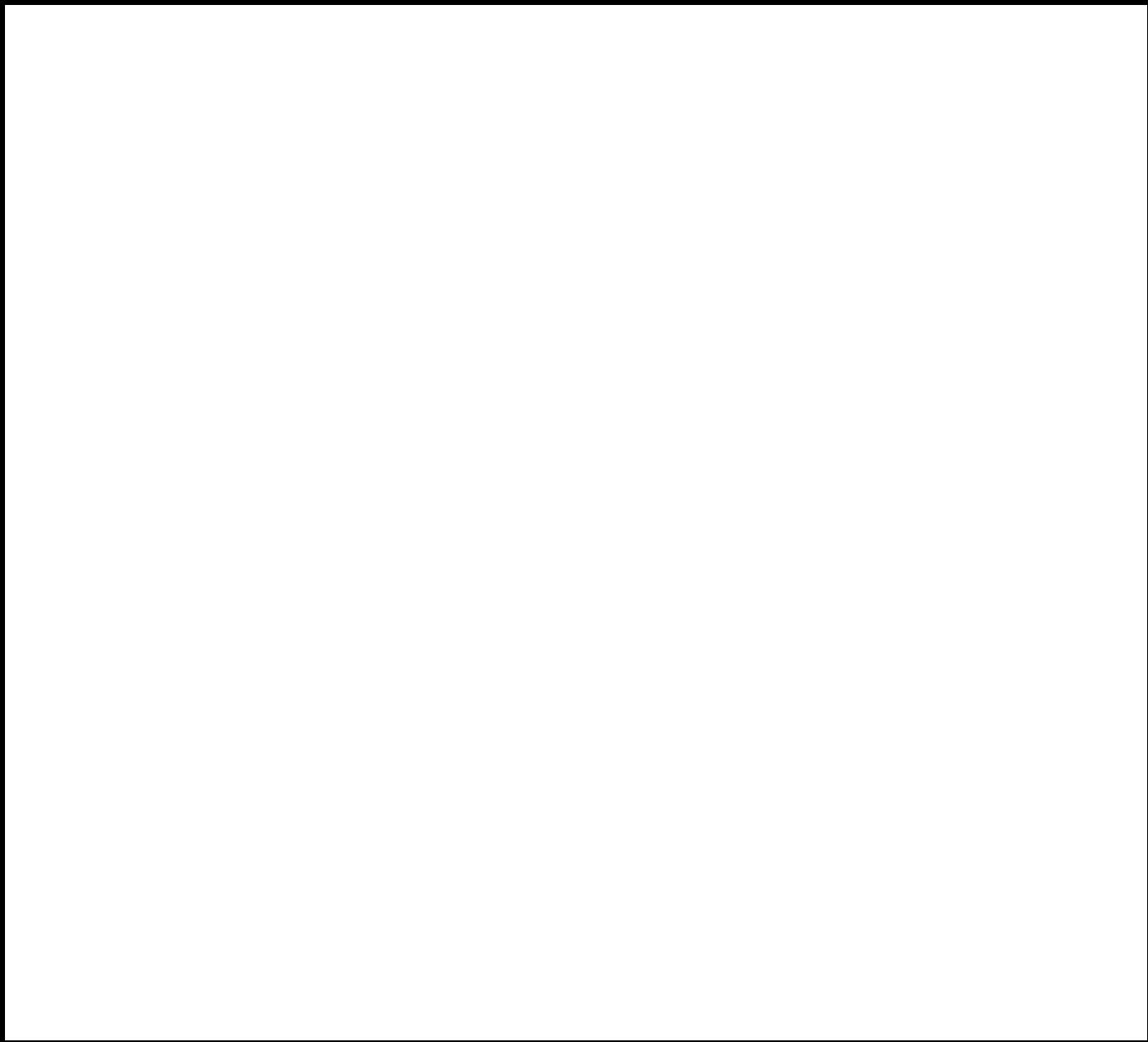
BLOOD PRESSURE MEASURED IN THE LEFT ARM [HMs AGED ≥ 15 YEARS OLD]

J04	a. Was the first blood pressure measurement taken:	1. Yes	2. No → J.07	<input type="checkbox"/>
	b. Systolic blood pressure (mmHg)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Diastolic blood pressure (mmHg)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
J05	a. Was a second blood pressure measurement taken:	1. Yes	2. No → J.07	<input type="checkbox"/>
	b. Systolic blood pressure (mmHg)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Diastolic blood pressure (mmHg)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
J06	a. Was a third blood pressure measurement taken:	1. Yes	2. No → J.07	<input type="checkbox"/>
	b. Systolic blood pressure (mmHg)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Diastolic blood pressure (mmHg)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

UPPER ARM CIRCUMFERENCE [HMS WOMEN OF REPRODUCTIVE AGE (10-54 YEARS OLD) OR PREGNANT WOMEN]

J07	a. Was [NAME] measured Upper Arm Circumference (LILA)?	1. Yes	2. No	<input type="checkbox"/>
	b. Upper Arm Circumference (cm)	..... cm		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> , <input type="checkbox"/>

NOTES



HELP SHEET FOR CALCULATING PHYSICAL ACTIVITIES (G.36 – G.41)

WRITE IN DETAIL ALL PHYSICAL ACTIVITIES USUALLY PERFORMED
BY TYPE AND DURATION OF THE ACTIVITIES:

1. Morning: (sitting / standing / walking) [* SEVERE / MODERATE CRITERIA]

HOUR (_ : _ - _ : _)	Qty (MINUTES)		CRITERIA*

2. Afternoon (sitting / standing / walking) [*SEVERE / MODERATE CRITERIA]

HOUR (_ : _ - _ : _)	Qty (MINUTES)		CRITERIA*

3. Evening (sitting / standing / walking) [* SEVERE / MODERATE CRITERIA]

HOUR (_ : _ - _ : _)	Qty (MINUTES)		CRITERIA*

4. Other times (sitting / standing / walking) [*SEVERE / MODERATE CRITERIA]

HOUR (_ : _ - _ : _)	Qty (MINUTES)		CRITERIA*

HELP SHEET FOR 24 HOUR RECALL CHILDREN AGED 6-23 MONTHS OLD

PLACE RECOGNITION																		
Province		Regency / City			Sub-district			Village/Urban village			D/K		Sample Code Number				Household member serial number	

RESPONDENT IDENTIFICATION			
1. Name of HMs:	.....	3. Serial number of HMs:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
2. Date data collection:	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - 2023	4. Name of Enumerator:	.....

TIME	DISH	DETAILS OF FOOD INGREDIENTS	CODE

MOTHER'S PREGNANCY HISTORY HELP SHEET

PLACE RECOGNITION																	
Prov		Kab/Kota		Kec			Desa/Kel			D/K		Nomor Kode Sampel				No. Urut RT	

RESPONDENT IDENTIFICATION			
1. Name HMs :	.....	3. Sec. of HMs:	<input type="text"/> <input type="text"/>
2. Date data collection:	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - 2023	4. Name of Enumerator:	.....

Sec. Number of pregnancy	Child name's	Pregnancy result	Date of month delivery	According to the time period January 1, 2018 until the time of the interview (√)