Tribhuwan University, Faculty of Humanity and Social Sciences, Central Department of Population Studies

"Factors Associated with Utilization of Sexual and Reproductive Health Services by Women with Disabilities in Ilam District, Nepal"

Note: Please mark "O" in the correct answer or fill in the blanks.

Respondents: Women with disabilities aged 15-45 years or her guardian/caretaker in case if she is unable to respond.

ID Number:	P P W W C Q N N N
Name of Interviewee:	....
Name of Interviewer:	....
Date of Interview (DD/MM/YYYY	D D M M Y Y Y Y

Section 1: Demographic Characteristics

S.N.	Question	Answers	Code	Remarks
1	Full name of respondent	....		
2	Full name of person with disability	....		
3	Caste/ Ethnicity of person with disability (Please ask surname and code accordingly)	**Dalits**-Hill- Biswokarma, Pariyar, Sarki, Gandharwa, Badi etc., Terai-Kalar, Kakaihiya, Kori, Khatik, Khatwe, Chamar, Chidimar etc. **Janajati**-Hill –Sherpa, Bhote, Thakali, Magar, Newar, Rai, Gurung, Rai, Sunuwar, Yakkha, Chhantyal, Lepcha etc., Terai-Tharu, Dhanuk, Rajbansi, Satar, Dhimal, Gangai etc. **Madhesi**- Yadav, Teli, Kalwar, Sudhi, Koiri, Kurmi, Kanu, Haluwai, Hajam/Thakur, Badhae, Rajbhar **Muslim**- Muslim, Churaute **Brahman/Chhetri**- Brahman (Hill), Chhetri (Hill) **Others**- Thakuri, Sanyasi/Dasnami	1 2 3 4 5 6	
4	Relationship with person with disability	Self Others ....(Please specify)	01 96	
5	Age of person with disability (Completed Age)	☐☐ (Years)		
6	Name of rural municipality or municipality (New)	....		
7	Name of village/tole/settlement (New)	....		
8	Ward number (New)	☐☐		

9	Name of rural municipality or municipality (Old)	…………………………………………………………………		
10	Name of village/tole/settlement (Old)	…………………………………………………………………		
11	Ward number (Old)	☐ ☐		
12	Telephone/mobile number	…………………………………………………………………		
13	What is your (name of person with disability's) religion?	Hindu Buddhist Kirat Muslim Christian Other (Specify) ………………………..	01 02 03 04 05 96	
14	What is your (name of person with disability's) highest educational qualification? **(Mention in number for grade 1 to 9)**	ECD of less than grade 1 ☐ ☐ Grade 1-9 SLC/SEE Certificate level Bachelor or above Resource center Special school Never attained school and illiterate Never attained school and literate	00 10 11 12 55 66 77 88	
15	What is your (name of person with disability's) occupation?	Unemployed (Do not earn any money) Government service Non-government service Agriculture Petty Business Daily wages Student Homemaker Business Foreign labor Other (specify)……………….	01 02 03 04 05 06 07 08 09 10 96	
16	Does you (person with disability) earn any cash or kinds?	Cash only In-kinds only Both cash and in-kinds Not paid	1 2 3 4	
17	What is your (name of person with disability's) marital status?	Married (Monogamous) Married (Polygamous) Widow Divorced Separated Never married	1 2 3 4 5 6 →	 18
17.1	At what age you (name of person with disability) were married?	☐ ☐ Years		

18	What is your (name of person with disability) type of family?	Nuclear Joint	1 2	
19	How many members are there in your (name of person with disability's) family?	☐☐ Members		
20	By whom you (name of person with disability) are often cared?	None Husband Father Mother Mother-in-law Father-in-law Son Daughter Brother Sister Personal assistance Staying in rehabilitation center Other (please specify)………………………	01 → 02 03 04 05 06 07 08 09 10 11 12 96	23
21	Name of caretaker	………………………………………………………		
22	What is the highest educational qualification of caretaker? (Mention in number for grade 1 to 9)	ECD of less than grade 1 ☐ ☐ Grade 1-9 SLC/SEE Certificate level Bachelor or above Never attained school and illiterate Never attained school and literate	00 10 11 12 77 88	

Section 2: Washington Group Short Set Questions

S.N.	Question	Answers	Code	Remarks
23	Do you (name of person with disability) have difficulty seeing, even if wearing glasses?	No - no difficulty Yes – some difficulty Yes – a lot of difficulty Cannot do at all	1 2 3 4	
24	Do you (name of person with disability) have difficulty hearing, even if using a hearing aid?	No - no difficulty Yes – some difficulty Yes – a lot of difficulty Cannot do at all	1 2 3 4	
25	Do you (name of person with disability) have difficulty walking or climbing steps?	No - no difficulty Yes – some difficulty Yes – a lot of difficulty Cannot do at all	1 2 3 4	
26	Do you (name of person with disability) have difficulty remembering or concentrating?	No - no difficulty Yes – some difficulty Yes – a lot of difficulty Cannot do at all	1 2 3 4	
27	Do you (person with disability) have difficulty (with self-care such as)	No - no difficulty Yes – some difficulty Yes – a lot of difficulty	1 2 3	

	washing all over or dressing?	Cannot do at all	4	
28	Using your (person with disability) usual (customary) language, do you have difficulty communicating, for example understanding or being understood?	No - no difficulty Yes – some difficulty Yes – a lot of difficulty Cannot do at all	1 2 3 4	

Section 3: Disability Related Information

S.N.	Question	Answers	Code	Remarks
29	Do you (name of person with disability) consider yourself (herself) having any disability?	Yes No	1 2	If there is no any 3or 4 response from S.N. 23 to 28, end the interview
30	How do you (name of person with disability) define disability?	………………………………………………..		
31	What type of disability do you (name of person with disability) have?	Physical disability **Disability related to vision** – Blindness – Low vision – Complete blind **Disability related to hearing** – Deaf – Hard of hearing DeafBlind Disability related to voice and speech Mental or psychosocial disability Intellectual disability Disability related to genetic bleeding (Hemophilia) Disability related to Autism Multiple disability	01 02 03 04 05 06 07 08 09 10 11 12 13	
32	Do you (name of person with disability) feel that other people are noticing your (her) disability?	Not at all Slightly Sometimes Often Always	1 2 3 4 5	
33	When is the onset of your (name of person with disability's) disability?	Before birth At birth After birth	1 2 3	} 34
33.1	If after birth, at what age did you (name of person with disability) notice that you have (she has) have disability?	☐ ☐ Years		

34	Do /did you have (name of person with disability has) have disability ID card? (Please observe)	Yes, have disability ID card Yes, but currently do not have No	1 2 3 →	 35
34.1	What types (color) of disability ID card do you have (name of person with disability has)?	Red Blue Yellow White Old card	1 2 3 4 5	 35
34.2	Do you (name of person with disability) receive any social protection allowance? Ask only to red and blue card holders	Receiving disability allowance Receiving other social protection allowance Not receiving any social protection allowance	1 2 3	
35	How does your (name of person with disability's) family member behave towards you (name of person with disability)?	Very bad Bad Neither good nor bad Good Very good	1 2 3 4 5	
36	How does your (name of person with disability's) society behave towards you (name of person with disability)?	Very bad Bad Neither good nor bad Good Very good	1 2 3 4 5	
37	Is there any difference how family member and society behave towards men with disabilities and women with disabilities? Compared to men with disabilities, women with disabilities are treated ………	Very good Good No any difference Bad Very bad	1 2 3 4 5	

Section 4: Quality of Life

S.N.	Question	Answers	Code	Remarks
38	How much is your (name of person with disability's) life affected by your disability?	Not at all A little Moderately Mostly Totally	1 2 3 4 5	
39	Are you (name of person with disability) currently ill?	Yes No	1 2	 → 40
39.1	If yes, mention type of your (name of person with disability's) illness	………………………………..		

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last two weeks.**

		Answer and Code

S.N.	Question	Very poor	Poor	Neither poor nor good	Good	Very good
40	How would you (name of person with disability) rate your quality of life?	1	2	3	4	5

S.N.	Question	Answer and Code				
		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very Satisfied
41	How satisfied are you (name of person with disability) with your(her) health?	1	2	3	4	5

S.N.	Question	Answer and Code				
		Not at all	A little	A moderate amount	Very much	An Extreme amount
42	To what extent do you (name of person with disability) feel that physical pain prevents you (her) from doing what you need to do?	1	2	3	4	5
43	How much do you (name of person with disability) need any medical treatment to function in your (her) daily life?	1	2	3	4	5
44	How much do you (name of person with disability) enjoy life?	1	2	3	4	5
45	To what extent do you (name of person with disability) feel your (her) life to be meaningful?	1	2	3	4	5
46	How well are you (name of person with disability) able to concentrate?	1	2	3	4	5
47	How safe do you (name of person with disability) feel in your daily life?	1	2	3	4	5
48	How healthy is your (her) physical environment?	1	2	3	4	5

		Answer and Code

S.N.	Question	Not at all	A little	Moderately	Mostly	Completely
49	Do you have (name of person with disability has) enough energy for everyday life?	1	2	3	4	5
50	Are you (name of person with disability) able to accept your (her) bodily appearance?	1	2	3	4	5
51	Have you (name of person with disability) enough money to meet your (her) needs?	1	2	3	4	5
52	How available to you (name of person with disability) is the information that you (she) need in your (her) day-to-day life?	1	2	3	4	5
53	To what extent do you (name of person with disability) have the opportunity for leisure activities?	1	2	3	4	5

S.N.	Question	Answer and Code				
		Very poor	Poor	Neither poor nor good	Good	Very good
54	How well are you (name of person with disability) able to get around?	1	2	3	4	5

S.N.	Question	Answer and Code				
		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
55	How satisfied are you (name of person with disability) with your sleep?	1	2	3	4	5
56	How satisfied are you (name of person with disability) with your (her) ability to perform your (her) daily living activities?	1	2	3	4	5
57	How satisfied are you (name of person with disability) with your (her) capacity for work?	1	2	3	4	5
58	How satisfied are you (name of person with disability) with yourself (herself)?	1	2	3	4	5
59	How satisfied are you (name of person with disability) with your (her) personal	1	2	3	4	5

	relationships?					
60	How satisfied are you (name of person with disability) with your (her) sex life?	1	2	3	4	5
61	How satisfied are you (name of person with disability) with the support you (she) get from your (her) friends?	1	2	3	4	5
62	How satisfied are you (name of person with disability) with the conditions of your (her) living place?	1	2	3	4	5
63	How satisfied are you (name of person with disability) with your (her) access to health services?	1	2	3	4	5
64	How satisfied are you (name of person with disability) with your (her) transport?	1	2	3	4	5

S.N.	**Question**	**Answer and Code**				
		Never	**Seldom**	**Quite often**	**Very often**	**Always**
65	How often do you (name of person with disability) have negative feelings such as blue mood, despair, anxiety, and depression?	1	2	3	4	5

Section 5: Knowledge, Attitude and Behavior Related to Sexual and Reproductive Health

Knowledge on Sexual and Reproductive Health				
S.N.	**Question**	**Answers**	**Code**	**Remarks**
66	Have you (name of person with disability) heard about sexual and reproductive health?	Yes No	1 2	 → 67
66.1	From where did you (name of person with disability) get information about sexual and reproductive health? **(Multiple Possible Answers)**	Friend Family Member Health worker Female Community Health Volunteer (FCHV) Teacher Mother's/Women's group Training Radio, FM TV Internet Newspaper	A B C D E F G H I J K	

No.	Question	Response	Code	Skip
		Poster, Pamphlet Other (specify)……………	L M	
67	How often do you (name of person with disability) listen to radio/FM?	Daily At least once a week Less than once a week Never Not applicable	1 2 3 4 5	
68	How often do you (name of person with disability) watch TV?	Daily At least once a week Less than once a week Never Not applicable	1 2 3 4 5	
69	How often do you (name of person with disability) read newspaper?	Daily At least once a week Less than once a week Never Not applicable	1 2 3 4 5	
70	How often do you (name of person with disability) surf internet to get information on health?	Daily At least once a week Less than once a week Never Not applicable	1 2 3 4 5	
71	Do you (name of person with disability) know what are included in Sexual and Reproductive Health(SRH)?	Yes No	1 2	 → 72
71.1	If yes, what does SRH include? **(Without Probe)** **(Multiple Possible Answers)**	Maternal and newborn care Contraceptive information and services Prevention and appropriate treatment of infertility Safe abortion and post-abortion care Combatting HIV/AIDS and other sexually transmitted diseases Prevention of gender based violence, care for victims and information, education and counseling on sexual violence Actions to eliminate harmful traditional practices such as female genital mutilation and early and forced marriage Comprehensive sexuality education and youth friendly services Others (specify)………………….	A B C D E F G H I	
72	If yes, what does SRH include? **(With probe)** **(Multiple Possible Answers)**		Yes / No	
		A Maternal and newborn care	1 / 2	
		B Contraceptive information and services	1 / 2	
		C Prevention and appropriate treatment of infertility	1 / 2	
		D Safe abortion and post-abortion care	1 / 2	
		E Combatting HIV/AIDS and other sexually	1 / 2	

No.	Question		Response		Code	Skip
			transmitted diseases			
		F	Prevention of gender based violence, care for victims and information, education and counseling on sexual violence	1	2	
		G	Actions to eliminate harmful traditional practices such as female genital mutilation and early and forced marriage	1	2	
		H	Comprehensive sexuality education and youth friendly services	1	2	
73	Do you (name of person with disability) perceive that utilization of SRH service is beneficial? ***Perceived benefits of behavior change***		Yes No		1 2	 → 74
73.1	If yes, what are the benefits of utilization of SRH services? ***Perceived benefits of behavior change*** **(Multiple Possible Answers)**		Prevention of sexually transmitted infection Both mother and child will be safe Other (specify)………….		A B C	
74	At what time of period probability of conceiving is high after having sexual intercourse?		At the beginning of period During period At the end of period In-between two consecutive periods Don't know		01 02 03 04 88	
75	After delivery of child, can woman conceive before resuming her period?		Yes No Don't know		01 02 88	
76	Have you (name of person with disability) heard about Sexually Transmitted Infection (STI) or HIV?		Yes No		1 2	 → 82
77	How is HIV transmitted? **(Multiple Possible Answers)**		Unsafe sexual contact Unsafe use of needle Unsafe blood transfusion Breast feeding Mosquito bites or any other insect bites Kissing someone who has HIV/AIDS Touching someone who has HIV/AIDS Sharing food with person who has HIV/AIDS Others (specify)……………….		A B C D E F G H I	
78	Do you (name of person with disability) know about signs and symptoms of STI?		Yes No		1 2	 → 79
78.1	If yes, what are signs and		Sores on the genitals Swelling in the genitals		A B	

	symptoms of STI? **(Multiple Possible Answers)**	Foul discharge from vagina Painful micturition Others (specify)………..	C D E	
79	Is it possible for a healthy-looking person to have HIV?	Yes No Don't know	01 02 88	
80	Does STI/HIV transmit in single sexual contact with person having STI/HIV?	Yes No Don't know	01 02 88	
81	Do you (name of person with disability) know preventive measures of STI and HIV?	Yes No	1 2	→ 82
81.1	If yes, what are the preventive measures of STI and HIV? **(Multiple Possible Answers)**	Use condom Have sexual contact with single faithful partner Avoid using unsafe needles Avoid using unsafe blood transfusion Others (specify)………………………………	A B C D E	
82	Have you (name of person with disability) heard about HIV testing?	Yes No	1 2	
83	Is abortion legal in Nepal?	Yes No Don't know	01 02 88	} 84
83.1	In what condition, abortion is legal after taking consent of pregnant women? **(Multiple Possible Answers)**	Up to 12 weeks of gestation on the request of the pregnant women. Up to 18 weeks of gestation in case of rape or incest. At any gestation if the pregnancy is detrimental to the pregnant women's physical and mental health, as certified by an expert physician. At any gestation if the fetus is suffering from a severely debilitating or fatal deformity as certified by an expert physician. Others (specify)………………………………	A B C D E	
84	Do you (name of person with disability) know where safe abortion services are available?	Yes No	1 2	→ 85
84.1	If yes, where are safe abortion services available? **(Multiple Possible Answers)**	**<u>Government</u>** Government Hospital Primary Health Care Centers Health Post Outreach clinic Health camp **<u>Non-Government</u>** Private hospital Private clinic Teaching hospital/ Medical College Mission/ NGO/ Community Hospital	 A B C D E F G H I	

		FPAN Marie Stopes Others (specify)…………………………………	J K L	

Utilization of Sexual and Reproductive Health Services								
S.N.	**Utilization of Sexual and Reproductive Health Service**	**Nearest health facility from your home**	**How long does it takes to reach the nearest health facility by available quickest means of transportation? (in minutes)**	**How far is the nearest health facility? (in meter)**	**Have you ever utilized service from the nearest health facility?**	**If no, mention reason**	**If yes, last time the services was availed (in year)**	**Areas of improvement**
85	Maternal and newborn care		…………….minute	…………….meter				
86	Contraceptive information and services		…………….minute	…………….meter				
87	Prevention and appropriate treatment of infertility		…………….minute	…………….meter				
88	Safe abortion and post-abortion care		…………….minute	…………….meter				
89	Combatting HIV/AIDS and other sexually transmitted diseases		…………….minute	…………….meter				
90	Prevention of gender based violence, care for victims and information, education and counseling on sexual violence		…………….minute	…………….meter				
91	Actions to eliminate harmful traditional practices such as female genital mutilation and early and forced marriage		…………….minute	…………….meter				
92	Comprehensive sexuality education and youth friendly services		…………….minute	…………….meter				

Nearest health facility	Code	Utilization	Code	Reason for not availing services	Code	Areas of improvement	Code
<u>Government</u>		Yes	1	Did not feel the need	01	Physical infrastructure	01
Government hospital	01	Never	2	Providers are unfriendly	02	Improve skill of health workers	02
PHCC	02			/rude/disrespectful		Ensure availability of medine	
Health Post	03			Providers are not competent	03	available	
Government Ayurvedic clinic	04			Providers are often unavailable	04	Ensure availability of equipment	03
Government	05			Health worker are of opposite sex	05	Improve behavior of health worker	04
Homeopathy/Unani				Facility too far away	06	Ensure sanctioned posts of health	05
<u>Non -Government</u>				Not customary	07	workers are fulfilled	06
Private hospital	06			Inconvenient opening hours	08	Others (specify)………..	96
Private clinic	07			Health facility is not disability-	09		
Pharmacy	08			friendly			
Medical college/ teaching	09			Prefer to receive care at home	10		
hospital				Travel costs too expensive	11		
Mission/NGO	10			Treatment costs too expensive	12		
hospital/community hospital				Not given permission by household	13		
Other (specify)……………….	96			members			
				No one available to accompany	14		
				Discrimination based on	15		
				caste/ethnicity and poverty			
				Lack of privacy	16		
				Lack of medicine	17		
				Long waiting hours	18		
				No quality service	19		
				Language barrier	20		
				Don't know	21		
				Other (specify)……………….	96		

Attitude and Behavior Related to Sexual and Reproductive Health				
S.N.	**Question**	**Answers**	**Code**	**Remarks**
93	Do you (name of person with disability) know about your HIV status?	Yes No	1 2	
94	In your (her) opinion, what are possible cues to action that reminds you (name of person with disability) to utilize the SRH health services? **(Multiple Possible Answers)**	Have not utilized any SRH services yet SRH problem related signs and symptoms Pain and discomfort Illness of family member or friend Information from Radio, FM, TV Information from newspaper Best wishes card Poster, pamphlet, wall painting Information from relative, friends Information from health worker (mobile messaging) Information from health worker (other than mobile messaging) Information from FCHV Awareness raising program Other (specify)…………….	A B C D E F G H I J K L M N	]
95	In your (name of person with disability's) opinion, do person with disability need SRH services?	Yes No	1 2	
96	Do you (name of person with disability) perceive yourself susceptibility to SRH related diseases? ***Perceived susceptibility to disease***	Yes No	1 2	
97	In your (name of person with disability's) opinion, how severe if SRH related disease? ***Perceived severity of disease***	Not at all Mild Moderate Severe Very severe	1 2 3 4 5	
98	How do you (name of person with disability) perceive yourself competent enough to successfully perform a behavior and use SRH services? ***Self-efficacy***	Not at all Slightly competent Moderate competent Competent Very competent	1 2 3 4 5	
99	In your (name of person with disability's) opinion, what motivates you to utilize SRH services?	………………………………………………………………		
100	In your (name of person	………………………………………………………………		

	with disability's) opinion, what hinders you (her) or create obstacles to utilize SRH services? ***Perceived barriers to behavior change***			
101	Are you (name of person with disability) enrolled in national health insurance?	Yes No	1 2	
102	Is your nearest health facility disability friendly?	Yes No	1 → 2	103
102.1	If no, why? **Multiple Possible Answers**	Road to reach health facility is not disability friendly No ramp in health facility The room inside health facility is not disability friendly Bad behavior of health workers Discriminating No disability friendly IEC/BCC materials Other (specify)………………	A B C D E F G	

Section 6: Maternal Health

S.N.	Question	Answers	Code	Remarks
103	What is your (name of person with disability's) marital status?	Never married Married (monogamous) Married (polygamous) Widowed Divorced Separated	1 → 2 3 4 5 6	Section 7 106 (4–6)
103.1	Do you (name of person with disability) have marriage registration card?	Yes, have the card Yes, don't have the card No	1 2 3	
104	Do your (name of person with disability) husband has any form of disability?	Yes No	1 2	
105	Are you (name of person with disability) using any method of family planning?	Yes No	1 2 →	106
105.1	What method of family planning are you (name of person with disability) currently using?	Pills Depo IUCD/ Copper T Norplant Condom (for male) Permanent sterilization (for female) Permanent sterilization (for male) Others (specify)………………	01 02 03 04 05 06 07 96	
106	Do you (name of person with disability) have child?	Yes No	1 2 →	Section 7
106.1	How many children do you			

	(name of person with disability) have?	☐		
107	What is name of your (name of person with disability's) last child?	……………………		
108	How old is (name of the last child) ? In months	☐ ☐ ☐		
109	Did you (name of person with disability) have ANC check up during your (her) last pregnancy?	Yes No	1 2 →	 110
109.1	Which months of pregnancy did you attend antenatal care with health worker? **(Please verify with ANC card)** **(Multiple possible answers)**	1 month 2 months 3 months 4 months 5 months 6 months 7 months 8 months 9 months	A B C D E F G H I	
110	Did you (name of person with disability) take Iron and Folic Acid tablet during your (her) last pregnancy?	Yes No	1 2 →	 111
110.1	How many Iron and Folic Acid tablet did you take during your (name of person with disability) last pregnancy?	☐ ☐ ☐ Days		
111	Did you (name of person with disability) take deworming tablet during your (her) last pregnancy?	Yes No	1 2	
112	How many TD vaccinations did you (name of person with disability) take during your (her) last pregnancy?	1 2 TT2+ Did not receive any	1 2 3 4	
113	Where did your (name of person with disability's) last delivery take place?	**<u>Government</u>** Gov. hospital PHCC HP **<u>Non-Government</u>** Private hospital Private clinic Medical college/ teaching hospital Mission/NGO/community hospital At home On the way Other (specify)………….	 01 02 03 04 05 06 07 08 09 96	
114	Who assisted you (name of person with disability) when you (she) gave birth to (name of child)?	**<u>Formal health provider</u>** Doctor Nurse/ANM Health Assistant/SAHW/AHW	 01 02 03	

		Informal FCHV Family members Relative/friend TBA Quack No one Other (specify)………………	 04 05 06 07 08 09 96	
115	Did you (name of person with disability) receive Postnatal Care service?	Yes No	1 2 →	116
115.1	How many times did you make PNC visit by health workers? **(Multiple Possible Answers)**	Within 24 hours On 3rd day ON 7th day Other (specify)…………….	A B C D	
115.2	After the birth of (name of child), who did your (name of person with disability's) PNC checkup?	Doctor Nurse /ANM Health Assistant/SAHW/AHW FCHV TBA Quack No check up Other (specify) …………….	01 02 03 04 05 06 96	
116	Did you (name of person with disability) take vitamin A capsule after you (she) gave birth to (name of child)?	Yes No	1 2	
117	Did you (name of person with disability) take Iron and Folic Acid tablet after you (she) gave birth to (name of child)?	Yes No	1 2 →	118
117.1	If yes, for how long did you (name of person with disability) take Iron and Folic Acid tablets after giving birth to (name of child)?	☐ ☐ Days		
118	After the birth of (name of child), did you (name of person with disability) get newborn checkup?	Yes No	1 2 →	119
118.1	If yes, after the birth of (name of child), at what time did you (name of person with disability) go for newborn checkup? **(Multiple Possible Answers)**	Within 24 hours On 3rd day On 7th day On 28th day Other (specify)………………….	A B C D E	
119	Did (name of child) receive completed vaccination?	Yes No	1 2	

Section 7: Information on Women Empowerment

S.N.	Question	Answers	Code	Remarks
120	Do you (name of person with disability) belong to any women's group?	Yes No	1 2	
121	Do you (name of person with disability) belong to any saving/co-operative group?	Yes No	1 2	
122	Do you (name of person with disability) belong to any women's group?	Yes No	1 2	
123	Do you (name of person with disability) belong to any other group?	Yes (specify)………………….. No	1 2	
124	Do you (name of person with disability) own this or any other house either alone or jointly with someone else?	Respondent only Her husband only Both jointly Other (specify)…………………..	1 2 3 96	
125	Do you (name of person with disability) own any land either alone or jointly with someone else?	Respondent only Her husband only Both jointly Other (specify)…………………..	1 2 3 96	
126	Who usually makes decisions about health care for yourself (name of person with disability)?	Respondent only Her husband only Both jointly Other (specify)…………………..	1 2 3 96	
127	Who usually makes decisions about making major household purchases?	Respondent only Her husband only Both jointly Other (specify)…………………..	1 2 3 96	
128	Who usually makes decisions about visits to your (name of person with disability's) family or relatives?	Respondent only Her husband only Both jointly Other (specify)…………………..	1 2 3 96	

Section 9: Information Related to Home Environment and Economic Status

S.N.	Question	Answers	Code	Remarks
129	What is the **main** source of drinking water for members of your (name of person with disability's) household?	**Piped water** Piped into dwelling Piped to yard/ plot Public tap/standpipe Tube well/bore hole **Dug well** Protected well Unprotected well	 01 02 03 04 05 06	

		Water from spring Protected spring Unprotected spring Rain water Tanker truck Surface water (river/dam/lake/pond/stream/canal/irrigation channel) Bottled water Other (specify)……………….	 07 08 09 10 11 12 96	
130	What is the **main** toilet facility used by members of your (name of person with disability's) household?	**Flush or pour flush toilet** Flush to piped sewer system Flush to septic tank Flush to pit latrine Flush to somewhere else Flush, don't know where **Pit Latrine** Ventilated improved pit latrine Pit latrine with slab Pit latrine without slab/open pit Composting toilet No facility/bush/field Other (specify)……………….	 01 02 03 04 05 06 07 08 09 10 96	
131	What type of fuel does your (name of person with disability's) household **mainly** use for cooking?	Electricity LPG Natural gas Biogas Kerosene Coal, lignite Charcoal Wood Straw/shrubs/grass/agricultural crop Animal dung No food cooked in household Other (specify)……………….	01 02 03 04 05 06 07 08 09 10 11 96	
132	What is the **main** material of the floor of the house? ***(Interviewer observes. One response only)***	**Natural floor** Earth/sand Dung **Rudimentary floor** Wood planks Palm/Bamboo **Finished floor** Parquet or polished wood Ceramic tiles Cement Other (specify)……………….	 01 02 03 04 05 06 07 96	

133	What is the **main** material of the roof of the house? ***(Interviewer observe One response only)***	**Natural roofing** No roof Thatch/Palm leaf **Rudimentary roof** Rustic mat Palm/Bamboo Wood planks Cardboard Tiles/Stone **Finished Roofing** Galvanized Sheet/ Tin Calamine/Cement fiber Ceramic tiles Cemented Other (specify)……………….	 01 02 03 04 05 06 07 08 09 10 11 96	
134	What is the **main** material of the exterior walls of the house? ***(Interviewer observe One response only)***	**Natural walls** No walls Cane/Palm/Trunks Mud/Sand **Rudimentary walls** Bamboo with mud Stone with mud Raw Brick Plywood Cardboard Reused wood **Finished walls** Stone and cement Bricks Brick and cement Cement blocks Wood planks/Shingles Other (specify)……………….	 01 02 03 04 05 06 07 08 09 10 11 12 13 14 96	
135	What is the **main** source of income in your (name of person with disability's) family?	Agriculture Livestock Business Service Daily wages Foreign employment Other (specify)……………….	01 02 03 04 05 06 96	
136	Total family annual income	NPR……………….		
137	Do you your (name of person with disability's) family have cultivated land?	Yes No	1 2	 → 138
137.1	If yes, how much land do your (name of person with disability's) family member have?	Aana …………		
138	Which of the following items does your (name of person with disability's) household have?	A Electricity — Yes 1 B Radio — Yes 1 C TV — Yes 1	No 2 2 2	

	(Ask each options and then circle all apply. Interviewer observe where possible)	D Mobile phone E Non-mobile telephone/Landline F Refrigerator G Sofa H Cupboard I Computer/laptop J Fan K Bicycle L Motorcycle/scooter	1 1 1 1 1 1 1 1 1	2 2 2 2 2 2 2 2 2	
139	Which of the following items does your (name of person with disability's) household have? **(Ask each options and then circle all apply. Interviewer observe where possible**) If not write "00". If there is more than 95 write "95". If don't know write "98"	A Cow/ bull/ buffalo B Horse/Donkey/Mule C Goat D Sheep E Pig/Wild Boar F Hen or other birds		_ _ _ _ _ _ _ _ _ _ _ _	

Thank you for your valuable time and cooperation!

Total time taken for interview. ………Minutes

Time of closing of interview...........am/pm