ANNEXURE – III

SEMI-STRUCTURED INTERVIEW SCHEDULE

PART – A

HOUSEHOLD CHARACTERISTICS SCHEDULE

1. Respondent I.D. No.: _____

2. Name of the respondent: ____________________________________________

3. Address of the respondent: ____________________________________________

4. Religion: ___________________________________________________________

5. Caste: _______________________________________________________________

6. Type of house: _________________________________________________________

7. Total number of rooms excluding kitchen: _________________________________

   Ratio of Room per Person: ______________________________________________

8. House ownership status: _______________________________________________

9. Source of drinking water: ______________________________________________

10. Source of lighting: _____________________________________________________

11. Fuel used for cooking: _________________________________________________

12. Toilet facility: _________________________________________________________

13. Household assets:

   Vehicle — Cycle, scooter, car.
   Entertainment — Radio, stereo, b/w TV, colored TV, cable.
   Luxury items — Fan, water-cooler, refrigerator, washing machine, telephone, sofa-set, dining table, double bed, carpet.

14. Per Capita Monthly Income: ___________________________________________
### FAMILY CHARACTERISTICS

<table>
<thead>
<tr>
<th>S.no.</th>
<th>Name of the head of the family</th>
<th>Relationship with head of the family</th>
<th>Sex</th>
<th>Age</th>
<th>Marital status</th>
<th>Educational status</th>
<th>Occupation main</th>
<th>subsidiary</th>
<th>Average monthly income</th>
<th>Remarks</th>
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PART – B

PREVALENCE OF REPRODUCTIVE MORBIDITIES

Respondent I.D. No.: ______
Age in years: ________________
Order of birth: ________________
Weight in Kgs.: ________________
Height in Cms. ________________
Marital status: ________________

1. Where is your birthplace? (Ask to specify whether it is rural or urban and write the state.) ________________________________________

2. Have you started menstruating?
   2.1 No ________________
   2.2 Yes If No go to Q.No.79

3. If yes, what was your age when you had menses for the first time?
   ________ __years and ________ months.

4. Did you know about menstruation before your first periods?
   4.1 No If No go to Q.No.6
   4.2 Yes

5. If yes, from where did you get to know about it?
   5.1 Relatives (specify) ______________________
   5.2 Friends (specify) ______________________
   5.3 Medical Professionals (specify) __________
   5.4 Any other (specify) ______________________

6. When you had it for the first time whom did you tell first of all?
   5.1 Relatives (specify) ______________________
   5.2 Friends (specify) ______________________
   5.3 Medical Professionals (specify) __________
   5.4 Any other (specify) ______________________

7. Do you observe some restrictions during the menses?
   7.1 No If No go to Q.No.11
   7.2 Yes

8. If yes, which of the following activities are restricted?
   8.1 Going to school
   8.2 Going to play
   8.3 Going to work
   8.4 Going to holy places; Do not take prasad
   8.5 Going to social gathering
   8.6 Working in kitchen

   x
8.7 Avoid heavy work
8.8 Avoid eating citric preparations
8.9 Avoid cold drinks
8.10 Taking bath
8.11 Do not put hand in pickles
8.12 Intercourse
8.13 Hot drinks
8.14 Eating rice
8.15 Eating spicy foods
8.16 Any other (specify)________________

9. On which days of the menses, do you restrict these activities?
9.1 First day
9.2 All days
9.3 Some days (specify)________________

10. Why are these activities restricted?

11. Did you experience any menstrual problem since it has started ?
11.1 No  If No go to Q.No.14
11.2 Yes

12. If yes, which problems were faced by you?
12.1 Premenstrual symptoms
12.2 Dysmenorrhoea
12.3 Polymenorrhoea
12.4 Menorrhagia
12.5 Oligomenorrhoea
12.6 Metrorrhagia
12.7 Amenorrhoea
12.8 Irregular periods
12.9 Any other (specify)________________

13. When did you first notice this problem?

Go to Q.No.1 in Part – C

14. Did you ever had excessive vaginal discharge?
14.1 No  If No go to Q.No.18
14.2 Yes

15. If yes, since when do you have this problem?
16. What was the nature of the discharge?
   16.1 White thick discharge
   16.2 Mucoid (white egg) like discharge
   16.3 Blood stained
   16.4 Foul smelling
   16.5 Any other (specify)________________________

17. Did you have some other symptoms along with vaginal discharge?
   17.1 Local redness
   17.2 Local rashes
   17.3 Itching
   17.4 Urinary symptoms
   17.5 Backache
   17.6 Weakness
   17.7 Dysmenorrhea
   17.8 None
   17.9 Pain in lower abdomen
   17.10 Any other specify)________________________

Go to Q.No. 1 in Part – C

18. Have you ever had low backache during last year?
   18.1 No If No go to Q.No.24
   18.2 Yes

19. If yes, since when do you have this pain?

____ ______days.

20. In last one month, for how many days did you had this type of pain?

____ ______days.

21. At what time of the day do you have this pain?
   21.1 Throughout the day and night
   21.2 Only during day
   21.3 Only during night
   21.4 In the evening
   21.5 In the morning
   21.6 During the sexual activity
   21.7 Any time of the day, not specified
   21.8 When heavy work is done
   21.9 Any other (specify)________________________

22. Is there any effect of the season on this pain?
   22.1 No If No go to Q.No.1 in Part - C
   22.2 Yes

23. If yes, in which season is it more severe?
   23.1 Summer
   23.2 Winter
23.3 Rainy season
23.4 Any other (specify)

Go to Q.No. 1 in Part – C

24. Do you ever, experience pressure on the lower part of the abdomen, or feel something is coming out of the vagina?

24.1 No \hspace{1cm} \text{If No go to Q.No.27}
24.2 Yes

25. If yes, since when do you have this problem?

26. What time of the day do you have this feeling?

26.1 Throughout the day
26.2 While sitting on the bed/ chair
26.3 While sitting in the squatting position
26.4 While standing
26.5 During sexual activity
26.6 Any time of the day, not specified
26.7 Any other (specify)

Go to Q.No. 1 in Part – C

27. Do you have any urinary problem?

27.1 No \hspace{1cm} \text{If No go to Q.No.33}
27.2 Yes \hspace{1cm} \text{If unmarried go to Part - D}

28. If yes, what type of problem do you have?

28.1 Frequent urge to pass urine
28.2 Difficulty or pain while passing urine
28.3 Incontinence of urine
28.4 Urine dribbles while coughing/ sneezing
28.5 Any other (specify)

29. When did you first notice it?

(If married proceed further, otherwise go to Q.No.1 in Part-C)

30. Is it related to any of the delivery?

30.1 No \hspace{1cm} \text{If No go to Q.No.33}
30.2 Yes

31. If yes, what type of delivery did you have?

31.1 Normal without episiotomy
31.2 Normal with episiotomy
31.3 Forceps / instrumental
31.4 Caesarian section
32. Who had conducted the delivery?
   32.1 Dai / TBA
   32.2 Health worker
   32.3 Government doctor
   32.4 Private doctor
   32.5 Friend / relative
   32.6 Any other (specify)

   Go to Q.No. 1 in Part – C

33. What was your age at marriage?
   _______ __years ________________ months

34. Did you come to your husband’s house immediately after marriage?
   34.1 No
   34.2 Yes

35. For how many years are you staying / did you stay with your husband?
   ________________ years

36. Did you conceive during this period?
   36.1 No
   36.2 Yes
   If Yes, go to Q.No. 64

37. If yes, what was the outcome of pregnancy?
   (Write in chronological order)

<table>
<thead>
<tr>
<th>Sr.No</th>
<th>Age of mother</th>
<th>Outcome</th>
<th>Period of gestation</th>
<th>Sex of baby</th>
<th>Surviving status/age of baby</th>
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38. Are you pregnant at present?
   38.1 No
   38.2 Yes
   If Yes, go to Q.No. 49 if conceived earlier and Q.No. 64 if never conceived

39. Did you have an antenatal check-up?
   39.1 No
   39.2 Yes
   If No, go to Q.No. 43

40. If yes, at what period of gestation did you have first check-up?

41. Where did you get yourself examined?
   41.1 At home by a Dai/ TBA
   41.2 At home by ANM/LHV/Health worker
41.3 In a government dispensary/hospital
41.4 In a private clinic
41.5 Any other (specify)_________________

42. How many times you have been examined during your pregnancy?_________________

43. Did you have T.T. immunization?
   43.1 No
   43.2 Yes
   If Yes, how many doses?_________________
   Source of immunization__________________________

44. Are you taking iron and folic acid tablets?
   44.1 No
   44.2 Yes
   If Yes, how many tablets have been prescribed per month?________
   Source of procuring tablets__________________________

45. Where do you plan to deliver?
   45.1 At home
   45.2 In a government hospital
   45.3 At a private nursing home
   45.4 Do not know, whatever husband or mother-in-law says
   45.5 Any other (specify)_________________

46. If at home, whom will you call to conduct the delivery?
   46.1 A relative / friend / neighbor
   46.2 Daì / TBA
   46.3 Midwife / health worker from govt. dispensary
   46.4 Private practitioner
   46.5 Do not know
   46.6 Any other (specify)_________________

47. Do you have any of the following signs and symptoms or health problems?
   47.1 Nausea and vomiting
   47.2 Swelling of hands and feet
   47.3 Weakness or tiredness
   47.4 Dizziness, headache
   47.5 Paleness / anemia
   47.6 Visual disturbances
   47.7 Bleeding per vagina
   47.8 Convulsions or fits
   47.9 None or less fetal movements
   47.10 None
   47.11 Fever
   47.12 Any other (specify)_________________
   If None go to Q.No. 49

  xv
48. If you have some complaint, tell in detail about it.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Signs and symptoms</th>
<th>Period of gestation when it appeared</th>
<th>Duration of problem</th>
<th>RX taken Yes/No</th>
<th>Place of RX</th>
<th>Type of RX</th>
<th>Cost of RX</th>
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</table>

Go to Q.No.1 in Part – C

49. Did you have an antenatal check-up during last pregnancy?
   49.1 No
   49.2 Yes
   If No go to Q.No.53

50. If yes, at what period of gestation did you get first checkup?

51. Where did you get yourself examined?
   51.1 At home by a Dai / TBA
   51.2 At home by ANM / LHV / Health worker
   51.3 In a government dispensary/hospital
   51.4 In a private clinic
   51.5 Any other (specify) ____________________________

52. How many times have you been examined during your pregnancy?

53. Did you have T.T. immunization for the last pregnancy?
   53.1 No
   53.2 Yes
   If Yes, how many doses? ____________________________
   Source of immunization ____________________________

54. Did you take iron and folic acid tablets for the last pregnancy?
   54.1 No
   54.2 Yes
   If Yes, how many tablets did you take per month? ________
For how many months did you take them? ____________
Total tablets taken ____________
Source of procuring tablets ____________

55. Where did you deliver?
   55.1 At home
   55.2 In a government hospital
   55.3 At a private nursing home
   55.4 Any other (specify) ______________

56. If at home, who conducted the delivery?
   56.1 A relative / friend / neighbor
   56.2 Dai / TBA
   56.3 Midwife / health worker from govt. dispensary
   56.4 Private practitioner
   56.5 Spontaneous abortion
   56.6 Any other (specify) ______________

57. What was the status of the newborn baby?
   57.1 Alive
   57.2 Still born

58. Did you have any of these signs and symptoms during your last pregnancy?
   58.1 Nausea and vomiting
   58.2 Swelling of hands and feet
   58.3 Weakness or tiredness
   58.4 Dizziness, headache
   58.5 Paleness / anemia
   58.6 Visual disturbances
   58.7 Bleeding per vagina
   58.8 Convulsions or fits
   58.9 None or less fetal movements
   58.10 Fever
   58.11 Acidity
   58.12 Pain in abdomen
   58.13 Prolonged labor
   58.14 Jaundice
   58.15 Diarrhoea
   58.16 None
   58.17 Any other (specify) ______________

   If None go to Q.No. 60

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59. If you had some complaint, tell in detail about it.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Signs and symptoms</th>
<th>Period of gestation when it appeared</th>
<th>Duration of problem</th>
<th>Rx taken Yes/No</th>
<th>Place of Rx</th>
<th>Type of Rx</th>
<th>Cost of Rx</th>
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Go to Q.No.1 in Part-C

60. Did you have any of the following health problems within 42 days of delivery?
   60.1 High fever
   60.2 Lower abdominal pain
   60.3 Foul smelling discharge
   60.4 Excessive vaginal bleeding
   60.5 Dizziness, severe headache
   60.6 Anxiety or fear episodes
   60.7 Episiotomy infection
   60.8 Diarrhoea
   60.9 Pain while urinating
   60.10 None
   60.11 Any other (specify)
   If None go to Q.No. 66

61. Tell in detail about the health problem you had.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Health problem</th>
<th>Day after delivery on which it appeared</th>
<th>Duration of the problem</th>
<th>Rx taken Yes/No</th>
<th>Place of Rx</th>
<th>Type of Rx</th>
<th>Cost of Rx</th>
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Go to Q.No.1 in Part-C

xviii
62. In case of MTP/ Abortion, did you have any health problem within 42 days of the termination of pregnancy?
   62.1 No         **If No go to Q. No. 65**
   62.2 Yes
   **If Yes which of the following problem?**
   AB1 Heavy Bleeding
   AB2 Fever
   AB3 Bodyache
   AB4 Hallucinations

63. Tell in detail about the health problem you had.

<table>
<thead>
<tr>
<th>S.No</th>
<th>Health Problem</th>
<th>Post MTP day on which it appeared</th>
<th>Duration of the problem</th>
<th>Rx taken Yes/No</th>
<th>Place of Rx</th>
<th>Type of Rx</th>
<th>Cost of Rx</th>
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**Go to Q.No.1 in Part – C**

64. Why did you not conceive?
   64.1 Using a contraceptive
   64.2 Husband have some problem
   64.3 You have some problem
   64.4 Both of you have some problem
   64.5 Do not know
   64.6 Married for less than 1 year
   64.7 Any other (specify) 

**If Yes to option 64.1 \ using a contraceptive at present proceed further, otherwise go to Q.No. 1 in Part- C**

**If not using any contraceptive then to Q.No. 78**

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65. If using a contraceptive which of the following do you use?
   65.1 Condoms
   65.2 Oral pills
   65.3 IUD / CUT
   65.4 Foams / jellies
   65.5 Injectables
   65.6 Female sterilization
   65.7 Male sterilization
   65.8 Withdrawal / abstinence
   65.9 Home remedies
   65.10 Lactational ammenorrhea
   65.11 Any other (specify)_________________________

66. From where did you come to know about this contraceptive?
   66.1 Relatives (specify)_________________________
   66.2 Friends (specify)__________________________
   66.3 Medical Professionals (specify)_____________
   66.4 Any other (specify)________________________

67. Since how long are you using this contraceptive?
   ___________ years ___________ months

68. From where do you get the contraceptive?
   _____________________________________________

69. Do you have any problem in procuring it?
   69.1 No If No go to Q.No.71
   69.2 Yes
   69.3 Not applicable

70. If yes, what type of problem?
   _____________________________________________

71. Do you have any problem with its use?
   71.1 No If No go to Q.No.75
   71.2 Yes
72. If yes, specify the problem.

73. Have you sought any treatment for it?
   73.1 No If No go to Q.No.77
   73.2 Yes

74. If yes, what was the treatment?

Go to Q.No. 1 in Part- C

75. For how long do you intend to use this contraceptive?

76. Would you like to switch to some other contraceptive?
   76.1 No
   76.2 Yes
   If yes, when and which?____________________________

77. If no, treatment was sought for the problem, why did you not seek?

78. If not using any contraceptive, why don’t you use?
   78.1 Do not know about contraceptives
   78.2 Religion does not permit
   78.3 Afraid of side-effects
   78.4 Costly
   78.5 Not readily available
   78.6 Inconvenient to use
   78.7 Husband do not agree
   78.8 In-laws do not agree
   78.9 You do not want, because you need more children
   78.10 Will give for adoption if I have a male child
   78.11 Do not have any child
   78.12 Want a male child
   78.13 Have amennorrhoea
78.14 Want one more male child
78.15 I am divorced
78.16 Have secondary infertility
78.17 Lactational ammenorrhoea
78.18 Any other (specify)

Further questions to be asked only from females who have not yet attained menarche

79. Have you heard about menstruation?
   79.1 No
   79.2 Yes If Yes proceed further otherwise go to Part-D

80. From where did you get to know about it?

81. What do you know about it?

82. Who all in your house have menstruation?

83. Do they have some restrictions during menstruation?
   83.1 No
   83.2 Yes
   83.3 Do not know

84. If yes, what restrictions do they observe?

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PART – C

TREATMENT SEEKING BEHAVIOUR

1. Did you talk to someone for this problem?
   1.1 No
   1.2 Yes

2. If yes, to whom did you talk first of all about this problem?
   5.1 Relatives (specify)
   5.2 Friends (specify)
   5.3 Medical Professionals (specify)
   5.4 Any other (specify)

3. Did you take some treatment for the problem?
   3.1 No
   3.2 Yes If Yes go to Q.No.5

4. If no, treatment taken, why did you not take treatment?
   4.1 You considered it normal
   4.2 Family didn’t allow to seek Rx. Who?
   4.3 It is incurable
   4.4 You felt shy
   4.5 Did not feel any discomfort
   4.6 It was not so severe to be treated
   4.7 It is the part of destiny
   4.8 Husband did not agree
   4.9 Mother-in-law/Sister-in-law did not agree
   4.10 No one was there to accompany you
   4.11 No male member was there to accompany you
   4.12 Female doctor not available in the dispensary/hospital
   4.13 Health worker not available
   4.14 Did not know whom to consult
   4.15 Treatment was costly
   4.16 Dispensary/Hospital was far off
   4.17 It is not good to talk about such things
   4.18 Teachers in the school said not to take
   4.19 Medicine should not be taken as it may harm the uterus
   4.20 It is good that menses had stopped/ reduced
   4.21 No time to go
   4.22 Health worker said it is normal
   4.23 Any other (specify)

5. If yes, after how many days did you go for treatment?
   5.1 Same day
   5.2 Within a week
   5.3 Within a month
5.4 1 6 months
5.5 6 – 12 months
5.6 >1 year

6. CHRONOLOGY OF TREATMENT SEEKING BEHAVIOUR

<table>
<thead>
<tr>
<th>Order of Rx taken</th>
<th>Agency of Rx taken</th>
<th>Referred by whom</th>
<th>Nature of Rx taken</th>
<th>Duration of Rx taken</th>
<th>Result of Rx taken</th>
<th>Rs. spent on Rx taken</th>
<th>Reason for switching the agency</th>
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7. Have you ever gone to someone who can treat this type of problem with magic, prayer, stones or amulets?
   7.1 No
   7.2 Yes

8. If yes, what all did you do for this problem?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
PART – D

ATTITUDES, PERCEPTIONS AND PRACTICES

1. In your opinion, which of these problems are curable?

2. Where do you place yourself, in the rating scale in comparison to others of same age?

3. How much control do you have to keep yourself healthy?

4. What do you do to keep yourself healthy?

5. Do you have some problem in doing these?

6. What more can be done to keep oneself healthy?

7. Why don’t you do these?

8. What does good reproductive health mean to you?

9. If you fall sick, who decides most of the time for plan of action?

10. Where do you most of the time go for Rx?

11. Are you satisfied with it?
12. If not, where would you like to go by yourself?

13. Why don’t you go by yourself?

14. Who does the shopping of the following things in your house?
   1. Ration
   2. Kitchen appliances
   3. Your clothes
   4. Clothes for other members
   5. Other articles of the house

15. Are you satisfied with the shopping done?

15. If not, what changes would you like to do?