16. Have You Ever Experienced a Constant Leakage of Urine or Stool from Your Vagina During The Day and Night?
   If No, Skip to #33

17. Did this Problem Occur Within the Last 12 Months?
   If Yes, Skip to #20

18. What Year Did this Problem Occur?

19. a) Did this Problem Occur After a Delivery?

19. b) Did this Problem Occur after an Operation in your Pelvic Area?

20. How Many ANC Check-ups You Have Attended?

21. Did this Problem Occur After a Normal Labor and Delivery, or After a Very Difficult Labor and Delivery?

22. Where did the Delivery Take Place?

23. Walking Distance from Nearest Health Facility:

24. How Long After the Labor Pains Began did You Go to the Facility?

25. Did You Get a Caesarean Section at the Facility?

26. Was this Baby Born Alive?

27. After Which Delivery did this Occur?

28. How Many Days After Did the Leakage Start?
29. Have You Sought Treatment for This Condition?
(If Yes, What Form of Treatment?
(If Yes, What Form of Treatment?)

If No, Skip to #31

30. From Whom Did You Last Seek Treatment?
(If Yes, What Form of Treatment?)

Health Professional/Doctor/ Clinical Officer
(If Yes, What Form of Treatment?)

Nurse/Midwife
(If Yes, What Form of Treatment?)

Patient Attendant
(If Yes, What Form of Treatment?)

Other Person-Untrained Village Doctor
(If Yes, What Form of Treatment?)

Pharmacist
(If Yes, What Form of Treatment?)

If Other, Please Specify
(If Yes, What Form of Treatment?)

31. Why Have You Not Sought Treatment?
(If Yes, What Form of Treatment?)

Did not Know how it could be fixed
(If Yes, What Form of Treatment?)

Do not Know Where to Go
(If Yes, What Form of Treatment?)

Too Expensive
(If Yes, What Form of Treatment?)

Poor Quality of Care
(If Yes, What Form of Treatment?)

Could not Get Permission
(If Yes, What Form of Treatment?)

Emarrassment
(If Yes, What Form of Treatment?)

If Other, Please Specify
(If Yes, What Form of Treatment?)

32. Did the Treatment Stop the Problem?
(If Yes, What Form of Treatment?)

Yes, No More Leakage At All
(If Yes, What Form of Treatment?)

Yes, But Still Some Leakage
(If Yes, What Form of Treatment?)

33. Are There Any (Other) Women in Your Household Who Suffer from Vesicovaginal Fistula/Obstetric Fistula?
(If Yes, What Form of Treatment?)

No
(If Yes, What Form of Treatment?)

34. How Many (Other) Women in your Household Suffer from Vesicovaginal Fistula/Obstetric Fistula?
(If Yes, What Form of Treatment?)

Number
(If Yes, What Form of Treatment?)

Don’t Know
(If Yes, What Form of Treatment?)

35. Did She/They Undergo Any Screening or Treatment or Are They Planning to Do So?
(If Yes, What Form of Treatment?)

Don’t Know
(If Yes, What Form of Treatment?)

36. Communication Devices Available at your Home?
(If Yes, What Form of Treatment?)

Television
(If Yes, What Form of Treatment?)

Radio
(If Yes, What Form of Treatment?)

37. The Continuous Leakage of Urine or Feces or Both Through Woman’s Private Part is Called Fistula.
(If Yes, What Form of Treatment?)

Don’t Know
(If Yes, What Form of Treatment?)

38. This Condition Can be Completely Treated Through Surgical Operation in the Hospital.
(If Yes, What Form of Treatment?)

Don’t Know
(If Yes, What Form of Treatment?)

39. Woman with Other Forms of Leakage Not Related to Fistula Will Be Referred to Other Hospitals to Get Treatment, Where They Shall Bear the Cost of Transportation and Operation.
(If Yes, What Form of Treatment?)

Don’t Know
(If Yes, What Form of Treatment?)

40. The Women Who Are Identified with This Condition at the Screening Will Be Operated Free of Charge.
(If Yes, What Form of Treatment?)

Don’t Know
(If Yes, What Form of Treatment?)

41. Screening Should Be Done to Identify Fistula.
(If Yes, What Form of Treatment?)

Don’t Know
(If Yes, What Form of Treatment?)

42. Who Will Accompany You For Treatment?
(If Yes, What Form of Treatment?)

Alone/ Self
(If Yes, What Form of Treatment?)

Mother/ Father
(If Yes, What Form of Treatment?)

Friend/Acquaintance
(If Yes, What Form of Treatment?)

If Other, Please Specify
(If Yes, What Form of Treatment?)

43. What Are Your Perceptions of Causes of Fistula?
(If Yes, What Form of Treatment?)

Delay in Getting a Caesarean Section
(If Yes, What Form of Treatment?)

Delay in Delaying Delivery
(If Yes, What Form of Treatment?)

Delay in Prolonged Delivery
(If Yes, What Form of Treatment?)

Operation (Caesarean Section)
(If Yes, What Form of Treatment?)

Delivery Delay
(If Yes, What Form of Treatment?)

Use of Instruments During Delivery
(If Yes, What Form of Treatment?)

Providers Fault
(If Yes, What Form of Treatment?)

Failure to Deliberate at a Hospital/ Being Too Young
(If Yes, What Form of Treatment?)

Lack of Care by Provider
(If Yes, What Form of Treatment?)

44. Family Members Perceptions of Causes of Fistula.
(If Yes, What Form of Treatment?)

Bewitchment
(If Yes, What Form of Treatment?)

Use of Instruments during Delivery/ Provider Mistake
(If Yes, What Form of Treatment?)

God’s Will
(If Yes, What Form of Treatment?)

Failure to Deliberate at a Hospital/ Being Too Young/ Lack of Care by Provider
(If Yes, What Form of Treatment?)

45. Health Seeking Practices:
(If Yes, What Form of Treatment?)

1. Have You Gone For Antenatal Visits?
(If Yes, What Form of Treatment?)

2. Number of Moves Made By You from Initiation of Labour to Final Delivery?
(If Yes, What Form of Treatment?)

3. Types of Delay Experienced by Women with Fistula?
(If Yes, What Form of Treatment?)

4. Family Support for Treatment
(If Yes, What Form of Treatment?)

5. Have You Taken Any Other Type of Treatment for Fistula?
(If Yes, What Form of Treatment?)

6. What is the Impact of Post-Fistula Condition in Your Life?
(If Yes, What Form of Treatment?)

Nothing Change
(If Yes, What Form of Treatment?)

Domestic Violence
(If Yes, What Form of Treatment?)

Do Not Wish to Respond
(If Yes, What Form of Treatment?)