


Appendix IXa: Census Questionnaire - Housing



40479

**ANTIGUA AND BARBUDA
STATISTICS DIVISION**

**POPULATION AND HOUSING CENSUS
27 MAY 2011**

CONFIDENTIAL WHEN COMPLETE

1) USE ONLY 2B PENCILS

2) Please print carefully and avoid contact with the edges of the box. Example: 4 5 6

3) IMPORTANT!!! Place an X in the box for multiple choice options

4) Erase cleanly and make no stray marks on this form

IMPORTANT!!!

IDENTIFICATION Transfer the ED, Block and Household Numbers to the top of EACH individual questionnaire

ED No

Block No

Building No

Dwelling No

Household No

Address of Household _____

Community _____

Town/Village _____

District/Parish _____

INTERVIEWER SAY:
I am the Census Interviewer assigned to this area and I would like to get some information about this household and its members.
Here is my identification card. (Show card)

INTERVIEWER RECORD OF VISITS

Visit Number	Date (DD/MM/YY)	Time Started	Time Ended	Duration (in minutes)	*Results
1	<div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div>/</div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div>/</div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>			<div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>
2	<div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div>/</div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div>/</div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>			<div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>
3	<div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div>/</div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div>/</div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>			<div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>
4	<div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div>/</div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div>/</div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>			<div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>	<div style="border: 1px solid black; width: 20px; height: 20px;"></div>

***RESULTS CODES:** 1 = Completed 2 = Partially Completed, call back 3 = Closed Dwelling
4 = Vacant Dwelling 5 = No Suitable respondent at home 6 = Refusal 8 = Other

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40479	<u>First Name</u>	<u>Surname</u>	<u>Date</u>	<u>Signature</u>	<u>Code</u>
Liaison officer					<input type="text"/>
Supervisor					<input type="text"/>
Interviewer					<input type="text"/>
Editor/coder					<input type="text"/>

INTERVIEWER SAY: Please give me the names of all the persons who usually live and share one daily meal with your household starting with the head.

REMEMBER: Probe for infants, elderly, new born babies, disabled and persons who died but were members of the household at midnight on the 27 May 2011.

1 (a): LISTING OF HOUSEHOLD MEMBERS

Confidential

<u>Surname</u>	<u>First Name</u>	<u>Sex</u>	<u>Surname</u>	<u>First Name</u>	<u>Sex</u>
01		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	11		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
02		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	12		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
03		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	13		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
04		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	14		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
05		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	15		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
06		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	16		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
07		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	17		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
08		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	18		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
09		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	19		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F
10		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	20		<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F

1(b) Total Number of Persons

COMMENTS

Mark multiple choice boxes like this ☒

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INTERVIEWER SAY: Now I would like to ask a few questions about the dwelling which your household occupies and the facilities that you have.

SECTION 1: HOUSING		Remember to mark multiple choice boxes like this <input checked="" type="checkbox"/>
<p>2. What is the MAIN material of the outer walls?</p> <p><input type="checkbox"/> 1 Concrete <input type="checkbox"/> 7 Wood and brick</p> <p><input type="checkbox"/> 2 Concrete and Blocks <input type="checkbox"/> 8 Wood & Concrete</p> <p><input type="checkbox"/> 3 Improvised/ Makeshift <input type="checkbox"/> 9 Wood and galvanized</p> <p><input type="checkbox"/> 4 Stone <input type="checkbox"/> 88 Other</p> <p><input type="checkbox"/> 5 Stone and brick <input type="checkbox"/> 99 Don't know/not stated</p> <p><input type="checkbox"/> 6 Wood</p> <p>3: What is the MAIN material used for roofing?</p> <p><input type="checkbox"/> 1 Concrete <input type="checkbox"/> 6 Shingle (wood)</p> <p><input type="checkbox"/> 2 Improvised/Makeshift <input type="checkbox"/> 7 Tarpaulin</p> <p><input type="checkbox"/> 3 Sheet metal* <input type="checkbox"/> 8 Tile</p> <p><input type="checkbox"/> 4 Shingle (asphalt) <input type="checkbox"/> 88 Other (Specify) _____</p> <p><input type="checkbox"/> 5 Shingle (other) <input type="checkbox"/> 99 Don't know/Not stated</p> <p><i>*(zinc, aluminum, galvanise)</i></p> <p>4. In which year/ period was this building built?</p> <p><input type="checkbox"/> 1 Before 1980 <input type="checkbox"/> 6 2008</p> <p><input type="checkbox"/> 2 1980 - 1989 <input type="checkbox"/> 7 2009</p> <p><input type="checkbox"/> 3 1990 - 1999 <input type="checkbox"/> 8 2010</p> <p><input type="checkbox"/> 4 2000 - 2006 <input type="checkbox"/> 9 Don't Know/Not stated</p> <p><input type="checkbox"/> 5 2007</p> <p>5. What type of dwelling does this household occupy?</p> <p><input type="checkbox"/> 1 Separate house/ detached</p> <p><input type="checkbox"/> 2 Part of a private house/attached</p> <p><input type="checkbox"/> 3 Flat, apartment, condominium</p> <p><input type="checkbox"/> 4 Double house/Duplex</p> <p><input type="checkbox"/> 5 Townhouse</p> <p><input type="checkbox"/> 6 Combine business and dwelling</p> <p><input type="checkbox"/> 7 Barracks</p> <p><input type="checkbox"/> 8 Other (Specify) _____</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p>	<p>6. How would you best describe the ownership of this dwelling unit?</p> <p><input type="checkbox"/> 1 Owned with a mortgage <input type="checkbox"/> 6 Rented private (paying)</p> <p><input type="checkbox"/> 2 Owned outright <input type="checkbox"/> 7 Squatted</p> <p><input type="checkbox"/> 3 Leased <input type="checkbox"/> 8 Other (Specify) _____</p> <p><input type="checkbox"/> 4 Rent-free <input type="checkbox"/> 9 Don't know/Not stated</p> <p><input type="checkbox"/> 5 Rented gov.(paying)</p> <p>7. Under what type of arrangement is the land occupied?</p> <p><input type="checkbox"/> 1 Lease-hold <input type="checkbox"/> 6 Sharecropping</p> <p><input type="checkbox"/> 2 Owned/Freehold <input type="checkbox"/> 7 Squatted</p> <p><input type="checkbox"/> 3 Permission to work land <input type="checkbox"/> 8 Other (Specify) _____</p> <p><input type="checkbox"/> 4 Rented (paying) <input type="checkbox"/> 9 Don't Know/Not Stated</p> <p><input type="checkbox"/> 5 Rent-free</p> <p>8. Is this dwelling insured?</p> <p><input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 9 Don't Know/Not Stated</p> <p>9: Are the contents of this dwelling insured?</p> <p><input type="checkbox"/> 1 Yes, all</p> <p><input type="checkbox"/> 2 Yes, partially</p> <p><input type="checkbox"/> 3 No, none</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>10: What type of fuel does this household use <u>MOST</u> for cooking?</p> <p><input type="checkbox"/> 1 Cooking gas/LPG</p> <p><input type="checkbox"/> 2 Electricity</p> <p><input type="checkbox"/> 3 Kerosene</p> <p><input type="checkbox"/> 4 Wood/charcoal</p> <p><input type="checkbox"/> 5 None</p> <p><input type="checkbox"/> 6 Other (Specify) _____</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>11: How does this household usually dispose of garbage?</p> <p><input type="checkbox"/> 1 Burning</p> <p><input type="checkbox"/> 2 Burying</p> <p><input type="checkbox"/> 3 Compost</p> <p><input type="checkbox"/> 4 Dumping (land)</p> <p><input type="checkbox"/> 5 Dumping (throwing into river/sea/pond)</p> <p><input type="checkbox"/> 6 Garbage truck -Private</p> <p><input type="checkbox"/> 7 Garbage truck/skip/bin/ -Public</p> <p><input type="checkbox"/> 8 Other (Specify) _____</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p>	

Remember to mark multiple choice boxes like this ☒

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Remember to mark multiple choice boxes like this ☒

SECTION 1: HOUSING	continued				
<p>12: What is your <u>MAIN</u> source of water supply?</p> <p><input type="checkbox"/> 1 Private not piped into dwelling</p> <p><input type="checkbox"/> 2 Private, piped into dwelling</p> <p><input type="checkbox"/> 3 Public standpipe</p> <p><input type="checkbox"/> 4 Public well/tank</p> <p><input type="checkbox"/> 5 Public piped into dwelling</p> <p><input type="checkbox"/> 6 Public, piped into yard</p> <p><input type="checkbox"/> 7 Spring/River</p> <p><input type="checkbox"/> 8 Cistern/Tank</p> <p><input type="checkbox"/> 88 Other (Specify) _____</p> <p><input type="checkbox"/> 99 DK/NS</p> <p>13: What is your <u>MAIN</u> source of <u>DRINKING</u> water?</p> <p><input type="checkbox"/> 1 Bottled water</p> <p><input type="checkbox"/> 2 Private, not piped into dwelling</p> <p><input type="checkbox"/> 3 Private, piped into dwelling</p> <p><input type="checkbox"/> 4 Public standpipe</p> <p><input type="checkbox"/> 5 Public well/tank</p> <p><input type="checkbox"/> 99 Don't know/Not stated</p> <p><input type="checkbox"/> 6 Public, piped into dwelling</p> <p><input type="checkbox"/> 7 Public, piped into yard</p> <p><input type="checkbox"/> 8 Spring/River</p> <p><input type="checkbox"/> 9 Cistern/Tank</p> <p><input type="checkbox"/> 88 Other (Specify) _____</p> <p>14: What type of toilet facility does this household have?</p> <p><input type="checkbox"/> 1 Pit latrine not ventilated</p> <p><input type="checkbox"/> 2 Pit latrine ventilated and elevated/Ventilated Improved Pit (VIP)</p> <p><input type="checkbox"/> 3 Pit-latrine ventilated and not elevated</p> <p><input type="checkbox"/> 4 Water Closet (WC) (flush toilet) linked to septic tank/Soak-away</p> <p><input type="checkbox"/> 5 Water Closet (WC) (flush toilet) linked to sewer</p> <p><input type="checkbox"/> 6 None (Skip to 15)</p> <p><input type="checkbox"/> 8 Other (Specify) _____</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>15: Is this toilet shared with any other household?</p> <p><input type="checkbox"/> 1 Yes</p> <p><input type="checkbox"/> 2 No</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>16: Are your bathing facilities indoors?</p> <p><input type="checkbox"/> 1 Yes</p> <p><input type="checkbox"/> 2 No</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p>	<p>17: Are your bathing facilities shared with another household?</p> <p><input type="checkbox"/> 1 Yes</p> <p><input type="checkbox"/> 2 No</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>18: Is your main kitchen inside the dwelling unit or outside?</p> <p><input type="checkbox"/> 1 Inside</p> <p><input type="checkbox"/> 2 Outside</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>19: Is your <u>main</u> kitchen shared with another person not of this household?</p> <p><input type="checkbox"/> 1 Yes</p> <p><input type="checkbox"/> 2 No</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>20: What is the <u>MAIN</u> source of lighting for this household?</p> <p><input type="checkbox"/> 1 Electricity - Private Generator</p> <p><input type="checkbox"/> 2 Electricity - Public</p> <p><input type="checkbox"/> 3 Gas Lantern</p> <p><input type="checkbox"/> 4 Kerosene</p> <p><input type="checkbox"/> 5 Solar</p> <p><input type="checkbox"/> 6 None</p> <p><input type="checkbox"/> 8 Other (Specify) _____</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>21: How many rooms does this household unit have? (A room is enclosed by walls of at least 2m (6.5ft) high, and at least 4 square metres (43 square feet) in area. Do not count bathrooms and porches).</p> <p>Number of Rooms</p> <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table> <p>22: How many bedrooms does this household unit have? (Bedrooms are rooms used mainly for sleeping and exclude makeshift and temporary sleeping quarters. Count all bedrooms including spares not occupied).</p> <p>Number of Bedrooms</p> <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>				
<input type="text"/>	<input type="text"/>				

Remember to mark multiple choice boxes like this ☒

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Remember to mark multiple choice boxes like this ☒

SECTION 1: HOUSING				concluded			
23. Which of these appliances or household equipment does this household have in use?							
	Yes	No	How Many?		Yes	No	How Many?
1. Air condition	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	10. Radio	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
2. Clothes dryer	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	11. Refrigerator	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
3. Computers:				12. Satellite dish	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
(a) Desktop	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	13. Stereo	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
(b) Laptop	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	14. Stove (Gas/electric/solar)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
(c) Other	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	15. Television (Flat screen)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
4. Dish washer	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	16. Television (Regular)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
5. DVD/MP3 player	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	17. Washing machine	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
6. Freezer	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	18. Water heater	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
7. Generator	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	19. Water pump	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
8. Microwave	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>				
9. Mobile/cellular	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>				
24: How many motor vehicles does this household have in use?				25: Which of the following services does your household have in use?			
<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div>				<input type="checkbox"/> 1 Fixed line tel <input type="checkbox"/> 4 Internet access <input type="checkbox"/> 2 Cable TV <input type="checkbox"/> 9 DK/NS <input type="checkbox"/> 3 Satellite TV			
SECTION 2: CRIME							
26. Was any member of this household a victim of any crime during the past twelve months?				28. If no, why was/were the crime(s) not reported?			
<i>(If NO, skip to Section 3)</i> <input type="checkbox"/> 1 No <i>If Yes, (X all that apply)</i> Yes				<input type="checkbox"/> 1 No confidence in the administration of justice <input type="checkbox"/> 2 Afraid of perpetrator <input type="checkbox"/> 3 Not serious enough <input type="checkbox"/> 8 Other (Specify _____) <input type="checkbox"/> 9 DK/NS			
(a) Murder <input type="checkbox"/> (b) Kidnapping <input type="checkbox"/> (c) Shooting <input type="checkbox"/> (d) Rape/Abuse <input type="checkbox"/> (e) Wounding <input type="checkbox"/> (f) Larceny - Housebreaking <input type="checkbox"/> (g) Larceny - Auto theft <input type="checkbox"/> (h) Larceny - Other <input type="checkbox"/> (i) Other (specify) <input type="checkbox"/>				29. If yes, what was the result? <input type="checkbox"/> 1 Pending <input type="checkbox"/> 2 Convicted <input type="checkbox"/> 3 Dismissed <input type="checkbox"/> 8 Other (Specify _____) <input type="checkbox"/> 9 DK/NS			
27. Was the crime reported?							
<input type="checkbox"/> 1 Yes (GO TO Q29) <input type="checkbox"/> 2 No (GO TO Q28) <input type="checkbox"/> 9 DK/NS							

Remember to mark multiple choice boxes like this ☒

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Mark multiple choice boxes like this ☒

SECTION 3: INTERNATIONAL MIGRATION

For persons 15 years and over when moved

30: Did anyone in this household move abroad to live between 2001 and 2011 and is still living abroad?

31: How many persons?

- ☐ 1 Yes (if Yes, continue)
☐ 2 No (SKIP TO SECTION 4)
☐ 9 DK/NS (SKIP TO SECTION 4)

32	33	34	35	36	37	38	39
Person Number	Sex	Age when moved IF AGE IS LESS THAN 15 YEARS SKIP TO 36	Occupation when moved Describe as clearly as possible the person(s) occupation when he/she moved. For Persons 15 years and over when moved	Highest level of education attained when moved 1 None/No schooling 2 Pre-primary education 3 Primary 4 Secondary 5 Post Secondary 6 University 8 Other 9 DK/NS	Which country did this person migrate to?	In which year did this person migrate?	What was the main reason for migrating at time of departure? 1 Family reunification 2 Employment 3 Study 4 Crime Rate 5 Medical 8 Other 9 DK/NS
1	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	<input type="text"/>		<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8
2	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	<input type="text"/>		<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8
3	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	<input type="text"/>		<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8
4	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	<input type="text"/>		<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8
5	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	<input type="text"/>		<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8
6	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	<input type="text"/>		<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 9 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 8

Remember to mark multiple choice boxes like this ☒

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Remember to mark multiple choice boxes like this ☒

SECTION 4: MORTALITY

To be answered by Head of Household or Responsible adult

40: Did any member of this household die during the past 12 months

☐ 1 Yes

☐ 2 No (SKIP TO SECTION 5)

☐ 9 DK/NS (SKIP TO SECTION 5)

41: How many persons?

42: Please tell me the sex and age of each household member who died from this household during the past 12 months?


	How old was..... when he /she died?	Sex of deceased	INTERVIEWER: For Females who died aged 14-49 years only Did the death occur during...? INTERVIEWER: READ OPTIONS BELOW
1	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	<input type="checkbox"/> 1 Pregnancy <input type="checkbox"/> 2 During child birth <input type="checkbox"/> 3 During six weeks after the end of pregnancy <input type="checkbox"/> 8 Other
2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	<input type="checkbox"/> 1 Pregnancy <input type="checkbox"/> 2 During child birth <input type="checkbox"/> 3 During six weeks after the end of pregnancy <input type="checkbox"/> 8 Other
3	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	<input type="checkbox"/> 1 Pregnancy <input type="checkbox"/> 2 During child birth <input type="checkbox"/> 3 During six weeks after the end of pregnancy <input type="checkbox"/> 8 Other
4	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	<input type="checkbox"/> 1 Pregnancy <input type="checkbox"/> 2 During child birth <input type="checkbox"/> 3 During six weeks after the end of pregnancy <input type="checkbox"/> 8 Other
5	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	<input type="checkbox"/> 1 Pregnancy <input type="checkbox"/> 2 During child birth <input type="checkbox"/> 3 During six weeks after the end of pregnancy <input type="checkbox"/> 8 Other
6	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	<input type="checkbox"/> 1 Pregnancy <input type="checkbox"/> 2 During child birth <input type="checkbox"/> 3 During six weeks after the end of pregnancy <input type="checkbox"/> 8 Other

Remember to mark multiple choice boxes like this ☒

End of Household Questionnaire. Go to Person Questionnaire.

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Appendix IXb: Census Questionnaire - Person


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IMPORTANT!!!
Transfer ED, Block and Household Numbers to the top of EACH individual questionnaire from Household Questionnaire

Mark multiple choice boxes like this ☒

<i>ED No</i>	<i>Block No</i>	<i>Household No</i>
<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>

INTERVIEWER:
Whenever a dotted line (...) appears in a question, call the name of the person to whom the information relates, if it is not the respondent himself/herself. Else say "You"/"Your". X the appropriate box. Please do not write over the responses:

SECTION 5: GENERAL CHARACTERISTICS	For All Persons
<p>43: Please fill in this person's name and assigned number. _____ <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div></p> <p>44: What is your/.....relationship to the head of the household?</p> <p><input type="checkbox"/> 1 Head</p> <p><input type="checkbox"/> 2 Spouse/Partner of Head</p> <p><input type="checkbox"/> 3 Child of Head and Spouse/Partner</p> <p><input type="checkbox"/> 4 Child of Head only</p> <p><input type="checkbox"/> 5 Child of Spouse/Partner only</p> <p><input type="checkbox"/> 6 Spouse/Partner of Child of Head</p> <p><input type="checkbox"/> 7 Grandchild of Head/Spouse/Partner</p> <p><input type="checkbox"/> 8 Parents of Head/Spouse/Partner</p> <p><input type="checkbox"/> 9 Other Relative of Head/Spouse/Partner</p> <p><input type="checkbox"/> 10 Non-Relative</p> <p><input type="checkbox"/> 99 Don't know/Not Stated</p> <p>45: What is your/.....'s sex?</p> <p><input type="checkbox"/> 1 Male</p> <p><input type="checkbox"/> 2 Female</p> <p><input type="checkbox"/> 9 Don't know/Not stated</p> <p>46: What is your/.....'s date of birth?</p> <p>Day Month Year</p> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <p><input type="checkbox"/> 9 Don't know/Not stated</p>	<p>47: What was your/.....'s age at his/her last birthday? <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div> <div style="display: inline-block; border: 1px solid black; width: 20px; height: 20px;"></div></p> <p>48: To which ethnic group do you/ does.....belong?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><input type="checkbox"/> 1 African/Black/Negro</p> <p><input type="checkbox"/> 2 Amerindian/Carib</p> <p><input type="checkbox"/> 3 Asian</p> <p><input type="checkbox"/> 4 Caucasian/White</p> <p><input type="checkbox"/> 5 Chinese</p> <p><input type="checkbox"/> 6 East Indian/Indian</p> <p><input type="checkbox"/> 7 Mixed (Black/White)</p> </div> <div style="width: 45%;"> <p><input type="checkbox"/> 8 Mixed (Other)</p> <p><input type="checkbox"/> 9 Portuguese</p> <p><input type="checkbox"/> 10 Hispanic</p> <p><input type="checkbox"/> 11 Syrian/Lebanese</p> <p><input type="checkbox"/> 88 Other ethnic group (specify) _____</p> <p><input type="checkbox"/> 99 Don't know/Not stated</p> </div> </div> <p>49: What is your/.....'s religious affiliation/denomination?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><input type="checkbox"/> 1 Adventist</p> <p><input type="checkbox"/> 2 Anglican</p> <p><input type="checkbox"/> 3 Baha'i</p> <p><input type="checkbox"/> 4 Baptist</p> <p><input type="checkbox"/> 5 Bretheren</p> <p><input type="checkbox"/> 6 Church of God</p> <p><input type="checkbox"/> 7 Evangelical</p> <p><input type="checkbox"/> 8 Hindu</p> <p><input type="checkbox"/> 9 Jehovah witness</p> <p><input type="checkbox"/> 10 Judaism</p> <p><input type="checkbox"/> 11 Methodist</p> <p><input type="checkbox"/> 12 Moravian</p> </div> <div style="width: 45%;"> <p><input type="checkbox"/> 13 Mormon</p> <p><input type="checkbox"/> 14 Muslim/Islam</p> <p><input type="checkbox"/> 15 Nazarene</p> <p><input type="checkbox"/> 16 None/No religion</p> <p><input type="checkbox"/> 17 Pentecostal</p> <p><input type="checkbox"/> 18 Presbyterian</p> <p><input type="checkbox"/> 19 Rastafarian</p> <p><input type="checkbox"/> 20 Roman Catholic</p> <p><input type="checkbox"/> 21 Salvation Army</p> <p><input type="checkbox"/> 22 Wesleyan Holiness</p> <p><input type="checkbox"/> 88 Other (Specify) _____</p> <p><input type="checkbox"/> 99 DK/NS</p> </div> </div>


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Remember to mark multiple choice boxes like this ☒

SECTION 6: DISABILITY AND HEALTH		For All Persons																																																																																					
<p>50. Do you/does..... have difficulty</p> <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"> INTERVIEWER: READ OPTIONS BELOW. MULTIPLE RESPONSES ALLOWED. </div> <p style="text-align: center;">Rate responses as follows:</p> <div style="display: flex; justify-content: space-around; font-size: small;"> 1 No - No Difficulty 3 Yes - Lots of Difficulty 9 DK/NS </div> <div style="display: flex; justify-content: space-around; font-size: small;"> 2 Yes - Some Difficulty 4 Cannot do (it) at all </div> <table style="width: 100%; font-size: x-small;"> <tr> <td>1. Seeing (even with glasses)?</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 9</td> </tr> <tr> <td>2. Hearing (even using hearing aid)?</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 9</td> </tr> <tr> <td>3. Walking, standing, or climbing stairs?</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 9</td> </tr> <tr> <td>4. Remembering or concentrating?</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 9</td> </tr> <tr> <td>5. Self care?</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 9</td> </tr> <tr> <td>6. Upper body function?</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 9</td> </tr> <tr> <td>7. Communicating because of a physical, mental or emotional health condition</td> <td><input type="checkbox"/> 1</td> <td><input type="checkbox"/> 2</td> <td><input type="checkbox"/> 3</td> <td><input type="checkbox"/> 4</td> <td><input type="checkbox"/> 9</td> </tr> </table> <p><i>If No Difficulty for all options, Skip to Q52.</i></p> <p>51: What is the origin of your/.....'s disability?</p> <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"> INTERVIEWER: READ OPTIONS SELECTED BY RESPONDENTS IN Q50. MULTIPLE RESPONSES ALLOWED. </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> 1. From Birth 2. Illness 3. Accident 4. Old age 8. Other (Specify) </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> 9. DK/NS </div> <table style="width: 100%; font-size: x-small;"> <tr> <td>1. Seeing, even with glasses?</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>2. Hearing, even using a hearing aid?</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>3. Walking or climbing stairs?</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>4. With upper body functions?</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>5. With self-care</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>6. Remembering or concentrating?</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>7. 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MULTIPLE RESPONSES ALLOWED. </div> <table style="width: 100%; font-size: x-small;"> <tr> <td><input type="checkbox"/> 1 AIDS</td> <td><input type="checkbox"/> 11 HIV</td> </tr> <tr> <td><input type="checkbox"/> 2 Allergies</td> <td><input type="checkbox"/> 12 Hypertension</td> </tr> <tr> <td><input type="checkbox"/> 3 Anemia</td> <td><input type="checkbox"/> 13 Kidney diseases</td> </tr> <tr> <td><input type="checkbox"/> 4 Arthritis</td> <td><input type="checkbox"/> 14 Lupus</td> </tr> <tr> <td><input type="checkbox"/> 5 Asthma</td> <td><input type="checkbox"/> 15 Mental illness</td> </tr> <tr> <td><input type="checkbox"/> 6 Cancer</td> <td><input type="checkbox"/> 16 Sickle cell</td> </tr> <tr> <td><input type="checkbox"/> 7 Carpal Tunnel Syndrome</td> <td><input type="checkbox"/> 17 Stroke</td> </tr> <tr> <td><input type="checkbox"/> 8 Diabetes</td> <td><input type="checkbox"/> 88 Other (Specify) _____</td> </tr> <tr> <td><input type="checkbox"/> 9 Glaucoma</td> <td><input type="checkbox"/> 99 DK/NS</td> </tr> <tr> <td><input type="checkbox"/> 10 Heart disease</td> <td></td> </tr> </table> <p>53: Are you/ is.....covered by insurance (health, life, national, other)?</p> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No (SKIP TO SECTION 7) </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <input type="checkbox"/> 9 DK/NS (SKIP TO SECTION 7) </div> <p>54: Which of the following insurance plan(s) do you/does.....have? (MULTIPLE RESPONSES ALLOWED)</p> <table style="width: 100%; font-size: x-small;"> <tr> <td><input type="checkbox"/> 1 Social Security</td> <td><input type="checkbox"/> 6 Endowment with Health</td> </tr> <tr> <td><input type="checkbox"/> 2 Life Only</td> <td><input type="checkbox"/> 7 Endowment</td> </tr> <tr> <td><input type="checkbox"/> 3 Life and Health</td> <td><input type="checkbox"/> 8 Other (Specify) _____</td> </tr> <tr> <td><input type="checkbox"/> 4 Group Health</td> <td><input type="checkbox"/> 9 DK/NS</td> </tr> <tr> <td><input type="checkbox"/> 5 Individual Health</td> <td></td> </tr> </table>	<input type="checkbox"/> 1 AIDS	<input type="checkbox"/> 11 HIV	<input type="checkbox"/> 2 Allergies	<input type="checkbox"/> 12 Hypertension	<input type="checkbox"/> 3 Anemia	<input type="checkbox"/> 13 Kidney diseases	<input type="checkbox"/> 4 Arthritis	<input type="checkbox"/> 14 Lupus	<input type="checkbox"/> 5 Asthma	<input type="checkbox"/> 15 Mental illness	<input type="checkbox"/> 6 Cancer	<input type="checkbox"/> 16 Sickle cell	<input type="checkbox"/> 7 Carpal Tunnel Syndrome	<input type="checkbox"/> 17 Stroke	<input type="checkbox"/> 8 Diabetes	<input type="checkbox"/> 88 Other (Specify) _____	<input type="checkbox"/> 9 Glaucoma	<input type="checkbox"/> 99 DK/NS	<input type="checkbox"/> 10 Heart disease		<input type="checkbox"/> 1 Social Security	<input type="checkbox"/> 6 Endowment with Health	<input type="checkbox"/> 2 Life Only	<input type="checkbox"/> 7 Endowment	<input type="checkbox"/> 3 Life and Health	<input type="checkbox"/> 8 Other (Specify) _____	<input type="checkbox"/> 4 Group Health	<input type="checkbox"/> 9 DK/NS	<input type="checkbox"/> 5 Individual Health	
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SECTION 7: INTERNET USE		For All Persons																																																																																					
<p>55: Have you /has.....used the internet within the past 3 months?</p> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No (SKIP TO SECTION 8) </div> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <input type="checkbox"/> 9 DK/NS (SKIP TO SECTION 8) </div> <p>56: Where did you/has....used the Internet within the past 3 months? (MULTIPLE RESPONSES ALLOWED)</p> <table style="width: 100%; font-size: x-small;"> <tr> <td><input type="checkbox"/> 1 Home</td> <td><input type="checkbox"/> 6 Other mobile access device</td> </tr> <tr> <td><input type="checkbox"/> 2 Work</td> <td><input type="checkbox"/> 7 Family/friends house (fixed line)</td> </tr> <tr> <td><input type="checkbox"/> 3 School</td> <td><input type="checkbox"/> 8 Other (specify) _____</td> </tr> <tr> <td><input type="checkbox"/> 4 Internet Cafe</td> <td><input type="checkbox"/> 9 DK/NS</td> </tr> <tr> <td><input type="checkbox"/> 5 Cellular phone</td> <td></td> </tr> </table>			<input type="checkbox"/> 1 Home	<input type="checkbox"/> 6 Other mobile access device	<input type="checkbox"/> 2 Work	<input type="checkbox"/> 7 Family/friends house (fixed line)	<input type="checkbox"/> 3 School	<input type="checkbox"/> 8 Other (specify) _____	<input type="checkbox"/> 4 Internet Cafe	<input type="checkbox"/> 9 DK/NS	<input type="checkbox"/> 5 Cellular phone																																																																												
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Remember to mark multiple choice boxes like this ☒

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Remember to mark multiple choice boxes like this ☒

SECTION 8: BIRTHPLACE AND RESIDENCE

For All Persons

57: Where do you/does... usually live?

☐ 1 At this address
Parish _____ Village _____

☐ 2 Elsewhere
Parish _____ Village _____

☐ 3 In another village
Parish _____ Village _____

☐ 4 Abroad
Name of country _____

INTERVIEWER: For persons born in Antigua & Barbuda what is required at Q58 is the mother's usual residence at the time of birth.

58: Where were you/was... born?

☐ 1 In this country (SKIP TO Q61)
Parish _____ Village _____

☐ 2 Abroad
Name of country _____

59: In what year did you /... first come to live in Antigua and Barbuda?

Year

60: What is the main reason for your present residence in Antigua and Barbuda?

1. Economic Activity under Free Movement

☐ 1.1 Skilled CARICOM national
☐ 1.2 Service Provider
☐ 1.3 Rights of Establishment/Commercial presence
☐ 1.4 Employee of non-wage earner
☐ 2 Other Economic Activity
☐ 3 Dependent
☐ 8 Other (Specify) _____

(Go to Q65)

Q61 TO Q64 ARE FOR LOCAL BORN ONLY

61: Have you/has... ever lived in another country?

☐ 1 Yes ☐ 2 No (SKIP TO Q65) ☐ 9 DK/NS (SKIP TO Q 65)

62: In which country did you/... last live?

Name of country _____

Q63 and Q64 are for local born who answered yes to Q61

63: In what year did you/... return to live in Antigua & Barbuda?

Year

64: What is the main reason for you/... to return to live in Antigua & Barbuda?

☐ 1 Regard it as home
☐ 2 Family is here
☐ 3 Involuntary return
☐ 4 To start a business
☐ 5 Employment/work

☐ 6 Education
☐ 7 Retired
☐ 8 Homesick
☐ 88 Other (Specify) _____

65: In what year did you/... last come to live in this Parish?

Year ☐ 1 Never moved (SKIP TO Q67)

66: In which Parish and Village did you/... last live?

Parish _____ Village _____

Q67 to Q71 are for 5 years old and over

67: Did you/... live at this address five years ago?

☐ 1 Yes (SKIP TO Q71) ☐ 2 No

68: In which country or parish and village did you/... live five years ago?


☐ 1 In another Parish and village
Parish _____ Village _____

☐ 2 Abroad
Name of country _____

Remember to mark multiple choice boxes like this ☒

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SECTION 8: BIRTHPLACE AND RESIDENCE <small>concluded</small>	SECTION 9: EDUCATION <small>For All Persons concluded</small>
<p>Q69 to Q73 are for 10 years and over</p> <p>69: Did you/... live at this address ten years ago? <input type="checkbox"/> 1 Yes (SKIP TO Q71) <input type="checkbox"/> 2 No</p> <p>70: In which country or parish and village did you/...live ten years ago? <input type="checkbox"/> 1 In another Parish and village Parish _____ Village _____</p> <p><input type="checkbox"/> 2 Abroad Name of country _____</p> <p>71: Which country or countries are you/... a citizen of ? (List up to two countries). 1. _____ 2. _____</p>	<p>75: What is the <u>HIGHEST</u> level of education that you have/...has attained? <input type="checkbox"/> 1 None/ No schooling <input type="checkbox"/> 10 Sixth Form (A'level) - Lower <input type="checkbox"/> 2 Day care/nursery <input type="checkbox"/> 11 Sixth Form (A'level) - Upper <input type="checkbox"/> 3 Pre-school <input type="checkbox"/> 12 Post Secondary <input type="checkbox"/> 4 Infant/Kindergarten <input type="checkbox"/> 13 Post Sec/Pre-University/College <input type="checkbox"/> 5 Primary/elementary (1-3) <input type="checkbox"/> 14 Post Primary-Vocational/Trade <input type="checkbox"/> 6 Primary/elementary (4-7) <input type="checkbox"/> 15 Special School/Education <input type="checkbox"/> 7 Junior Secondary <input type="checkbox"/> 16 University <input type="checkbox"/> 8 Secondary (Form 1-3) <input type="checkbox"/> 88 Other (Specify) _____ <input type="checkbox"/> 9 Secondary (Form 4-5) <input type="checkbox"/> 99 DK/NS</p> <p>76: What is the <u>HIGHEST</u> examination you have/...has ever passed? <input type="checkbox"/> 1 None <input type="checkbox"/> 9 Bachelor's Degree <input type="checkbox"/> 2 School leaving certificate <input type="checkbox"/> 10 Post Graduate Diploma <input type="checkbox"/> 3 High School Certificate <input type="checkbox"/> 11 Professional Certificate <input type="checkbox"/> 4 Cambridge School/CXC <input type="checkbox"/> 12 Masters Degree <input type="checkbox"/> 5 GCE O'levels/CXC General <input type="checkbox"/> 13 Doctoral Degree <input type="checkbox"/> 6 GCE A' levels 1234+ <input type="checkbox"/> 88 Other (Specify) _____ <input type="checkbox"/> 7 College Certificate/Diploma <input type="checkbox"/> 99 DK/NS <input type="checkbox"/> 8 Associate Degree</p>
<p>SECTION 9: EDUCATION For All Persons</p> <p>72: Are you/is.....currently in an educational institution <input type="checkbox"/> 1 Yes, fulltime <input type="checkbox"/> 2 Yes, part-time <input type="checkbox"/> 3 No. (SKIP TO Q75)</p> <p>73: What type of educational institution are you/is.....attending? <input type="checkbox"/> 1 Day care/nursery <input type="checkbox"/> 9 Sixth Form (A' level) <input type="checkbox"/> 2 Pre-school <input type="checkbox"/> 10 Post Secondary School <input type="checkbox"/> 3 Gov. Primary School <input type="checkbox"/> 11 Voc/Trade/(Post primary) <input type="checkbox"/> 4 Private Primary School <input type="checkbox"/> 12 Adult/Continue classes <input type="checkbox"/> 5 Gov. Assisted Primary <input type="checkbox"/> 13 University <input type="checkbox"/> 6 Special education <input type="checkbox"/> 88 Other (Specify) _____ <input type="checkbox"/> 7 Secondary <input type="checkbox"/> 99 DK/NS <input type="checkbox"/> 8 Community/State College</p> <p>74: Please give the name and address of the school or institution that you are/...is attending? Name _____ Address _____</p>	<p>SECTION 10: TRAINING For Persons 15 years and over</p> <p>77: Have you/has...ever received or attempted any <u>skills</u> training or are you/... currently receiving any <u>skills</u> training to equip you/... for employment, occupation/profession? <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No (SKIP TO SECTION 11) <input type="checkbox"/> 9 DK/NS (SKIP TO SECTION 11)</p> <p>78: Which category of training status applies to you/...? <input type="checkbox"/> 1 Completed training <input type="checkbox"/> 2 Undergoing training currently <input type="checkbox"/> 3 Attempted training but not completed <input type="checkbox"/> 9 DK/NS</p> <p>79: What is the field(s) for which the highest level of training was completed, attempted or is undergoing by you/...? _____</p>

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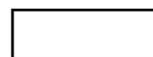
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SECTION 10: TRAINING For Persons 15 years and over concluded	SECTION 11: ECONOMIC ACTIVITY For Persons 15 years and over																										
<p>80: What was the MAIN method used by you/...to train in this field? (SINGLE RESPONSE)</p> <p><input type="checkbox"/> 1 On the job</p> <p><input type="checkbox"/> 2 Apprenticeship</p> <p><input type="checkbox"/> 3 Correspondence/distance learning/on-line</p> <p><input type="checkbox"/> 4 Secondary School</p> <p><input type="checkbox"/> 5 Vocational/Trade school/Technical Institution</p> <p><input type="checkbox"/> 6 Commercial/Secretarial School</p> <p><input type="checkbox"/> 7 Business/Computer School</p> <p><input type="checkbox"/> 8 University (on campus)</p> <p><input type="checkbox"/> 9 Private Study</p> <p><input type="checkbox"/> 88 Other (Specify) _____</p> <p><input type="checkbox"/> 99 DK/NS</p> <p>81: How long was the period of your/...s HIGHEST level of training? (SINGLE RESPONSE)</p> <p><input type="checkbox"/> 1 Under 3 months</p> <p><input type="checkbox"/> 2 3 months and less than 6 months</p> <p><input type="checkbox"/> 3 6 months and less than 1 year</p> <p><input type="checkbox"/> 4 1 year and less than 1.5 years</p> <p><input type="checkbox"/> 5 1.5 years and less than 2 years</p> <p><input type="checkbox"/> 6 2 years and less than 3 years</p> <p><input type="checkbox"/> 7 3 years and less than 4 years</p> <p><input type="checkbox"/> 8 4 years and over</p> <p><input type="checkbox"/> 9 DK/NS</p> <p>82: What type of qualification or certification did you/...receive on completion of the training at the HIGHEST level? (SINGLE RESPONSE)</p> <p><input type="checkbox"/> 1 None <input type="checkbox"/> 7 First Degree</p> <p><input type="checkbox"/> 2 Certificate with exam <input type="checkbox"/> 8 Post Grad. Degree</p> <p><input type="checkbox"/> 3 Certificate without exam <input type="checkbox"/> 9 Professional Qualification</p> <p><input type="checkbox"/> 4 Diploma <input type="checkbox"/> 88 Other (Specify)</p> <p><input type="checkbox"/> 5 Advanced Diploma <input type="checkbox"/> 99 DK/NS</p> <p><input type="checkbox"/> 6 Associate Degree</p> <p>83: Is your/... recent training related to your/...present job?</p> <p><input type="checkbox"/> 1 Yes</p> <p><input type="checkbox"/> 2 No</p> <p><input type="checkbox"/> 9 DK/NS</p>	<p>84: What did you/... do during the past 12 months? (SINGLE RESPONSE)</p> <p><input type="checkbox"/> 1 Had a job and worked (GO TO Q85)</p> <p><input type="checkbox"/> 2 Had a job, but did not work (SKIP TO Q87)</p> <p><input type="checkbox"/> 3 Seeking first job</p> <p><input type="checkbox"/> 4 Seeking a job which was not the first</p> <p><input type="checkbox"/> 5 Did not seek but wanted work and was available</p> <p><input type="checkbox"/> 6 Attended school/Student</p> <p><input type="checkbox"/> 7 Did home duties</p> <p><input type="checkbox"/> 8 Retired, did not work</p> <p><input type="checkbox"/> 9 Disabled, unable to work</p> <p><input type="checkbox"/> 88 Other (Specify) _____</p> <p><input type="checkbox"/> 99 DK/NS</p> <p>85: For how many months did you/..... work during the past 12 months? <i>Number of months</i></p> <table border="1"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table> <p>86: Did you/..... work for pay, profit or family gain, during the past week? This includes helping in a family business or farm, street vending or any work. Note: Exclude Domestic Work at home (SINGLE RESPONSE)</p> <p>IF YES, Did you?</p> <p><input type="checkbox"/> 1 Work (SKIP TO Q88)</p> <p><input type="checkbox"/> 2 Had a job but did not work (GO TO Q87)</p> <p>IF NO, What did you do during the past week?</p> <p><input type="checkbox"/> 3 Seeking first job</p> <p><input type="checkbox"/> 4 Seek job which was not first</p> <p><input type="checkbox"/> 5 Wanted work and available</p> <p><input type="checkbox"/> 6 Home Duties</p> <p><input type="checkbox"/> 7 Attended School</p> <p><input type="checkbox"/> 8 Retired - did not work</p> <p><input type="checkbox"/> 9 Disabled, unable to work</p> <p><input type="checkbox"/> 88 Other (Specify) _____</p> <p>87: Why were you/...temporarily absent from your/ his/her job?</p> <p><input type="checkbox"/> 1 On vacation leave <input type="checkbox"/> 6 Temporary lay off</p> <p><input type="checkbox"/> 2 Maternity/sick leave <input type="checkbox"/> 7 Currently in the off season</p> <p><input type="checkbox"/> 3 Personal responsibility <input type="checkbox"/> 8 Sent on unpaid leave</p> <p><input type="checkbox"/> 4 Study/training leave <input type="checkbox"/> 88 Other reason (Specify) _____</p> <p><input type="checkbox"/> 5 Strike/lock out</p>	0	1	2	3	4	5	6	7	8	9	10	11	12	<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"/>	<input type="checkbox"/>
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SECTION 11: ECONOMIC ACTIVITY	For Persons 15 years and over	continued
<p>88. What type of worker status applies to you /..... in your job?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> 1 Paid employee, / Government/Local and Central Gov. <input type="checkbox"/> 2 Paid employee, State Owned Company/Statutory Body <input type="checkbox"/> 3 Paid employee, Private Business <input type="checkbox"/> 4 Paid employee, Private Home <input type="checkbox"/> 5 Own business with paid employees <input type="checkbox"/> 6 Own business without paid employee <input type="checkbox"/> 7 Apprentice/Learner <input type="checkbox"/> 8 Contributing family worker <input type="checkbox"/> 9 Volunteer worker <input type="checkbox"/> 88 Other (Specify) _____ <input type="checkbox"/> 99 DK/NS </div> <div style="width: 50%; text-align: right;"> GO TO Q89 SKIP TO Q92 </div> </div> <p>89. What kind of accounts do you keep for this activity/business?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> 1 Complete set of written accounts <input type="checkbox"/> 2 Only through informal records of orders, sales, purchases <input type="checkbox"/> 3 Simplified written accounts <input type="checkbox"/> 4 No records are kept. </div> <div style="width: 50%;"></div> </div> <p>90. Are you registered with the Social Security Scheme as a self-employed person or an employer?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> 1 Employer <input type="checkbox"/> 2 Self-Employed <input type="checkbox"/> 3 Not Registered </div> <div style="width: 50%;"></div> </div> <p>91. Estimate how much did you/...earn from your business during the past month?</p> <div style="display: flex; align-items: center;"> \$ <div style="border: 1px solid black; width: 100px; height: 20px; position: relative;"> <div style="position: absolute; top: 0; left: 0; right: 0; bottom: 0; border-bottom: 1px solid black;"></div> </div> </div> <p>92. Describe the type of work you do/...does in your/his/her main job?</p> <p>Occupation: _____</p> <p>_____</p> <p>93. What is the main business activity carried out at your/his/her workplace?</p> <p>Industry _____</p> <p>94. How many hours did you/...work during the past week?</p> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 20px; position: relative;"> <div style="position: absolute; top: 0; left: 0; right: 0; bottom: 0; border-bottom: 1px solid black;"></div> </div> Hours <div style="margin-left: 20px;"> <input type="checkbox"/> 99 DK/NS </div> </div>	<p>95. Where is your/...place of work?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> 1 At a fixed place of work outside the home <input type="checkbox"/> 2 Work at home (SKIP TO SECTION 12) <input type="checkbox"/> 3 No fixed place of work (SKIP TO SECTION 12) <input type="checkbox"/> 9 DK/NS </div> <div style="width: 50%;"></div> </div> <p>96. What is the name and address of your/his/her workplace?</p> <p>Name _____</p> <p>Address _____</p> <p>97. Did you/... seek work during the past four weeks?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> 1 Yes (GO TO Q98) <input type="checkbox"/> 2 No (SKIP TO Q99) </div> <div style="width: 50%;"></div> </div> <p>98. What did you/... actually do to find work or establish your/his/her own business?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> 1 Did nothing/Undertook no (active) steps (GO TO Q99) <input type="checkbox"/> 2 Registered at a public employment exchange <input type="checkbox"/> 3 Registered at a private employment agency <input type="checkbox"/> 4 Checked at work-site, farms, factories <input type="checkbox"/> 5 Looked up and responded to advertisements <input type="checkbox"/> 6 Asked for assistance from friends, relatives <input type="checkbox"/> 7 Tried to establish my/(his/her) own business <input type="checkbox"/> 8 Tried to work on a family farm or business <input type="checkbox"/> 88 Other (Specify) _____ <input type="checkbox"/> 99 DK/NS </div> <div style="width: 50%; text-align: right;"> (SKIP TO Q100) </div> </div> <p>99. Why did you/... not seek work in the past four weeks? (SINGLE RESPONSE)</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> 1 Already found job/made arrangements to start own business <input type="checkbox"/> 2 Already found job/made arrangements to start own business <input type="checkbox"/> 3 Cannot find work, lack of business opportunities <input type="checkbox"/> 4 Lack of finance, raw materials to start own business <input type="checkbox"/> 5 Awaiting busy/high season <input type="checkbox"/> 6 Awaiting recall from previous job <input type="checkbox"/> 7 Thinks he/she lacks skills <input type="checkbox"/> 8 Discrimination <input type="checkbox"/> 9 Don't know where/how to seek <input type="checkbox"/> 10 Other (Specify) _____ <input type="checkbox"/> 11 Household duties <input type="checkbox"/> 12 Student <input type="checkbox"/> 13 Illness/Disability <input type="checkbox"/> 14 Family reason, pregnant, other personal reason </div> <div style="width: 50%;"></div> </div>	


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SECTION 11: ECONOMIC ACTIVITY For Persons 15 years and over concluded	SECTION 13: FERTILITY For women 15 years and over																						
<p>100: If you would have been offered an opportunity to work during the last <u>week</u> would you have been able to start?</p> <p> <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/> 2.1 In school, training <input type="checkbox"/> 2.2 Retirement/Old age <input type="checkbox"/> 2.3 Illness/Disability <input type="checkbox"/> 2.4 Family duties <input type="checkbox"/> 2.5 Other (Specify) _____ </p>	<p>105: How many live born children have you/has....ever had and how many are males and females?</p> <p>(IF ZERO, enter 00 & Go to Section 14)</p> <table style="width: 100%; text-align: center; margin: 10px 0;"> <tr> <td>Total</td> <td>M</td> <td>F</td> </tr> <tr> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> </tr> </table> <p>106: How many of your /...s live born children are still alive?</p> <table style="width: 100%; text-align: center; margin: 10px 0;"> <tr> <td>Total</td> <td>M</td> <td>F</td> </tr> <tr> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> </tr> </table> <p>107: How old were you/was...when you/she had your/her first live born child?</p> <p style="text-align: center;">Age <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></p> <p>108: How old were you/was... when you/she had your/her <u>last</u> live born child?</p> <p style="text-align: center;">Age <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></p> <p>109: What was the date of birth of the last child born alive to you?</p> <table style="width: 100%; text-align: center; margin: 10px 0;"> <tr> <td>Day</td> <td></td> <td>Month</td> <td></td> <td>Year</td> </tr> <tr> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td>/</td> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td>/</td> <td><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> </tr> </table>	Total	M	F	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	Total	M	F	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	Day		Month		Year	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	/	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	/	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>
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SECTION 12: MARITAL AND UNION STATUS For Persons 15 years and over																							
<p>101: What is your/...s legal marital status?</p> <p> <input type="checkbox"/> 1 Single/Never married <input type="checkbox"/> 2 Married <input type="checkbox"/> 3 Divorced <input type="checkbox"/> 4 Widowed <input type="checkbox"/> 5 Legally separated <input type="checkbox"/> 9 DK/NS </p> <p>102: What is your/...s present union status?</p> <p> <input type="checkbox"/> 1 Married and living with spouse <div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block;"></div> (SKIP TO Q104) <input type="checkbox"/> 2 Common law/de facto marriage <div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block;"></div> <input type="checkbox"/> 3 Visiting partner <div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block;"></div> <input type="checkbox"/> 4 Not in union presently <div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block;"></div> (GO TO Q103) <input type="checkbox"/> 9 DK/NS <div style="border: 1px solid black; width: 50px; height: 20px; display: inline-block;"></div> </p> <p>103: Have you ever been in a common-law union?</p> <p> <input type="checkbox"/> 1 Yes (SKIP TO SECTION 13) <input type="checkbox"/> 2 No (SKIP TO SECTION 13) <input type="checkbox"/> 9 DK/NS </p> <p>104: How old were/was you /he/she when you/he/she was first married or in a union for the first time?</p> <p style="text-align: center;">Age <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></p>																							

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SECTION 13: FERTILITY For women 15 years and over concluded	SECTION 14: INCOME AND LIVELIHOOD For Persons 15 Years and Over																					
<p>110: How many live births did you/...have in the past 12 months?</p> <p><input type="checkbox"/> 1 None (GO TO SECTION 14)</p> <p><input type="checkbox"/> 2 One birth with one baby</p> <p><input type="checkbox"/> 3 Two separate births</p> <p><input type="checkbox"/> 4 Twins</p> <p><input type="checkbox"/> 5 Three or more</p> <p><input type="checkbox"/> 9 DK/NS</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0; text-align: center;"> Q111 TO Q113 APPLY ONLY TO FEMALES UNDER 50. ALL OTHERS GO TO SECTION </div> <p>111: What is/are the sex(es) of this child/these children? (Born within the last 12 months)</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 50%;">Boys</td> <td style="text-align: center; width: 50%;">Girls</td> </tr> <tr> <td style="text-align: center;"> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 </td> <td style="text-align: center;"> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 </td> </tr> </table> <p>112: Have any of these children died?</p> <p><input type="checkbox"/> 1 Yes</p> <p><input type="checkbox"/> 2 No (GO TO SECTION 14)</p> <p><input type="checkbox"/> 9 DK/NS (GO TO SECTION 14)</p> <p>113: Of what sex and age, in months, was each child that died in the past 12 months?</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 30%;">How many months old was .../ when he/she died?</th> <th style="width: 65%;">Sex of deceased</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;"><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td style="text-align: center;"><input type="checkbox"/> 1 M <input type="checkbox"/> 2 F</td> </tr> <tr> <td style="text-align: center;">2</td> <td style="text-align: center;"><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td style="text-align: center;"><input type="checkbox"/> 1 M <input type="checkbox"/> 2 F</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: center;"><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td style="text-align: center;"><input type="checkbox"/> 1 M <input type="checkbox"/> 2 F</td> </tr> <tr> <td style="text-align: center;">4</td> <td style="text-align: center;"><div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div></td> <td style="text-align: center;"><input type="checkbox"/> 1 M <input type="checkbox"/> 2 F</td> </tr> </tbody> </table>	Boys	Girls	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		How many months old was .../ when he/she died?	Sex of deceased	1	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	2	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	3	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	4	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>	<input type="checkbox"/> 1 M <input type="checkbox"/> 2 F	<p>114: Do you /does ...normally receive your wage/salary from your main job at the end of every....? (PAID EMPLOYEES ONLY)</p> <p><input type="checkbox"/> 1 Day</p> <p><input type="checkbox"/> 2 Week</p> <p><input type="checkbox"/> 3 Fortnight</p> <p><input type="checkbox"/> 4 Month</p> <p><input type="checkbox"/> 8 Other Specify) _____</p> <p>115: In which category on this flashcard did your/... pay/income fall during the last pay period from your main job?</p> <p style="text-align: center;">Income Group <div style="display: inline-block; border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div></p> <p>116: What are your/... sources of livelihood? (Indicate as many sources as supply)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> 1 Disability benefits <input type="checkbox"/> 2 Employment <input type="checkbox"/> 3 Investment <input type="checkbox"/> 4 Other public assistance <input type="checkbox"/> 5 Pension (local) <input type="checkbox"/> 6 Pension (overseas) <input type="checkbox"/> 7 Remittances (overseas) <input type="checkbox"/> 8 Savings/Interest on savings </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> 9 Social security benefits <input type="checkbox"/> 10 Subsistence farming <input type="checkbox"/> 11 Support from friends/relatives (overseas - cash/kind) <input type="checkbox"/> 12 Support from friends/relatives (local cash/kind) <input type="checkbox"/> 13 Unemployment benefit <input type="checkbox"/> 88 Other (Specify) _____ <input type="checkbox"/> 99 DK/NS </td> </tr> </table> <p>117: Approximately how much money did you/... receive last year from family and or friends abroad?</p> <p style="text-align: center;">\$ <div style="display: inline-block; border: 1px solid black; width: 60px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin: 0 5px;"></div></p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px; text-align: center;"> SECTION 15: WHERE SPENT CENSUS NIGHT </div> <p>118: Where did you/.....spend census night?</p> <p><input type="checkbox"/> 1 At this address</p> <p><input type="checkbox"/> 2 Elsewhere in this country</p> <p><input type="checkbox"/> 3 Abroad (END INTERVIEW)</p> <p>119: What part of the country was that? Please specify.</p> <p>_____</p>	<input type="checkbox"/> 1 Disability benefits <input type="checkbox"/> 2 Employment <input type="checkbox"/> 3 Investment <input type="checkbox"/> 4 Other public assistance <input type="checkbox"/> 5 Pension (local) <input type="checkbox"/> 6 Pension (overseas) <input type="checkbox"/> 7 Remittances (overseas) <input type="checkbox"/> 8 Savings/Interest on savings	<input type="checkbox"/> 9 Social security benefits <input type="checkbox"/> 10 Subsistence farming <input type="checkbox"/> 11 Support from friends/relatives (overseas - cash/kind) <input type="checkbox"/> 12 Support from friends/relatives (local cash/kind) <input type="checkbox"/> 13 Unemployment benefit <input type="checkbox"/> 88 Other (Specify) _____ <input type="checkbox"/> 99 DK/NS
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Remember to mark multiple choice boxes like this ☒

