
**TABLE OF CONTENTS**

**Section A Recodes:**
- Age, formal and informal marital status (AGER, FMARITAL, RMARITAL) ........................................ 5
- Number of years of schooling and highest degree received (EDUCAT, HIEDUC) ......................... 6
- Race and Hispanic origin (HISPANIC, RACE, HISPRACE, HISPRACE2) ........................................... 8
- Number of children and other family members in household (NUMKDHH, NUMFMHH, HHFAMTYP, HIPARTYP, NCHILDHH, HKIDTYP, CSPBBHH, CSPBSHH, CSPOKDHH) ........ 10
- Intact status of childhood living arrangement, living arrangement at 14 (INTCTFAM, PARAGE14) ........................................................................................................................ 15
- Mother’s education and age at first birth (EDUCMOM, AGEMOMB1) ............................................. 17

**Section B Recodes:**
- Whether currently pregnant (RCURPREG) ..................................................................................... 19
- Total number of pregnancies and number of pregnancies by type of outcome (PREGNUM, COMPREG, LOSSNUM, ABORTION, LBREGS) .......................................................... 19
- Number of live births and number of births in last 5 years (PARITY, BIRTHS5) ............................ 23
- Pregnancy recodes (from pregnancy file; arrays here for user convenience)
  - Outcome, end date, and age at outcome (OUTCOMnn, DATENDnn, AGEPRGnn) .................. 24
  - Conception date and age at conception (DATCONnn, AGECONnn) ...................................... 25
  - Formal & informal marital status at outcome and at conception (MAROUTnn, RMAROUTnn, MARCONnn, RMARCONnn) ............................................................. 25
  - Living arrangements of 1st liveborn child from delivery (LIVCHILDnn) ............................ 27
  - Number of children born out of wedlock and in cohabiting unions (CEBOW, CEBOWC) ...... 28
  - First live birth (date and R’s age) (DATBABY1, AGEBABY1) ................................................... 29

**Section C Recodes:**
- Number of formal marriages (FMARNO) ...................................................................................... 30
- Number of biological children R has had with current spouse or cohabiting partner
  (CSPBIOKD) ................................................................................................................................. 30
- Marriage start and end dates, and mode of dissolution (MARDATnn, MARDISnn, MARENDnn) ................................................................................................................................. 31
- First marriage
  - Age at 1st marriage and age at dissolution of 1st marriage (FMAR1AGE, AGEDISS1) ......... 32
  - Age at end of 1st marriage (due to divorce or death) (AGEDD1) ............................................. 33
  - Months between 1st marriage and dissolution of 1st marriage (MAR1DISS) ...................... 33
  - Months between end of 1st marriage (due to divorce or death) and remarriage (DD1REMAR) ......................................................................................................................... 34
  - Months between 1st marriage and 1st birth and 1st conception (MAR1BIR1, MAR1CON1) ........................................................................................................................ 35
  - Months between 1st conception and 1st marriage (CON1MAR1) .......................................... 36
  - Whether 1st birth was premarital (B1PREMAR) ...................................................................... 37
Whether ever cohabited outside of marriage and whether ever married or cohabited (COHEVER, EVMARCOH) ................................................................. 37

Cohabitation
- Numbers of cohabiting partners (PMARRNO, NONMARR, TIMESCOH) ........................................ 38
- Date of 1st cohabitation (COHAB1) .................................................................................................. 39
- Timing of 1st cohabitation relative to 1st marriage (COHSTAT) .................................................... 40
- Outcome and duration of 1st cohabitation (COHOUT, COH1DUR) ............................................... 40

Ever had sexual intercourse and ever had sexual intercourse after menarche (HADSEX, SEXEVER) ................................................................. 42

Age and date of 1st sexual intercourse (ever and after menarche) (VRY1STAG, SEX1AGE, VRY1STSX, DATESEX1) ........................................ 43

Whether had sex only once (SEXONCE) ...................................................................................... 46

Age of 1st partner (FSEXPAGE) .................................................................................................... 46

Number of months between first and last/most recent sexual intercourse with first partner ever (FPDUR) ............................................................................. 48

Months between 1st sex (ever and after menarche) and 1st marriage (SEXMAR, SEX1FOR) ...... 48

Months between first intercourse (even if before first menstrual period) and first coresidential union (or interview) (SEXUNION) ........................................ 50

Outcome of first sexual intercourse (SEXOUT) ............................................................................. 51

Relationship at first sexual intercourse with (most recent / second-to-last / third-to-last) sexual partner in the past 12 months (RELATP1-RELATP3) ............................................................................ 52

Number of months between first and most recent sexual intercourse with (most recent / second-to-last / third-to-last) sexual partner in the past 12 months (PARTDUR1-PARTDUR3) .......................................................................................................................... 53

Date of and age at most recent sexual intercourse (LSEXDATE, LSEXRAGE) .............................. 54

Number of sexual partners (in last 12 months, in lifetime) (PARTS1YR, LIFPRTNR) ....................... 55

Number of partners in last 3 months (NUMP3MOS) ...................................................................... 56

Had sexual intercourse in last 3 months (last sex date) (SEX3MO) ................................................. 58

Sections D & E Recodes:

Type of sterilization operation in effect at time of interview (STRLOPER) ...................................... 59

Fecundity and infertility status (FECUND, INFERT) ....................................................................... 61

Ever used any method (ANYMTHD) ............................................................................................. 68

Number of months of non-intercourse in last 12 months (NOSEX12) ........................................... 68

Whether sexual intercourse in last 3 months (non-intercourse series) (SEXP3MO) ............................ 69

Current contraceptive status (CONSTAT1–CONSTAT4) ............................................................... 69

Ever used a pill (PILLR) ............................................................................................................... 74

Ever used a condom (CONDOMR) .................................................................................................. 75

Method use at 1st sex (SEX1MTHD1–SEX1MTHD4) ...................................................................... 76

Whether method used at last sex in last 12 months, specific method in last 12 months (MTHUSE12, METH12M1–METH12M4) ......................................................... 78

Whether method used at last sex in last 3 months, specific method in last 3 months (MTHUSE3, METH3M1–METH3M4) ................................................................. 80

First method ever used and date used 1st method (FMETHOD1–FMETHOD4, DATEUSE1) .......... 82

Wantedness of each pregnancy (from pregnancy file; arrays here for user convenience)

Wantedness of pregnancy of respondent & respondent’s partner (cycle 4 version) (OLDWPnn, OLDWRnn) ............................................................................. 85
Wantedness of pregnancy of respondent & respondent’s partner (cycle 6 version)
(WANTRPnn, WANTPnn) ...................................................................................................................... 85
Wantedness of pregnancy of respondent, same as WANTRPnn but with detail in “too
soon./mistimed”)
(NEWWANTRPnn).............................................................................................................................. 86
Number of wanted pregnancies in the last 5 years (WANTP5) .................................................... 87

Section F Recodes:
Type of clinic used for services received in last 12 months (FPTIT12, FPTITMED) ............ 88
Source of services received in last 12 months (FPTITSTE, FPTITBC, FPTITCHK, FPTITCBC,
FPTITCST, FPTITEC, FPTITCEC, FPTITPRE, FPTITABO, FPTITPAP, FPTITPEL, FPTITPRN,
FPTITPPR, FPTITSTD).............................................................................................................................. 89
Whether clinic used in last 12 months is regular place for medical care (FPREGFP,
FPREGMED).......................................................................................................................................... 108

Section G Recodes:
Intention for additional births (INTENT) ...................................................................................... 110
Central number of additional births expected (ADDEXP) .......................................................... 111

Section H Recodes:
Any medical help to become pregnant and any medical help to prevent miscarriage
(ANYPRGHP, ANYMSCHP) .................................................................................................................. 113
Ever used infertility services (INFEVER) .......................................................................................... 114
Whether received specific infertility services: ........................................................................... 114
drugs to improve ovulation (OVULATE), surgery to correct blocked tubes (TUBES),
infertility testing (R or H/P) (INFERTR, INFERTH), advice (ADVICE), artificial
insemination (INSEM), in vitro fertilization (INVITRO), surgery/treatment for
endometriosis (ENDOMET), surgery for uterine fibroids (FIBROIDS)
Ever been treated for PID (PIDTREAT) .................................................................................. 119
Ever been tested for HIV (EVHIVTST) ...................................................................................... 119
Source of HIV test in the last 12 months (FPTITHIV) ................................................................. 120

Section I Recodes:
Current health insurance coverage (CURR_INS) ........................................................................ 122
Current metropolitan residence (METRO) .................................................................................. 123
Current religious affiliation (RELIGION) .................................................................................. 123
Current labor force status (LABORFOR) .................................................................................. 124

Section J Recodes (Audio-CASI):
Poverty level of household income (POVERTY) ........................................................................ 127
Total household income (TOTINCR) ......................................................................................... 128
Whether received public assistance in last year (PUBASSIS) .................................................. 128

The CAPI Reference Questionnaire (CRQ) contains the full specifications for the computer-
assisted survey instrument, including all CRQ flow checks (routing statements) referenced below.

For selected recodes on the female respondent file, some form of collapsing, topcoding, or
bottomcoding values was required to minimize the risk of disclosure and include the variables on
the public use files. For these particular recodes, the original, “inhouse” variables (beginning with the prefix “IN”) are listed in the specifications below. To access these restricted-use variables (also listed in Appendix 7), users must apply to the NCHS Research Data Center. Please see “Protections to Minimize Risk of Disclosure for Individual-Level Data” in Part 1 of the User’s Guide and “VARIABLES MODIFIED OR SUPPRESSED FOR PUBLIC USE” in Appendix 7c of the User’s Guide for further details.

** A double asterisk after the recode name indicates there was a comparable recode of the same name in the 2011-2013 NSFG. Please also see User’s Guide Appendix 4, presenting “cross-walk” spreadsheets of the NSFG recode.
Section A: Demographic Characteristics; Household Roster; Childhood Background

AGER**: “R’s age at interview”

AGER = age_r

Values of Blaise-computed variable age_r are used to determine values of AGER:

If there was a valid response in date of birth (AA-2 BIRTHDAY), then
age_r = INT[(date of interview (in m/d/y) - m/d/y date of birth (AA-2 BIRTHDAY))/365.25]
else
age_r = age in years (AA-1 AGE_A)

User Note: Respondents aged 45 at interview were 44 at time of household screener.

Code categories:
15-45 = age in years

FMARITAL**: “Formal (legal) marital status”

Note: This recode defines formal (legal) marital status based only on opposite-sex couples.

FMARITAL = fmarit

Values of Blaise-computed variable fmarit are used to determine values of FMARITAL:

fmarit = 1 (married) If R is married (AB-1 MARSTAT = 1)
fmarit = 2 (widowed) If R is widowed (AB-1 MARSTAT = 3 or AB-2 FMARSTAT=3)
fmarit = 3 (divorced) If R is divorced (AB-1 MARSTAT = 4 or AB-2 FMARSTAT=4)
fmarit = 4 (separated) If R is separated (AB-1 MARSTAT = 5 or AB-2 FMARSTAT=5)
fmarit = 5 (never married) If R is never married (AB-1 MARSTAT = 6 or AB-2 FMARSTAT=6)
fmarit=0 (missing) If R is missing or DK/RF on either AB-1 MARSTAT or AB-2 FMARSTAT

Imputation note: Imputed if fmarit=0 (response to AB-1 MARSTAT was DK/RF or is missing or AB-2 FMARSTAT was DK/RF). In instrument, cases with fmarit=0 were routed as “never married” – thus if FMARIT=0, FMARITAL is logically imputed to =5.

Code categories:
1 = Married to a person of the opposite sex
2 = Widowed
3 = Divorced or annulled
4 = Separated
5 = Never married
RMARITAL**: “Informal marital status”

Note: This recode defines informal marital status based only on opposite-sex couples.

RMARITAL = 1 if R is married to a person of the opposite sex (AB-1 MARSTAT = 1).

Else
RMARITAL = 2 if R reports living with a partner of the opposite sex (AB-1 MARSTAT = 2).

Else
RMARITAL = 3 if R is widowed (AB-1 MARSTAT = 3).

Else
RMARITAL = 4 if R is divorced (AB-1 MARSTAT = 4).

Else
RMARITAL = 5 if R is separated (AB-1 MARSTAT = 5).

Else
RMARITAL = 6 if R has never been married (AB-1 MARSTAT = 6).

Imputation Note: In instrument cases with AB-1 MARSTAT = DK/RF/missing were routed as never married thus RMARITAL is imputed to = 6 (never married).

Code categories:
1 = Currently married to a person of the opposite sex
2 = Not married but living with a partner of the opposite sex
3 = Widowed
4 = Divorced or annulled
5 = Separated (for reasons of marital discord)
6 = Never been married

EDUCAT**: “Education (number of years of schooling)”

-- If R completed the highest grade she attended (AF-4 COMPGRD = 1), then her education is the highest grade she attended (EDUCAT = AF-3 HIGRADE).

-- If R did not complete (or has not yet completed) the highest grade she attended (AF-4 COMPGRD = 5), her education is the grade below the highest grade she attended (EDUCAT = AF-3 HIGRADE minus 1).

-- If R had no formal schooling (AF-3 HIGRADE = 0), then she completed no years of formal schooling (EDUCAT = 0).

-- If R reported the highest grade she attended (AF-3 HIGRADE = 1-19), but did not report whether or not she had completed that grade (AF-4 COMPGRD = DK, RF, missing), then her education is the highest grade she attended (EDUCAT = AF-3 HIGRADE).

Note: The original EDUCAT recode, as defined above, was bottom-coded for public use at 9 to
represents “9th grade or less.” The full-detail variable called INEDUCAT is available through the NCHS Research Data Center.

**Imputation Note:** Imputed if AF-3 HIGRADE is DK/RF/missing.

**Code categories:**
- 9 = 9th grade or less
- 10-12 = 10th – 12th grade
- 13-18 = 1-6 years of college/grad school
- 19 = 7 or more years of college and/or grad school

**HIEDUC**: “Highest completed year of school or highest degree received”

-- If R has no degrees ((AF-6 DIPGED=5, or BLANK) and (AF-10 HAVEDEG=5 or BLANK)), then HIEDUC=1-8, or 10. Assign based on completed years of schooling (recode EDUCAT) value corresponding to the appropriate HIEDUC category.

-- If R has no college or university degrees (AF-10 HAVEDEG=5 or BLANK), and if R has a high school diploma and/or GED (AF-6 DIPGED=1 or 2 or 3), and if completed years of school is 12 or fewer (EDUCAT<=12), then HIEDUC=9

-- If R has no college or university degrees (AF-10 HAVEDEG=5 or BLANK), and if R has a high school diploma and/or GED (AF-6 DIPGED=1 or 2 or 3), and if completed years of school is more than 12 (EDUCAT>12), then HIEDUC=10

-- Else, if R has an associate’s degree (AF-11 DEGREES=1), then HIEDUC=11
  - if R has a bachelor’s degree (AF-11 DEGREES=2), then HIEDUC=12
  - if R has a master’s degree (AF-11 DEGREES=3), then HIEDUC=13
  - if R has a doctorate degree (AF-11 DEGREES=4), then HIEDUC=14
  - if R has a professional degree (AF-11 DEGREES=5) then HIEDUC=15

**Note:** The original HIEDUC recode, as defined above, was bottom-coded for public use at 5 to represent “9th grade or less.” The full-detail variable called INHIEDUC is available through the NCHS Research Data Center.

**Imputation Note:** This recode is computed using imputed values for EDUCAT, but some cases require imputation – those with AF-11 DEGREES= DK/RF/missing or AF-6 DIPGED= DK/RF/missing.

**Code categories for HIEDUC (public-use variable):**
- 5 = 9th grade or less
- 6 = 10th grade
- 7 = 11th grade
- 8 = 12th grade, no diploma (nor GED)
- 9 = High school graduate (high school diploma or GED)
- 10 = Some college but no degree
- 11 = Associate degree in college/university
12 = Bachelor’s degree
13 = Master’s degree
14 = Doctorate degree
15 = Professional degree

Code categories for INHIEDUC (restricted-use variable):
1 = no formal schooling
2 = 1st-4th grade
3 = 5th-6th grade
4 = 7th-8th grade
5 = 9th grade
6 = 10th grade
7 = 11th grade
8 = 12th grade, no diploma (nor GED)
9 = High school graduate (high school diploma or GED)
10 = Some college but no degree
11 = Associate degree in college/university
12 = Bachelor’s degree
13 = Master’s degree
14 = Doctorate degree
15 = Professional degree

HISPANIC**: “Hispanic origin”

IF AC-1 HISP =1 then HISPANIC=1.
ELSE IF HISP=5 THEN HISPANIC=2.

Imputation Note: Needed if HISP = DK or RF.

Code categories:
1 = Hispanic
2 = Non-Hispanic

RACE**: “Race of respondent”

If R reported only one race (AC-3 RRACE_01 = 1 to 14 ) and reported that:
-- she is black (AC-3 RRACE_01= 2), then RACE=1.
-- she is white (AC-3 RRACE_01= 1), then RACE=2.
-- she is some other race (AC-3 RRACE_01 = 3 to 14), then RACE=3.

If R reported more than one race (more than one nonmissing value on AC-3 RRACE_01 through RRACE_14), and reported that the race that best describes her is:
-- black (AC-4 RACEBEST_=2), then RACE=1.
-- white (AC-4 RACEBEST_=1), then RACE=2.
-- some other race (AC-4 RACEBEST_=3 to 14), then RACE=3.
If R did not report her race (AC-3 RRACE_01 = RF/DK), or she reported more than one race but did not choose which race best describes her (AC-4 RACEBEST_=RF/DK), then RACE= race by interviewer observation (AC-5 OBSERVE) coded as follows:

-- Interviewer chose black (AC-5 OBSERVE=1), then RACE=1.
-- Interviewer chose white (AC-5 OBSERVE=2), then RACE=2.
-- Interviewer chose other (AC-5 OBSERVE=7), then RACE=3.

**Imputation Note:** Needed if AC-5 OBSERVE = DK or RF. For a small number of cases information from the screener interview was used to impute a value on RACE. Consult Part 2 of the User’s Guide for further information related to this recode.

Code categories:
1 = Black
2 = White
3 = Other

**HISPRACE**: “Race and Hispanic origin – based on 1977 OMB guidelines”

If recode HISPANIC=1 then HISPRACE=1. Else, if recode RACE=1 then HISPRACE=3. Else, if RACE=2 then HISPRACE=2. Else, if RACE=3 then HISPRACE=4.

**Imputation Note:** Computed based on imputed values of source recodes. For a small number of cases information from the screener interview was used to impute a value on HISPRACE. Consult Part 2 of the User’s Guide for further information related to this recode.

Code categories:
1 = Hispanic (regardless of race reporting)
2 = Non-Hispanic White
3 = Non-Hispanic Black
4 = Non-Hispanic Other

**HISPRACE2**: “Race and Hispanic origin – based on 1997 OMB guidelines”

Define intermediate variable NUMRACE (included on public use data file) for multiple race reporting:

NUMRACE=1 if AC-4 RACEBEST_ =blank (not asked because R reported only 1 race)
NUMRACE=2 if RACEBEST_ NE blank (more than 1 race reported)

If NUMRACE=1 or HISPRACE=1 (Hispanic) then HISPRACE2=HISPRACE. Else if NUMRACE=2 then HISPRACE2=4.
**Imputation Note:** Computed based on imputed values of source recodes. For a small number of cases information from the screener interview was used to impute a value on HISPRACE2. Consult Part 2 of the User’s Guide for further information related to this recode.

Code categories:
- 1 = Hispanic (regardless of race reporting)
- 2 = Non-Hispanic White, Single Race
- 3 = Non-Hispanic Black, Single Race
- 4 = Non-Hispanic Other or Multiple Race

**NUMKDH**: “Number of biological/adoptive/related/legal children under age 18 in household”

NUMKDH is initialized to 0. For each member of the household, NUMKDH is increased by one each time a household member’s relationship to R is biological child, adopted child, step child, partner’s child, grandchild, niece/nephew, legal ward, or foster child (AD-5 RELAR[x]=3 or 4 or 5 or 6 or 7 or 8 or 9 or 10) and age is less than 18 (AD-4 Age[x]<18) and it is the household member’s usual residence (AD-2 USUALRES[x] = 1).

Note: This is comparable to recode of the same name on the data file for males, which is intended to define the universe of children in the household for whom he may play a fathering role, and about whom “parenting activities” questions are asked. This differs from the Cycle 5 recode NUMKDH which captured only biological and adopted children in the household.

Note: The original NUMKDH recode, as defined above, was top-coded for public use at 5 to represent “5 children or more.” The full-detail variable called INNUMKDH is available through the NCHS Research Data Center.

**Imputation Note:** No imputation needed because NUMKDH is initialized to 0.

Code categories:
- 0-4 = number of children
- 5 = 5 children or more

**NUMFMH**: “Number of family members in household”

NUMFMH is initialized to 0. For each member of the household, NUMFMH is increased by one each time a household member’s relationship to R is husband/wife, male/female partner, biological child, step-child, adopted child, grandchild, niece/nephew, biological parent, step-parent, adoptive parent, grandparent, aunt/uncle, brother/sister, other relative, (AD-5 RELAR[x] = 1, 2, 3, 4, 5, 9, 10, 11, 12, 13, 17, 18, 19, 20) and it is the household member’s usual residence (AD-2 USUALRES[x] = 1).
Note: The original NUMFMHH recode, as defined above, was top-coded for public use at 7 to represent “7 family members or more.” The full-detail variable called INNUMFMHH is available through the NCHS Research Data Center.

Imputation Note: No imputation needed because NUMFMHH is initialized to 0.

Code categories:
- 0-6 = number of family members
- 7 = 7 or more family members

HHFAMTYP**: “Type of household/family structure”

This variable provides a summary measure of household/family structure at the time of interview.

If there is no spouse in the household (no AD-5 RELAR[x] = 1) and there is no partner in the household (no AD-5 RELAR[x] = 2) and no household members are “child under age 19” (child includes biological child, stepchild, adopted child, legal ward, foster child, or partner’s child) (no AD-5 RELAR[x] = 3 through 8, with AD-4 AGE[x] less than 19) Then HHFAMTYP=1

else, if
There is a spouse or partner in the household (AD-5 RELAR[x]=1 or 2) but no children under age 19 in the household, (no AD-5 RELAR[x] = 3 through 8, with AD-4 AGE[x] less than 19), then HHFAMTYP=2

else, if
There is a spouse in the household (AD-5 RELAR[x]=1) and one or more children under age 19 in the household, (any AD-5 RELAR[x] = 3 through 8, with AD-4 AGE[x] less than 19), then HHFAMTYP=3

else, if
There is a partner in the household (AD-5 RELAR[x]=2) and one or more children under age 19 in the household, (any AD-5 RELAR[x] = 3 through 8, with AD-4 AGE[x] less than 19), then HHFAMTYP=4

else, HHFAMTYP=5

Imputation Note: No imputation needed because HHFAMTYP defaults to 5.

Code categories:
- 1=No spouse/partner and no child(ren) (of R) 18 or younger
- 2=Spouse/partner, but no child(ren) (of R) 18 or younger
- 3=Spouse and R’s child(ren) 18 or younger
- 4=Cohabiting partner and R’s child(ren) 18 or younger
- 5=No spouse/partner, but child(ren) of R, 18 or younger
HHPARTYP: “Type of parental situation in household”

This variable provides a summary measure of the respondent’s parental living situation at the time of interview.

- if there are two biological parents in the household (AD-5 RELAR[x]=11 for 2 household members) or two adoptive parents in the household (AD-5 RELAR[x]=13 for 2 household members),
then HHPARTYP=1

- else if there is a biological parent in the household, along with a step or adoptive parent (any AD-5 RELAR[x]=11, and any AD-5 RELAR[x]=12 or 13),
then HHPARTYP=2

- else if there is only one biological, adoptive, or stepparent in the household, HHPARTYP=3

- else, HHPARTYP=4

*Imputation note: No imputation needed because HHPARTYP defaults to 4.*

Code categories:
1=Both biological or both adoptive parents
2=Biological and step- or adoptive parent
3=Single parent (biological, adoptive, or stepparent)
4=Other

NCHILDHH**: “Number of respondent’s children (18 or younger) living in household”

This variable provides a counter of all persons in the household 18 or younger who can be considered the respondent’s child. This includes biological child, stepchild, adopted child, legal ward, foster child, or partner’s child.

NCHILDHH is initialized to 0.
For each member of the household who is respondent’s child under age 19, NCHILDHH is incremented by one. (for each time AD-5 RELAR[x] = 3 through 8, with AD-4 AGE[x] less than 19, NCHILDHH=NCHILDHH+1).

If NCHILDHH is greater than or equal to 3, NCHILDHH=3.

*Imputation Note: No imputation needed because NCHILDHH is initialized to 0.*

Code categories:
0-2 = number of respondent’s children 18 or younger in the household
3 = 3 or more of respondent’s children 18 or younger in the household

**HHKIDTYP**: “Whether R has children (18 or younger), and whether bio/non-bio, living in household”

This variable provides a summary description of persons 18 or younger living in the household, based on their relationship to the respondent and their age.

If
There are no biological children age 18 or under in the household (no AD-1 RELAR[x]=3, with AD-4 AGE[x]<19) and there are no non-biological children age 18 or under in the household (no AD-1 RELAR[x]=4 through 8, with AD-4 AGE[x]<19)
(note: there could be biological or non-biological children 19 or older in the household)
Then HHKIDTYP=0

Else, if
There are no non-biological children of any age in the household (no AD-1 RELAR[x]=4 through 8), then if there are any biological children age 18 or under in the household (any AD-1 RELAR[x]=3, with AD-4 AGE[x]<19)
Then HHKIDTYP=1

Else, if
There are any non-biological children age 18 or under in the household (any AD-1 RELAR[x]=4 through 8, with AD-4 AGE[x]<19)
Then HHKIDTYP=2

**Imputation note**: No imputation needed because HHKIDTYP defaults to 0.

Code categories:
0 = no child(ren) 18 or younger in HH or only older child(ren)
1 = at least one biological child (of R’s) under 18 in HH, no nonbiological child(ren)
2 = any non-biological child (of R’s) 18 or younger in HH

**CSPBBHH**: “Number of R’s biological children (aged 18 or younger) with current husband or cohabiting partner who live in the household”

CSPBBHH is blank (inapplicable) if R is not currently married or cohabiting with a male partner (AB-1 MARSTAT NE 1 or 2).

This variable indicates the number of the married or cohabiting female respondent’s biological children who are also the biological children of her current husband or cohabiting partner, are 18 or younger, and who live in the household.

For each member of the household 18 years of age or younger (AD-4 AGE[x] <= 18), CSPBBHH is increased by one each time a household member’s relationship to the R is biological child (AD-5 RELAR[x] = 3 and her husband or partner is the biological father of this child (AD-9 RELMAN
Note:  The original CSPBBHH recode, as defined above, was top-coded for public use at 3 to represent “3 or more joint biological children.” The full-detail variable called INCSPBBHH is available through the NCHS Research Data Center.

Imputation Note:  No imputation needed because CSPBBHH is initialized to 0 for applicable respondents.

Code categories:
Blank  = inapplicable
0-2 = number of joint biological children 18 or younger in household
3    = 3 or more joint biological children 18 or younger in household

CSPBSHH**:  “Number of female R’s biological children (aged 18 or younger) in household who are not the biological children of her current husband or cohabiting partner”

CSPBSHH is blank (inapplicable) if R is not currently married or cohabiting with a male partner (AB-1 MARSTAT NE 1 or 2).

This variable indicates the number of the married or cohabiting female respondent’s biological children who are related to, but not the biological children of, her current husband or cohabiting partner.

For each member of the household 18 years of age or younger (AD-4 AGE[x] <= 18), CSPBSHH is increased by one each time a household member’s relationship to the R is biological child (AD-5 RELAR[x] = 3 and her husband or partner is related to, but NOT the biological father, foster father, or legal guardian of this household member (AD-9 RELMAN = 2, 3, or 4).

Note:  The original CSPBSHH recode, as defined above, was top-coded for public use at 1 to represent “1 child or more.” The full-detail variable called INCSPBSHH is available through the NCHS Research Data Center.

Imputation Note:  No imputation needed because CSPBSHH is initialized to 0 for applicable respondents.

Code categories:
Blank  = inapplicable
0        = No children under 19 in household
1    = 1 or more children under 19 in household

CSPOKDHH**:  “Number of all other children (aged 18 or younger) in household living with R and her current husband or cohabiting partner”

CSPOKDHH is blank (inapplicable) if R is not currently married or cohabiting with a male...
This variable indicates the number of children in the married or cohabiting female’s household who are:

1) her biological children and the relationship of the child to her current husband or cohabiting partner is unknown or not related, OR
2) her step, adopted, partner’s, or foster child, or legal ward.

For each member of the household 18 years of age or younger (AD-4 AGE[x] <= 18), CSPOKDHH is increased by one each time a household member’s relationship to the R is:

1) her biological child (AD-5 RELAR[x] = 3) and the relationship of the current husband or partner to the child is missing or not related (legally or by blood (AD-9 RELMAN = . (system-missing), 5, or 6) OR
2) her step, adopted, partner’s, or foster child, or legal ward, (AD-5 RELAR[x] = 4, 5, 6, 7, or 8) regardless of the relationship of her current husband or partner to the child.

Note: The original CSPOKDHH recode, as defined above, was top-coded for public use at 1 to represent “1 child or more.” The full-detail variable called INCSPOKDHH is available through the NCHS Research Data Center.

Imputation Note: No imputation needed because CSPOKDHH is initialized to 0 for applicable respondents.

Code categories:
Blank = inapplicable
0 = No children under 19 in household
1 = 1 or more children under 19 in household

INTCTFAM**: “Intact status of childhood family”

INTCTFAM=intact18

Values of Blaise-computed variable intact18 are used to determine values of INTCTFAM:

intact18 = 1 (yes) if R always lived with both biological/adoptive parents from birth until age 18 or until interview or until lived on own (for Rs under 18 who have lived on own) (AG-1 INTACT=1)

intact18 = 2 (no) -- if R did not always live with both biological/adoptive parents from birth until time specified above (AG-1 INTACT=5) or
-- if R is less than 18 (AGE_R<18) and doesn’t currently live with both biological/adoptive parents (computed variable wthparnw=2) and has never lived away from parents/guardians (computed variable onown18 NE 1).

Imputation note: Imputation only needed when intact18 is missing.
Code categories:
1 = two biological or adoptive parents from birth
2 = anything other than 2 biological or adoptive parents from birth

PARAGE14**: “Parental living situation at age 14”

PARAGE14=1 If R always lived with both biological or adoptive-parents from birth until age 18/interview/living on own (computed variable intact18=1).

OR

If R lived with both biological or two adoptive parents at age 14 (AG-3 LVSIT14F=2 and AG-4 LVSIT14M=2) or (AG-3 LVSIT14F=4 AND AG-4 LVSIT14M=4)

Else
PARAGE14=2 If R lived with biological mother and step-father at age 14 (AG-3 LVSIT14F=2 and AG-4 LVSIT14M=3).

Else
PARAGE14=3 If R lived in any other parental situation at age 14, including: one biological parent and no other parent(s)/parent-figures; or no parent(s)/parent-figures.

Note: This recode PARAGE14 is based on original, full-detail versions inputs INLVSIT14F and INLVSIT14M. The PUF versions of these inputs had categories combined for reduction of disclosure risk. The full-detail variables, INLVSIT14F and INLVSIT14M, are available through the NCHS Research Center. The full-detail recode called INPARAGE14 is also available through the NCHS Research Center.

Imputation note: Imputed when intact18 ne 1 and LVSIT14F and/or LVSIT14M are missing.

Code categories for PARAGE14 categories (public-use variable):
1 = R lived with both biological or adoptive parents at age 14
2 = R lived with biological mother and step-father at age 14
3 = R lived in any other parental situation or a non-parental situation at age 14

Code categories for INPARAGE14 categories (restricted-use variable):
1=R lived with both biological or adoptive parents at age 14
2=R lived with one biological parent and one adoptive parent at age 14
3=R lived with one biological and one step-parent at age 14
4=R lived with one biological parent and no other parent/parent-figure at age 14
5=R lived with other parent(s)/parent-figure(s) or in non-parental situation at age 14
EDUCMOM**: “Mother’s (or mother-figure’s) education”

EDUCMOM = Highest level of education completed by mother or mother-figure (AG-6 MOMDEGRE).

EDUCMOM=95 If R was asked who she thought of as the woman who mostly raised her when she was a teenager, and identified no one, (AG-5 WOMRASDU = 9, 98,99), (no mother-figure identified or refused or don’t know response to AF-5 WOMRASDU).

Note: MOMDEGRE is based on a question asking about the education of the mother/mother-figure whose identity is defined in the following way: For respondents who grew up in intact family (biological/adoptive mother and father) (AG-1 INTACT), that is who is being asked about. For all other respondents, the identity is established with the question (AG-5 WOMRASDU)

“Who, if anyone, do you think of as the woman who mostly raised you when you were growing up?”

Respondents eligible for that question were allowed to respond “no such person,” coded 95 on EDUCMOM.

Note: The original EDUCMOM recode, as defined above, was collapsed into 4 categories for public use so that 3 represents “Some college, including 2 year degrees” and 4 represents “Bachelor’s degree or higher.” The full-detail variable called INEDUCMOM is available through the NCHS Research Data Center.

Imputation note: Imputation only needed when MOMDEGRE is missing for respondents who have a mother or mother figure.

Code categories for EDUCMOM (public-use variable):
1 = Less than high school
2 = High school graduate or GED
3 = Some college, including 2-year degrees
4 = Bachelor’s degree or higher
95 = No mother/mother-figure identified

Code categories for INEDUCMOM (restricted-use variable):
1 = Less than high school
2 = High school graduate or GED
3 = Some college but no degree
4 = 2-year college degree (e.g., Associates degree)
5 = 4-year college graduate (e.g., BA, BS)
6 = graduate or professional school
95 = No mother/mother-figure identified

AGEMOMB1**: “Age of mother (or mother-figure) at first birth”

If R reported a valid age for her mother at first birth (1 LE AG-9 MOMFSTCH LE 5), then
AGEMOMB1 = AG-9 MOMFSTCH.

Else if R doesn’t know or refused to answer mother’s age at first live birth (AG-9 MOMFSTCH=DK/RF) then do:

If she estimates she was under 18 (AG-10 MOM18=1) then AGEMOMB1=91.
Else if she estimates she was aged 18-19 (AG-10 MOM18=2) then AGEMOMB1=92.
Else if she estimates she was aged 20-24 (AG-10 MOM18=3) then AGEMOMB1=93.
Else if she estimates she was aged 25 or older (AG-10 MOM18=4) then AGEMOMB1=94.

Else if R did not identify a mother or mother-figure (AG-5 WOMRASDU =9,98,99) then AGEMOMB1=95.

Else if R’s mother-figure had no children (AG-9 MOMFSTCH=96), AGEMOMB1=96.

Note: AGEMOMB1 is based on a question asking about the age at first birth of the mother/mother-figure whose identity is defined in the following way: For respondents who grew up in intact family (biological/adoptive mother and father) (AG-1 INTACT), that is who is being asked about. For all other respondents, the identity is established with the question (AG-5 WOMRASDU) 

“Who, if anyone, do you think of as the woman who mostly raised you when you were growing up?”

AGEMOMB1 is coded 96 if R’s mother or mother-figure had no biological children (e.g., she only had adopted children).

Note: The original AGEMOMB1 recode, as defined above, was collapsed for public use into 5 categories. The full-detail variable called INAGEMOMB1 is available through the NCHS Research Data Center.

Imputation note: Imputation only needed when MOMFSTCH is missing and MOM18 is missing for applicable for respondents.

Code categories for AGEMOMB1 (public-use variable):
1 = Less than 18 years
2 = 18-19 years
3 = 20-24 years
4 = 25-29 years
5 = 30 or older
95 = No mother or mother-figure
96 = Mother-figure had no children

Code categories for INAGEMOMB1 (restricted-use variable):
xx-nn = Age in years at 1st biological child’s birth
95 = No mother or mother-figure
96 = Mother-figure had no children
**Section B: Pregnancy and Birth History**

**RCURPREG**: “Whether R is currently pregnant”

RCURPREG = currpreg

Values of Blaise-computed variable currpreg (defined in Flow Check B-4) are used to determine values of RCURPREG:
- currpreg = 1 (yes) if R reports that she is currently pregnant (BA-2 PREGNOWQ = 1) or that she thinks she is probably pregnant (BA-3 MAYBPREG = 1)
- Else currpreg = 5 (no) in all other cases (including those where both PREGNOWQ and MAYBPREG = DK/RF)

SAS logic:
- If currpreg = 1 then RCURPREG = 1;
- Else if currpreg = 5 then RCURPREG = 2;
- /* if currpreg is not missing, then assign RCURPREG = currpreg */
- If PREGNOWQ in(8,9) and MAYBPREG in(.,8,9) then RCURPREG = 2;
- /* flag as logical imputation */

*Imputation Note:* All cases with PREGNOWQ = DK/RF and MAYBPREG = DK/RF are logically imputed to “no,” to mirror how they are routed in the instrument.

Code categories:
- 1 = Yes (currently pregnant)
- 2 = No (not currently pregnant)

**PREGNUM**: “CAPI-based total number of pregnancies”

If R has not yet begun her menstrual periods (BA-1 MENARCHE = 96), set PREGNUM = 0, and flag as logical imputation.

Otherwise, PREGNUM is based on non-missing values of the Blaise-computed variable NPREGS_S (defined in Flow Check B-40d), which accounts for any corrections that took place in the verification screens at the end of the pregnancy history.

SAS Logic:
- If MENARCHE = 96 then do;
  - PREGNUM = 0;
  - PREGNUM_I = 2;
  - End;
- Else if 0 LE NPREGS_S LT 96 then PREGNUM = NPREGS_S;
- Else if NPREGS_S in(.,98,99) then impute PREGNUM;
**COMPREG**: “CAPI-based number of completed pregnancies”

If R is currently pregnant (recode RCURPREG = 1), the number of completed pregnancies is one less than the total number of pregnancies coded in recode PREGNUM. Otherwise, COMPREG EQ PREGNUM.

**SAS Logic:**

If RCURPREG = 1 then COMPREG = (PREGNUM - 1);
Else if RCURPREG = 2 then COMPREG = PREGNUM;

**Imputation Note:** Computed based on imputed values of source recodes.

**LOSSNUM**: “CAPI-based number of completed pregnancies ending in spontaneous pregnancy loss”

LOSSNUM is blank (inapplicable) if R has no completed pregnancies (recode COMPREG=0).

Otherwise, LOSSNUM indicates the total number of pregnancies R has had that ended in miscarriage, ectopic pregnancy, or stillbirth.

Each such pregnancy is counted regardless of any other outcomes reported for the pregnancy. For example, if a pregnancy ended in live birth and stillbirth, it is counted towards both LBPREGS and LOSSNUM recodes. As a result, COMPREG (the number of completed pregnancies may not equal the sum of LOSSNUM, ABORTION, and LBPREGS values. The raw variable indicating pregnancy outcome is BC-1 PREGEND, and for each pregnancy, up to 6 outcomes are recorded. (No case in 2013-2015 NSFG reported more than 2 outcomes.) There is also a Blaise-computed variable `outcom_s` that indicates whether pregnancy ended in live birth (code 1), ended in non-live birth (code 2), or is a current pregnancy (code 3). The `outcom_s` variable reflects the pregnancy outcome after all corrections have been made in the pregnancy summary screens; only one main outcome is coded. If no corrections were needed to outcome or pregnancy order, then `outcom_s` is equivalent to the originally computed variable `prgoutcome`.

**SAS Logic:**

if first.caseid and (outcom_s in(1,2) or OUTCOME in(1,2,3,4,5)) then LOSSNUM=0;
/* initialized to 0 only if 1st pregnancy is a completed pregnancy */
if PREGEND1 in(1,2,4) or PREGEND2 in(1,2,4) or OUTCOME in(3,4,5) then
  LOSSNUM+1;
retain LOSSNUM;
if last.caseid then output LOSSNUM;

Note: This is a respondent file recode, but it is constructed based on the pregnancy-file data.

Imputation Note: If outcom_s = system-missing, for any of a respondent’s pregnancies, this recode must be imputed. Imputed values of LOSSNUM are based on imputed values of the pregnancy file recode OUTCOME, in conjunction with any valid PREGEND1-2 values from pregnancy records where OUTCOME was not imputed.

Code categories:
  Blank = inapplicable
  00-nn = number of spontaneous losses

ABORTION**: “CAPI-based number of completed pregnancies ending in induced abortion”

ABORTION is blank (inapplicable) if R has no completed pregnancies (recode COMPREG=0).

Otherwise, ABORTION indicates the total number of pregnancies R has had that ended in induced abortion (as reported in Section B, not in Section J, Audio CASI).

Each such pregnancy is counted regardless of any other outcomes reported for the pregnancy. For example, if a pregnancy ended in live birth and stillbirth, it is counted towards both LBPREGS and LOSSNUM recodes. As a result, COMPREG (the number of completed pregnancies may not equal the sum of LOSSNUM, ABORTION, and LBPREGS values. The raw variable indicating pregnancy outcome is BC-1 PREGEND, and for each pregnancy, up to 6 outcomes are recorded. (No case in 2013-2015 NSFG reported more than 2 outcomes.) There is also a Blaise-computed variable outcom_s that indicates whether pregnancy ended in live birth (code 1), ended in non-live birth (code 2), or is a current pregnancy (code 3). The outcom_s variable reflects the pregnancy outcome after all corrections have been made in the pregnancy summary screens; only one main outcome is coded. If no corrections were needed to outcome or pregnancy order, then outcom_s is equivalent to the originally computed variable prgoutcome.

SAS Logic:
(based on pregnancy-file data sorted by case ID number and chronologically)

if first.caseid and outcom_s in(1,2) or OUTCOME in(1,2,3,4,5)) then ABORTION=0;
/* initialized to 0 only if 1st pregnancy is a completed pregnancy */
if PREGEND1=3 or PREGEND2=3 or OUTCOME=2 then ABORTION+1;
retain ABORTION;
if last.caseid then output ABORTION;

Note: This is a respondent file recode, but it is constructed based on the pregnancy-file data.
Imputation Note: If outcom_s = system-missing, for any of a respondent’s pregnancies, this recode must be imputed. Imputed values of ABORTION are based on imputed values of the pregnancy file recode OUTCOME, in conjunction with any valid PREGEND1-2 values from pregnancy records where OUTCOME was not imputed.

Code categories:
  Blank = inapplicable
  00-nn = number of abortions

LBPREGS**: “CAPI-based number of completed pregnancies ending in live birth”

LBPREGS is blank (inapplicable) if R has no completed pregnancies (recode COMPREG=0).

Otherwise, LBPREGS indicates the total number of pregnancies R has had that ended in live birth, either by vaginal or Caesarean delivery. If the woman has never had a multiple birth, then LBPREGS is equivalent to the PARITY recode.

Each such pregnancy is counted regardless of any other outcomes reported for the pregnancy. For example, if a pregnancy ended in live birth and stillbirth, it is counted towards both LBPREGS and LOSSNUM recodes. As a result, COMPREG (the number of completed pregnancies may not equal the sum of LOSSNUM, ABORTION, and LBPREGS values.

Unlike the definitions of LOSSNUM and ABORTION, the LBPREGS recode can be defined solely on the basis of the recode OUTCOME that indicates how the pregnancy ended, with live birth taking precedence over all other outcomes. The OUTCOME recode is based on a Blaise-computed variable called outcom_s, which reflects the pregnancy outcome after all corrections have been made in the pregnancy summary screens. If no corrections were needed to outcome or pregnancy order, then outcom_s is equivalent to the originally computed variable prgoutcome.

SAS Logic:
(based on pregnancy-file data sorted by case ID number and chronologically)

if first.caseid and OUTCOME NE 6 then LBPREGS=0;
  /* initialized to 0 only if 1st pregnancy is a completed pregnancy */
if OUTCOME=1 then LBPREGS+1;
retain LBPREGS;
if last.caseid then output LBPREGS;

Note: This is a respondent file recode, but it is constructed based on the pregnancy-file data.

Imputation Note: If OUTCOME is flagged for imputation for any of a respondent’s pregnancies, the LBPREGS recode must be imputed, with a lower bound based on any validly reported values of OUTCOME for the respondent’s other pregnancies.
Code categories:
    Blank = inapplicable
    00-nn = number of pregnancies ending in live birth

**PARITY**: “CAPI-based total number of live births (accounting for multiple births)”

Values of Blaise-computed variable `numbabes` are used to determine values of PARITY. It is then updated based on information from the verification screens at the end of the pregnancy history.

```
numbabes (number of babies born alive) =
a “counter” variable in the instrument that is initialized to zero, and incremented based on
the number of babies born alive (BC-2 NBRNALIV) from each pregnancy that resulted in
a live birth.
```

SAS Logic:
```
If numbabes NE . then PARITY=numbabes;
Else if numbabes = . then PARITY=0; /* missing values assigned to 0 */
If nbabes_s NE PARITY and nbabes_s < 97 then PARITY=nbabes_s;
```

Code categories:
    00-nn = number of live births

**BIRTHS5**: “Number of pregnancies ending in live birth in the last 5 years”

BIRTHS5 is blank (inapplicable) if R has had no completed pregnancies (recode COMPREG=0). Otherwise, BIRTHS5 indicates the total number of pregnancies ending in live birth that R has had within the 60 months before interview.

```
Blaise-computed variable cmintvw indicates “century month” date of interview.
Recode OUTCOME = 1 for any pregnancy that results in live birth
Recode DATEND indicates century-month date when the pregnancy ended
```

SAS Logic:
```
(based on pregnancy-file data sorted by case ID number and chronologically)

if first.caseid and OUTCOME NE 6 then BIRTHS5=0;
    /* initialized to 0 only if 1st pregnancy is a completed pregnancy */
if OUTCOME=1 and ((cmintvw-60)) <= DATEND) then BIRTHS5+1;
retain BIRTHS5;
if last.caseid then output BIRTHS5;
```

*Note: This is a respondent file recode, but it is constructed based on the pregnancy-file data.*
Imputation note: Based on imputed values of DATEND and OUTCOME.

Code categories:
  Blank  = Inapplicable
  0-n    = Number of pregnancies ending in live birth in last 5 years

OUTCOMMnn**: “Outcome of Nth pregnancy”

OUTCOMMnn is blank (inapplicable) if R has been pregnant less than N times (recode PREGNUM LT N).

Else, OUTCOMMnn is transferred from pregnancy file recode OUTCOME for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
  Blank  = Inapplicable
  1      = Live birth
  2      = Induced abortion
  3      = Stillbirth
  4      = Miscarriage
  5      = Ectopic pregnancy
  6      = Current pregnancy

DATENDnn**: “CM date Nth pregnancy ended”

DATENDnn is blank (inapplicable) if:
-- R has been pregnant less than N times (recode PREGNUM LT N), or
-- R is currently pregnant with her Nth pregnancy (recode PREGNUM EQ N and recode RCURPREG EQ YES)

Otherwise, if R has had N or more completed pregnancies (recode COMPREG GE N), then DATENDnn is transferred from pregnancy file recode DATEND for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
  Blank  = inapplicable
  xxxx-nnnn = date (century month) Nth pregnancy ended

AGEPRGnn**: “Age at Nth pregnancy outcome”

AGEPRGnn is blank (inapplicable) if:
-- R has been pregnant less than N times (recode PREGNUM LT N), or
-- R is currently pregnant with her Nth pregnancy (recode PREGNUM EQ N and recode
Otherwise, if R has had N or more completed pregnancies (recode COMPREG GE N), then AGEPRGnn is transferred from pregnancy file recode AGEPREG for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
Blank = inapplicable
xxxx-4499 = age at Nth pregnancy outcome

**DATCONnn**: “CM date of Nth conception”

DATCONnn is blank (inapplicable) if R has been pregnant less than N times (recode PREGNUM LT N).

Otherwise, if R has had an Nth pregnancy (recode PREGNUM GE N), then DATCONnn is transferred from pregnancy file recode DATECON for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
Blank = inapplicable
xxxx-nnnn = date (century month) of Nth conception

**AGECONnn**: “Age at Nth conception”

AGECONnn is blank (inapplicable) if R has been pregnant less than N times (recode PREGNUM LT N).

Otherwise, if R has had an Nth pregnancy (recode PREGNUM GE 1), then AGECONnn is transferred from pregnancy file recode AGECON for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
Blank = inapplicable
xxxx-4499 = age at first conception

**MAROUTnn**: “Formal marital status at Nth pregnancy outcome”

MAROUTnn is blank (inapplicable) if:
-- R has been pregnant less than N times (recode PREGNUM LT N), or
-- R is currently pregnant with her Nth pregnancy (recode PREGNUM EQ N and recode RCURPREG EQ YES)

Otherwise,
If R has had N or more completed pregnancies (recode COMPREG GE N), then MAROUTnn is transferred from pregnancy file recode FMAROUT5 for R’s Nth pregnancy, and no further imputation is needed.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>1</td>
<td>Married</td>
</tr>
<tr>
<td>2</td>
<td>Divorced</td>
</tr>
<tr>
<td>3</td>
<td>Widowed</td>
</tr>
<tr>
<td>4</td>
<td>Separated</td>
</tr>
<tr>
<td>5</td>
<td>Never married</td>
</tr>
</tbody>
</table>

RMAROUTnn**: “Informal marital status at Nth pregnancy outcome”

RMAROUTnn is blank (inapplicable) if:
-- R has been pregnant less than N times (recode PREGNUM LT N), or
-- R is currently pregnant with her Nth pregnancy (recode PREGNUM EQ N and recode RCURPREG EQ YES)

Otherwise,
If R has had N or more completed pregnancies (recode COMPREG GE N), then RMAROUTnn is transferred from pregnancy file recode RMAROUT6 for R’s Nth pregnancy, and no further imputation is needed.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>1</td>
<td>Married</td>
</tr>
<tr>
<td>2</td>
<td>Divorced</td>
</tr>
<tr>
<td>3</td>
<td>Widowed</td>
</tr>
<tr>
<td>4</td>
<td>Separated</td>
</tr>
<tr>
<td>5</td>
<td>Cohabiting</td>
</tr>
<tr>
<td>6</td>
<td>Never married, not cohabiting</td>
</tr>
</tbody>
</table>

MARCONnn**: “Formal marital status at Nth pregnancy conception”

MARCONnn is blank (inapplicable) if R has been pregnant less than N times (recode PREGNUM LT N).

Otherwise,
If R has had an Nth pregnancy (recode PREGNUM GE N), then MARCONnn is transferred from pregnancy file recode FMARCON5 for R’s Nth pregnancy, and no further imputation is needed.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>1</td>
<td>Married</td>
</tr>
<tr>
<td>2</td>
<td>Divorced</td>
</tr>
<tr>
<td>3</td>
<td>Widowed</td>
</tr>
</tbody>
</table>
RMARCONnn: “Informal marital status at Nth pregnancy outcome”

RMARCONnn is blank (inapplicable) if:
-- R has been pregnant less than N times (recode PREGNUM LT N)

Otherwise,
If R has had N or more pregnancies (recode PREGNUM GE N), then RMARCONnn is transferred from pregnancy file recode RMARCON6 for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
Blank = Inapplicable
1 = Married
2 = Divorced
3 = Widowed
4 = Separated
5 = Cohabiting
6 = Never married, not cohabiting

LIVCHILDnn: “Current living arrangements of first liveborn child from Nth pregnancy”

LIVCHILDnn is blank (inapplicable) if:
-- R has been pregnant less than N times (recode PREGNUM LT N), or
-- R is currently pregnant with her Nth pregnancy (recode PREGNUM EQ N and recode RCURPREG EQ YES), or
-- Nth pregnancy did not result in live birth (recode OUTCOMnn NE 1)

Otherwise,
if R has had N or more completed pregnancies (recode COMPREG GE N), then LIVCHILDnn is transferred from pregnancy file recode LIVCHILD for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
Blank = inapplicable
1 = Child lives with R
2 = Child is dead
3 = Child lives with adoptive parents/family
4 = Child lives with biological father
5 = Child lives with other relatives
6 = Child’s living arrangements are other or unknown
CEBOW**: “Number of children born out of wedlock”

CEBOW is blank (inapplicable) if R has never had a live birth (recode PARITY=0).

Otherwise, CEBOW indicates the total number of children R has had out of wedlock, based on values of:
- pregnancy file recodes FMAROUT5 and OUTCOME
- pregnancy file Blaise-computed variable nbrnlv_s indicating number of babies born alive from the pregnancy

Note:  
CEBOW is only incremented by values >1 if nbrnlv_s > 1, that is, if it was a multiple birth.

Births occurring when R was legally separated (pregnancy file recode FMAROUT5=4) are counted as marital births.

SAS Logic:
(based on pregnancy-file data sorted by case ID number and chronologically)

if first.caseid and OUTCOME NE 6 then CEBOW=0;  
/* initialized to 0 only if 1st pregnancy is a completed pregnancy */
if FMAROUT5 in(2,3,5) and OUTCOME=1 then do;
  if 1 LE nbrnlv_s LT 97  then CEBOW + nbrnlv_s;
end;
retain CEBOW;
if last.caseid then output CEBOW;

Note:  This is a respondent file recode, but it is constructed based on the pregnancy-file data.

Code categories:
- Blank = inapplicable
- 00-nn = number of children born out of wedlock

CEBOWC**: “Number of children born in cohabiting unions”

CEBOWC is blank (inapplicable) if R has never had a live birth (recode PARITY=0).

Otherwise, CEBOWC indicates the total number of children R has had during cohabiting unions, based on values of:
- pregnancy file recodes RMAROUT6 and OUTCOME
- pregnancy file Blaise-computed variable nbrnlv_s indicating number of babies born alive from the pregnancy

Note:  
CEBOWC is only incremented by values >1 if nbrnlv_s > 1 (multiple birth).

SAS Logic:
(based on pregnancy-file data sorted by case ID number and chronologically)
if first.caseid and OUTCOME NE 6 then CEBOWC=0;
   /* initialized to 0 only if 1st pregnancy is a completed pregnancy */
if RMAROUT6=5 and OUTCOME=1 then do;
   if 1 LE nbrnlv_s LT 97 then CEBOWC + nbrnlv_s;
   end;
retain CEBOWC;
if last.caseid then output CEBOWC;

Note:  This is a respondent file recode, but it is constructed based on the pregnancy-file data.

Code categories:
   Blank  = inapplicable
   00-nn   = number of children born in cohabiting unions

DATBABY1**:  “CM date of first live birth”

DATBABY1 is blank (inapplicable) if R has never had a live birth (recode PARITY=0).

Otherwise, DATBABY1 is equal to the pregnancy file recode DATEND for R’s first pregnancy that ended in a live birth (where recode OUTCOME first equals 1).

Imputation Note:  Computed based on imputed values of source recodes.

Code categories:
   Blank  = inapplicable
   xxxx-nnnn = date (century month) of first live birth

AGEBABY1**:  “Age at first live birth”

AGEBABY1 is blank (inapplicable) if R has never had a live birth (recode PARITY=0).

Otherwise, AGEBABY1 is computed based on recode DATBABY1 and Blaise-computed variable cmbirth, which is the century-month when R was born.

   AGEBABY1 = INT((( DATBABY1 – cmbirth)/12)*100)

Imputation Note:  Computed based on imputed values of source recodes.

Code categories:
   Blank  = inapplicable
   xxxx-4499 = age at first live birth
Section C: Marriage and Relationship History

**FMARNO**: “Number of formal (legal) marriages”

*Note:* The FMARNO recode for males is defined based on male Section A.

FMARNO = 0 if R has never been married (recode FMARITAL = 5).

Else, if R has ever been married (FMARITAL NE 5) then FMARNO is transferred from CA-1 TIMESMAR.

*Imputation Note:* Cases with CA-1 TIMESMAR = DK/RF are logically imputed to 1 to match how such cases were routed through 1 marriage loop.

**CSPBIOKD**: “Number of biological children R has had with her current spouse or cohabiting partner”

CSPBIOKD is blank (inapplicable):
- if R is not currently married or cohabiting with a male partner (recode RMARITAL NE 1 or 2), or

This variable indicates the number of biological children the married or cohabiting female respondent has ever had with her current husband or partner, regardless of these children’s current ages or living arrangements.

If R is currently cohabiting (RMARITAL=2) then CSPBIOKD is based on CC-19 BIOCP and CC-20 BIONUMCP:

If RMARITAL=2 then do;
    If BIOCP in(5,8,9) or HASBABES=5 then CSPBIOKD=0;
    Else if BIOCP=1 and (1 <= BIONUMCP <= 25) then CSPBIOKD=BIONUMCP;
    Else if BIOCP=1 then impute CSPBIOKD;
End;

If R is currently married (RMARITAL=1) then CSPBIOKD is based on CB-18b BIOHUSBxx and CB-18c BIONUMHxx from the latest loop of the marriage history, which describes R’s current husband (i.e., where xx=TIMESMAR and TIMESMAR NE DK/RF). If R is currently married to her 1st husband and her 1st pregnancy ended after her marriage date, then CSPBIOKD is based on PARITY.

If RMARITAL=1 then do;
    if hasbabes=1 and TIMESMAR=1 and (cmfstprg > cmmarrch) and biohusbx=. 

Page 30
NSFG_2013-2015_UG_App3a_FemRespRecodeSpecs
then CSPBIOKD=PARITY;
else if BIOHUSBxx in(5,8,9) or HASBABES=5 then CSPBIOKD=0;
Else if BIOHUSBxx=1 and (1 <= BIONUMHxx <= 25) then
  CSPBIOKD=BIONUMHxx;
Else if BIOHUSBxx=1 then impute CSPBIOKD;
End;

Code categories:
  Blank   = inapplicable
  0-nn    = number of biological children R has had with her current husband or cohabiting
           partner

MARDATnn**:  “Date of Nth marriage”

MARDATnn is blank (inapplicable) if R has been married fewer than N times (recode FMARNO
LT N).

Otherwise,
MARDATnn is transferred from Blaise-computed variable cmmarrhx corresponding to R’s Nth
husband.

Code categories:
  Blank   = inapplicable
  xxxx-nnnn = date (century month) of Nth marriage

MARDISnn**:  “Date of dissolution of Nth marriage”

MARDISnn is blank (inapplicable) if:
--  R has been married fewer than N times (recode FMARNO LT N); or.
--  R has been married N times (FMARNO = N) and that Nth marriage is intact (recode
    FMARITAL = 1).

Otherwise,
MARDISnn is transferred from the appropriate non-blank Blaise-computed variable indicating
century-month when R’s Nth marriage dissolved:

  cmhsbdix  -  if marriage ended when husband died.
  cmstphsbx -  if marriage ended in separation, or
                if it ended in divorce/annulment but R stopped living with husband before
                divorce/annulment, or
                if DK/RF how it ended but valid date reported in this variable.
  cmdivorcx -  if marriage ended in divorce/annulment and R did not stop living with
                husband prior to divorce/annulment.

Code categories:
  Blank   = inapplicable
xxxx-nnnn  = date (century month) Nth marriage ended

MARENDDnn**: “How the Nth marriage ended”

MARENDDnn is blank (inapplicable) if:
-- R has been married fewer than N times (recode FMARNO LT N); or.
-- R has been married N times (FMARNO = N) and that Nth marriage is intact (recode FMARITAL = 1).

Otherwise,

If R has been married N times, define MARENDDnn based on values of recode FMARITAL:

If FMARITAL=3, then MARENDDn=1 (divorced or annulled)
If FMARITAL=4, then MARENDDn=2 (separated)
If FMARITAL=2, then MARENDDn=3 (widowed)

Else, if R has been married more than N times (FMARNO GT N), define MARENDDn based on responses to CB-19 MARENDDHx corresponding to the Nth marriage:
(note that separation is not possible for MARENDDnn if FMARNO GT N.)
If MARENDDHx=2 or 3, then MARENDDn=1 (divorced or annulled)
If MARENDDHx=1, then MARENDDn=3 (widowed)

Imputation Note: Imputed for cases with DK/RF values on CB-19 MARENDDHx.

Code categories:
Blank  = inapplicable
1      = Divorced or annulled
2      = Separated
3      = Widowed

FMAR1AGE**: “Age at first marriage”

FMAR1AGE is blank (inapplicable) if R has never been married (recode FMARITAL = 5).

Otherwise,

FMAR1AGE is computed as follows:

FMAR1AGE= INT[(MARDAT01 - cmbirth)/12]

Code categories:
Blank  = inapplicable
xx-nn  = age (in years) at first marriage
AGEDISS1**: “Age at dissolution of first marriage”

AGEDISS1 is blank (inapplicable) if:
-- R has never been married (recode FMARITAL = 5) or
-- R’s first marriage is intact (recode FMARNO = 1 and FMARITAL = 1)

Otherwise, AGEDISS1 is computed as follows:

AGEDISS1 = INT[(MARDIS01 - cmbirth)/12]

Code categories:
Blank = inapplicable
xx-nn = age (in years) at dissolution of first marriage

AGEDD1**: “Age at divorce or death: 1st marriage”

AGEDD1 is blank (inapplicable) if:
-- R has never been married (recode FMARITAL = 5) or
-- R’s first marriage is intact (recode FMARNO = 1 and FMARITAL = 1) or
-- R’s first marriage dissolved by separation only (FMARNO = 1 and FMARITAL = 4).

Otherwise, AGEDD1 = AGEDISS1:
-- If R’s first marriage ended in widowhood (recode MAREND01=3); or
-- If R’s first marriage ended in divorce or annulment (recode MAREND01=1) and the date of divorce (Blaise-computed variable cmdivorcx) LE date when R last lived with her first husband (Blaise-computed variable cmstphsbx).

AGEDD1 = INT[(cmdivorcx - cmbirth)/12]:
-- If R’s first marriage ended in divorce or annulment (recode MAREND01=1) and the date of divorce (cmdivorcx) GT date when R last lived with her first husband (cmstphsbx).
(For these cases AGEDISS1 captures date when coresidence ended, and AGEDD1 captures date when formal marital dissolution occurred.)

Code categories:
Blank = inapplicable
xx-nn = age (in years) when 1st marriage ended in divorce or widowhood

MAR1DISS**: “Months between first marriage and dissolution of first marriage (or interview)”

MAR1DISS is blank (inapplicable) if R has never been married (recode FMARITAL = 5).

OTHERWISE:
MAR1DISS = cmintvw - MARDAT01
if R’s first marriage is still intact (FMARNO = 1 and FMARITAL = 1).

Else, MAR1DISS = MARDIS01 - MARDAT01:
-- If R has been married more than once (recode FMARNO GT 1); or
-- If R has been married only once (FMARNO = 1) and the marriage is NOT intact
  (FMARITAL = 2, 3, or 4).

User Note: If R stopped living with her 1st husband before her divorce or annulment became
final, recall that date of dissolution (MARDIS01) is defined as the date when she
last lived with him. If you wish to examine months between first marriage and
divorce/annulment date, subtract MARDAT01 from Blaise-computed variable
cmdivorc1.

Imputation Note: Computed based on imputed values of source recodes.

Code categories:
  Blank   = inapplicable
  000     = less than 1 month
  001-nnn = months between 1st marriage and dissolution (or interview)

DD1REMAR**: “Months between divorce or death (first marriage) and remarriage (or
interview)”

DD1REMAR is blank (inapplicable) if:
-- R has never been married (recode FMARITAL = 5); or
-- R’s first marriage is intact (recode FMARNO = 1 and FMARITAL = 1); or
-- R’s first marriage ended in separation only (FMARNO = 1 and MAREND01 = 2).

OTHERWISE,

DD1REMAR = cmintvw - cmdivorc:
If R has been married only once (FMARNO = 1) and her first marriage ended in divorce or
annulment (FMARITAL = 3).

Else, DD1REMAR = cmintvw - cmhsbdiex:
If R has been married only once (FMARNO = 1) and her first marriage ended in widowhood
(FMARITAL = 2).

Else, DD1REMAR = MARDAT02 - cmdivorc:
If R has been married more than once (FMARNO GT 1) and her first marriage ended in divorce
or annulment (MAREND01 = 1).

Else, DD1REMAR = MARDAT02 - cmhsbdiex:
If R has been married more than once (FMARNO GT 1) and her first marriage ended in
widowhood (MAREND01 = 3).
**Imputation Note:** Computed based on imputed values of source recodes.

Code categories:
- Blank = inapplicable
- 000 = less than one month
- 001-nnn = months between end of 1st marriage and remarriage (or interview)

**MAR1BIR1**: “Months between first marriage and first birth or date of interview”

MAR1BIR1 is blank (inapplicable) if R has never been married (recode FMARITAL = 5) and has never had a live birth (recode PARITY = 0).

OTHERWISE:

\[ \text{MAR1BIR1} = \text{cmintvw} - \text{MARDAT01} \]
If R has ever been married (FMARITAL NE 5), but has not had a live birth (PARITY = 0).

Else, \[ \text{MAR1BIR1} = \text{DATBABY1} - \text{MARDAT01} \]
If R has ever been married (FMARITAL NE 5) AND has had a live birth (PARITY GT 0) AND the date of her first live birth is equal to or later than the date of her first marriage (recode DATBABY1 GE MARDAT01).

Else, MAR1BIR1 = 888
- If R has never been married (FMARITAL = 5), but has had a live birth (PARITY GT 0); or
- If R has ever been married (FMARITAL NE 5) AND has had a live birth (PARITY GT 0) AND the date of her first live birth is earlier than the date of her first marriage (DATBABY1 LT MARDAT01).

**Imputation Note:** Computed based on imputed values of source recodes.

Code categories:
- Blank = inapplicable
- 000 = less than 1 month
- 001-nnn = months between 1st marriage and 1st birth (or interview date)
- 888 = 1st birth occurred before 1st marriage

**MAR1CON1**: “Months between first marriage and first conception or interview date”

MAR1CON1 is blank (inapplicable) if R has never been pregnant (recode PREGNUM = 0) and has never been married (recode FMARITAL = 5).

OTHERWISE:
MAR1CON1 = 996 if R has ever been pregnant (PREGNUM GT 0) but has never been married (FMARITAL = 5).

If R has ever been pregnant (PREGNUM GT 0) and has ever been married (FMARITAL NE 5), then:

If the date of first conception is less than the date of first marriage (recode DATCON01 LT recode MARDAT01), then first conception occurred before marriage, and MAR1CON1 = 995.

If the date of first conception is equal to or greater than the date of first marriage (DATCON01 GE MARDAT01), then MAR1CON1 = (DATCON01 - MARDAT01).

If R has never been pregnant (PREGNUM = 0) but has ever been married (FMARITAL NE 6), then MAR1CON1 = cmintvw - MARDAT01.

Imputation Note: Computed based on imputed values of source recodes.

Code categories:
Blank  = inapplicable
000    = less than 1 month
001-nnn = months between 1st marriage and 1st conception (or interview)
995    = 1st conception occurred before 1st marriage
996    = has been pregnant, but has never been married

CON1MAR1**: “Months between first conception and first marriage or interview date”

CON1MAR1 is blank (inapplicable) if R has never been pregnant (recode PREGNUM = 0) and has never been married (recode FMARITAL = 5).

If R has ever been pregnant (PREGNUM GT 0) and has ever been married (FMARITAL NE 5), then:

if the date of first marriage is the same or earlier than the date of first conception (recode MARDAT01 LE recode DATCON01), then first conception occurred after or in the same month as first marriage, and CON1MAR1 = 995.

if the date of first marriage is later than the date of first conception (MARDAT01 GT DATCON01), then CON1MAR1 = (MARDAT01 - DATCON01).

If R has ever been pregnant (PREGNUM GT 0) but has never been married (FMARITAL = 5), then CON1MAR1 = (cmintvw - DATCON01).

If R has never been pregnant (PREGNUM = 0) but has ever been married (FMARITAL NE 5), then CON1MAR1 = 996.
**B1PREMAR**: “Whether R’s first birth was premarital”

B1PREMAR is blank (inapplicable) if R has never had a live birth (recode PARITY=0).

Otherwise:

B1PREMAR=1 (yes) if: --R has never been married (recode FMARITAL=5), or 
--respondent file recode DATBABY1 < recode MARDAT01

B1PREMAR=2 (no) if: DATBABY1 >= MARDAT01

Note: If users wish to limit to respondents who have ever been married, they should subset cases with FMARITAL NE 5.

**COHEVER**: “Whether R ever cohabited outside of marriage”

Values of Blaise-computed variable evrcohab are used to determine values of COHEVER, which indicates any cohabitation experience, either premaritally or with a partner whom R never married. See Flow Check C-32 in CRQ for definition of evrcohab.

User Note: This recode has no inapplicable category. If you wish to limit analysis of cohabitation to those who have ever had intercourse, use SEXEVER or HADSEX, depending on the manner in which you wish to handle the timing of first intercourse relative to menarche.

Code categories:

1 = Yes, ever cohabited (lived with a man outside of marriage)
2 = No, never cohabited (lived with a man outside of marriage)
EVMARCOH**: “Whether R ever married or cohabited”

Recodes FMARITAL and COHEVER are used to define EVMARCOH.

SAS Logic:
If FMARITAL NE 5 or COHEVER = 1 then EVMARCOH = 1;
Else EVMARCOH = 2;

Imputation Note: Computed based on imputed values of source recodes.

Code categories:
1 = Yes, ever married or cohabited
2 = No, never married or cohabited

PMARRNO**: “Number of premarital cohabitations”

-- PMARRNO is initialized to 0 and increased by one for each premarital cohabitation (CB-5 LIVTOGHX =1).

SAS logic:
array PCOH [6] LIVTOGHX LIVTOGHX2-LIVTOGHX6;
pmarrno=0;
pmarmiss=0;
do i=1 to fmarno;
if PCOH[i]=1 then PMARRNO=PMARRNO+1;
if pcoh[i] in (8,9) then pmarmiss=pmarmiss+1;
end;
if pmarmiss GT 0 then pmarrno=-1; /*flag to be imputed*/

Imputation Note: Impute when CB-5 LIVTOGHX[X] = DK/RF. PMARRNO must be constrained to be LE FMARNO.

Code categories:
0-n = number of premarital cohabiting partners

NONMARR**: “Number of nonmarital cohabitations (i.e., cohabitations not ending in marriage)”

-- NONMARR = 0
if R has never cohabited (evrcohab=5)
or if R has never lived with a man and is not currently cohabiting or living with a male partner [(CD-1 LIVEOTH = 5) and (RMARITAL NE 2)]

Else,
-- NONMARR = (prevcohb + 1)
if R is currently cohabiting (RMARITAL=2)
Else,
-- NONMARR = prevcohb
if R is not currently cohabiting (RMARITAL NE 2)

SAS logic:
nonmarr=.;
if hmothmen not in (98,99) and liveoth not in (8,9) then do;
   if (evrcohab=5) or ((liveoth =5) and (RMARITAL NE 2)) then
      nonmarr=0;
   else if (RMARITAL=2) then nonmarr=prevcohb + 1;
   else if (RMARITAL NE 2) then nonmarr=prevcohb;
   end;
   if hmothmen in (98,99) or liveoth in (8,9) then nonmarr = -1;
   /*flag to be imputed*/

Imputation Note: Imputed if CD-2 Hmothmen is DK/RF OR CD-1 Liveoth is DK/RF

Code categories:
0-n = number of nonmarital cohabiting partners

TIMESCOH**: “Total number of cohabitations”

-- TIMESCOH = recode PMARRNO + recode NONMARR

SAS logic:
if pmarrno GE 0 and nonmarr GE 0 then do;
timescoh=pmarrno+nonmarr;
end;
if pmarrno LT 0 or nonmarr LT 0 then timescoh = -1; /*flag to be imputed*/
run;

Imputation Note: Computed based on imputed values of source recodes.

Code categories:
0-n = total number of cohabiting partners ever

COHAB1**: “Date of first cohabitation (including premarital cohabitation)”

COHAB1 is blank (inapplicable) if R has never cohabited outside of marriage (COHEVER=2).

OTHERWISE,
COHAB1 is the earliest, nonmissing date from among:
cmpmcohx - CM when R began premarital cohabitation with X-order husband (note: unlikely that premarital cohabitation with 2nd+ order husband would be earlier than premarital cohabitation with 1st husband, but must check all dates to be sure.)
cmstrtcpx - CM when R began living with current cohabiting partner
cmcohstx - CM when R began living with all other cohabiting partners (up to total number of previous cohabiting partners, given by Blaise-computed variable *prevcohb*) *(we need to check more than the 1st former cohabiting partner start dates because R may not have reported her former partners chronologically.)*

Code categories:

- Blank = inapplicable
- xxxx-nnnn = date (century month) of first cohabitation

**COHSTAT**: *“Cohabitation experience relative to first marriage”*

- COHSTAT = 1 if R has never cohabited (recode COHEVER = 2).
- Else
  - COHSTAT = 2 -- if R has never been married (recode FMARITAL = 5) but has cohabited (COHEVER =1); or
  - -- if R has ever been married (FMARITAL NE 5) and has cohabited (COHEVER =1) and date of first cohabitation (recode COHAB1) is same as or earlier than date of first marriage (recode MARDAT01).
- Else
  - COHSTAT = 3 if R has ever been married (FMARITAL NE 5) and has cohabited (COHEVER =1) and date of first cohabitation is greater than date of first marriage (COHAB1 GT MARDAT01).

SAS Logic:

- If COHEVER = 2 then COHSTAT = 1;
- Else if (FMARITAL=6 and COHEVER=1) or (FMARITAL NE 5 and COHEVER=1 and COHAB1 LE MARDAT01) then COHSTAT = 2;
- Else if (FMARITAL NE 5 and COHEVER=1 and COHAB1 > MARDAT01) then COHSTAT = 3;

**Imputation Note**: Computed based on imputed values of source recodes.

Code categories:

- 1 = never cohabited outside of marriage
- 2 = first cohabited before first marriage
- 3 = first cohabited after first marriage

**COHOUT**: *“Outcome of first cohabitation”*

COHOUT is blank (inapplicable) if R has never cohabited outside of marriage (recode COHEVER = 2).

COHOUT = 1
if R is currently cohabiting and her first cohabitation is intact (recode RMARITAL = 2 and
recode COHAB1 came from cmstrtcp).  *(Blaise-computed variable cmstrtcp indicates start of cohabitation with current partner.)*

Else COHOUT = 2
if R is currently married to her first cohabitation partner (RMARITAL=1 and the date of her first cohabitation COHAB1 came from cmpmcohx or cmpmcohx2-cmpmcohx6 corresponding to her most recent marriage; for example, COHAB1=cmpmcohx if FMARNO=1, COHAB1=cmpmcohx2 if FMARNO=2, etc.).  *(Blaise-computed variables cmpmcohx and cmpmcohx2-cmpmcohx6 indicates CM start dates of premarital cohabitation with 1st-6th husbands.)*

Else COHOUT = 3
if R is not currently married (RMARITAL NE 1) and the outcome of R’s first cohabitation is a marriage that dissolved (COHAB1 came from cmpmcohx or cmpmcohx2-cmpmcohx6, and FMARITAL = 2, 3, or 4); or if R is married but not for first time (RMARITAL=1 and FMARNO>1) and her first cohabitation was with a former husband (COHAB1 came from cmpmcohx or cmpmcohx2-cmpmcohx6).

Else COHOUT = 4
if the outcome of R’s first cohabitation is dissolution without marriage (COHAB1 came from cmcohstx or cmcohstx2-cmcohstx8).  *(Blaise-computed variables cmcohstx and cmcohstx2-cmcohstx8 indicate CM start dates of cohabitation with X-order former cohabiting partner.  See specs for COHAB1 for reason why we don’t just look at 1st partner reported.)*

*Imputation Note:*  Computed based on imputed values of source recodes.

**Code categories:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>inapplicable</td>
</tr>
<tr>
<td>1</td>
<td>intact cohabitation</td>
</tr>
<tr>
<td>2</td>
<td>intact marriage</td>
</tr>
<tr>
<td>3</td>
<td>dissolved marriage</td>
</tr>
<tr>
<td>4</td>
<td>dissolved cohabitation</td>
</tr>
</tbody>
</table>

**COH1DUR**:

“Duration (in months) of R’s first cohabitation”

COH1DUR is blank (inapplicable) if R has never cohabited (recode COHEVER=no).

Otherwise, COH1DUR = number of months between recode COHAB1 and appropriate end date from below:

-- Blaise-computed cmintvw if 1st cohabitation is intact (recode COHOUT=1)

or -- appropriate recode among MARDAT01-MARDAT06 if 1st cohabitation resulted in marriage, whether intact or dissolved marriage (COHOUT=2 or 3)

or -- end date of 1st cohabitation (Blaise-computed cmstpcohx or cmstpcohx2-cmstpcohx8, depending on which former cohabiting partner was her first) if 1st cohabitation dissolved (COHOUT=4)

*Note:*  In cases where COHOUT=2 or 3 (1st cohabitation resulted in marriage), COH1DUR
indicates duration of premarital cohabitation. Users may wish to subset cases based on value of COHOUT, the recode indicating outcome of R’s first cohabitation.

**Imputation Note:** Computed based on imputed values of source recodes.

Code categories:
- Blank = inapplicable
- 0 = Less than 1 month
- 1-nn = number of months

**HADSEX**: “Whether R has ever had sexual intercourse with a male”

If rhadsex=1 then HADSEX=1.
Else if rhadsex=5 then HADSEX=2.

Values of Blaise-computed variable rhadsex are used to determine values of HADSEX (see Flow Checks C-42 and C-44 for the definition of rhadsex).

**Imputation Note:** None is needed because rhadsex was set to 5 when CE-1 EVERSEX=5, DK or RF.

Code categories:
- 1 = Yes, R ever had intercourse
- 2 = No, R never had intercourse

**SEXEVER**: “Whether R has ever had sexual intercourse with a male since first menstrual period”

SEXEVER=1 (yes) if:
-- R’s first intercourse occurred after her first menstrual period (pre-imputation recode VRY1STAG GT BA-1 MENARCHE or CG-8 WHICH1ST = 2), or
-- R’s first intercourse occurred before her first menstrual period (pre-imputation recode VRY1STAG LT BA-1 MENARCHE or CG-8 WHICH1ST = 1, system-missing, 8, or 9) but she did have intercourse after menarche (CG-9 SEXAFMEN=1 or cmsexafm < 9996 or CG-11 AGESXAFM<98). (Blaise-computed variable cmsexafm indicates century-month when R first had sex after menarche if her first sex was before menarche.)

SEXEVER=2 (no) if:
-- R has not yet had her first menstrual period (BA-1 MENARCHE = 96); or
-- R has never had sexual intercourse at all (recode HADSEX = 2); or
-- R’s first intercourse occurred before menarche (pre-imputation recode VRY1STAG LT BA-1 MENARCHE or CG-8 WHICH1ST = system-missing, 1, 8, 9), and she did not have intercourse after menarche (CG-9 SEXAFMEN=5 or cmsexafm = 9996).

Code categories:
- 1 = Yes, R has had sexual intercourse after her 1st menstrual period
2 = No, R has not had first menstrual period, has not had sexual intercourse at all, or has not had sexual intercourse since her 1st menstrual period

Imputation note: Imputation uses recode VRY1STAG, but uses pre-imputation values only.

VRY1STAG**: “Age at first intercourse (even if before first menstrual period)”

VRY1STAG is blank (inapplicable) if R has never had intercourse (recode HADSEX=2).

OTHERWISE,

If CE-4 AGEFSTSX is not missing (AGEFSTSX LT 98), then:
VRY1STAG = AGEFSTSX

Else,
if CE-4 AGEFSTSX is missing (AGEFSTSX = 98 or 99) and R reported a valid date of first sex (cmfstsex LT end of data collection period), then:

VRY1STAG = INT((cmfstsex - cmbirth)/12)  (Blaise-computed variable cmfstsex indicates CM of 1st sex)

Else,
if CE-4 AGEFSTSX = DK or RF and cmfstsex is DK or RF, then estimate VRY1STAG as follows:

If R was between 15 and 18 at first intercourse (CE-5 C_SEX18 = 1 and CE-6 C_SEX15 = 2), then VRY1STAG=16.

If R was between 18 and 20 at first intercourse (CE-5 C_SEX18 = 2 and CE-7 C_SEX20 = 1), then VRY1STAG=19.

Imputation Notes:  -- Imputation needed for cases with DK or RF on CE-5 C_SEX18, CE-6 C_SEX15, or CE-7 C_SEX20 (who also have AGEFSTSX=DK/RF and cmfstsex=DK/RF).
-- Some cases may have valid data on C_SEX18, C_SEX15 and/or C_SEX20, but still designated for imputation because the criteria for the combination specified above was not met. These were used to guide imputation. For example, if case meets criteria for receiving value from CE-5 C_SEX18, CE-6 C_SEX15, or CE-7 C_SEX20, but remains -1 because C_SEX15 or C_SEX20=dk/RF, imputed value min and max should be guided by C_SEX18. That is: if C_SEX18=1 and C_SEX15=DK/RF, then max imputed value should be 17. If C_SEX18=2 and C_SEX20=DK/RF, then min imputed value should be 18.

Code categories:
Blank = inapplicable
00 = less than a year old
01 - 44 = 1 - 44 years old
SEX1AGE**: “Age at first intercourse since first menstrual period”

SEX1AGE is blank (inapplicable) if R has never had intercourse at all (recode HADSEX=2) or if she has never had intercourse since first menstrual period (recode SEXEVER=2) or she has not had first menstrual period (BA-1 MENARCHE=96).

**OTHERWISE, for all Rs who have had sexual intercourse since menarche (SEXEVER=1):**

If her first intercourse occurred after her first menstrual period (recode VRY1STAG GT BA-1 MENARCHE or CG-8 WHICH1ST=2), then:

\[
\text{SEX1AGE} = \text{recode VRY1STAG}
\]

Else, if her first intercourse was before her first menstrual period (recode VRY1STAG LT BA-1 MENARCHE or CG-8 WHICH1ST=1), then:

If CG-11 AGESXAFM is not missing (AGESXAFM LT 98), then:

\[
\text{SEX1AGE} = \text{CG-11 AGESXAFM}
\]

Else, if CG-11 AGESXAFM is missing (AGESXAFM GE 98) and R reported a valid date of first sex after menarche (cmsexafm LT end of data collection period), then:

\[
\text{SEX1AGE} = \text{INT}((\text{cmsexafm} - \text{cmbirth})/12)
\]

(Blaise-computed variable cmsexafm indicates CM of 1st sex since menarche)

Else, if CG-11 AGESXAFM = DK or RF and cmsexafm is DK or RF, then estimate SEX1AGE as follows:

If R was between 15 and 18 at first intercourse after menarche (CG-12 AFMEN18 = 1 and CG-13 AFMEN15 = 2), then SEX1AGE=16.

If R was between 18 and 20 at first intercourse after menarche (CG-12 AFMEN18 = 2 and CG-14 AFMEN20 = 1), then SEX1AGE=19.

*Imputation Notes: Imputation needed for cases with BA-1 MENARCHE=DK/RF, or (AGEFSTSX=DK/RF and cmfstsex=DK/RF, who also have DK or RF on CG-12 AFMEN18, CG-13 AFMEN15, and CG-14 AFMEN20), or have a combination of values on AFMEN18, AFMEN15, and AFMEN20 that do not permit estimation. If the latter is true, any available information on AFMEN18, AFMEN15, or AFMEN20 is used to guide imputation. For example, if case meets criteria for receiving value from CG-12 AFMEN18, CG-13 AFMEN15, and CG-14 AFMEN20, but remains -1 because AFMEN18 or AFMEN20=dk/rf, imputed value min and
max should be guided by AFMEN18. That is: if AFMEN18=1 and AFMEN15=DK/RF, then max imputed value should be 17. If AFMEN18=2 and AFMEN20=DK/RF, then min imputed value should be 18. Imputation also needed for cases with agesxafm<menarche and no further information available in AFMEN15, AFMEN18, and AFMEN20.

Code categories:
- BLANK = inapplicable
- 00 = less than a year old
- 01 - 44 = 1 - 44 years old

**VRY1STSX**: “Date of first intercourse (even if before first menstrual period)”

VRY1STSX is blank (inapplicable) if R has never had sexual intercourse at all (recode HADSEX = 2).

Otherwise,
\[ VRY1STSX = cmfstsex \]

Values of Blaise-computed variable cmfstsex are used to determine values of VRY1STSX (see Flow Check C-44 for the definition of cmfstsex).

**Imputation Note**: Needed for cases where cmfstsex = DK or RF

Code categories:
- Blank = inapplicable
- xxxx-nnnn = CM date of first intercourse
- 9996 = responded she never had intercourse

**DATESEX1**: “Date of first intercourse after first menstrual period”

DATESEX1 is blank (inapplicable) if R has never had intercourse at all (recode HADSEX=2) or if she has never had intercourse since first menstrual period (recode SEXEVER=2).

If R has not had her first menstrual period (BA-1 MENARCHE = 96) but has had intercourse (recode HADSEX=1), then DATESEX1 = 9595.

Otherwise, for all Rs who have had sexual intercourse since menarche (SEXEVER=1):

If her first intercourse occurred after her first menstrual period (recode VRY1STAG GT BA-1 MENARCHE or CG-8 WHICH1ST=2), then:

\[ DATESEX1 = VRY1STSX \]

Else, if her first intercourse was before her first menstrual period (cmsexafm not equal to system-missing, 9998 or 9999) and (recode VRY1STAG LT BA-1 MENARCHE or CG-8
WHICH1ST=1 or SEXAFMEN=1), then:

\[
\text{DATESEX1} = \text{cmsexafm}
\]

(Values of Blaise-computed variable cmsexafm are used to determine values of \text{DATESEX1} -- see Flow Check C-60 for the definition of cmsexafm).

Code categories:
- Blank = inapplicable
- xxxx-nnnn = CM date of first intercourse after menarche
- 9595 = never had a menstrual period but has had intercourse

**SEXONCE**: “Whether R has had sex only once”

SEXONCE is blank (inapplicable) if R has never had sexual intercourse (recode HADSEX=no).

Otherwise:

SEXONCE=1 (R has had sex only once) if CE-9 SXMTONCE=5 (no).

SEXONCE=2 (R has had sex more than once) if:
- R has ever been married or ever cohabited (recode EVMARCOH=1) or
- R reported that she has had sex more than once (CE-9 SXMTONCE=1)

*Imputation Note:* Imputation needed for cases with CE-9 SXMTONCE = DK or RF.

Code categories:
- Blank = inapplicable
- 1 = Yes (R has had sex only once)
- 2 = No (R has had sex more than once)

**FSEXPAGE**: “Age of R’s 1st sexual partner at time of R’s 1st sex”

FSEXPAGE is blank (inapplicable) if R has never had sexual intercourse (recode HADSEX=2).

Otherwise:

If R is 18 or older (Blaise-computed variable age_r GE 18) then:
- If CG-4 FPAGE NE DK/RF then FSEXPAGE=CG-4 FPAGE

Else if R is under age 18 (Blaise-computed variable age_r LT 18) then:
- If JD-3 AGEVAGM NE DK/RF then FSEXPAGE=JD-3 AGEVAGM

Else if R is 18 or older (age_r GE 18) and CG-4 FPAGE=DK/RF then:
- [If partner was 1-2 years older, add 2 years to R’s age at 1st sex and flag with leading 9]
- if (CG-4b FPRELAGE=1 and CG-4c FPRELYRS=1) then
FSEXPAGE=(VRY1STAG + 2) + 900
[If partner was 3-5 years older, add 4 years to R’s age at 1st sex and flag with leading 9]
if (CG-4b FPRELAGE=1 and CG-4c FPRELYRS=2) then
FSEXPAGE=(VRY1STAG + 4) + 900
[If partner was 6-10 years older, add 8 years to R’s age at 1st sex and flag with leading 9]
if (CG-4b FPRELAGE=1 and CG-4c FPRELYRS=3) then
FSEXPAGE=(VRY1STAG + 8) + 900
[If partner was more than 10 years older, add 10 years to R’s age at 1st sex and flag with leading 9]
if (CG-4b FPRELAGE=1 and CG-4c FPRELYRS=4) then
FSEXPAGE=(VRY1STAG + 10) + 900

[If partner was 1-2 years younger, subtract 2 years from R’s age at 1st sex and flag with leading 9]
if (CG-4b FPRELAGE=2 and CG-4c FPRELYRS=1) then
FSEXPAGE=(VRY1STAG - 2) + 900
[If partner was 3-5 years younger, subtract 4 years from R’s age at 1st sex and flag with leading 9]
if (CG-4b FPRELAGE=2 and CG-4c FPRELYRS=2) then
FSEXPAGE=(VRY1STAG - 4) + 900
[If partner was 6-10 years younger, subtract 8 years from R’s age at 1st sex and flag with leading 9]
if (CG-4b FPRELAGE=2 and CG-4c FPRELYRS=3) then
FSEXPAGE=(VRY1STAG - 8) + 900
[If partner was more than 10 years younger, subtract 10 years from R’s age at 1st sex and flag with leading 9]
if (CG-4b FPRELAGE=2 and CG-4c FPRELYRS=4) then
FSEXPAGE=(VRY1STAG - 10) + 900

[If partner was the same age as the R, set FSEXPAGE to R’s age at 1st sex and flag with leading 9]
if CG-4b FPRELAGE=3 then FSEXPAGE=VRY1STAG + 900

Imputation note: In some cases, the “don’t know followup” questions (fprelage, fprelyrs), have valid data but were not used above because the combinations of values didn’t meet the criteria above. In these cases, these data were used for guiding imputation.
-- For some conditions this recode uses imputed values of VRY1STAG.
-- Specifically, if case meets criteria for receiving value from CG-4b FPRELAGE and CG-4c FPRELYRS, but remains -1 because FPRELYRS is dk/rf, imputed value min and max should be guided by FPRELAGE. That is, if FPRELAGE=1 (older) then min imputed value should be VRY1STAG+1. If FPRELAGE=2 (younger), max imputed value should be VRY1STAG-1.

Code categories:
Blank = inapplicable
xx-nn = partner’s age at first sexual intercourse
9xx-9nn = partner’s age at first sexual intercourse, estimated

**FPDUR**: “Number of months between first and last/most recent sexual intercourse with first partner ever”

FPDUR is blank (inapplicable) if R has never had sexual intercourse (recode HADSEX=2).

Else if Blaise-computed variable cmalsexfp (Flow check C-57) not system-missing, 9998, or 9999 then:

- If cmalsexfp=9996 then FPDUR=997
- Else FPDUR = cmalsexfp minus VRY1STSX

*Imputation note:* Imputation needed if inputs are missing and also computed based on imputed values of VRY1STSX. Imputation needed if cmalsexfp is earlier (less than) VRY1STSX.

Code categories:
- Blank = Inapplicable
- 0 – nnn = number of months
- 997 = only had sex once with partner

**SEXMAR**: “Months between first intercourse (even if before first menstrual period) and first marriage (or interview)”

SEXMAR is blank (inapplicable) if R has never had intercourse at all (recode HADSEX=2).

Otherwise,

SEXMAR is the number of months between “the end of the interval” and the date of first intercourse (recode VRY1STSX). The end of the interval is defined as follows:

- if R has never been married (recode FMARITAL = 5), use cmintvw
  
  SEXMAR=CMINTVW-VRY1STSX

- if R has ever been married (FMARITAL NE 5), use recode MARDAT01
  
  if date of first intercourse was before or same as date of first marriage then
  
  SEXMAR = MARDAT01 minus VRY1STSX.
  
  (if VRY1STSX LE MARDAT01 then SEXMAR = MARDAT01 - VRY1STSX)

  if date of first intercourse was after date of first marriage then SEXMAR=996
  
  (if VRY1STSX GT MARDAT01 then SEXMAR=996)

*Imputation Note:* Computed based on imputed values of source recodes.
Code categories:
Blank = inapplicable
000 = first intercourse in same month as marriage
001-nnn = 1 to nnn months after first intercourse
996 = first intercourse after first marriage

SEX1FOR**: “Months between first intercourse after first menstrual period and first marriage (or interview)”

SEX1FOR is blank (inapplicable) if R has never had intercourse at all (recode HADSEX=2) or if she has never had intercourse since first menstrual period (recode SEXEVER=2).

Otherwise, for Rs who have had intercourse since menarche (SEXEVER=1):

If her first intercourse occurred after her first menstrual period (recode VRY1STAG GT BA-1 MENARCHE or CG-8 WHICH1ST=2), then:
SEX1FOR = SEXMAR

Else, if her first intercourse was before her first menstrual period (cmsexafm not equal to system-missing, 9998 or 9999) and (recode VRY1STAG LT BA-1 MENARCHE or CG-8 WHICH1ST=1 or SEXAFMEN=1), then:

SEX1FOR is the number of months between “the end of the interval” and the date of first intercourse since menarche (recode DATESEX1). The end of the interval is defined as follows:

if R has never been married (recode FMARITAL = 5), use cmintvw:
SEX1FOR=cmintvw-DATESEX1

if R has ever been married (FMARITAL NE 5), use recode MARDAT01:
if date of first intercourse after menarche was before or same as date of first marriage then SEX1FOR = MARDAT01 minus DATESEX1
(if DATESEX1 LE MARDAT01 then SEX1FOR = MARDAT01 – DATESEX1)

if date of first intercourse after menarche was after date of first marriage then SEX1FOR=996
(if DATESEX1 GT MARDAT01 then SEX1FOR=996)

Code categories:
Blank = inapplicable
000 = first intercourse after menarche was in same month as marriage
001 to nnn = 1 to nnn months after first intercourse after menarche
996 = first intercourse after menarche was after first marriage
SEXUNION**: “Months between first intercourse (even if before first menstrual period) and first coresidential union (or interview)”

SEXUNION is blank (inapplicable) if R has never had intercourse at all (recode HADSEX=2).

Otherwise,

SEXMAR is the number of months between “the end of the interval” and the date of first intercourse (recode VRY1STSX). The end of the interval is the earliest, valid date amongst the date of 1st marriage, the date of 1st cohabitation outside of marriage, and the date of interview.

If R has never been married (recode FMARITAL = 5) and never cohabited (COHEVER=2), SEXUNION is based on interval between 1st sexual intercourse and the interview:

\[ \text{SEXUNION} = \text{CMINTVW} - \text{VRY1STSX} \]

Else, if R has ever been married (FMARITAL NE 5) but has never cohabited outside of marriage (COHEVER=2), SEXUNION is equal to SEXMAR value:

\[ \text{SEXUNION} = \text{SEXMAR} \]

Else, if R has never been married (FMARITAL=5) but has ever cohabited outside of marriage (COHEVER=1), SEXUNION is based on the interval between 1st sexual intercourse and 1st cohabitation:

If COHAB1 < VRY1STSX, then set SEXUNION=996 (1st intercourse occurred later than 1st cohabitation).
Else, \[ \text{SEXUNION} = \text{COHAB1} - \text{VRY1STSX} \]

 Else, if R has ever been married (FMARITAL NE 5), has ever cohabited outside of marriage (COHEVER=1), and 1st cohabitation began before 1st marriage (COHSTAT=2):

If COHAB1 < VRY1STSX, then set SEXUNION=996 (1st intercourse occurred later than 1st cohabitation).
Else, \[ \text{SEXUNION} = \text{COHAB1} - \text{VRY1STSX} \]

Else, if R has ever been married (FMARITAL NE 5), has ever cohabited outside of marriage (COHEVER=1), and 1st cohabitation began after 1st marriage (COHSTAT=3):

\[ \text{SEXUNION} = \text{SEXMAR} \]

SAS logic:
If hadsex=2 then sexunion=.;
Else if fmartial=5 and cohever=2 then sexunion=cmintvw-vry1stsx;
Else if fmartial NE 5 and (cohever=2 or cohstat=3) then sexunion=sexm;
Else if (fmartial=5 and cohever=1) or (fmartial NE 5 and cohstat=2) then do;
if cohab1 GE vry1stsx then sexunion=cohab1-vry1stsx;
else if cohab1 LT vry1stsx then sexunion=996;
end;

Imputation Note: Computed based on imputed values of source recodes.

Code categories:
Blank = inapplicable
000 = first intercourse in same month as marriage or cohabitation
001-nnn = 1 to nnn months after first intercourse
996 = first intercourse after first marriage or cohabitation

SEXOUT**: “Outcome of first sexual intercourse”

SEXOUT is blank (inapplicable) if R has never had sexual intercourse with a male partner (recode HADSEX = 2).

Else SEXOUT = 1
if R is currently cohabiting with her first sexual partner (recode RMARITAL = 2 and CG-3 WHOFSTPR=8, current cohabiting partner).

Else SEXOUT = 2
if R is currently married to her first sexual partner (RMARITAL=1 and CG-3 WHOFSTPR=7, current husband).

Else SEXOUT = 3
if R is not currently married (RMARITAL NE 1) and CG-3 WHOFSTPR in (1 2 3 4 5 6 7, any former or separated husband). (including code 7 to cover cases where R is separated from this husband – not strictly “dissolved” but not “intact” either)

Else SEXOUT = 4
if the outcome of R’s first sexual intercourse is a cohabitation that dissolved without marriage (CG-3 WHOFSTPR in(9 10 11 12), any of up to 4 former cohabiting partners to whom R was never married).

Else SEXOUT = 5
If R’s first sexual partner was never a husband or a cohabiting partner (CG-3 WHOFSTPR=20 or CG-2 SAMEMAN = 5, DK, RF, or system-missing).

Imputation note: Imputed if CG-3 WHOFSTPR=DK/RF.

Code categories:
Blank = inapplicable
1 = intact cohabitation
2 = intact marriage
3 = dissolved marriage
4 = dissolved cohabitation
5 = never married or cohabited with 1st sexual partner

RELATP1-3**: “Relationship at first sexual intercourse with (most recent / second-to-last / third-to-last) sexual partner (in the past 12 months)”

Most recent partner:

RELATP1 is blank (inapplicable) if R had no partners in the past 12 months (PARTS1YR = 0 or sysmis).

If R’s most recent partner was R’s first partner ever (LIFEPRT=1 or MATCHFP=1 or p1yrelp=13 or (p1yrelp=7 and CG-2 SAMEMAN=1 and CA-1 TIMESMAR=1) or (p1yrelp=8 and CG-2 SAMEMAN=1 and TIMESCOH=1)) then if there is a valid response to relationship at first sex with R’s first partner ever (CG-5 KNOWFP ne ., dk, rf):

RELATP1 = CG-5 KNOWFP

Else if R’s most recent partner was not R’s first partner ever (LIFEPRT>1 and p1yrelp NE 13) then if there is a valid response to relationship at first sex with R’s most recent partner (CI-11 P1YRFX ne ., dk, rf):

RELATP1 = CI-11 P1YRFX

Second- and third-most recent partners:

RELATP2 is blank (inapplicable) if:
-- R has never had sexual intercourse (recode HADSEX=2), or if
-- R had no partners or only 1 partner (parts12 = 0 or 1) in the past 12 months

RELATP3 is blank (inapplicable) if:
-- R has never had sexual intercourse (recode HADSEX=2), or if
-- R had no partners, or only 1 or 2 partners (parts12 = 0, 1, or 2) in the past 12 months

If R’s 2nd / 3rd most recent partner was R’s first partner ever (p1yrelp2/3 = 13) then if there is a valid response to relationship at first sex with R’s first partner ever (CG-5 KNOWFP ne ., dk, rf):

RELATP1 = CG-5 KNOWFP

Else if R’s most recent partner was not R’s first partner ever (LIFEPRT>=2/3 and p1yrelp2/3 NE 13) then if there is a valid response to relationship at first sex with R’s 2nd / 3rd most recent partner (CI-11 P1YRFX2/3 ne ., dk, rf):

RELATP2/3 = P1YRFX2/3

Imputation note: Needed for cases meeting applicable criterion and for whom KNOWFP or P1YRFX, P1YRFX2, or P1YRFX3, whichever is applicable, is sysmis, dk, or rf.
Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>1</td>
<td>Married to him</td>
</tr>
<tr>
<td>2</td>
<td>Engaged to him</td>
</tr>
<tr>
<td>3</td>
<td>Living together in a sexual relationship, but not engaged</td>
</tr>
<tr>
<td>4</td>
<td>Going out with him or going steady</td>
</tr>
<tr>
<td>5</td>
<td>Going out with him once in a while</td>
</tr>
<tr>
<td>6</td>
<td>Just friends</td>
</tr>
<tr>
<td>7</td>
<td>Had just met him</td>
</tr>
<tr>
<td>8</td>
<td>Something else</td>
</tr>
</tbody>
</table>

**PARTDUR1-3**: “Number of months between first and most recent sexual intercourse with (most recent or last ever/ second-to-last / third-to-last) sexual partner (in the past 12 months)”

PARTDUR1 is blank (inapplicable) if R has never had sexual intercourse (recode HADSEX=2)

Most recent partner:
If R’s most recent partner was R’s first partner ever
(LIFEPR=1 or MATCHFP=1 or p1yrelp=13 or (p1yrelp=7 and CG-2 SAMEMAN=1 and CA-1 TIMESMAR=1) or (p1yrelp=8 and CG-2 SAMEMAN=1 and TIMESCOH=1)):

\[ \text{PARTDUR1} = \text{FPDUR} \]

Else if R’s most recent partner was not R’s first partner ever (LIFEPR>1 and p1yrelp NE 13):
If Blaise-computed variable cmfsex (Flow check C-77) not sysmis, 9998, or 9999 then:
- If cmfsex=9996 then PARTDUR1 = 997
- Else PARTDUR1 = (LSEXDATE minus cmfsex)

Second- and third- most recent partners:

PARTDUR2 is blank (inapplicable) if:
- R has never had sexual intercourse (recode HADSEX=2), or if
- R had no partners or only 1 partner (parts12 = 0 or 1) in the past 12 months

PARTDUR3 is blank (inapplicable) if:
- R has never had sexual intercourse (recode HADSEX=2), or if
- R had no partners, or only 1 or 2 partners (parts12 = 0, 1, or 2) in the past 12 months

If R’s 2nd / 3rd most recent partner was R’s first partner ever (p1yrelp2/3 = 13):
If cmlsexfp not sysmis, 9998, or 9999 and cmfstsex not sysmis, 9998, or 9999 then:
If cmlsexfp=9996 then PARTDUR1=997
Else PARTDUR2/3 = FPDUR

Else if R’s most recent partner was not R’s first partner ever (LIFEPR>=2/3 and p1yrelp2/3 NE 13):

If cmfsex2/3 not sysmis, 9998, or 9999 and cmlsex2/3 not sysmis, 9998, or 9999 then:

If cmfsex2/3=9996 then PARTDUR2/3=997
Else PARTDUR2/3 = (cmlsex2/3 minus cmfsex2/3)

**Imputation note:** Imputation needed if recode uses cmfsex / cmlsex; cmfsex2 / cmlsex2; or cmfsex3 / cmlsex3, and the relevant pair includes dk/rf. Imputation needed if cmfsex[n] is earlier than (less than) corresponding cmfsex[n]. (subtracting the dates yields a negative value)

**Code categories:**
- Blank = Inapplicable
- 0 – mnn = number of months
- 997 = only had sex once with partner

**LSEXDATE**: “CM date of last or most recent sexual intercourse”

LSEXDATE is blank (inapplicable) if R has never had sexual intercourse (recode HADSEX = 2).

Otherwise:
LSEXDATE is determined by the most recent, or only, value on cmlsex (computed in Flow Check C-71) and cmfplast (computed in Flow Check C-57).

If cmlsex is blank and cmfplast is a valid date then LSEXDATE=cmfplast.

If cmfplast is a valid date and cmlsex is a valid date, LSEXDATE is the most recent one of the two.

Otherwise LSEXDATE=cmlsex.

**Imputation Note:** Imputation needed if cmlsex is missing/dk/rf.
Recode PARTSIYR is reconciled with LSEXDATE in cases where they are inconsistent. See recode specs and imputation notes for PARTSIYR.

**Note:** LSEXDATE only considers cmlsex (and cmfplast). In rare cases there is a date in cmlsex2 or cmlsex3 that is more recent. Regardless, all raw, computed, and recode variables on characteristics of last partner refer to the last partner based on cmlsex (or cmfplast), not cmlsex2 or cmlsex3. Recode NUMP3MOS (number of partners in the past 3 months) considers cmlsex, cmlsex2, and cmlsex3. For this reason, in rare cases, NUMP3MOS may be inconsistent with LSEXDATE.
Code categories:
   Blank       = inapplicable
   xxxx - nnnn = CM date of last or most recent sexual intercourse

LSEXRAGE**: “R’s age at last or most recent sexual intercourse”

LSEXRAGE is blank (inapplicable) if R has never had sexual intercourse (recode HADSEX = 2).

Otherwise:
LSEXRAGE = INT[(recode LSEXDATE) - cmbirth / 12]

User Note: Consult FEMALE RESPONDENT FILE NOTES in Part 2 of User’s Guide for further information related to this recode.

Code categories:
   Blank       = inapplicable
   xx - 44     = age in years at last or most recent sexual intercourse

PARTS1YR**: “Number of opposite-sex sexual partners in last 12 months”

PARTS1YR is blank (inapplicable) if R has never had sexual intercourse (recode HADSEX = 2).

Otherwise:
PARTS1YR is based on the value of computed variable parts12.

The sas program below
1) assigns 0 to parts1yr if parts12 was 98 or 99, because this is how they were routed in the questionnaire.
2) addresses cases that gave inconsistent information on whether they had sexual intercourse in the last 12 months in the directly asked questions about “numbers of partners” versus “dates of last sex with each recent partner.”

SAS logic:

IF HADSEX=2 THEN PARTS1YR=.;
IF PARTS12 IN (0,98,99) THEN PARTS1YR=0;
ELSE IF 1 LE PARTS12 LT 95 THEN PARTS1YR=PARTS12;
*** below: to address inconsistent cases between PARTS1YR & LSEXDATE;
IF PARTS1YR=0 and LSEXDATE GE (cmintvw - 11) then impute PARTS1YR;
ELSE IF PARTS1YR GE 1 and (-1 LT LSEXDATE LT (cmintvw - 11)) then PARTS1YR=0; (see imputation note).

User Notes: Male version of PARTS1YR is defined for all respondents, not just those with HADSEX=1.
PARTS1YR is defined even if one or more of the dates are DK/RF. In other words,
it is incremented for any valid date falling within the past 12 months. The original PARTS1YR recode, as defined above, was topcoded for public use at “7 or more opposite-sex partners”. The full-detail variable called INPARTS1YR is available through the NCHS Research Data Center.

**Imputation Note:** Needed for cases where PARTS1YR originally equals 0 but LSEXDATE is within 12 month window (LSEXDATE GE (cmintvw-11)).
- Minimum value should be the number of dates falling within cmintvw-11, among: LSEXDATE, cmlsex2, and cmlsex3.
- Maximum value should be LIFEPRTNR.

**Code categories:**
- Blank = inapplicable
- 0 - nn = number of opposite-sex partners in last 12 months

**LIFPRTNR**: “Number of opposite-sex sexual partners in lifetime”

LIFPRTNR = lifeprts *(defined for all Rs)*

Values of Blaise-computed variable lifeprts are used to determine values of LIFPRTNR (see Flow Check C-83 for the full definition of lifeprts).

*(The lifeprts variable was based primarily on responses to CH-1 LIFEPRT. If LIFEPRT=DK or RF, lifeprts=CH-1b LIFEPRT_LO, which could have been answered with DK/RF. This would be the only way for lifeprts to be DK/RF.)*

**SAS Logic:**

If rhadsex=5 then LIFPRTNR=0;
Else if (1 <= LIFEPRT <= 995) then LIFPRTNR=lifeprts;
Else if LIFEPRT in(998,999) and (1 <= LIFEPRT_LO <= 995) then LIFPRTNR=LIFEPRT_LO;

**Imputation Note:** Needed if Blaise-computed lifeprts=DK/RF.

**Note:** The original LIFPRTNR recode, as defined above, was top-coded for public use at “50 or more opposite-sex partners.” The full-detail variable called INLIFPRTNR is available through the NCHS Research Data Center.

**Code categories:**
- 0 - 49 = number of opposite-sex partners in lifetime
- 50 = 50 or more opposite-sex partners in lifetime

**NUMP3MOS**: “Number of male partners in past 3 months”

NUMP3MOS is blank (inapplicable) if R has never had sexual intercourse (recode HADSEX=2).
Otherwise:
If R had no sex partners in the last 3 months (SEX3MO=2), then NUMP3MOS=0
Else if R had 1 or more sex partners in the last 3 months (SEX3MO=1), then:

For the dates to look at, for whether it falls in the past 3 months, if any of the
partners was same as the first partner, or the first partner was same as cohabiting
partner or husband already discussed and number of lifetime partners is > 1, use
only the dates for the last 3 partners.
If CI-4 MATCHFP=1 or MATCHFP2=1 or MATCHFP3=1 or (CG-2
SAMEMAN=1 and LIFEPRT>1) then use:
    cmlsex, cmlsex2, cmlsex3
Else use:
    cmfplast, cmlsex, cmlsex2, cmlsex3

The condition implicit in the above else statement is:
1) if none of the partners was the first partner, or
2) first partner was same as husband/cohab, and only one partner in life,
use the dates for the last 3 partners, plus the date for the first partner.
if
1) (CI-4 MATCHFP=5 or system-missing and MATCHFP2=5 or system-missing
and MATCHFP3=5 or system-missing and CG-2 SAMEMAN =5 or system-
missing) or
2) (CG-2 SAMEMAN=1 and LIFEPRT=1)

If 1,2,or 3 partners in the past year (PARTS1YR<4) then do:
For each partner for whom the date of last sex is within past 3 months (computed
variable for date, as defined above is GE cmintvw-2), increment NUMP3MOS by
1. (NUMP3MOS=1, 2, or 3)

Else if more than 3 partners in the last 12 months (PARTS1YR>=4) then:
For each partner with whom the date of last sex is within the past 3 months
(computed variable for date, as defined above, is GE cmintvw-2), increment
NUMP3MOS by 1 (NUMP3MOS=1, 2, or 3), except if all 3 partners fall within
past 3 months, then NUMP3MOS=4.

Else, for each partner with whom the date of last sex (computed variables set as defined above) is
within the past 3 (computed variable for date, as defined above, is GE cmintvw-2), increment
NUMP3MOS by 1.

User Notes:
-- Computed variable cmintvw is defined in Flow Check A-1

-- Code categories:
The questionnaire was designed to capture a maximum of 3 partners within the past year. Therefore for respondents who had 4 or more partners in the past year, there is some degree of unknown with respect to numbers of partners in the past 3 months. If all 3 partner slots are filled with dates in the past 3 months, there could have been one or more additional partners within the past 3 months, but this is not ascertainable. This is the
reason for code category “4” and the distinction between categories 3 and 4.

-- NUMP3MOS is defined even if one or more of the dates are “don’t know” or “refused.” In other words, NUMP3MOS is incremented for any valid date falling within the past 3 months.

-- NUMP3MOS can exceed PARTS1YR (3 cases in the 2013-2015 release). This is because the R provided inconsistent information in the interview: Reported “1” to number of partners in the past year, but identified 2 dates of last sex within the past 3 months, and reported they were not the same partner.

Imputation Note: Computed based on imputed values of the source recodes.

Code categories:

<table>
<thead>
<tr>
<th>Blank</th>
<th>= Inapplicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>= 0 partners</td>
</tr>
<tr>
<td>1</td>
<td>= 1 partner</td>
</tr>
<tr>
<td>2</td>
<td>= 2 partners</td>
</tr>
<tr>
<td>3</td>
<td>= 3 partners exactly</td>
</tr>
<tr>
<td>4</td>
<td>= 3, possibly more partners</td>
</tr>
</tbody>
</table>

SEX3MO**: “Intercourse in the past 3 months (including interview month) (based on last sexual partner date -- LSEXDATE)"

SEX3MO=blank (inapplicable) if recode HADSEX=no.

SEX3MO=1: if recode LSEXDATE is \( \geq \text{cmintvw} - 2 \)
SEX3MO=2: if recode LSEXDATE is \( \text{lt cmintvw} - 2 \)

Notes: -- This recode is comparable to the male recode with the same name.
-- SEX3MO only draws from cmlsex (and cmfplast). In rare cases SEX3MO might be “no” but dates on cmlsex2 or cmlsex3 are still within the past 3 months. This is because the order the R reported the partners in takes precedence over dates. The partner corresponding to cmlsex is considered to be the last partner, and it is this partner who is represented in “characteristics of last partner” variables/recodes.

Imputation Note: Based on imputed values of source recode.

Code categories:

<table>
<thead>
<tr>
<th>blank</th>
<th>= Inapplicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>= Yes, had intercourse in the past 3 months (including interview month)</td>
</tr>
<tr>
<td>2</td>
<td>= No, did not have intercourse in the past 3 months (including interview month)</td>
</tr>
</tbody>
</table>
STRLOPER**: “Type of sterilization operation in effect”

This recode specifies the type of sterilization operation “in effect” at the time of interview.

- For tubal sterilizations and vasectomies, the recode takes into account whether R or her current husband or cohabiting partner had a reversal operation.

- For cases where there were multiple operations, the recode assigns precedence to female operations and earlier operations.

- Operations other than tubal sterilization, vasectomy, hysterectomy, and removal of ovaries are counted as sterilization operations only if R said that she (or her current husband or cohabiting partner) was completely sterile as a result.

**STEP 1: Tubal Sterilization, Vasectomy, Hysterectomy, and Bilateral Ovary Removal**

a) The computed variable tubs, defined in Flow Check D-22, indicates whether R is surgically sterile at time of interview, due to either an unreversed tubal sterilization or a reversal failure. Essure is included as a method of tubal sterilization.

b) The computed variable vasect, defined in Flow Check D-22, indicates whether R’s current husband or cohabiting partner is surgically sterile at time of interview due to either an unreversed vasectomy or a reversal failure.

c) The computed variable hyst, defined in Flow Check D-5, indicates whether R has ever had a hysterectomy.

d) The computed variable ovarem, defined in Flow Check D-5, indicates whether R has ever had both ovaries removed, either in a single operation or more than 1 operation.

**STEP 2: Other Sterilizing Operations**

a) The computed variable othr, defined in Flow Check D-7, indicates whether R has ever had any other sterilizing operation, even if that was not its primary purpose.

b) The variable othrm, defined in Flow Check D-7, indicates whether R’s current husband or cohabiting partner has ever had any other sterilizing operation, even if that was not its primary purpose.

**STEP 3: Overall Female and Male Surgical Sterilization Status**

a) Blaise-computed variable rsurgstr indicates overall female surgical sterilization status at time of interview, taking into account whether her tubal sterilization was reversed. For further details, see Flow Check D-22.
b) Blaise-computed variable \texttt{psurgstr} indicates overall surgical sterilization status of R’s current husband or cohabiting partner, taking into account whether his vasectomy was reversed. This variable is set to “no” for Rs who are not currently married or cohabiting. For further details, see Flow Check D-22.

**STEP 4: Definition of STRLOPER**

a) STRLOPER=5 (not surgically sterile) if neither R nor her current husband or cohabiting partner is “surgically sterile” at time of interview (rsurgstr = no and psurgstr = no).

b) Else, if there is only one sterilization operation reported (Only 1 YES among TUBS, HYST, OVAREM, OTHR, VASECT, OTHRM), then:
   1. IF TUBS = YES THEN STRLOPER=1 (tubal sterilization)
   2. IF HYST = YES THEN STRLOPER=2 (hysterectomy)
   3. IF VASECT = YES THEN STRLOPER=3 (vasectomy)
   4. IF OVARM = YES OR OTHR = YES OR OTHRM = YES THEN STRLOPER=4 (other operation or type unknown)

c) Else, if there are two or more operations reported (more than 1 YES among TUBS, HYST, OVAREM, OTHR, VASECT, OTHRM), then:

If there is a male operation reported (psurgstr = yes) and one or more female operations reported (rsurgstr = yes), then STRLOPER codes the earliest female operation.

*Dates* for sterilization operations are given in the following Blaise-computed variables:
\begin{itemize}
  \item \texttt{cmtublig} -- Tubal sterilization (including Essure)
  \item \texttt{cmhyst} -- Hysterectomy
  \item \texttt{cmovarem} -- Ovary removal
  \item \texttt{cmotsurg} -- Other female sterilizing operation
  \item \texttt{cmmaleop} -- Vasectomy or other male sterilizing operation
\end{itemize}

*Further criteria for determining which operation to code in STRLOPER:*

-- If the date of one operation is missing and the date of the other operation is known, R is classified based on the operation with a known date.

-- If the dates are the same for all operations and one of them is a hysterectomy (e.g., the woman has a hysterectomy and both ovaries removed in the same operation), STRLOPER is coded “hysterectomy.”

-- If the dates are missing for all female operations, if hysterectomy is one of the operations, and tubal sterilization is NOT among the operations, then STRLOPER is coded “hysterectomy.” However, if tubal sterilization is among the operations, STRLOPER is coded “tubal sterilization.”

*Imputation note:* Due to defaulting to code 5, STRLOPER should not require imputation.
unless there is significant missing data.

Code categories:
1 = Tubal ligation or sterilization
2 = Hysterectomy
3 = Vasectomy
4 = Other operation or type unknown
5 = Not surgically sterile

**FECUND**: “Fecundity status”

The FECUND recode describes the respondent’s ability to get pregnant and carry a baby to term. Women may be classified in one of the “non-fecund” categories if they are surgically sterile or if their fecundity is impaired in some other way.

Respondents are classified in hierarchical order, from codes 1 to 6, with 6 (fecund) being the residual category. For example, a respondent may fulfill the definition for “long interval without conception” but if she also fulfills the definition for “subfecund” she is classified as “subfecund.” The exception is that we begin by classifying all currently pregnant respondents as FECUND=6.

Note: A married or cohabiting respondent is considered “surgically sterile” based on sterilizing operations that either she had or her husband or partner had. In this respect, this recode for fecundity status is “couple-based.” If you wish to analyze a “woman-based” fecundity status, you can compute a comparable recode limited to female sterilizing operations, regardless of R’s marital or cohabitation status.

If R is currently pregnant and her husband/partner is not surgically sterile (recode RCURPREG = 1 and recode STRLOPER = 5), then FECUND=6.

ELSE:

If R has reported a sterilization “in effect” at interview (STRLOPER NE 5), then she is classified as surgically sterile (FECUND=1 or FECUND=2), based on the contraceptive intent of the sterilization operation.

Contraceptive intent is defined for the operation that is coded in STRLOPER because this recode has already assigned priority in cases of multiple sterilizing operations.

Female “reasons for the operation” variables:
DB-3a RHADALLx - codes whether R had had all the children she wanted
DB-3b HHADALLx - codes whether her current husband/partner had had all the children he wanted
DB-4 FMEDREASx - allows coding for up to 5 medical reasons for operation
DB-5a BCREASx - codes whether R had reasons related to birth control methods
DB-5b BCWHYFx - codes whether BC reasons were health-related or other

Because up to 4 female sterilization operations could be reported, there are 4 clusters of
the above variables, and each is reserved for a particular type of operation:

1st cluster - tubal sterilization (including Essure)
2nd cluster - hysterectomy
3rd cluster - ovary removal
4th cluster - “other female sterilizing operation.”

Only 1 male sterilization operation could be reported, and the “reasons for operation” variables are:

DB-11a RHADALLM - codes whether R had had all the children she wanted
DB-11b HHADALLM - codes whether her current husband/partner had had all the children he wanted
DB-12 MEDREASx - allows coding for up to 5 medical reasons for operation
DB-13a BCREASM - codes whether R had reasons related to birth control methods
DB-13b BCWHYM - codes whether BC reasons were health-related or other

**FECUND=1 (Surgically Sterile, Contraceptive):**

If it is impossible for R or her husband/partner to have another baby because of a sterilizing operation that was done, at least in part, for contraceptive reasons, then she is *surgically sterile for contraceptive reasons* and FECUND=1.

A female operation is defined as having *contraceptive intent*:

--  if R reported any reasons other than “medical reasons” (DB-3a RHADALL=1 or DB-3b HHADALL=1 or DB-5a BCREAS=1) OR
--  if she only reported “medical reasons” but none of them were “medical problems with female organs” [(DB-3a RHADALL NE 1 and DB-3b HHADALL NE 1 and DB-5a BCREAS ne1 and DB-4 FMEDREAS(1st mention) NE 6, DK, or RF) and (none of the 5 mentions for DB-4 FMEDREAS include code 1)].

Similarly, a male operation is defined as having *contraceptive intent*:

--  if R reported any reasons other than “medical reasons” (DB-11a RHADALLM=1 or DB-11b HHADALLM=1 or DB-13a BCREASM=1) OR
--  if she only reported “medical reasons” but none of them were “pregnancy would be dangerous for your health” [(DB-11a RHADALLM NE 1 and DB-11b HHADALLM NE 1 and DB-13a BCREASM NE 1 and DB-12 MEDREAS(1st mention) NE 6, DK, or RF) and (none of the 5 mentions for DB-12 MEDREAS include code 1)].

**FECUND=2 (Surgically Sterile, Noncontraceptive):**

If it is impossible for R or her husband/partner to have another baby because of a sterilizing operation that was ONLY done for NONcontraceptive reasons, then she is *surgically sterile for noncontraceptive reasons* and FECUND=2.

A female operation is defined as having *solely non-contraceptive intent* if R ONLY cited “medical reasons” (DB-3a RHADALL NE 1 and DB-3b HHADALL NE 1 and DB-5a BCREAS ne1 and DB-4 FMEDREAS(1st mention) NE 6, DK, or RF) AND the specific...
medical reasons cited in DB-4 FMEDREASx includes “medical problems with your female organs.”

Similarly, a male operation is defined as having solely non-contraceptive intent if she only reported “medical reasons” but at least one of them was “pregnancy would be dangerous for your health” [(DB-11a RHADALLM NE 1 and DB-11b HHADALLM NE 1 and DB-13a BCREASM NE 1 and DB-12 MEDREAS(1st mention) NE 6, DK, or RF) and (any of the 5 mentions for DB-12 MEDREAS include code 1)].

**If reasons for STRLOPER operation are missing, then FECUND may still be coded 1 or 2, based on the following assumptions:**

If STRLOPER NE 5 and reasons for the operation coded in STRLOPER are missing (all “reasons” variables are GE 97), then:

- IF STRLOPER=1 THEN FECUND=1 (assume tubal sterilizations are contraceptive)
- IF STRLOPER=2 THEN FECUND=2 (assume hysterectomies are non-contraceptive)
- IF STRLOPER=3 THEN FECUND=1 (assume vasectomies are contraceptive)
- IF STRLOPER=4 THEN FECUND=2 (assume “other operations” are non-contraceptive)

The remaining categories of FECUND are limited to respondents who are not surgically sterile at interview (STRLOPER EQ 5), and are defined in the order shown below. *(Note: This means, for example, that a respondent who fulfills the definition of FECUND=4 and FECUND=5 will get coded as FECUND=4.)*

**FECUND=3 (Nonsurgically Sterile):**

If R reports that it is impossible for her to have a(nother) baby for reasons other than surgical sterilization (DE-1 POSIBLPG=5) or for her husband or cohabiting partner to father a(nother) baby (DE-3 POSIBLMN=5), then she is nonsurgically sterile and FECUND=3.

**FECUND=4 (Subfecund):**

If R reports that it is difficult for her, and/or her current husband, to conceive or deliver a(nother) baby (DF-1 CANHAVER=1 OR DF-3 CANHAVEM=1), OR if a medical doctor advised her NEVER to become pregnant (again) (DF-4 PREGNONO=1), then she is subfecund and FECUND=4.

**FECUND=5 (Long Interval Without Conception):**

If, during the 36 months or more of continuous marriage or cohabitation prior to interview, R did not have a pregnancy, used no contraception, and had no months of non-intercourse, she is classified as having a long interval without conception.

*Must first define intermediate variables for “any method use in last 36 months” and “any*
months of non-intercourse in last 36 months”:

- To define **ANYBC36** (any contraceptive use in last 36 months), check array of method calendar variables for contraceptive use in the 36 months preceding the interview. METHX1 through METHX192 contain contraceptive method(s) used, if any, for each of (up to) 48 months prior to and including the interview month. Check each one within the time frame [cmintvw minus 36] through cmintvw. If any of them = 3-21 or 25-26 (see ED-6 METHHIST in the CAPI reference questionnaire) then a contraceptive method was used.

  \[
  \text{ANYBC36} = 1 \quad \text{("yes, at least one month of reported method use")}
  \]
  - if R reported any method use in the last 36 months (ED-6 METHHIST >=3 and <=21 or =25, 26)
  Else
  \[
  \text{ANYBC36} = 2 \quad \text{("no, no months of method use – nothing used in all months")}
  \]
  - if R reported “1” -”none” or system-missing in all months (all system-missing means everused=5)*
  or R reported don’t know or refused (98, 99) in any of the 36 months (and reported no months of method use).

  *If everused is system-missing or “7” then method use was not ascertained so ANYBC36 cannot be ascertained and remains 2.

- To define **NOSEX36** (any months of non-intercourse in last 36 months), check values of EC-8 MONSX[nnnn] through MONSX[nnnn-36], where nnnn=cmintvw.

  \[
  \text{NOSEX36} = 2 \quad \text{(yes, one or more months of nonintercourse)}
  \]
  - if R reported any months of non-intercourse in any of the last 36 months (any occurrence of code 5 or system-missing or don’t know or refused)
  Else
  \[
  \text{NOSEX36} = 1 \quad \text{(no, no months of non-intercourse – intercourse in all months)}
  \]
  - if R reported intercourse in all 36 months (code 1) and no missing values in the 36 months (don’t know or refused (8,9), or system-missing)

Once these 2 intermediate variables are defined, proceed as follows:

(a) if the interval between the date of interview and the date when R began living with her current husband/cohabiting partner is 36 months or more and if there were no months of nonintercourse reported in the 36 months prior to interview:

\[
\text{If } ((\text{cmintvw} - \text{cmstrthp}) \geq 36) \quad \text{AND} \quad \text{No months of nonintercourse in 36 months prior to interview (NOSEX36=NO)}
\]

Continue with step (b).

(Blaise-computed cmstrthp indicates century-month when R began living with current husband or cohabiting partner.)

(b) (1) If R has:
Never been pregnant (recode PREGNUM = 0) and
Had sexual intercourse since menarche (recode SEEVER = 1) and
Never used a contraceptive method (recode ANYMTHD = NO),

THEN R has a long interval (FECUND = 5).

(2) If R has:
Never been pregnant (PREGNUM = 0) and
Had sexual intercourse since menarche (SEEVER = 1) and
Ever used a contraceptive method (ANYMTHD = 1),

THEN if R has NOT used any contraceptive during the past 36 months
(ANYBC36=NO), then R has a long interval (FECUND = 5).

(3) If R has:
Ever been pregnant (PREGNUM GE 1) but is not currently
pregnant (recode RCURPREG=NO)
THEN:
If her last pregnancy ended at least 36 months prior to interview [(cmintvw - cmlstprg) GE 36)] and R never used a method in the last 36 months
(ANYBC36=NO),
THEN R has a long interval and FECUND=5.

**FECUND=6 (Fecund):**

If R has not been classified thus far, she is considered *fecund* (the residual category) and
FECUND=6.

*User Note:* The 2 intermediate variables defined for computation of FECUND are included on
the public-use data file -- ANYBC36 & NOSEX36.

*Imputation note:* Due to defaulting to code 6, FECUND should not require imputation
unless there is significant missing data.

Code categories:
1 = Surgically Sterile, Contraceptive
2 = Surgically Sterile, Noncontraceptive
3 = Sterile, Nonsurgical
4 = Subfecund
5 = Long interval
6 = Fecund

**INFERT**: "Infertility status"

Infertility is defined as 12 or more months of intercourse without pregnancy and without
contraception. The INFERT recode is defined for respondents who are currently married or
cohabiting.
INFERT is blank (inapplicable) if R is not currently married or cohabiting (recode RMARITAL NE 1 or 2).

FOR ALL RESPONDENTS WHO ARE CURRENTLY MARRIED OR COHABITING (RMARITAL=1 or 2):

1. If R or her husband/partner is surgically sterile (recode STRLOPER NE 5), then INFERT=1 (surgically sterile).

2. If R has never had a menstrual period (BA-1 MENARCHE = 96), then INFERT=2 (infertile). (Recall that this recode is only defined for currently married or cohabiting women, so this would be quite rare and probably indicative of a fertility problem.)

3. If R is currently pregnant (recode RCURPREG EQ YES) or if she has had a month or more of nonintercourse in the 12 months prior to interview (0< recode NOSEX12<95), then INFERT=3 (fecund).

4. If R has used a method at all in the 12 months prior to interview (ANYBC12= YES), then INFERT=3 (fecund).

- To define ANYBC12 (any contraceptive use in last 12 months), check array of method calendar variables for contraceptive use in the 12 months preceding the interview.
  METHX1 through METHX192 contain contraceptive method(s) used, if any, for each of (up to) 48 months prior to and including the interview month. Check each one within the time frame [cmintvw minus 12] through cmintvw. If any of them = 3-21 or 25-26 (see ED-6 METHHIST in the CAPI reference questionnaire) then a contraceptive method was used.

  ANYBC12 = 1 (“yes, at least one month of reported method use”)  
  if R reported any method use in the last 12 months (ED-6 METHHIST >=3 and <=21 or =25, 26)

  Else
  ANYBC12 = 2 (“no, no months of method use – nothing used in all months”)  
  If R reported “1” -“none” or system-missing in all months (all system-missing means everused=5)*  
  or R reported don’t know or refused (98, 99) in any of the 12 months (and reported no months of method use).

  *If everused is system-missing or “7” then method use was not ascertained so ANYBC12 cannot be ascertained and remains 2.

5. If, during the 12 months or more of continuous marriage/union with no months of nonintercourse, the couple did not have a pregnancy and used no contraception, R is considered infertile (INFERT=2). That is,

  a. If R has been in her current marriage or cohabiting union for 12 months or more [(cmintvw - cmstrthp) GE 12] and there were no months of nonintercourse
reported in those 12 months (NOSEX12=0), continue with step 5b. *(Blaise-computed cminstrhp indicates century-month when R began living with current husband or cohabiting partner.)*

(b) R is classified as follows:

1) If R has never been pregnant (recode PREGNUM=0) and never used a method since first intercourse (recode ANYMTHD=NO), then R is considered infertile and INFERT=2.

2) If R has never been pregnant (PREGNUM=0) and EVER used a method since first intercourse (ANYMTHD=YES), then:
   - If R has not used a contraceptive method in the past 12 months (ANYBC12=NO), then R is considered infertile and INFERT=2.

3) If R has ever been pregnant (PREGNUM GE 1), and there have been at least 12 months since her last pregnancy ended ((cmintvw - cmlstprg) GE 12), and R has not used any contraceptive methods in last 12 months (ANYBC12=NO), then R is considered infertile, and INFERT=2.
   *(Blaise-computed cmlstprg, defined in Flow Check B-42d, indicates century-month when R’s last completed pregnancy ended.)*

   Note: As with FECUND’s “long interval” classification, some respondents classified as “infertile” based on having no pregnancies in the 12 months prior to interview, could have reported an abortion in the Audio-CASI portion of the interview.

(6) If extensive missing data made a case bypass steps 1-5 above, then:

(a) If the 4 method calendar variables corresponding to the month of interview show method use other than female or male surgical sterilization (ED-6 METHHISTxxx include only codes 3, 4, 7-21, 25, 26), then R is considered fecund and INFERT=3.
   *(There should be no married/cohabiting cases with METHHISTnnnn codes of 5 or 6 in month of interview who don’t also have recode STRLOPER NE 5.)*

(b) If there is still too much missing data to classify R, the case needs to be examined by NCHS and ISR staff and imputed if necessary. Unless there is evidence to the contrary, such cases are generally be assumed to be fecund and INFERT=3.

User Note: The intermediate variable (ANYBC12) defined for computation of INFERT is included on the public-use data file.

Imputation note: Due to defaulting to code 3, INFERT should not require imputation unless there is significant missing data.

Code categories:
- Blank = Inapplicable
- 1 = Surgically sterile
2  = Infertile
3  = Fecund

ANYMTHD**: “Ever used any method for any reason”

If (computed variable everused=yes) or (DA-1 EVERTUBS=1 or 6) or (DA-9 WHATOPSM=1 or 6) then ANYMTHD=1.

Otherwise, if everused=no and (DB-1 EVERTUBS NE 1 and NE 6) and (DB-9 WHATOPSM NE 1 and NE 6) then ANYMTHD=2.

Note: Since this is meant to capture method use for any reason, and method use by those planning to have intercourse, those who never had intercourse are not excluded.

Code categories:

1  = Yes
2  = No

NOSEX12**: “Number of months of nonintercourse in the 12 months prior to interview”

If R never had intercourse (recode HADSEX = 2), then NOSEX12=95.

If R has had no months of nonintercourse since cmjan3yr (January of year of interview minus 3) (EC-3 INTR-EC3 =5)
and date of first sex was earlier than or equal to 12 months prior to interview, (cmfstsex LE (cmintvw-11)),
or date of first sex is unknown (cmfstsex=9998 or 9999)
Then NOSEX12=0

Else if R has had no months of nonintercourse since cmfstsex (EC-3 INTR-EC3=5)
and date of first sex was within the 12 months prior to interview, (cmfstsex GT cmintvw-11), then NOSEX12=the number of months between 12 months prior to the interview, and first sex (cmfstsex - (cmintvw-11)).

Else if R has had one or more months of nonintercourse since cmjan3yr (January of year of interview minus 3) (EC-3 INTR-EC3=1): 
and date of first sex was earlier than or equal to 12 months prior to interview, (cmfstsex LE (cmintvw-11)),
Count the months of nonintercourse (5) in the 12 months prior to interview (using EC-8 MONSXnn through MONSXnn-11, where nn corresponds to the MONSX for the month of interview) and sum to create total number of months

Else if R has had one or more months of nonintercourse since cmfstsex (EC-3 INTR-EC3=1): 
and date of first sex was within the 12 months prior to interview, (cmfstsex GT cmintvw-11),
Count the months of nonintercourse (5) in the 12 months prior to interview (using EC-8 MONSXnn through MONSXnn-11, where nn corresponds to the MONSX for the month of interview) and sum to create total number of months.

Else if R reported “don’t know” or “refused” to whether one or more months of nonintercourse since cmjan3yr / cmfstsex, (EC-3 INTR-EC3=8 or 9) but there are valid responses in MONSXnn through MONSXnn-11:

Count the months of nonintercourse (5) in the 12 months prior to interview (using EC-8 MONSXnn through MONSXnn-11, where nn corresponds to the MONSX for the month of interview) and sum to create total number of months.

Else if first sex was same as interview month (EC-3 INTR_EC3=. and cmintvw=cmfstsex) then NOSEX12=11

Code categories:

00-12 = Number of months of nonintercourse
95 = Never had intercourse

SEXP3MO**: “Intercourse in the past 3 months (including interview month) (based on nonintercourse series (EC))”

SEXP3MO=blank (inapplicable) if recode HADSEX=no.

SEXP3MO=1:
-- if R has had no periods of non-intercourse since [year of interview minus 3] (or first sex) (EC-3 INTR-EC3 = 5 or (EC-3 INTR-EC3=blank and cmfstsex=cmintvw))
-- if R reported intercourse in any of the two months prior to interview month or in interview month, (EC-8 MONSX[nnn], or EC-8 MONSX[nnn]-1 = 1, or EC-8 MONSX[nnn]-2=1, where nnnn=CM of interview)

SEXP3MO=2:
-- if R reported no intercourse in interview month and the two months prior to interview month, (EC-8 MONSX[nnnn] = 5 and EC-8 MONSX[nnnn]-1 = 5, and EC-8 MONSX[nnnn]-2=5, where nnnn=CM of interview)

Code categories:

blank = Inapplicable
1 = Yes, had intercourse in past 3 months (including interview month)
2 = No, did not have intercourse in past 3 months (including interview month)

CONSTAT1**: “Current contraceptive status”

This recode is designed to show current contraceptive status as used in Cycles 3, 4, 5, 6, 2006-2010, and 2011-2013 of the NSFG. It refers to the method used in the month of interview, or “current month.” In cases where multiple methods were used in the current (interview) month,
CONSTAT1 codes the HIGHEST priority method reported, according to a predetermined ranking of use-effectiveness, as used in earlier NSFG cycles. Up to four methods for the current month are ranked; the second, third, and fourth highest priority methods are coded in CONSTAT2-CONSTAT4, respectively. (See specifications that follow CONSTAT1.)

Code categories for CONSTAT1 are arranged below to distinguish contraceptors from noncontraceptors for analytic purposes.

Using Contraception:

01 = Female sterilization
02 = Male sterilization
03 = Hormonal implant
05 = Depo-Provera (injectable)
06 = Pill
07 = Contraceptive Patch
08 = Contraceptive Ring
09 = Emergency contraception
10 = IUD
11 = Diaphragm (with or w/out jelly or cream)
12 = (Male) Condom
13 = Female condom/vaginal pouch
14 = Foam
15 = Cervical Cap
16 = Today(TM) Sponge
17 = Suppository or insert
18 = Jelly or cream (not with diaphragm)
19 = Periodic abstinence: NFP, cervical mucus test or temperature rhythm
20 = Periodic abstinence: calendar rhythm
21 = Withdrawal
22 = Other method

Not using contraception:

30 = Pregnant
31 = Seeking Pregnancy
32 = Postpartum
33 = Sterile--nonsurgical--female
34 = Sterile--nonsurgical--male
35 = Sterile--surgical--female (noncontraceptive)
36 = Sterile--surgical--male (noncontraceptive)
37 = [code not used]
38 = Sterile--unknown reasons -male
39 = [code not used]
40 = Other nonuser--never had intercourse since first period
41 = Other nonuser--has had intercourse, but not in the 3 months prior to interview
42 = Other nonuser--had intercourse in the 3 months prior to interview
88 = inapplicable (no 2nd, 3rd, or 4th method reported -- applies to CONSTAT2-CONSTAT4 only)
If R is pregnant at interview (RCURPREG=YES), then CONSTAT1=30.

Else, if R or her current husband or cohabiting partner is surgically sterile at interview (STRLOPER NE 5)
Or she reported any sterilizing operation in the method history calendar:

CONSTAT1=01 (sterile--surgical--female):
If FECUND=1 and (STRLOPER in(1,2) or (STRLOPER=4 and rsurgstr=yes))
or
If FECUND NE 3 and (ED-6 METHHISTnnn-METHHISTnnnn+4 for month of interview = 6)

Else CONSTAT1=35 (sterile --surgical—female (noncontraceptive))
If FECUND=2 and (STRLOPER in(1,2) or (STRLOPER=4 and rsurgstr=yes))

Else CONSTAT1=02 (sterile--surgical--male):
If FECUND=1 and (STRLOPER=3 or (STRLOPER=4 and psurgstr=yes))
or
If (ED-6 METHHISTnnn-METHHISTnnnn+4 for month of interview = 5)

Else CONSTAT1=36 (sterile--surgical—male (noncontraceptive)):
If FECUND=2 and (STRLOPER=3 or (STRLOPER=4 and psurgstr=yes))

Else, if R is nonsurgically sterile (FECUND=3 and DE-1 POSIBLPG=5), then

CONSTAT1=33 (sterile--nonsurgical--female)

Else, if R’s current husband or partner is nonsurgically sterile (FECUND=3 and DE-3 POSIBLMN=5), then

CONSTAT1=34 (sterile--nonsurgical--male)

Else, If R is using any method in the month of interview, (ED-6 METHHISTnnn for month of interview)* NE 1 and NE system-missing (inapplicable):
*\[only need to check the first METHHIST variable because looking for “no method”\]

If R is using only 1 method, CONSTAT1=this method,

CONSTAT1=(ED-6 METHHISTnnn for month of interview)

If R is using 2 or more methods:

CONSTAT1= method in (ED-6 METHHISTnnn - METHHISTnnn+4 for month of interview) with the highest priority (see table below).

The table below lists methods in order of priority (from highest to lowest) and gives the code
equivalents for ED-6 METHHIST and CONSTAT1.

<table>
<thead>
<tr>
<th>Code in METHHIST:</th>
<th>CONSTAT1 CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sterilization</td>
<td>06 01</td>
</tr>
<tr>
<td>Respondent sterile (not on card)</td>
<td>22 33</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>05 02</td>
</tr>
<tr>
<td>Partner sterile(not on card)</td>
<td>23 38</td>
</tr>
<tr>
<td>Hormonal implant</td>
<td>09 03</td>
</tr>
<tr>
<td>IUD</td>
<td>19 10</td>
</tr>
<tr>
<td>Depo-Provera injectable</td>
<td>08 05</td>
</tr>
<tr>
<td>Pill</td>
<td>03 06</td>
</tr>
<tr>
<td>Contraceptive patch</td>
<td>25 07</td>
</tr>
<tr>
<td>Contraceptive ring</td>
<td>26 08</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>20 09</td>
</tr>
<tr>
<td>(Male) condom</td>
<td>04 12</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>12 11</td>
</tr>
<tr>
<td>Female condom/vaginal pouch</td>
<td>13 13</td>
</tr>
<tr>
<td>Today (TM) Sponge</td>
<td>18 16</td>
</tr>
<tr>
<td>Cervical cap</td>
<td>16 15</td>
</tr>
<tr>
<td>NFP, Temperature rhythm</td>
<td>11 19</td>
</tr>
<tr>
<td>Calendar rhythm</td>
<td>10 20</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>07 21</td>
</tr>
<tr>
<td>Foam</td>
<td>14 14</td>
</tr>
<tr>
<td>Suppository or insert</td>
<td>17 17</td>
</tr>
<tr>
<td>Jelly or cream alone</td>
<td>15 18</td>
</tr>
<tr>
<td>Other method</td>
<td>21 22</td>
</tr>
</tbody>
</table>

---

Else, if R is seeking pregnancy (EH-1 WYNOTUSE =1 or EH-2 HPPREGQ =1):

CONSTAT1=31.

Else, if R is postpartum, as defined by:

-- Interview Date (Month/Day/Year of interview) is before the 15th day of the month, and the difference between the interview month (cmintvw) and the month of the last pregnancy termination (computed variable cmlstprg) is less than or equal to 2 months, or

-- Interview date (Month/Day/Year of interview) is on or after the 15th day of the month and the difference between the interview month (cmintvw) and the month of the last pregnancy termination (computed variable cmlstprg) is less than or equal to 1 month. then

CONSTAT1=32

Note: Computed variable cmlstprg is defined in Flow Check B-42d in the CAPI Reference Questionnaire.
Else, if R never had intercourse since her first menstrual period (SEXEVER=2), then

\[
\text{CONSTAT1}=40
\]

Else, if (ED-6 METHHISTnnn for month of interview)=1 (no method used), or ANYMTHD=2 (never used a method) then:

\[
\begin{align*}
\text{CONSTAT1}&=41 \quad \text{If R had no intercourse in the 3 months prior to interview} \\
&\quad \text{(SEXP3MO=2)} \\
\text{CONSTAT1}&=42 \quad \text{If R had intercourse in the 3 months prior to interview} \\
&\quad \text{(SEXP3MO=1)}
\end{align*}
\]

\text{CONSTAT2**: "2nd priority code for current contraceptive status"}

If CONSTAT1=1 and R reported any male sterilization operation (psurgstr=1 or any code 5 in METHHISTnnn vars for month of interview), then:

\[
\begin{align*}
\text{CONSTAT2}&=02 \quad \text{(sterile--surgical--male):} \\
&\quad \text{If FECUND=1 and (STRLOPER=3 or (STRLOPER=4 and psurgstr=yes))} \\
&\quad \quad \text{or} \\
&\quad \quad \text{If (ED-6 METHHISTnnn-METHHISTnnnn+4 for month of interview = 5)}
\end{align*}
\]

Else, \text{CONSTAT2}=36 (sterile--surgical—male (noncontraceptive)):

\[
\begin{align*}
&\quad \text{If FECUND=2 and (STRLOPER=3 or (STRLOPER=4 and psurgstr=yes))}
\end{align*}
\]

Else, if R is nonsurgically sterile (FECUND=3 and DE-1, POSIBLPG=5), then

\[
\text{CONSTAT2}=33 \quad \text{(sterile--nonsurgical--female)}
\]

Else, if R’s current husband or partner is nonsurgically sterile (FECUND=3 and DE-3, POSIBLMN=5), then

\[
\text{CONSTAT2}=34 \quad \text{(sterile--nonsurgical--male)}
\]

Else if R is using a method in the month of interview, (ED-6 METHHISTnnn-METHHISTnnnn+4 for month of interview) NE 1 and NE system-missing and NE 6 (female sterilization already captured in CONSTAT1):

\[
\begin{align*}
&\quad \text{If R is using ONE method, CONSTAT2=\text{this method.}} \\
&\quad \text{If R is using more than 1 method,} \\
&\quad \quad \text{CONSTAT2= method in (ED-6 METHHISTnnn - METHHISTnnnn+4 for month of interview) with the highest priority (see table above in CONSTAT1).}
\end{align*}
\]

Code categories:

See CONSTAT1
CONSTAT3**: “3rd priority code for current contraceptive status”

If R is using a method in the month of interview, (ED-6 METHHISTnnn-METHHISTnnnn+4 for month of interview) NE 1 and NE system-missing and NE 6 (female sterilization already captured in CONSTAT1):

- If R is using ONE method, CONSTAT3=this method.
- If R is using more than 1 method, CONSTAT3= method in (ED-6 METHHISTnnn - METHHISTnnnn+4 for month of interview) with the next highest priority (see table above in CONSTAT1).

The code categories and specifications for CONSTAT3 are the same as for CONSTAT2. If CONSTAT1 is imputed, then CONSTAT3 is also imputed. If CONSTAT1 does not need imputation and there is no third method reported in (ED-6 METHHISTnnn - METHHISTnnnn+4 for month of interview), then CONSTAT3=88 (inapplicable).

Code categories:
See CONSTAT1

CONSTAT4**: “4th priority code for current contraceptive status”

If R is using a method in the month of interview, (ED-6 METHHISTnnn-METHHISTnnnn+4 for month of interview) NE 1 and NE system-missing and NE 6 (female sterilization already captured in CONSTAT1):

- If R is using ONE method, CONSTAT4=this method.
- If R is using more than 1 method, CONSTAT4= method in (ED-6 METHHISTnnn - METHHISTnnnn+4 for month of interview) with the next highest priority (see table above in CONSTAT1).

The code categories and specifications for CONSTAT4 are the same as for CONSTAT2. If CONSTAT1 is imputed, then CONSTAT4 is also imputed. If CONSTAT1 does not need imputation and there is no fourth method reported in (ED-6 METHHISTnnn - METHHISTnnnn+4 for month of interview), then CONSTAT4=88 (inapplicable).

Code categories:
See CONSTAT1

PILLR**: “Ever used the pill for any reason”

PILLR=1 if:
- R has ever used the pill (EA-1 PILL=1); or
- R says she never used the pill (EA-1 PILL=5) but the pill was:
  - One of the methods stopped due to dissatisfaction (EA-17 METHSTOP=3)
  - Her first method ever (EB-1 FIRSMETH1-FIRSMETH4=3),
  - or her method at first intercourse (any of computed variables mthfstsx1 –
mthfstsx4=3),
- or the last method she used before a pregnancy (EG-4 WHATMETH1-WHATMETH80=3),
- or a method she used sometime during the last 4 years (ED-6 METHX1-METHX192=3),
or the method she used at last or first intercourse with partner(s) in past 12 months (EF-2 LSTMTHP1-LSTMTHP4=3 or LSTMTHP5-LSTMTHP8=3 or LSTMTHP9-LSTMTHP12=3 or FSTMTHP1-FSTMTHP4=3 or FSTMTHP5-FSTMTHP8=3 or FSTMTHP9-FSTMTHP12=3).

Else if none of the above indicated pill use and EA-1 PILL=5 then PILL=2.

Imputation Note: PILLR is imputed if [EA-1 PILL is missing (DK or RF) and if (mthfstsx1-4, EB-1, EG-4, ED-6, and EF-2) are all missing (DK or RF) or not equal to the pill].

Note: Computed variables mthfstsx1-4 are defined in Flow Check E-18 and Flow Check E-32 in the CAPI Reference Questionnaire

Note: Since this is meant to capture pill use for any reason, and pill use by those planning to have intercourse, those who never had intercourse are not excluded.

Code categories:
1=Yes
2=No

CONDOMR**: “Ever used a condom”

CONDOMR=blank (inapplicable) if R has never had intercourse (recode HADSEX=no).

CONDOMR=1 if:
-- R has ever used condoms for any reason (EA-2 CONDOM=1); or
-- R says she has never used condoms (EA-2 CONDOM=5) but the condom was:
  - One of the methods stopped due to dissatisfaction (EA-17 METHSTOP=4)
  Her first method ever (EB-1 FIRSMETH1-FIRSMETH4=4),
or her method at first intercourse (any of computed variables mthfstsx1 – mthfstsx4=4),
or the last method she used before a pregnancy (EG-4 WHATMETH1-WHATMETH80=4),
or a method she used sometime during the last 4 years (ED-6 METHX1-METHX192=4),
or the method she used at last or first intercourse with partner(s) in past 12 months (EF-2 LSTMTHP1-LSTMTHP4=4 or LSTMTHP5-LSTMTHP8=4 or LSTMTHP9-LSTMTHP12=4 or FSTMTHP1-FSTMTHP4=4 or FSTMTHP5-FSTMTHP8=4 or FSTMTHP9-FSTMTHP12=4).

Else if none of the above indicated condom use and EA-2 CONDOM=5 then CONDOMR=2.
Imputation note: CONDOMR is imputed if
[EA-5 CONDOM is missing (DK or RF)
and
if (mthfstsx1-4, EB-1, EG-4, ED-6, and EF-2) are all missing (DK or RF) or not
equal to the condom].

Note: Computed variables mthfstsx1-4, are defined in Flow Check E-18 and Flow Check E-32 in
the CAPI Reference Questionnaire

Code categories:
Blank = Inapplicable
1 = Yes
2 = No

**SEX1MTHD1**: “Method used at first intercourse, if any-1st method”

SEX1MTHD1=blank (inapplicable) if R has never had intercourse (recode HADSEX=2).

SEX1MTHD1=95: if R has never used a method (recode ANYMTHD=2).

SEX1MTHD1=96: if R did not use a method at first intercourse (computed
variable usefstsx=5)

Otherwise,
SEX1MTHD1=(computed variable mthfstsx1) (subtract 2 from the mthfstsx1 value to
result in the correct values on SEX1MTHD)

Impute if missing (DK or RF):
-- The 1st method ever used is missing (EB-1 FIRSMETH=DK or RF)
-- The timing of first use is missing (EB-2 FIRSTIME1/FIRSTIME2=DK or RF)
-- The method used at first intercourse (for those whose 1st method use was before 1st sex)
is missing (EB-8 MTHFRSTS=DK or RF)

Note: Computed variables usefstsx and mthfstsx1 are defined in Flow Check E-18, Flow Check
E-29 and Flow Check E-32 in the CAPI Reference Questionnaire.

Imputation Note: Cases with FIRSTIME2=1 (first method use was before first sex), but date
of first method use greater than date of first sex, are imputed. In those
cases, use FIRSMETH1 to guide or determine imputed value.

Code categories:
Blank= inapplicable
1= Pill
2= Condom
3= Partner’s vasectomy
4= Female sterilizing operation/tubal ligation
5 = Withdrawal
6 = Depo-Provera, injectables
7 = Hormonal implant
8 = Rhythm or safe period by calendar
9 = Safe period by temperature or cervical mucus test, natural family planning
10 = Diaphragm
11 = Female condom, vaginal pouch
12 = Foam
13 = Jelly or cream
14 = Cervical cap
15 = Suppository, insert
16 = Today™ sponge
17 = IUD, coil, loop
18 = Emergency contraception
19 = Other method
20 = Respondent sterile (aside from sterilizing operation above)
21 = Respondent’s partner sterile (aside from vasectomy above)
22 = Lunelle injectable
23 = Contraceptive patch
24 = Contraceptive ring
95 = Never used a method
96 = Did not use a method at 1st intercourse

SEX1MTHD2-SEX1MTHD4**: “Method used at first intercourse, if any-2nd/3rd/4th method”

SEX1MTHD2-4=blank (inapplicable): if R has never had intercourse (recode HADSEX=2), for if R did not use a 2nd/3rd/4th method at first sex (mthfstsx02/03/04=blank).

Repeat specifications for SEX1MTHD1 for remaining values of SEX1MTHD2-4. Substitute computed variable mthfstsx2/3/4 for mthfstsx1 as in the following:
SEX1MTHD2=(computed variable mthfstsx2)

Impute if missing (DK or RF):
-- The 1st method ever used is missing (EB-1 FIRSMETH1-4=DK or RF)
-- The timing of first use is missing (EB-2 FIRSTIME1/FIRSTIME2=DK or RF)
-- The method used at 1st intercourse (for those whose 1st method use was before 1st sex) is missing (EB-8 MTHFRSTS=DK or RF)

Note: Computed variables usefstsx and mthfstsx2/3/4 are defined in Flow Check E-18, Flow Check E-29 and Flow Check E-32 in the CAPI Reference Questionnaire.

Code categories:
see SEX1MTHD1
**MTHUSE12**: “Whether used any method at last intercourse in past 12 months”

MTHUSE12=BLANK (inapplicable) if:
- R has never had intercourse (HADSEX=2)
- R had no sexual partners in the past 12 months (recode PARTS1YR=0).

MTHUSE12=95 if R has never used a method (ANYMTHD=2)

If R has only had 1 sexual partner in the past 12 months and it was her first partner, and she has only had sex with him once, take the method use information from the EB series (first method use).

- If recode PARTS1YR=1 and LIFEPRT=1 and cmlsexfp=9996, then
  - if recode SEX1MTHD1 LT 96 then MTHUSE12=1
  - else if SEX1MTHD1=96 then MTHUSE12=2

Otherwise, take method use information from the direct questions about method use at last sex with partners in the past 12 months (EF-1 USELSTP).

- Else: if EF-1 USELSTP=1 then MTHUSE12=1
- if EF-1 USELSTP=5 then MTHUSE12=2

If nothing has been assigned on MTHUSE12 and R meets criteria for “applicable” and is not coded 95, then if R had a hysterectomy and used no methods during the past 3 years, assign “1”

- If INTR_ED4a=5 then MTHUSE12=1

*Note:* computed variable cmlsexfp is defined in Flow Check C-57 in the CAPI Reference Questionnaire.

**Imputation note:** App/Inapp based on imputed values of PARTS1YR and ANYMTHD

**Code categories:**
- blank= inapplicable
- 1= used a method at last intercourse in past 12 months
- 2= did not use a method at last intercourse in past 12 months
- 95= R has never used a method

**METH12M1**: “Method used at last sex in the past 12 months-1st method”

METH12M1=BLANK (inapplicable) if:
- R has never had intercourse (HADSEX=2)
- R had no sexual partners in the past 12 months (PARTS1YR=0).
- R has never used a method (ANYMTHD=2)
- R did not use a method at last sex in the past 12 months (MTHUSE12=2)

If R has only had 1 sexual partner in the past 12 months and it was her first partner, and she has only had sex with him once, take the method use information from the EB series (first method use).

- If recode PARTS1YR=1 and LIFEPRT=1 and cmlsexfp=9996, then METH12M1=recode SEX1MTHD1
Otherwise, take method use information from the direct questions about method use at last sex with partners in the past 12 months.

Else METH12M1=EF-2 LSTMTHP1 (subtract 2 from the LSTMTHP1 value to result in the below values on METH12M1)

If nothing has been assigned on METH12M1 and R meets criteria for “applicable,” then if R had a hysterectomy and used no methods during the past 3 years, assign “4” (female sterilizing operation or hysterectomy)

If INTR_ED4a=5 then METH12M1=4

Code categories:
- Blank= inapplicable
- 1= Pill
- 2= Condom
- 3= Partner’s vasectomy
- 4= Female sterilizing operation/hysterectomy
- 5= Withdrawal
- 6= Depo-Provera injectable
- 7= Hormonal implant
- 8= Rhythm or safe period by calendar
- 9= Safe period by temperature or cervical mucus test, natural family planning
- 10= Diaphragm
- 11= Female condom, vaginal pouch
- 12= Foam
- 13= Jelly or cream
- 14= Cervical cap
- 15= Suppository, insert
- 16= Today™ sponge
- 17= IUD, coil, loop
- 18= Emergency contraception
- 19= Other method
- 20= Respondent sterile (aside from sterilizing operation above)
- 21= Respondent’s partner sterile (aside from vasectomy above)
- 22= Lunelle injectable
- 23= Contraceptive patch
- 24= Contraceptive ring

METH12M2-METH12M4**: “Method used at last sex in the past 12 months-2nd/3rd/4th method”

METH12M2-4=inapplicable (BLANK) if:
- -- R has never had intercourse (HADSEX=2)
- -- R had no sexual partners in the past 12 months (recode PARTS1YR=0).
- -- R has never used a method (ANYMTHD=2)
- -- R did not use a method at last sex in the past 12 months (MTHUSE12=2)
- -- R did not use a 2nd/3rd/4th method at last sex in the past 12 months
If R has only had 1 sexual partner in the past 12 months and it was her first partner, and she has only had sex with him once, take the method use information from the EB series (first method use).

If recode PARTS1YR=1 and LIFEPRT=1 and cmllsexfp=9996, then METH12M2/3/4 = recode SEX1MTHD2/ SEX1MTHD3/ SEX1MTHD4

Otherwise, take method use information from the direct questions about method use at last sex with partners in the past 12 months.

Else METH12M2/3/4 = EF-2 LSTMTHP2/3/4 (subtract 2 from the LSTMTHP2-4 value to result in the correct values on METH12M2-4)

Code categories:
see METH12M1

MTHUSE3**: “Whether used any method at last sex in the past 3 months”

This is identical to MTHUSE12 except for the time frame/universe: this only includes those who had sex in the past three months (based on dates of last sex with partners).

MTHUSE3=BLANK (inapplicable) if:
-- R has never had intercourse (recode HADSEX=2)
-- R had no sexual partners in the past 3 months (SEX3MO=2)

MTHUSE3=95 if R has never used a method (recode ANYMTHD=2)

If R has only had 1 sexual partner in the past 3 months and it was her first partner, and she has only had sex with him once, take the method use information from the EB series (first method use).

If recode PARTS1YR=1 and LIFEPRT=1 and cmllsexfp=9996, then do;
  if recode SEX1MTHD1 < 95 then MTHUSE3=1
  else if recode SEX1MTHD1=96 then MTHUSE3=2

Otherwise, take method use information from the direct questions about method use at last sex with partners in the past 12 months (EF-1 USELSTP).

Else: if EF-1 USELSTP=1 then MTHUSE3=1
      if EF-1 USELSTP=5 then MTHUSE3=2

If nothing has been assigned on MTHUSE3 and R meets criteria for “applicable” and is not coded 95, then if R had a hysterectomy and used no methods during the past 3 years, assign “1”

If INTR_ED4a=5 then MTHUSE3=1

Note: If R had a hysterectomy during the method calendar (ED series) time frame, she was asked whether she used any contraceptive methods during this period. If she responded “no” she was skipped past the EF series. These respondents are coded “1” on this recode.

Impatation note: App/Inapp based on imputed values of SEX3MO and ANYMTHD
Code categories:

- blank = inapplicable
- 1 = used a method at last intercourse in past 3 months
- 2 = did not use a method at last intercourse in past 3 months
- 95 = R has never used a method

**METH3M1**: “Method used at last sex in past 3 months-1st method”

This is identical to METH12M1 except for the time frame/universe: this only includes those who had sex in the past three months (based on dates of last sex with partners).

METH3M1 = inapplicable (BLANK) if:

- R has never had intercourse (HADSEX=2)
- R has never used a method (ANYMTHD=2)
- R had no sexual partners in the past 3 months (SEX3MO=2).
- R did not use a method at last sex in the past 3 months (MTHUSE3=2)

If R has only had 1 sexual partner in the past 3 months and it was her first partner, and she has only had sex with him once, take the method use information from the EB series (first method use).

- If recode PARTS1YR=1 and LIFEPRT=1 and cmlsexfp=9996, then METH3M1 = SEX1MTHD1

Otherwise, take method use information from the direct questions about method use at last sex with partners in the past 12 months.

- Else METH3M1 = EF-2 LSTMTHP1 (subtract 2 from the LSTMTHP1 value to result in the below values on METH3M1)

If nothing has been assigned on METH3M1 and R meets criteria for “applicable,” then if R had a hysterectomy and used no methods during the past 3 years, assign “4” (female sterilizing operation or hysterectomy)

- If INTR_ED4a=5 then METH3M1 = 4

**Note**: If R had a hysterectomy during the method calendar (ED series) time frame, she was asked whether she used any contraceptive methods during this period. If she responded “no” she was skipped past the EF series. These respondents are coded “4” on this recode.

Code categories:

- Blank = inapplicable
- 1 = Pill
- 2 = Condom
- 3 = Partner’s vasectomy
- 4 = Female sterilizing operation/hysterectomy
- 5 = Withdrawal
- 6 = Depo-Provera, injectables
- 7 = Hormonal implant
8= Rhythm or safe period by calendar
9= Safe period by temperature or cervical mucus test, natural family planning
10= Diaphragm
11= Female condom, vaginal pouch
12= Foam
13= Jelly or cream
14= Cervical cap
15= Suppository, insert
16= Today™ sponge
17= IUD, coil, loop
18= Emergency contraception
19= Other method
20= Respondent sterile (aside from sterilizing operation above)
21= Respondent’s partner sterile (aside from vasectomy above)
22= Lunelle injectable
23= Contraceptive patch
24= Contraceptive ring

**METH3M2-METH3M4**: “Method used at last sex in past 3 months-2nd - 4th method”

This is identical to METH12M2-4 except for the time frame/universe: this only includes those who had sex in the past three months.

**METH3M2-4**=inapplicable (BLANK) if:
-- R has never had intercourse (HADSEX=2)
-- R has never used a method (ANYMTHD=2)
-- R had no sexual partners in the past 3 months (SEX3MO=2).
-- R did not use a method at last sex in the past 3 months (MTHUSE3=2)
-- R did not use a 2nd/3rd/4th method at last sex in the past 3 months

If R has only had 1 sexual partner in the past 3 months and it was her first partner, and she has only had sex with him once, take the method use information from the EB series (first method use).

If recode PARTS1YR=1 and LIFEPRT=1 and cmlsexfp=9996, then METH3M2/3/4 = SEX1MTHD2/SEX1MTHD3/SEX1MTHD4

Otherwise, take method use information from the direct questions about method use at last sex with partners in the past 12 months.

Else METH3M2/3/4 = EF-2 LSTMTHP2/3/4 (subtract 2 from the LSTMTHP2-4 value to result in the correct values on METH3M2-4)

*User Note:* See note on METH3M1

**FMETHOD1**: “First method ever used-1st”

Code categories:
See METH3M1
FMETHOD1= inapplicable (blank) if:
   if R has never used a method, including surgical sterilization (computed variable 
   ANYMTHD=2 and DA-9 WHATOPSM NE 2).

FMETHOD1= EB-1 FIRSMETH1 (subtract 2 from value for FIRSMETH1 to arrive at proper 
value for FMETHOD1)

Code categories:
   Blank = inapplicable
   1 = Pill
   2 = Condom
   3 = Partner’s vasectomy
   4 = Female sterilizing operation/tubal ligation
   5 = Withdrawal
   6 = Depo-Provera, injectables
   7 = Hormonal implant
   8 = Rhythm or safe period by calendar
   9 = Safe period by temperature or cervical mucus test, natural family planning
   10 = Diaphragm
   11 = Female condom, vaginal pouch
   12 = Foam
   13 = Jelly or cream
   14 = Cervical cap
   15 = Suppository, insert
   16 = Today™® sponge
   17 = IUD, coil, loop
   18 = Emergency contraception
   19 = Other method
   20 = Respondent sterile (aside from sterilizing operation above)
   21 = Respondent’s partner sterile (aside from vasectomy above)
   22 = Lunelle injectable
   23 = Contraceptive patch
   24 = Contraceptive ring

FMETHOD2-FMETHOD4**: “First method ever used-2nd-4th”

FMETHOD2-4= inapplicable (blank) if:
   - R has never used a method, including surgical sterilization (computed variable 
     ANYMTHD=2 and DB-9 WHATOPSM NE 2).
   - R did not use a 2nd/3rd/4th method the first time she used a method.

FMETHOD2-4= EB-1 FIRSMETH2/3/4 (subtract 2 from value for FIRSMETH2-4 to arrive at 
proper value for FMETHOD2-4)

Code categories:
   See FMETHOD1
DATEUSE1**: “Date R used first method for the first time”

DATEUSE1= inapplicable (BLANK) if:
-- R has never had intercourse (HADSEX=2); or
-- R has never used a method, including sterilization of R or current husband/partner
   (computed variable ANYMTHD=2).

DATEUSE1=(computed variable cmfirsm)

The following estimation procedure should be used for cases with inconsistent responses,
described below, to
1) EB-2 FIRSTIME1/FIRSTIME2 with respect to
2) cmfstuse / cmfstsex
(note: such inconsistency could have resulted by overriding EDIT CHECK EB3_7 or EB3_8)

If R has used a method (everused=1 or DA-1 EVERTUBS=1, 4, or 6 or DA-9 WHATOPSM=1, 2, or 6) and if there is a valid date for cmfirsm and cmfstsex
(cmfirsm/cmfstsex NE “DK/RF”)
-- and she used her first method after her first intercourse (EB_2 FIRSTIME1/FIRSTIME2=3,4,5 or 6), BUT her date of first method use is before
the date of first intercourse (computed variable cmfirsm < computed variable cmfstsex), then DATEUSE1 is estimated using the midpoint of the time interval
(EB_2 FIRSTIME1/FIRSTIME2) plus cmfstsex
-- and she used her first method at her first intercourse (EB_2 FIRSTIME1/FIRSTIME2=2), BUT her date of first method use is before or after
the date of first intercourse (computed variable cmfirsm < computed variable cmfstsex or cmfirsm > cmfstsex), then change DATEUSE1 to cmfstsex.

The midpoints of the intervals are estimated by:
If FIRSTIME1/2=2, the first time R had intercourse, then midpoint=0
FIRSTIME1/2=3, less than 1 month after first intercourse, then midpoint=1
FIRSTIME1/2=4, 1-3 months after first intercourse, then midpoint=2
FIRSTIME1/2=5, 4-12 months after first intercourse, then midpoint=8
FIRSTIME1/2=6, more than 12 months after first intercourse, then midpoint= 8

The following also uses the estimation procedure, this time to compensate for missing data:
If R reported “DK/RF” to either the month or the year in EB-3 WNSTUSE_M/WNSTUSE_Y,
but did report an interval after (or at) first intercourse (EB_2 FIRSTIM1/FIRSTIME2=2 through
6), and there is a valid date for cmfstsex (cmfstsex NE “DK/RF”) then: DATEUSE1= cmfstsex
plus the midpoint of the interval (estimated as above):

DATEUSE1=90000+cmfstsex+midpoint

Note: The first column of this century-month variable is “9” if the month is estimated from EB-2
FIRSTIME1/2, and “0” otherwise. This estimation procedure gives priority to the report
of relative timing of 1st method use and 1st sex (FIRSTIME1/2) over the report of date of
1st method use.

Imputation note: Imputation needed if cmfstsex=DK/RF and DATEUSE1 has not been assigned by the above criteria.

Code categories:
- BLANK = inapplicable
- xxxx - nnnn = date of 1st method use
- 9xxxx - 9nnnn = date of 1st method use (estimated)

OLDWPnn**: “Wantedness of pregnancy -- Respondent’s partner -- Cycle 4 version”

OLDWPnn is blank (inapplicable) if R has been pregnant less than N times (PREGNUM LT N).

Otherwise, if R has had an Nth pregnancy (recode PREGNUM GE N), then OLDWPnn is transferred from pregnancy file recode OLDWANTP for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
- blank = inapplicable (never had an Nth pregnancy)
- 1 = Later, overdue
- 2 = Right time
- 3 = Too soon, mistimed
- 4 = Didn’t care, indifferent
- 5 = Unwanted
- 6 = Don’t know, not sure

OLDWRnn**: “Wantedness of pregnancy -- Respondent -- Cycle 4 version”

OLDWRnn is blank (inapplicable) if R has been pregnant less than N times (PREGNUM LT N).

Otherwise, if R has had an Nth pregnancy (recode PREGNUM GE N), then OLDWRnn is transferred from pregnancy file recode OLDWANTR for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
- blank = inapplicable (never had an Nth pregnancy)
- 1 = Later, overdue
- 2 = Right time
- 3 = Too soon, mistimed
- 4 = Didn’t care, indifferent
- 5 = Unwanted
- 6 = Don’t know, not sure

WANTRPnn**: “Wantedness of pregnancy -- Respondent”
WANTRPnn is blank (inapplicable) if R has been pregnant less than N times (recode PREGNUM LT N).

Otherwise,
If R has had an Nth pregnancy (recode PREGNUM GE N), then WANTRPnn is transferred from pregnancy file recode WANTRESP for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
- blank = inapplicable (never had an Nth pregnancy)
- 1 = Later, overdue
- 2 = Right time
- 3 = Too soon, mistimed
- 4 = Didn’t care, indifferent
- 5 = Unwanted
- 6 = Don’t know, not sure

**WANTPnn**: “Wantedness of pregnancy -- Partner”

WANTPnn is blank (inapplicable) if R has been pregnant less than N times (recode PREGNUM LT N).

Otherwise,
If R has had an Nth pregnancy (recode PREGNUM GE N), then WANTPnn is transferred from pregnancy file recode WANTPART for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
- blank = inapplicable (never had Nth-order pregnancy)
- 1 = Later, overdue
- 2 = Right time
- 3 = Too soon, mistimed
- 4 = Didn’t care, indifferent
- 5 = Unwanted
- 6 = Don’t know, not sure

**NWWANTRPnn**: “Detailed Wantedness of pregnancy -- Respondent”

NWWANTRPnn is blank (inapplicable) if R has been pregnant less than N times (recode PREGNUM LT N).

Otherwise,
If R has had an Nth pregnancy (recode PREGNUM GE N), then NWWANTRPnn is transferred from pregnancy file recode NEWWANTR for R’s Nth pregnancy, and no further imputation is needed.

Code categories:
blank = inapplicable (never had an Nth pregnancy)
1 = Later, overdue
2 = Right time
3 = Too soon: by less than 2 years
4 = Too soon: by 2 years or more
5 = Didn't care, indifferent
6 = Unwanted
7 = Don’t know, not sure

WANTP5**: “Number of wanted pregnancies in the last 5 years”

This recode is the number of pregnancies (including a current pregnancy) that a respondent has had:
-- that she wanted (coded 1-4 in interval file recode WANTRESP, which is equivalent to respondent file recodes WANTRP01 through WANTRP20), and
-- that ended in the 60 months before the date of interview (including current pregnancies) (if (cmintvw minus recode DATENDnn for completed pregnancies) LE 60).

WANTP5 is inapplicable (blank) if:
   R has never been pregnant (recode PREGNUM=0) or had no pregnancies end in the 5 years before interview (if (cmintvw minus recode DATENDnn) GT 60).

If R is currently pregnant and she wanted this child (recode RCURPREG=yes and WANTRESP (or WANTRPnn) = 1, 2, 3, or 4) for the current pregnancy, then this pregnancy is counted towards WANTP5.

Note: The 60 months include the month of interview.

Imputation Note: Based on imputed values of source recodes.

Code categories:
   Blank = inapplicable
   0 = No wanted pregnancies in the last 5 years
   1-20 = Number of wanted pregnancies in the last 5 years
**Section F: Family Planning and Medical Services**

**FPTIT12**: “Type of clinic used for family planning services in last 12 months”

FPTIT12=blank (inapplicable) if:
R did not receive a family planning service in the last 12 months or R did not receive any family planning services in the last 12 months at a clinic (computed var IDCLINIC=0 or the place where received the family planning methods FA-5 BC12PLCX2 - BC12PLCX8 NE 3,4,6,7 or (said yes to at least 1 family planning method and numbcvis=1 and BC12PLCX NE 3,4,6,7).

*Family planning method in this recode refers to the following services: FA-1b BTHCON12, FA-1c MEDTST12, FA-1d BCCNS12, FA-1e STEROP12, FA-1f STCNS12, FA-1g EMCON12, and FA-1h ECCNS12.*

Computed variable IDCLINIC indicates the number of clinics R reported in the series BC12PLCX-BC12PLCX15. This revised recode will use the values of the recodes FPTITBC, FPTITCHK, FPTITCBC, FPTITSTE, FPTITCST, FPTITEC, AND FPTITCEC in order to determine if R visited a title x clinic in the last 12 months. Due to the task of identifying those reported as not in the database it is best to use the recodes themselves instead of the raw clinicfund_F_# variables.

Otherwise, Else if R received one or more family planning services in the last 12 months at a Title X database clinic then FPTIT12=1.

Else if (FPTITBC = 1 or 2 or 5) or (FPTITCHK = 1 or 2 or 5) or (FPTITCBC = 1 or 2 or 5 ) or (FPTITSTE = 1 or 2 or 5) or (FPTITCST = 1 or 2 or 5 ) or (FPTITEC = 1 or 2 or 5 ) or (FPTITCEC= 1 or 2 or 5)

Else if R received one or more family planning services in the last 12 months at a non-Title X database clinic, then FPTIT12=2.

Else if (FPTITBC NE 1 or 2 or 5) or (FPTITCHK NE 1 or 2 or 5) or (FPTITCBC NE 1 or 2 or 5 ) or (FPTITSTE NE 1 or 2 or 5) or (FPTITCST NE 1 or 2 or 5 ) or (FPTITEC NE 1 or 2 or 5 ) or (FPTITCEC NE 1 or 2 or 5)

**FPTITMED**: “Type of clinic used for “medical services” in last 12 months”

FPTITMED=blank (inapplicable) if:
R did not receive any listed medical services in the last 12 months at a clinic (FA-5 BC12PLCX9-BC12PLCX15 NE 3,4,6,7 only for medical services in last 12 months or (said yes to at least 1 medical service in the last 12 months and numbcvis=1 and BC12PLCX NE 3,4,6,7.)

*Medical services in this recode refers to FA-3a PRGTST12, FA-3b ABORT12, FA-3c PAP12, FA-3d PELVIC12, FA-3e PRENAT12, FA-3f PARTUM12, FA-3g STDSVC12.

This revised recode will use the values of the recodes FPTITPRE, FPTITABO, FPTITPAP, FPTITPEL, FPTITPRN, FPTITPPR, AND FPTITSTD in order to determine if R visited a title x
clinic in the last 12 months. Due to the task of identifying those reported as not in the database it is best to use the recodes themselves instead of the raw clinicfund_F_# variables.

Otherwise:
Else if R received one or more medical services in the last 12 months at a Title X database clinic, then FPTITMED=1.
   Else If (FPTITPRE = 1 or 2 or 5) or (FPTITABO = 1 or 2 or 5) or (FPTITPAP = 1 or 2 or 5) or (FPTITPEL = 1 or 2 or 5) or (FPTITPRN = 1 or 2 or 5) or (FPTITPPR= 1 or 2 or 5) or (FPTITSTD = 1 or 2 or 5)

Else if R received one or more medical services in the last 12 months at a non-Title X database clinic, then FPTITMED=2.
   Else If (FPTITPRE NE 1 or 2 or 5) or (FPTITABO NE 1 or 2 or 5) or (FPTITPAP NE 1 or 2 or 5) or (FPTITPEL NE 1 or 2 or 5) or (FPTITPRN NE 1 or 2 or 5) or (FPTITPPR NE 1 or 2 or 5) or (FPTITSTD NE 1 or 2 or 5)

Medical services in this recode refers to FA-3a PRGTST12, FA-3b ABORT12, FA-3c PAP12, FA-3d PELVIC12, FA-3e PRENAT12, FA-3f PARTUM12, FA-3g STDSVC12.

Code categories:
   Blank = Inapplicable
   1 = Title X database clinic
   2 = Non-Title X database clinic

FPTITSTE**: “Source of service in the last 12 months: Sterilization operation”

FPTITSTE=blank (inapplicable)
If R did not receive a sterilizing operation in the last 12 months (FA-1e STEROP12 = 5).

Otherwise if R had a sterilization operation in the last 12 months (FA-1e STEROP12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX5= 3,4,6,7) (i.e., the clinic database was invoked), then do:

   If R received it at a Title X clinic in a public health department (Clinicfund_F_05 = 1 and Clinictype_F_05 = 2), then FPTITSTE=1.

   Else if R received it at a Title X clinic and the agency type is unknown (Clinicfund_F_05= 1 and Clinictype_F_05--6), then FPTITSTE=5.

   Else if R received it at a non-Title X clinic and the agency type is unknown (Clinicfund_F_05= 0 and Clinictype_F_05--6), then FPTITSTE=6.

   Else if R received it at a Title X clinic sponsored by other than a public health department (Clinicfund_F_05 = 1 and Clinictype_F_05 NE 2), then FPTITSTE=2.

   Else if R received it at a non-Title X clinic sponsored by a public health department (Clinicfund_F_05 = 0 and Clinictype_F_05 = 2), then FPTITSTE=3.
Else if R received it at a non-Title X clinic that was sponsored by other than a public health department (Clinicfund_F_05 = 0 and Clinictype_F_05 NE 2), then FPTITSTE=4.

(The condition that follows is intended to capture cases who reported codes FA-5 BC12PLCX5=1, 2, 5, 8, 9, 10, or 20).

Else if FA-1e STEROP12 = 1 and FPTITSTE still = . and R gave information on place ( FA-5 BC12PLCX5 NE .) then do:

Else if R received it at an employer or company clinic (FA-5 BC12PLCX5 = 5), then FPTITSTE=7.

Else if R received it at a private doctor’s office or HMO (FA-5 BC12PLCX5 = 1 or 2), then FPTITSTE=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (FA-5 BC12PLCX5 = 8, 9, 10), then FPTITSTE=9.

Else if R received it some other place (FA-5 BC12PLCX5= 20), then FPTITSTE=10.

Else if (FA-1e STEROP12= 1 and NUMBCVIS=1) then instead of BC12PLCX5 use BC12PLCX, instead of Clinicfund_F_05 use Clinicfund_F_01, and instead of Clinictype_F_05 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>1</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>2</td>
<td>Clinic: Title X=yes; health department=no</td>
</tr>
<tr>
<td>3</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>4</td>
<td>Clinic: Title X=no; health department=no</td>
</tr>
<tr>
<td>5</td>
<td>Clinic: Title X=yes; agency unknown</td>
</tr>
<tr>
<td>6</td>
<td>Clinic: Title X=no; agency unknown</td>
</tr>
<tr>
<td>7</td>
<td>Employer or company clinic</td>
</tr>
<tr>
<td>8</td>
<td>Private doctor’s office or HMO</td>
</tr>
<tr>
<td>9</td>
<td>Hospital emergency room/regular room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Some other place</td>
</tr>
</tbody>
</table>

FPTITBC**: “Source of service in the last 12 months: Method of birth control or prescription for a method”

FPTITBC=blank (inapplicable) if R did not report receiving a method of birth control or prescription for a method from a medical care provider in the last 12 months (FA-1b BTHCON12 NE 1). This also includes DK (don’t know).

Otherwise,

If R received a method of birth control or prescription for a method from a medical care

---

*NSFG_2013-2015_UG_App3a_FemRespRecodeSpecs*
provider in the last 12 months (FA-1b BTHCON12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX2= 3,4,6,7) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_02= 1 AND Clinictype_F_02 = 2), then FPTITBC=1.

Else if R received it at a Title X clinic and the agency type is unknown (Clinicfund_F_02= 1 AND Clinictype_F_02=-6), then FPTITBC=5.

Else if R received it at a non-Title X clinic and the agency type is unknown (Clinicfund_F_02= 0 AND Clinictype_F_02=-6), then FPTITBC=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_02= 1 AND Clinictype_F_02 NE 2), then FPTITBC=2.

Else if R received it at a non-Title X clinic sponsored by a public health department (Clinicfund_F_02= 0 AND Clinictype_F_02= 2), then FPTITBC=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_02= 0 AND Clinictype_F_02 NE 2), then FPTITBC=4.

(The condition that follows is intended to capture cases who reported codes FA-5 BC12PLCX2=1, 2, 5, 8, 9, 10, or 20.)

Else if FA-1b BTHCON12 = 1 and FPTITBC still = . and R gave information on place ( FA-5 BC12PLCX2 NE .), then do:

If R received it at an employer or company clinic (FA-5 BC12PLCX2= 5), then FPTITBC=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX2= 1 or 2), then FPTITBC=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (FA-5 BC12PLCX2=8,9,10), then FPTITBC=9

Else if R received it at “some other place” (FA-5 BC12PLCX2= 20), then FPTITBC=10.

Else if (FA-1b BTHCON12 = 1 and NUMBCVIS=1 ) then instead of BC12PLCX2 use BC12PLCX, instead of Clinicfund_F_02 use Clinicfund_F_01, and instead of Clinictype_F_02 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
</tbody>
</table>
03 = Clinic: Title X=no; health department=yes
04 = Clinic: Title X=no; health department=no
05 = Clinic: Title X=yes; agency unknown
06 = Clinic: Title X=no; agency unknown
07 = Employer or company clinic
08 = Private doctor’s office or HMO
09 = Hospital emergency room/regular room/urgent care
10 = Some other place

FPTITCHK**: “Source of service in the last 12 months: Check-up or medical test related to using a birth control method”

FPTITCHK=blank (inapplicable) if R did not report receiving a check-up or medical test related to using a birth control from a medical care provider in the last 12 months (FA-1c MEDTST12 NE 1). This also includes DK (don’t know).

Otherwise,
If R received a check-up or medical test related to using a birth control from a medical provider in the last 12 months (FA-1c MEDTST12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX3= 3, 4, 6, 7) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_03= 1 AND Clinictype_F_03 = 2), then FPTITCHK=1.

Else if R received it at a Title X clinic and agency type is unknown (Clinicfund_F_03= 1 AND Clinictype_F_03=-6), then FPTITCHK=5.

Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_03 = 0 AND Clinictype_F_03 = -6), then FPTITCHK=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_03 = 1 AND Clinictype_F_03 NE 2), then FPTITCHK=2.

Else if R received it at a non-Title X clinic sponsored by a public health department (Clinicfund_F_03= 0 AND Clinictype_F_03 = 2), then FPTITCHK=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_03 = 0 AND Clinictype_F_03 NE 2), then FPTITCHK=4.

(The condition that follows is intended to capture cases who reported codes FA-5 BC12PLCX3= 1, 2, 5, 8, 9, 10, or 20.)

If FA-1c MEDTST12 = 1 and FPTITCHK still = . and R gave information on place (FA-5 BC12PLCX3 NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX3= 5), then FPTITCHK=7.
If R received it at private doctor’s office or HMO (FA-5 BC12PLCX3= 1 or 2), then FPTITCHK=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX3=8,9,10), then FPTITCHK=9

Else if R received it at “some other place” (FA-5 BC12PLCX3= 20), then FPTITCHK=10.

Else if (FA-1c MEDTST12 = 1 and NUMBCVIS=1) then instead of BC12PLCX3 use BC12PLCX, instead of Clinicfund_F_03 use Clinicfund_F_01, and instead of Clinictype_F_03 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department=no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency type unknown</td>
</tr>
<tr>
<td>07</td>
<td>Employer or company clinic</td>
</tr>
<tr>
<td>08</td>
<td>Private doctor’s office or HMO</td>
</tr>
<tr>
<td>09</td>
<td>Hospital emergency room/regular room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Some other place</td>
</tr>
</tbody>
</table>

**FPTITCBC**: “Source of service in the last 12 months: Counseling about BC”

FPTITCBC=blank (inapplicable) if R did not report receiving counseling or information about birth control from a medical care provider in the last 12 months (FA-1d BCCNS12 NE 1). This also includes DK (don’t know).

Otherwise,

If R received counseling or information about birth control from a medical care provider in the last 12 months (FA-1d BCCNS12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX4 = 3,4,6,7) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_04= 1 AND Clinictype_F_04 = 2), then FPTITCBC=1.

Else if R received it at a Title X clinic and agency type is unknown (Clinicfund_F_04 = 1 AND Clinictype_F_04 =-6), then FPTITCBC=5.

Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_04 = 0 AND Clinictype_F_04 = -6), then FPTITCBC=6.
Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_04 = 1 AND Clinictype_F_04 NE 2), then FPTITCBC=2.

Else if R received it at a non-Title X clinic sponsored by a public health department (Clinicfund_F_04 = 0 AND Clinictype_F_04 = 2), then FPTITCBC=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_04 = 0 AND Clinictype_F_04 NE 2), then FPTITCBC=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLCX4=1, 2, 5, 8, 9, 10, or 20.)
If FA-1d BCCNS12 = 1 and FPTITCBC still = . and R gave information on place (FA-5 BC12PLCX4 NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX4 = 5), then FPTITCBC=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX4 = 1 or 2), then FPTITCBC=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX4=8,9,10), then FPTITBC=9

Else if R received it at “some other place” (FA-5 BC12PLCX4 = 20), then FPTITCBC=10.

Else if (FA-1d BCCNS12 = 1 and NUMBCVIS=1) then instead of BC12PLCX4 use BC12PLCX, instead of Clinicfund_F_04 use Clinicfund_F_01, and instead of Clinictype_F_04 use Clinictype_F_01and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department=no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type is unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency type is unknown</td>
</tr>
<tr>
<td>07</td>
<td>Employer or company clinic</td>
</tr>
<tr>
<td>08</td>
<td>Private doctor’s office or HMO</td>
</tr>
<tr>
<td>09</td>
<td>Hospital emergency room/regular room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Some other place</td>
</tr>
</tbody>
</table>

FPTITCST**: “Source of service in the last 12 months: Counseling about sterilization”

FPTITCST=blank (inapplicable) if R did not report receiving counseling about getting a
sterilized from a medical care provider in the last 12 months (FA-1f STCNS12 NE 1). This also includes DK (don’t know).

Otherwise,
If R received counseling about getting sterilized from a medical care provider in the last 12 months (FA-1e STCNS12 = 1) and it was possibly received at a clinic (FA-5 BC12PLC6X6 = 3,4,6,7 ) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_06 = 1 AND Clinictype_F_06= 2), then FPTITCST=1.

Else if R received it at a Title X clinic and agency type is unknown (Clinicfund_F_06 = 1 AND Clinictype_F_06=6), then FPTITCST=5.

Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_06 = 0 AND Clinictype_F_06 = -6), then FPTITCST=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_06 = 1 AND Clinictype_F_06 NE 2), then FPTITCST=2.

Else if R received it at a non-Title X clinic sponsored by a public health department (Clinicfund_F_06 = 0 AND Clinictype_F_06 = 2), then FPTITCST=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_06 = 0 AND Clinictype_F_06 NE 2), then FPTITCST=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLC6X6 =1, 2, 5, 8, 9, 10, or 20.)
If FA-1e STCNS12 = 1 and FPTITCST still = . and R gave information on place (FA-5 BC12PLCX6= NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLC6X6 = 5), then FPTITCST=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLC6X6 =1 or 2), then FPTITCST=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX6=8,9,10), then FPTITCST=9

Else if R received it at “some other place” (FA-5 BC12PLC6X6 = 20), then FPTITCST=10.

Else if (FA-1e STCNS12 = 1 and NUMBCVIS=1) then instead of BC12PLC6X6 use BC12PLCX, instead of Clinicfund_F_06 use Clinicfund_F_01, and instead of Clinictype_F_06 use Clinictype_F_01 and proceed as specified above.

Code categories:
Blank = Inapplicable
01 = Clinic: Title X=yes; health department=yes
02 = Clinic: Title X=yes; health department=no
03 = Clinic: Title X=no; health department=yes
04 = Clinic: Title X=no; health department=no
05 = Clinic: Title X=yes; agency type unknown
06 = Clinic: Title X=no; agency type unknown
07 = Employer or company clinic
08 = Private doctor’s office or HMO
09 = Hospital emergency room/regular room/urgent care
10 = Some other place

FPTITEC**: “Source of service in the last 12 months: Emergency Contraception”

FPTITEC=blank (inapplicable) if R did not report receiving emergency contraception from a medical care provider in the last 12 months (FA-1g EMCON12 NE 1).

Otherwise,
If R received emergency contraception from a medical care provider in the last 12 months (FA-1g EMCON12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX7= 3,4,6,7) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_07 = 1 AND Clinictype_F_07= 2), then FPTITEC=1.

Else if R received it at a Title X clinic NOT and agency type is unknown (Clinicfund_F_07 = 1 AND Clinictype_F_07 = -6), then FPTITEC=5.

Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_07 = 0 AND Clinictype_F_07 = -6), then FPTITEC=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_07 = 1 AND Clinictype_F_07 NE 2), then FPTITEC=2.

Else if R received it at a non-Title X clinic sponsored by a public health department (Clinicfund_F_07 = 0 AND Clinictype_F_07 = 2), then FPTITEC=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_07= 0 AND Clinictype_F_07 NE 2), then FPTITEC=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLCX7 = 1, 2, 5, 8, 9, 10, or 20.)
If FA-1f EMCON12 = 1 and FPTITEC still = . and R gave information on place (FA-5 BC12PLCX7 NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX7= 5), then FPTITEC=7.
If R received it at private doctor’s office or HMO (FA-5 BC12PLCX7 = 1 or 2), then FPTITCEC=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX7 = 8,9,10), then FPTITCEC=9

Else if R received it at “some other place” (FA-5 BC12PLCX7 = 20), then FPTITCEC=10.

Else if (FA-1g EMCON12 = 1 and NUMBCVIS=1) then instead of BC12PLCX7 use BC12PLCX, instead of Clinicfund_F_07 use Clinicfund_F_01, and instead of Clinictype_F_07 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department=no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department=no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency type unknown</td>
</tr>
<tr>
<td>07</td>
<td>Employer or company clinic</td>
</tr>
<tr>
<td>08</td>
<td>Private doctor’s office or HMO</td>
</tr>
<tr>
<td>09</td>
<td>Hospital emergency room/regular room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Some other place</td>
</tr>
</tbody>
</table>

FPTITCEC**: “Source of service in the last 12 months: Counseling about Emergency Contraception”

FPTITCEC=blank (inapplicable) if R did not report receiving counseling about emergency contraception from a medical care provider in the last 12 months (FA-1h ECCNS12 NE 1).

Otherwise, if R received counseling about emergency contraception from a medical care provider in the last 12 months (FA-1h ECCNS12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX8 = 3,4,6,7) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (CLINICFUND_F_08= 1 AND CLINICTYPE_F_08= 2), then FPTITCEC=1.

Else if R received it at a Title X clinic and agency type is unknown (CLINICFUND_F_08= 1 AND CLINICTYPE_F_08= -6), then FPTITCEC=5.

Else if R received it at a non-Title X clinic and agency type is unknown (CLINICFUND_F_08 = 0 AND CLINICTYPE_F_08= -6), then FPTITCEC=6.
(CLINICFUND_F_08 = 1 AND CLINICTYPE_F_08 NE 2), then FPTITCEC=2.

Else if R received it at a non-Title X clinic sponsored by a public health department (CLINICFUND_F_08 = 0 AND CLINICTYPE_F_08 = 2), then FPTITCEC=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (CLINICFUND_F_08 = 0 AND CLINICTYPE_F_08 NE 2), then FPTITCEC=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLCX8 = 1, 2, 5, 8, 9, 10, or 20.)
If FA-1g ECCNS12 = 1 and FPTITCEC still = . and R gave information on place (FA-5 BC12PLCX8 NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX8 = 5), then FPTITCEC=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX8 = 1 or 2), then FPTITCEC=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX8 = 8,9,10), then FPTITCEC=9.

Else if R received it at ‘some other place” (FA-5 BC12PLCX8=20), then FPTITCEC=10.

Else if (FA-1h ECCNS12 = 1 and NUMBCVIS=1) then instead of BC12PLCX8 use BC12PLCX, instead of Clinicfund_F_08 use Clinicfund_F_01, and instead of Clinictype_F_08 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department =no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type is unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency type is unknown</td>
</tr>
<tr>
<td>07</td>
<td>Employer or company clinic</td>
</tr>
<tr>
<td>08</td>
<td>Private doctor’s office or HMO</td>
</tr>
<tr>
<td>09</td>
<td>Hospital emergency room/regular room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Some other place</td>
</tr>
</tbody>
</table>

FPTITPRE**: “Source of service in the last 12 months: Pregnancy test”

FPTITPRE=blank (inapplicable) if R did not report receiving a pregnancy test from a medical care provider in the last 12 months (FA-3a PRGTST12 NE 1). This also includes DK (don’t know).
Otherwise, If R received a pregnancy test from a medical care provider in the last 12 months (FA-3a PRGTST12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX9= 3,4,6,7) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (CLINICFUND_F_09 = 1 AND CLINICTYPE_F_09 = 2), then FPTITPRE=1.

Else if R received it at a Title X clinic and agency type is unknown (CLINICFUND_F_09 = 1 AND CLINICTYPE_F_09= -6), then FPTITPRE=5.

Else if R received it at a non-Title X clinic and agency type is unknown (CLINICFUND_F_09 = 0 AND CLINICTYPE_F_09 = -6), then FPTITPRE=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department (CLINICFUND_F_09 = 1 AND CLINICTYPE_F_09 NE 2), then FPTITPRE=2.

Else if R received it at a non-Title X clinic sponsored by a public health department (CLINICFUND_F_09 = 0 AND CLINICTYPE_F_09 = 2), then FPTITPRE=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (CLINICFUND_F_09 = 0 AND CLINICTYPE_F_09 NE 2), then FPTITPRE=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLCX7=1, 2, 5, 8, 9, 10, or 20.)
If FA-3a PRGTST12 = 1 and FPTITPRE still = . and R gave information on place ( FA-5 BC12PLCX9= NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX9= 5), then FPTITPRE=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX9= 1 or 2), then FPTITPRE=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX9=8,9,10), then FPTITPRE=9.

Else if R received it at “some other place” (FA-5 BC12PLCX9= 20), then FPTITPRE=10.

Else if (FA-3a PRGTST12 = 1 and NUMBCVIS=1) then instead of BC12PLCX9 use BC12PLCX, instead of Clinicfund_F_09 use Clinicfund_F_01, and instead of Clinictype_F_09 use Clinictype_F_01 and proceed as specified above.

Code categories:

Blank = Inapplicable
01 = Clinic: Title X=yes; health department=yes
02 = Clinic: Title X=yes; health department =no
FPTITABO**: “Source of service in the last 12 months: Abortion”

FPTITABO=blank (inapplicable) if R did not report receiving an abortion from a medical care provider in the last 12 months (FA-3b ABORT12 NE 1). This also includes DK (don’t know).

Otherwise, if R received an abortion from a medical care provider in the last 12 months (FA-3b ABORT12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX10= 3,4,6,7,) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_10 = 1 AND Clinictype_F_10 = 2), then FPTITABO=1.

Else if R received it at a Title X clinic and agency type is unknown (Clinicfund_F_10 = 1 AND Clinictype_F_10= -6), then FPTITABO=5.

Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_10 = 0 AND Clinictype_F_10 = -6), then FPTITABO=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_10= 1 AND Clinictype_F_10 NE 2), then FPTITABO=2.

Else if R received it at a non-Title X clinic sponsored by a public health department (Clinicfund_F_10= 0 AND Clinictype_F_10= 2), then FPTITABO=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_10= 0 AND Clinictype_F_10 NE 2), then FPTITABO=4.

(The condition that follows is intended to capture cases who reported codes FA-5 BC12PLCX8=1, 2, 5, 8, 9, 10, or 20.)

If FA-3b ABORT12 = 1 and FPTITABO still = . and R gave information on place (FA-5 BC12PLCX10 NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX10= 5), then FPTITABO=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX10=1 or 2), then FPTITABO=8.
Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX10=8,9,10), then FPTITABO=9

Else if R received it at “some other place” (FA-5 BC12PLCX10=20), then FPTITABO=10.

Else if (FA-3b ABORT12 = 1 and NUMBCVIS=1) then instead of BC12PLCX10 use BC12PLCX, instead of Clinicfund_F_10 use Clinicfund_F_01, and instead of Clinictype_F_10 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department =yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department =no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency type</td>
</tr>
<tr>
<td>07</td>
<td>Employer or company clinic</td>
</tr>
<tr>
<td>08</td>
<td>Private doctor’s office or HMO</td>
</tr>
<tr>
<td>09</td>
<td>Hospital emergency room/regular room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Some other place</td>
</tr>
</tbody>
</table>

FPTITPAP**: “Source of service in the last 12 months: Pap smear”

FPTITPAP=blank (inapplicable) if R did not report receiving a pap smear from a medical care provider in the last 12 months (FA-3c PAP12 NE 1). This also includes DK (don’t know).

Otherwise,

If R received a pap smear from a medical care provider in the last 12 months (FA-3c PAP12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX11 = 3,4,6,7) (i.e., the clinic database was invoked), then do:

- If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_11 = 1 AND Clinctype_F_11 = 2), then FPTITPAP=1.
- Else if R received it at a Title X clinic and agency type is unknown (Clinicfund_F_11 = 1 AND Clinctype_F_11= -6), then FPTITPAP=5.
- Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_11 = 0 AND Clinctype_F_11= -6), then FPTITPAP=6.
- Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_11 = 1 AND Clinctype_F_11 NE 2), then FPTITPAP=2.
- Else if R received it at a non-Title X clinic sponsored by a public health department
(Clinicfund_F_11 = 0 AND Clinictype_F_11 = 2), then FPTITPAP=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_11 = 0 AND Clinictype_F_11 NE 2), then FPTITPAP=4.

(The condition that follows is intended to capture cases who reported codes FA-5 BC12PLCX9 = 1, 2, 5, 8, 9, 10, or 20.)
If FA-3c PAP12 = 1 and FPTITPAP still = . and R gave information on place (FA-5 BC12PLCX11 NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX11 = 5), then FPTITPAP=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX11 = 1 or 2), then FPTITPAP=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX11=8,9,10), then FPTITPAP=9

Else if R received it at “some other place” (FA-5 BC12PLCX11 = 20), then FPTITPAP=10.

Else if (FA-3c PAP12 = 1 and NUMBCVIS=1) then instead of BC12PLCX11 use BC12PLCX, instead of Clinicfund_F_11 use Clinicfund_F_01, and instead of Clinictype_F_11 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department=no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency type unknown</td>
</tr>
<tr>
<td>07</td>
<td>Employer or company clinic</td>
</tr>
<tr>
<td>08</td>
<td>Private doctor’s office or HMO</td>
</tr>
<tr>
<td>09</td>
<td>Hospital doctor’s office/reg. room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Some other place</td>
</tr>
</tbody>
</table>

FPTITPEL**: “Source of service in the last 12 months: Pelvic exam”

FPTITPEL=blank (inapplicable) if R did not report receiving a pelvic exam from a medical care provider in the last 12 months (FA-3d PELVIC12 NE 1). This also includes DK (don’t know).

Otherwise,
If R received a pelvic exam from a medical care provider in the last 12 months (FA-3d PELVIC12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX12 = 3,4,6,7) (i.e., the
If R received it at a Title X clinic sponsored by a public health department
(Clinicfund_F_12 = 1 AND Clinictype_F_12 = 2), then FPTITPEL=1.

Else if R received it at a Title X clinic and agency type is unknown
(Clinicfund_F_12 = 1 AND Clinictype15= -6), then FPTITPEL=5.

Else if R received it at a non-Title X clinic and agency type is unknown
(Clinicfund_F_12 = 0 AND Clinictype_F_12 = -6), then FPTITPEL=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department
(Clinicfund_F_12 = 1 AND Clinictype_F_12 NE 2), then FPTITPEL=2.

Else if R received it at a non-Title X clinic sponsored by a public health department
Clinicfund_F_12 = 0 AND Clinictype_F_12 = 2), then FPTITPEL=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department
(Clinicfund_F_12 = 0 AND Clinictype_F_12 NE 2), then FPTITPEL=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLCX10= 1, 2, 5, 8, 9, 10, or 20.)
If FA-3d PELVIC12 = 1 and FPTITPEL still = . and R gave information on place (FA-5 BC12PLCX12 NE .), then do:

If R received it at an employer or company clinic (FA-5 BC12PLCX12 = 5), then FPTITPEL=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX12 = 1 or 2), then FPTITPEL=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX12)=8,9,10), then FPTITPEL=9

Else if R received it at “some other place” (FA-5 BC12PLCX12= 20), then FPTITPEL=10.

Else if (FA-3d PELVIC12 = 1 and NUMBCVIS=1) then instead of BC12PLCX12 use BC12PLCX, instead of Clinicfund_F_12 use Clinicfund_F_01, and instead of Clinictype_F_12 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department=no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type unknown</td>
</tr>
</tbody>
</table>
06 = Clinic: Title X=no; agency type unknown
07 = Employer or company clinic
08 = Private doctor’s office or HMO
09 = Hospital emergency room/regular room/urgent care
10 = Some other place

**FPTITPRN**: “Source of service in the last 12 months: Prenatal Care”

FPTITPRN=blank (inapplicable) if R did not report receiving prenatal care from a medical care provider in the last 12 months (FA-3e PRENAT12 NE 1). This also includes DK (don’t know).

Otherwise, if R received prenatal care from a medical care provider in the last 12 months (FA-3e PRENAT12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX13= 3,4,6,7) (i.e., the clinic database was invoked), then do:

- If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_13= 1 AND Clinictype_F_13 = 2), then FPTITPRN=1.
- Else if R received it at a Title X clinic and agency type is unknown (Clinicfund_F_13 = 1 AND Clinictype_F_13= -6), then FPTITPRN=5.
- Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_13= 0 AND Clinictype_F_13 = -6), then FPTITPRN=6.
- Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_13 = 1 AND Clinictype_F_13 NE 2), then FPTITPRN=2.
- Else if R received it at a non-Title X clinic sponsored by a public health department Clinicfund_F_13 = 0 AND Clinictype_F_13 = 2), then FPTITPRN=3.
- Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_13 = 0 AND Clinic F_13 NE 2), then FPTITPRN=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLCX13 = 1, 2, 5, 8, 9, 10, or 20.) If FA-3e PRENAT12 = 1 and FPTITPRN still = . and R gave information on place (FA-5 BC12PLCX13 NE .), then do:

- If R received it an employer or company clinic (FA-5 BC12PLCX13 = 5), then FPTITPRN=7.
- If R received it at private doctor’s office or HMO (FA-5 BC12PLCX13 = 1 or 2), then FPTITPRN=8.
- Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX13=8,9,10), then FPTITPRN=9.
Else if R received it at “some other place” (FA-5 BC12PLCX13 = 20), then FPTITPRN=10.

Else if (FA-3e PRENAT12 = 1 and NUMBCVIS=1) then instead of BC12PLCX13 use BC12PLCX, instead of Clinicfund_F_13 use Clinicfund_F_01, and instead of Clinictype_F_13 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department=no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency type unknown</td>
</tr>
<tr>
<td>07</td>
<td>Employer or company clinic</td>
</tr>
<tr>
<td>08</td>
<td>Private doctor’s office or HMO</td>
</tr>
<tr>
<td>09</td>
<td>Hospital emergency room/regular room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Some other place</td>
</tr>
</tbody>
</table>

**FPTITPPR**: “Source of service in the last 12 months: Post-pregnancy care”

FPTITPPR=blank (inapplicable) if R did not report receiving post-pregnancy care from a medical care provider in the last 12 months (FA-3f PARTUM12 NE 1). This also includes DK (don’t know).

Otherwise,

If R received post-pregnancy care from a medical care provider in the last 12 months (FA-3f PARTUM12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX14 = 3,4,6,7) (i.e., the clinic database was invoked), then do:

1. If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_14= 1 AND Clinictype_F_14= 2), then FPTITPPR=1.

2. Else if R received it at a Title X clinic and agency type is unknown (Clinicfund_F_14= 1 AND Clinictype_F_14= -6), then FPTITPPR=5.

3. Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_14 = 0 AND Clinictype_F_14 = -6), then FPTITPPR=6.

4. Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_14 = 1 AND Clinictype_F_14 NE 2), then FPTITPPR=2.

5. Else if R received it at a non-Title X clinic sponsored by a public health department Clinicfund_F_14 = 0 AND Clinictype_F_14 = 2), then FPTITPPR=3.
Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_14 = 0 AND Clinictype_F_14 NE 2), then FPTITPPR=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLCX14 =1, 2, 5, 8, 9, 10, or 20.)
If FA-3f PARTUM12 = 1 and FPTITPPR still = . and R gave information on place (FA-5 BC12PLCX14 NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX14 = 5), then FPTITPPR=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX14 = 1 or 2), then FPTITPPR=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX14=8,9,10), then FPTITPPR=9.

Else if R received it at “some other place” (FA-5 BC12PLCX14 = 20), then FPTITPPR=10.

Else if (FA-3f PARTUM12 = 1 and NUMBCVIS=1 then instead of BC12PLCX14 use BC12PLCX, instead of Clinicfund_F_14 use Clinicfund_F_01, and instead of Clinictype_F_14 use Clinictype_F_01 and proceed as specified above.

Code categories:
Blank = Inapplicable
01 = Clinic: Title X=yes; health department=yes
02 = Clinic: Title X=yes; health department =no
03 = Clinic: Title X=no; health department=yes
04 = Clinic: Title X=no; health department =no
05 = Clinic: Title X=yes; agency type unknown
06 = Clinic: Title X=no; agency type unknown
07 = Employer or company clinic
08 = Private doctor’s office or HMO
09 = Hospital emergency room/regular room/urgent care
10 = Some other place

FPTITSTD**: “Source of service in the last 12 months: Testing for STD"

FPTITSTD=blank (inapplicable) if R did not report receiving testing for a sexually transmitted disease by a medical care provider in the last 12 months (FA-3g STDSVC12 NE 1). This also includes DK (don’t know).

Otherwise,
If R received testing for a sexually transmitted disease by a medical care provider in the last 12 months (FA-3g STDSVC12 = 1) and it was possibly received at a clinic (FA-5 BC12PLCX15 = 3,4,6,7) (i.e., the clinic database was invoked), then do:
If R received it at a Title X clinic sponsored by a public health department (Clinicfund_F_15 = 1 AND Clinictype_F_15 = 2), then FPTITSTD=1.

Else if R received it at a Title X clinic and agency type is unknown (Clinicfund_F_15 = 1 AND Clinictype_F_15 = -6), then FPTITSTD=5.

Else if R received it at a non-Title X clinic and agency type is unknown (Clinicfund_F_15 = 0 AND Clinictype_F_15 = -6), then FPTITSTD=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department (Clinicfund_F_15 = 1 AND Clinictype_F_15 NE 2), then FPTITSTD=2.

Else if R received it at a non-Title X clinic sponsored by a public health department Clinicfund_F_15 = 0 AND Clinictype_F_15 = 2), then FPTITSTD=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (Clinicfund_F_15 = 0 AND Clinictype_F_15 NE 2), then FPTITSTD=4.

(The condition that follows is intended to capture cases who reported FA-5 BC12PLCX15 = 1, 2, 5, 8, 9, 10, or 20).
If FA-3g STDSVC12 = 1 and FPTITSTD still = . and R gave information on place (FA-5 BC12PLCX15 NE .), then do:

If R received it an employer or company clinic (FA-5 BC12PLCX15 = 5), then FPTITSTD=7.

If R received it at private doctor’s office or HMO (FA-5 BC12PLCX15 = 1 or 2), then FPTITSTD=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (BC12PLCX15=8,9,10), then FPTITSTD=9.

Else if R received it at “some other place” (FA-5 BC12PLCX15 = 20), then FPTITSTD=10.

Else if (FA-3g STDSVC12 = 1 and NUMBCVIS=1) then instead of BC12PLCX use BC12PLCX, instead of Clinicfund_F_15 use Clinicfund_F_01, and instead of Clinictype_F_15 use Clinictype_F_01 and proceed as specified above.

Code categories:

<table>
<thead>
<tr>
<th>Blank</th>
<th>Inapplicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department=no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency type unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency type unknown</td>
</tr>
</tbody>
</table>
07 = Employer or company clinic
08 = Private doctor’s office or HMO
09 = Hospital emergency room/regular room/urgent care
10 = Some other place

FPREGFP**: "Whether a Title X clinic where R received (a) family planning service(s) in the last 12 months was R's regular place for medical care"

FPREGFP=blank (inapplicable):
if R did not report receiving any family planning service at a Title X clinic in the last 12 months (FPTITBC NE 1 or 2 or 5 and FPTITCHK NE 1 or 2 or 5 and FPTITCSC NE 1 or 2 or 5 and FPTITCHK NE 1 or 2 or 5 and FPTITEC NE 1 or 2 or 5 and FPTITCSC NE 1 or 2 or 5 and FPTITSTE NE 1 or 2 or 5). *Family planning method in this recode refers to the following services: FA-1b BTHCON12, FA-1c MEDTST12, FA-1d BCCNS12, FA-1e STEROP12, FA-1f STCNS12, FA-1g EMCON12, FA-1h ECCNS12.*

Otherwise,
FPREGFP = 1:
If R received one or more family planning services at a Title X clinic in the last 12 months, and a Title X clinic at which R received a family planning service in the last 12 months was a regular place for medical care for R.

   Else If (FPTITBC  = 1 or 2 or 5 and regcar12_F_02= 1 or 2) or
   (FPTITCHK = 1 or 2 or 5 and regcar12_F_03= 1 or 2) or
   (FPTITCSC = 1 or 2 or 5 and regcar12_F_04= 1 or 2) or
   (FPTITCST = 1 or 2 or 5 and regcar12_F_05= 1 or 2) or
   (FPTITEC = 1 or 2 or 5 and regcar12_F_06= 1 or 2) or
   (FPTITCSC= 1 or 2 or 5 and regcar12_F_07= 1 or 2) or
   (FPTITCSC= 1 or 2 or 5 and regcar12_F_08= 1 or 2) or

Else, FPREGFP = 2:
If R received one or more family planning services at a Title X clinic in the last 12 months, and a Title X clinic at which R received a family planning service in the last 12 months was not a regular place for medical care for R.

   Else if (FPTITBC  = 1 or 2 or 5 and regcar12_F_02= 3 or 4) or
   (FPTITCHK = 1 or 2 or 5 and regcar12_F_03 =3 or 4) or
   (FPTITCSC = 1 or 2 or 5 and regcar12_F_04 = 3 or 4) or
   (FPTITCST = 1 or 2 or 5 and regcar12_F_05 = 3 or 4) or
   (FPTITEC = 1 or 2 or 5 and regcar12_F_06 = 3 or 4) or
   (FPTITEC= 1 or 2 or 5 and regcar12_F_07 =3 or 4) or
   (FPTITEC= 1 or 2 or 5 and regcar12_F_08 = 3 or 4) or

Note: (If received a family planning service and NUMBCVIS=1) or (received a family planning service and numsvc12=1 and NUMBCVIS=missing) then instead of regcar12_F_02- regcar12_F_08, should check regcar12_F_01 per instructions above.

Code categories:
   Blank  =  Inapplicable
1 = Yes
2 = No

FPREGMED**: "Whether a Title X clinic where R received (a) medical service(s) in the last 12 months was R's regular place for medical care"

FPREGMED = blank (inapplicable):
if R did not report receiving any medical service at a Title X clinic in the last 12 months
(FPTITPRE NE 1 or 2 or 5 and FPTITABO NE 1 or 2 or 5 and FPTITPAP NE 1 or 2 or 5 and
FPTITPEL NE 1 or 2 or 5 and FPTITPRN NE 1 or 2 or 5 and FPTITPPR NE 1 or 2 or 5 and
FPTITSTD NE 1 or 2 or 5). Medical service in this recode refers to FA-3a PGTST12, FA-3b
ABORT12, FA-3c PAP12, FA-3d PELVIC12, FA-3e PRENAT12, FA-3f PARTUM12, FA-3g
STDSVC12.

Otherwise, FPREGMED = 1:
if R received one or more medical services at a Title X clinic in the last 12 months, and a Title X
clinic at which R received a medical service in the last 12 month was a regular place for medical
care for R.
(FPTITPRE =1 or 2 or 5 and regcar12_F_09=1 or 2) or
(FPTITABO =1 or 2 or 5 and regcar12_F_10=1 or 2) or
(FPTITPAP =1 or 2 or 5 and regcar12_F_11=1 or 2) or
(FPTITPEL =1 or 2 or 5 and regcar12_F_12=1 or 2) or
(FPTITPRN =1 or 2 or 5 and regcar12_F_13=1 or 2) or
(FPTITPPR =1 or 2 or 5 and regcar12_F_14=1 or 2) or
(FPTITSTD =1 or 2 or 5 and regcar12_F_15=1 or 2)

Else, FPREGMED = 2:
if R received one or more medical services at a Title X clinic in the last 12 months, and a Title X
clinic at which R received a medical service in the last 12 months was not a regular place for medical
care for R.
(FPTITPRE =1 or 2 or 5 and regcar12_F_09=3 or 4 ) or
(FPTITABO =1 or 2 or 5 and regcar12_F_10=3 or 4) or
(FPTITPAP =1 or 2 or 5 and regcar12_F_11=3 or 4 ) or
(FPTITPEL =1 or 2 or 5 and regcar12_F_12=3 or 4 ) or
(FPTITPRN =1 or 2 or 5 and regcar12_F_13=3 or 4 ) or
(FPTITPPR =1 or 2 or 5 and regcar12_F_14=3 or 4 ) or
(FPTITSTD =1 or 2 or 5 and regcar12_F_15=3 or 4)

Note: (If received a medical service and NUMBCVIS=1) then instead of regcar12_F_09-
regcar12_F_15, should check regcar12_F_01 per instructions above.

Code categories:
Blank  =   Inapplicable
1      = Yes
2      = No
Section G: Desire and Expectation for Future Births

INTENT**: “Intentions for additional births”

Note: For currently pregnant women INTENT refers to intentions after the current pregnancy. In Cycle 5 (1995) NSFG, joint intentions were only asked of currently married women but starting in the 2002 NSFG, both currently married and cohabiting women were asked.

(Blaise-computed variables rstrstat and pstrstat are defined in Flow Check D-33 and indicate surgical or nonsurgical sterility at time of interview.

INTENT=1 (“intends to have (more) children”) if:
-- R is currently married or cohabiting (AB-1 MARSTAT=1 or 2), neither she nor her husband/partner is sterile (rstrstat=0 and pstrstat=0), and she and her husband/partner intend to have a(nother) baby (GB-1 JINTEND = 1); or
-- R is unmarried and not cohabiting (AB-1 MARSTAT NE 1 or 2), she is not sterile (rstrstat=0), and she intends to have a(nother) baby (GC-1 INTEND = 1).

INTENT=2 (“does not intend to have (more) children”) if:
-- R or her current husband/partner is sterile (rstrstat NE 0 or pstrstat NE 0); or
-- R is currently married or cohabiting (AB-1 MARSTAT=1 or 2), neither is sterile (rstrstat=0 and pstrstat=0), and they do not intend to have a(nother) baby (GB-1 JINTEND = 5); or
-- R is unmarried and not cohabiting (AB-1 MARSTAT NE 1 or 2), she is not sterile (rstrstat=0), and (she does not intend to have a(nother) baby (GC-1 INTEND = 5) or GC-1 INTEND = . And GA-1 RWANT=5 or 8).

INTENT=3 (“does not know her intent”) if:
-- R is currently married or cohabiting (AB-1 MARSTAT=1 or 2) and GB-1 JINTEND = DK); or
-- R is unmarried and not cohabiting (AB-1 MARSTAT NE 1 or 2) and GC-1 INTEND = DK).

Imputation Note: INTENT is imputed only if (GB-1 JINTEND = RF or “not ascertained”) or (GC-1 INTEND = RF or “not ascertained”).

Code categories:
1 = R intends to have (more) children
2 = R does not intend to have (more) children
3 = R does not know her intent
ADDEXP**: “Central number of additional births expected”

Note: In Cycle 5 (1995) NSFG, joint intentions were only asked of currently married women but starting in the 2002 NSFG, both currently married and cohabiting women were asked.

(Blaise-computed variables rstrstat and pstrstat are defined in Flow Check D-33 and indicate surgical or nonsurgical sterility at time of interview.)

If R or her current husband or cohabiting partner is sterile (rstrstat NE 0 or pstrstat NE 0), then ADDEXP=000.

Else if R is currently married or cohabiting (AB-1 MARSTAT=1 or 2) and neither is sterile (rstrstat=0 and pstrstat=0), then do:

- If R and her husband/partner do not intend to have a(nother) baby (GB-1 JINTEND = 5), then ADDEXP=0;
- Else if GB-1 JINTEND = DK, RF, “not ascertained” and her largest expected is zero (GB-1 JEXPECTL = 0), then ADDEXP=0;
- Else if R and her husband/partner intend to have a(nother) baby (GB-1 JINTEND = 1), and she gives an intended number (0 LE GB-3 JINTENDN LT 96), then ADDEXP=10*JINTENDN;
- Else if R and her husband/partner intend to have a(nother) baby (GB-1 JINTEND = 1), and she does not give an intended number (GB-3 JINTENDN=DK,RF) but gives largest and smallest (0 LE GB-5 JEXPECTS LT 96 AND 0 LT GB-4 JEXPECTL LT 96 ), then ADDEXP=10*((JEXPECTS +JEXPECTL)/2);
- Else if GB-1 JINTEND = DK, RF, or “not ascertained” but she did give a largest and smallest number expected (0 LE GB-4 JEXPECTL LT 96 and 0 LE GB-5 JEXPECTS LT 96), then ADDEXP=10* ((JEXPECTL + JEXPECTS)/2);
- Else if GB-1 JINTEND = DK, RF, or “not ascertained” and she gave a largest number expected but smallest number is unknown (0 LE GB-4 JEXPECTL LT 96 and GB-5 JEXPECTS = DK, RF, or “not ascertained”), then ADDEXP=10* ((JEXPECTL )/2);

Else if R is not currently married or cohabiting [(AB-1 MARSTAT NE 1 or 2)] and she is not sterile (rstrstat=0), then do:

- If R does not intend to have a(nother) baby (GC-1 INTEND = 5 ), then ADDEXP=0;
- Else if R intends to have a(nother) baby (GC-1 INTEND = 1), and she gives an intended number (0 LE C-3 INTENDN LT 96), then ADDEXP=10*INTENDN;
- Else if R intends to have a(nother) baby (GC-1 INTEND = 1), but she did not give an intended number (C-3 INTENDN=DK, RF) but she did give a largest and smallest number expected (0 LE GC-4 EXPECTL LT 96 and 0 LE GC-5 EXPECTS LT 96), then
ADDEXP = 10 * ((EXPECTL + EXPECTS)/2).

Else if GC-1 INTEND = . (not ascertained) and RWANT NE 1 then ADDEXP = 0;

Else if GC-1 INTEND = DK, RF, or “not ascertained” and her largest expected is zero (GC-4 EXPECTL = 0), then ADDEXP = 0;

Else if GC-1 INTEND = DK, RF, or “not ascertained” but she did give a largest and smallest number expected (0 LE GC-4 EXPECTL LT 96 and 0 LE GC-5 EXPECTS LT 96), then ADDEXP = 10 * ((EXPECTL + EXPECTS)/2).

Else if GC-1 INTEND = DK, RF, or “not ascertained” and she gave a largest number expected but smallest number is unknown (0 LE GC-4 EXPECTL LT 96 and GC-5 EXPECTS = DK), then ADDEXP = 10*((EXPECTL)/2).

Else if GC-1 INTEND = DK, RF, or “not ascertained” and she gave smallest number expected but largest number is unknown (0 LE GC-4 EXPECTS LT 96 and GC-5 EXPECTL = DK), then ADDEXP = 10*((EXPECTS)/2).

After all of the above statements have been executed, an additional pregnancy is added to ADDEXP for all currently pregnant Rs:

If R is currently pregnant (CURRPREG = 1), then ADDEXP = ADDEXP + 10

Code categories:

- 000 = No additional births expected
- 005 = .5 additional births
- 010 = 1 additional birth
- 015 = 1.5 additional births
- 020 = 2 additional births
- ... etc. through...
- 100 = 10 additional births
ANYPRGHP**: “Any medical help to become pregnant”

ANYPRGHP is inapplicable if R has never had sexual intercourse with a male (Blaise-computed variable \texttt{rhadsex} = 5) and she is younger than 18 years (Blaise-computed variable \texttt{age_r} < 18).

For all Rs who have ever had sexual intercourse with a male or who are 18 or older:

If R reported medical help to become pregnant (HA-1 HLPPRG = 1), then ANYPRGHP = 1 (yes).

Else if HA-1 HLPPRG=5 (no), then ANYPRGHP = 2 (no).

\textit{Imputation Note:} Needed if HA-1 HLPPRG = DK or RF.

Code categories:
- Blank = Inapplicable
- 1 = Yes
- 2 = No

ANYMSCHP**: “Any medical help to prevent miscarriage”

ANYMSCHP is inapplicable if R has never had sexual intercourse with a male (Blaise-computed variable \texttt{rhadsex} = 5) and she is younger than 18 years (Blaise-computed variable \texttt{age_r} < 18).

For all Rs who have ever had sexual intercourse with a male or who are 18 or older:

If R reported medical help to prevent miscarriage (HB-1 HLPMC = 1), then ANYMSCHP = 1 (yes).

Else if HB-1 HLPMC = 5 (no), then ANYMSCHP = 2 (no).

\textit{Imputation Note:} Needed if HB-1 HLPMC = DK or RF.

Code categories:
- Blank = Inapplicable
- 1 = Yes
- 2 = No

INFEVER**: “Ever used infertility services”

INFEVER is inapplicable if R has never had sexual intercourse with a male (Blaise-computed variable \texttt{rhadsex} = 5) and she is younger than 18 years (Blaise-computed variable \texttt{age_r} < 18).
For all Rs who have ever had sexual intercourse with a male or who are 18 or older:

If R reported seeking medical help either to get pregnant or to prevent miscarriage (ANYPRGHP=Yes or ANYMSCHP=Yes), INFEVER = 1 (yes).

Else if R reported neither form of help (ANYPRGHP=No and ANYMSCHP=No), INFEVER = 2 (no).

*Imputation Note:* Logically imputed based on imputed values of ANYPRGHP and ANYMSCHP.

Code categories:
- Blank = Inapplicable
- 1 = Yes
- 2 = No

**OVULATE**: “Infertility services: Drugs to improve ovulation”

OVULATE is inapplicable if:

- R has never had sexual intercourse with a male (Blaise-computed variable \texttt{rhadsex} = 5) and she is younger than 18 years (Blaise-computed variable \texttt{age_r} < 18)

OR

- R did not report seeking any medical help to become pregnant (HA-1 HLPPRG = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 HLPPRG = 1):

OVULATE is coded based on specific services reported in HA-5 TYPALLPGx. TYPALLPGx provides space for up to 6 “mentions” of services.

- If code 3 is given in TYPALLPGx, then OVULATE=1.
- Otherwise OVULATE=2.

*Imputation Note:* Model-based imputation needed contingent on imputed value of ANYPRGHP. If ANYPRGHP is imputed to NO, then this recode is imputed to “inapplicable”; if ANYPRGHP is imputed to YES, then this recode can be imputed to yes or no.

Code categories:
- Blank = Inapplicable
- 1 = Reported
- 2 = Not reported

**TUBES**: “Infertility services: Surgery to correct blocked tubes”

TUBES is inapplicable if:

- R has never had sexual intercourse with a male (Blaise-computed variable \texttt{rhadsex} = 5)
and she is younger than 18 years (Blaise-computed variable \texttt{age\_r < 18})

OR

-- R did not report seeking any medical help to become pregnant (HA-1 HLPPRG = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 HLPPRG = 1):

TUBES is coded based on specific services reported in HA-5 TYPALLPGx. TYPALLPGx provides space for up to 6 “mentions” of services.

If code 4 is given in TYPALLPGx, then TUBES=1.
Otherwise TUBES=2.

\textit{Imputation Note:} Model-based imputation needed contingent on imputed value of ANYPRGHP. If ANYPRGHP is imputed to NO, then this recode is imputed to “inapplicable”; if ANYPRGHP is imputed to YES, then this recode can be imputed to yes or no.

Code categories:
- Blank = Inapplicable
- 1 = Reported
- 2 = Not reported

\textbf{INFERTER**: “Infertility services: Infertility testing on respondent”}

INFERTER is inapplicable if:

-- R has never had sexual intercourse with a male (Blaise-computed variable \texttt{rhadsex = 5})
and she is younger than 18 years (Blaise-computed variable \texttt{age\_r < 18})

OR

-- R did not report seeking any medical help to become pregnant (HA-1 HLPPRG = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 HLPPRG = 1):

INFERTER is coded based on specific services reported in HA-5 TYPALLPGx and HA-5a WHOTEST. TYPALLPGx provides space for up to 6 “mentions” of services. WHOTEST indicates who received infertility testing.

If code 2 is given in TYPALLPGx and WHOTEST EQ 1 or 5, then INFERTER=1.
Otherwise INFERTER=2.

\textit{Imputation Note:} Model-based imputation needed contingent on imputed value of ANYPRGHP. If ANYPRGHP is imputed to NO, then this recode is imputed to “inapplicable”; if ANYPRGHP is imputed to YES, then this recode can be imputed to yes or no.

Code categories:
- Blank = Inapplicable
- 1 = Reported
INFERTH**: “Infertility services: Infertility testing on husband/partner”

INFERTH is inapplicable if:
-- R has never had sexual intercourse with a male (Blaise-computed variable rhadsex = 5) and she is younger than 18 years (Blaise-computed variable age_r < 18)
OR
-- R did not report seeking any medical help to become pregnant (HA-1 HLPPRG = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 HLPPRG = 1):

INFERTH is coded based on specific services reported in HA-5 TYPALLPGx and HA-5a WHOTEST. TYPALLPGx provides space for up to 6 “mentions” of services. WHOTEST indicates who received infertility testing.

If code 2 is given in TYPALLPGx and WHOTEST EQ 3 or 5, then INFERTH=1. Otherwise INFERTH=2.

Imputation Note: Model-based imputation needed contingent on imputed value of ANYPRGHP. If ANYPRGHP is imputed to NO, then this recode is imputed to “inapplicable”; if ANYPRGHP is imputed to YES, then this recode can be imputed to yes or no.

Code categories:
Blank = Inapplicable
1 = Reported
2 = Not reported

ADVICE**: “Infertility services: Advice”

ADVICE is inapplicable if:
-- R has never had sexual intercourse with a male (Blaise-computed variable rhadsex = 5) and she is younger than 18 years (Blaise-computed variable age_r < 18)
OR
-- R did not report seeking any medical help to become pregnant (HA-1 HLPPRG = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 HLPPRG = 1):

ADVICE is coded based on specific services reported in HA-5 TYPALLPGx. TYPALLPGx provides space for up to 6 “mentions” of services.

If code 1 is given in TYPALLPGx, then ADVICE=1. Otherwise ADVICE=2.

Imputation Note: Model-based imputation needed contingent on imputed value of ANYPRGHP.
ANYPRGHP. If ANYPRGHP is imputed to NO, then this recode is imputed to “inapplicable”; if ANYPRGHP is imputed to YES, then this recode can be imputed to yes or no.

Code categories:

- Blank = Inapplicable
- 1 = Reported
- 2 = Not reported

**INSEM**: “Infertility services: Artificial insemination”

INSEM is inapplicable if:
- R has never had sexual intercourse with a male (Blaise-computed variable rhadsex = 5) and she is younger than 18 years (Blaise-computed variable age_r < 18)
- OR
- R did not report seeking any medical help to become pregnant (HA-1 HLPPRG = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 HLPPRG = 1):
INSEM is coded based on specific services reported in HA-5 TYPALLPGx. TYPALLPGx provides space for up to 6 “mentions” of services.

- If code 5 is given in TYPALLPGx, then INSEM=1.
- Otherwise INSEM=2.

Imputation Note: Model-based imputation needed contingent on imputed value of ANYPRGHP. If ANYPRGHP is imputed to NO, then this recode is imputed to “inapplicable”; if ANYPRGHP is imputed to YES, then this recode can be imputed to yes or no.

Code categories:

- Blank = Inapplicable
- 1 = Reported
- 2 = Not reported

**INVITRO**: “Infertility services: In vitro fertilization or other assisted reproduction”

INVITRO is inapplicable if:
- R has never had sexual intercourse with a male (Blaise-computed variable rhadsex = 5) and she is younger than 18 years (Blaise-computed variable age_r < 18)
- OR
- R did not report seeking any medical help to become pregnant (HA-1 HLPPRG = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 HLPPRG = 1):
INVITRO is coded based on specific services reported in HA-5 TYPALLPGx and HA-5c OTMEDHEPx. TYPALLPGx provides space for up to 6 “mentions” of services. OTMEDHEPx
provides space for up to 5 “mentions” of other services.

If code 6 is given in TYPALLPGx and code 2 is given in OTMEDHEPx, then INVITRO=1.
Otherwise INVITRO=2.

**Imputation Note:** Model-based imputation needed contingent on imputed value of ANYPRGHP. If ANYPRGHP is imputed to NO, then this recode is imputed to “inapplicable”; if ANYPRGHP is imputed to YES, then this recode can be imputed to yes or no.

**Code categories:**

<table>
<thead>
<tr>
<th>Blank</th>
<th>Inapplicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reported</td>
</tr>
<tr>
<td>2</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

**ENDOMET**: “Infertility services: Surgery or drug treatment for endometriosis”

ENDOMET is inapplicable if:

- R has never had sexual intercourse with a male (Blaise-computed variable rhadsex = 5) and she is younger than 18 years (Blaise-computed variable age_r < 18)

OR

- R did not report seeking any medical help to become pregnant (HA-1 HLPPRG = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 HLPPRG = 1):

ENDOMET is coded based on specific services reported in HA-5 TYPALLPGx and HA-5c OTMEDHEPx. TYPALLPGx provides space for up to 6 “mentions” of services. OTMEDHEPx provides space for up to 5 “mentions” of other services.

If code 6 is given in TYPALLPGx and code 1 is given in OTMEDHEPx, then ENDOMET=1.
Otherwise ENDOMET=2.

**Imputation Note:** Model-based imputation needed contingent on imputed value of ANYPRGHP. If ANYPRGHP is imputed to NO, then this recode is imputed to “inapplicable”; if ANYPRGHP is imputed to YES, then this recode can be imputed to yes or no.

**Code categories:**

<table>
<thead>
<tr>
<th>Blank</th>
<th>Inapplicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reported</td>
</tr>
<tr>
<td>2</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

**FIBROIDS**: “Infertility services: Surgery for uterine fibroids”

FIBROIDS is inapplicable if:
-- R has never had sexual intercourse with a male (Blaise-computed variable \texttt{rhadsex} = 5) and she is younger than 18 years (Blaise-computed variable \texttt{age_r} < 18)

OR

-- R did not report seeking any medical help to become pregnant (HA-1 \texttt{HLPPRG} = 5 (no))

For all Rs who reported any medical help to become pregnant (HA-1 \texttt{HLPPRG} = 1):
FIBROIDS is coded based on specific services reported in HA-5 TYPALLPgx and HA-5c OTMEDHEPx. TYPALLPgx provides space for up to 6 “mentions” of services. OTMEDHEPx provides space for up to 5 “mentions” of other services.

If code 6 is given in TYPALLPgx and code 3 is given in OTMEDHEPx, then FIBROIDS=1.
Otherwise FIBROIDS=2.

\textit{Imputation Note:} Model-based imputation needed contingent on imputed value of \texttt{ANYPRGHP}. If \texttt{ANYPRGHP} is imputed to NO, then this recode is imputed to “inapplicable”; if \texttt{ANYPRGHP} is imputed to YES, then this recode can be imputed to yes or no.

Code categories:
\begin{itemize}
  \item Blank = Inapplicable
  \item 1 = Reported
  \item 2 = Not reported
\end{itemize}

\textbf{PIDTREAT**: “Ever been treated for PID”}

If PID treatment question is non-missing (HD-1 PID = 1 or 5), then PIDTREAT is based on PID as follows:

If PID=1 then PIDTREAT=1;
Else if PID=5 then PIDTREAT=2;

\textit{Imputation Note:} Cases imputed at least partly (if available) on response to HD-2 \texttt{PIDSYMPT}.

Code categories:
\begin{itemize}
  \item 1 = Yes
  \item 2 = No
\end{itemize}

\textbf{EVHIVTST**: “Ever had an HIV test”}

\texttt{EVHIVTST} = 0 if:
R has never donated blood, nor does she report ever having an HIV test.
(HE-1 DONBLOOD = 5(no) and HE-2 HIVTEST = 5(no))

else \texttt{EVHIVTST} = 1 if:
R has only had her blood tested for HIV in the context of a blood donation.
(HE-1 DONBLOOD = 1(yes) and HE-2 HIVTEST = 5(no))

else EVHIVTST = 2 if:
R has never donated blood but she reports an HIV test elsewhere.
(HE-1 DONBLOOD = 5(no) and HE-2 HIVTEST = 1(yes))

else EVHIVTST = 3 if:
R reported both blood donation and HIV testing outside of blood donation.
(HE-1 DONBLOOD = 1(yes) and HE-2 HIVTEST = 1(yes))

User Note: Some women may have answered no to HE-2 HIVTEST, but reported HIV testing during their most recent completed pregnancy (HE-9 PREGHIV). Users may wish to include such women as having had HIV testing outside of blood donation.

Imputation Note: Imputed if HE-1 DONBLOOD = DK or RF or if HE-2 HIVTEST = DK or RF.

Code categories:

0 = No HIV test reported
1 = Yes, only as part of blood donation
2 = Yes, only outside of blood donation
3 = Yes, in both contexts

FPTITHIV: “Source of HIV test received in the last 12 months”

FPTITHIV=blank (inapplicable) if R did not report receiving an HIV test in the last 12 months. (HE-2 HIVTEST=5, DK, RF or CMHIVTST LT CMLSTYR or CMHIVTST =DK,RF ).
(set to system-missing if test was more than 12 months ago or DK/RF)

Otherwise,
If R received an HIV test in the last 12 months (HE-2 HIVTEST=1 and CMHIVTST GE CMLSTYR ) and it was possibly received at a clinic (HE-4 PLCHIV = 3,4,6,7, 14) (i.e., the clinic database was invoked), then do:

If R received it at a Title X clinic sponsored by a public health department (ClinicFund_H_1= 1 AND ClinicType_H_1 = 2), then FPTITHIV=1.

Else if R received it at a Title X clinic and the agency type is unknown (ClinicFund_H_1= 1 AND ClinicType_H_1=-6), then FPTITHIV=5.

Else if R received it at a non-Title X clinic and the agency type is unknown (ClinicFund_H_1= 0 AND ClinicType_H_1=-6), then FPTITHIV=6.

Else if R received it at a Title X clinic NOT sponsored by a public health department (ClinicFund_H_1= 1 AND ClinicType_H_1 NE 2), then FPTITHIV=2.
Else if R received it at a non-Title X clinic sponsored by a public health department (ClinicFund_H_1= 0 AND ClinicType_H_1= 2), then FPTITHIV=3.

Else if R received it at a non-Title X clinic NOT sponsored by a public health department (ClinicFund_H_1= 0 AND ClinicType_H_1 NE 2), then FPTITHIV=4.

(The condition that follows is intended to capture cases who reported codes HE-4 PLCHIV = 1, 2, 5, 8, 9, 10, 11, 12, 13, 15, or 20.)

Else if R received an HIV test in the last 12 months (HE-2 HIVTEST=1 and CMHIVTST GE CMLSTYR ) and FPTITHIV still = . and R gave information on place (HE-4 PLCHIV NE . ), then do:

If R received it at an employer or company clinic or at work site (HE-4 PLCHIV = 5 or 11), then FPTITHIV=7.

If R received it at private doctor’s office or HMO (HE-4 PLCHIV = 1 or 2), then FPTITHIV=8.

Else if R received it at a hospital emergency room, hospital regular room, or urgi-care center (HE-4 PLCHIV =8,9,10), then FPTITHIV=9.

Else if R received HIV test at home (HE-4 PLCHIV=12) then FPTITHIV=10.

Else if R received HIV test at military site (HE-4 PLCHIV=13) then FPTITHIV=11.

Else if R received HIV test at lab or blood bank (HE-4 PLCHIV=15) then FPTITHIV=12.

Else if R received it at “some other place” (HE-4 PLCHIV = 20), then FPTITHIV=13.

Code categories:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank</td>
<td>Inapplicable</td>
</tr>
<tr>
<td>01</td>
<td>Clinic: Title X=yes; health department=yes</td>
</tr>
<tr>
<td>02</td>
<td>Clinic: Title X=yes; health department =no</td>
</tr>
<tr>
<td>03</td>
<td>Clinic: Title X=no; health department=yes</td>
</tr>
<tr>
<td>04</td>
<td>Clinic: Title X=no; health department= no</td>
</tr>
<tr>
<td>05</td>
<td>Clinic: Title X=yes; agency unknown</td>
</tr>
<tr>
<td>06</td>
<td>Clinic: Title X=no; agency unknown</td>
</tr>
<tr>
<td>07</td>
<td>Employer or company clinic/worksite</td>
</tr>
<tr>
<td>08</td>
<td>Private Doctor’s office or HMO</td>
</tr>
<tr>
<td>09</td>
<td>Hospital emergency room/regular room/urgent care</td>
</tr>
<tr>
<td>10</td>
<td>Home</td>
</tr>
<tr>
<td>11</td>
<td>Military site</td>
</tr>
<tr>
<td>12</td>
<td>Lab or blood bank</td>
</tr>
<tr>
<td>13</td>
<td>Some other place</td>
</tr>
</tbody>
</table>
Section I: Insurance; Residence; Religion; Work Status

CURR_INS**: “Current health insurance coverage status”

There are alternate ways in which the health insurance categories can be combined. This recode, CURR_INS, applies the same prioritization and collapsing rules as the National Health Interview Survey.

If R had insurance all 12 months (IA-1 COVER12 = 5) AND she reports only 1 type of insurance (IA-3 COVERHOW02 = .), then do:

   CURR_INS = 1  R reports either a private health insurance or Medi-Gap (IA-3 COVERHOW01 = 1 or 4)
   Else
   CURR_INS = 2  R is covered by Medicaid, CHIP, or state-sponsored health plans (IA-3 COVERHOW01 = 2, 7 or 8)
   Else
   CURR_INS = 3  R is covered by Medicare, Military health care, or other government health care (IA-3 COVERHOW01 = 3, 5, or 9)
   Else
   CURR_INS = 4  R has only a single service plan or only Indian Health Service (IA-3 COVERHOW01 = 6)

Else, if R had a period of time in the last 12 months when she did not have health insurance or doesn’t know or refuses to answer whether there was a time in the last 12 months when she did not have health insurance (IA-1 COVER12 = 1, 8, or 9) OR she reports more than 1 type of health insurance coverage in the last 12 months (IA-3 COVERHOW02 NE .) OR she does not report the type of coverage she had in the last 12 months but does report her current coverage ((IA-3 COVERHOW01 = 98 or 99) and (IA-4 NOWCOVER01 NE (., 98, or 99))), then do:

   CURR_INS = 1  Any mention of either a private health insurance plan or Medi-Gap in any of the 10 positions (IA-4 NOWCOVERnn = 1 or 4)
   Else
   CURR_INS = 2  Any mention of Medicaid, CHIP, or state-sponsored health plans (IA-4 NOWCOVERnn = 2, 7, or 8)
   Else
   CURR_INS = 3  Any mention of Medicare, Military health care, or other government health care (IA-4 any NOWCOVERnn = 3, 5, or 9)
   Else
CURR_INS = 4  R is not currently covered by health insurance, has only a single service plan, or only the Indian Health Service coverage (IA-4 NOWCOVERnn = 6)

Else, if R had no coverage for all of the past 12 months (IA-2 NUMNOCOV=12), then do:
CURR_INS = 4  No health insurance in the last 12 months

Imputation note:  Imputed if NOWCOVER is DK/RF.

Note:  The original 10 categories for the raw variables COVERHOWnn were collapsed for public-use into 9 categories and the original 11 categories for the raw variables NOWCOVERnn were collapsed for public-use into 10 categories (refer to VARIABLES SUPPRESSED OR MODIFIED FOR PUBLIC USE in Appendix 7c of the User’s Guide for more detail).  Therefore, the public-use versions of CURR_INS, COVERHOW and NOWCOVER cannot be aligned as given in the specifications above.  The full-detail variables of INCOVERHOWnn and INNOWCOVERnn are available through the NCHS Research Data Center.

Code categories:
1 = currently covered by private health insurance or Medi-Gap
2 = currently covered by Medicaid, CHIP, or a state-sponsored health plan
3 = currently covered by Medicare, Military health care, or other government health care
4 = currently covered only by a single-service plan, only by the Indian Health Service, or currently not covered by health insurance

METRO**:  “Place of residence (metropolitan-nonmetropolitan)”

METRO = R’s address at time of interview classified according to 2010 Census population counts. The U.S. Office of Management and Budget defines metropolitan statistical areas (MSA’s).

Code categories:
1 = Principal city of MSA
2 = Other MSA
3 = Not MSA

RELIGION**:  “Current religious affiliation”

RELIGION is a composite variable of the respondent’s current religious affiliation based on RELNOW, RELNOW1, and OTHRLNOW.  Response categories are: no religion (atheist), Catholic, Protestant, and other religion.

-- If IC-5 RELNOW = None (1) or IC-6 RELNOW1 = No particular faith (90), then RELIGION = 1
-- If IC-5 RELNOW = Catholic (2), then RELIGION = 2
-- If R reported any Protestant denomination
   IC-5 RELNOW = Southern Baptist (4), Baptist (5), Methodist or African Methodist (6),
   Lutheran (7), Presbyterian (8), Episcopal or Anglican (9)
   or
   IC-6 RELNOW1 = Assemblies of God (12), Church of Nazarene (13), The Church of God
   (14), The Church of God (Cleveland, TN) (15), The Church of God in Christ (16), 7th Day
   Adventist (17), United Pentecostal Church (18), Pentecostal Assemblies (19), Christian,
   another denomination not listed (21), Christian, no specific denomination (22), or
   Fundamental Protestant Bodies, Pentecostal (30),
   then RELIGION = 3
-- If R reported some other religion
   IC-5 RELNOW = Jewish (3) or Church of Jesus Christ of Latter Day Saints,
   (LDS/Mormon) (10),
   or
   IC-6 RELNOW1 = Jehovah’s Witness (20), Unitarian-Universalist (23), Greek Orthodox
   (24), Other Orthodox (25), Muslim (26), Buddhist (27), Hindu (28), Native American
   religions (31), Taoic religions (32), Neopagan religions (33), or Other,-not shown separately
   (95),
   then RELIGION = 4

User Note: Refer to RELIGION DATA IN THE NSFG in Part 2 of the User’s Guide for the
previous file release, 2011-2013, for information on the coding of verbatim
responses to OTHRLNOW into existing and new categories of RELNOW and
RELNOW1.

Imputation Note: Once all verbatim responses were assigned to an existing or newly created
category of IC-5 RELNOW or IC-6 RELNOW1, those values were used in
the construction of the RELIGION recode. Then any remaining missing
values on RELIGION were imputed.

Code categories:
   1 = No religion
   2 = Catholic
   3 = Protestant
   4 = Other religion

LABORFOR**: “Labor force status”

The LABORFOR recode is defined for all respondents and categorizes the respondent’s activities
in the week before the interview in hierarchical order based on her activity status (IE-1
DOLASTWKn) and whether she was working full or part-time (IE-4 RFTPTX).

Assign code to LABORFOR from IE-1 DOLASTWK1 through IE-1 DOLASTWK9, taking the
code highest in the ranking shown below.

-- If (IE-1 DOLASTWK1 - DOLASTWK9 = 1) and IE-4 RFTPTX = 1
   (R was working full-time last week)
then LABORFOR = 1
-- Else if (IE-1 DOLASTWK1 - DOLASTWK9 = 1) and IE-4 RFTPTX = 2 or 3
(R was working part-time last week)
   Note: “some of each” is coded as “part time”
then LABORFOR = 2
-- Else if IE-1 DOLASTWK1 - DOLASTWK9 = 2
(R was not working due to temporary illness, vacation, strike, etc.)
then LABORFOR = 3
-- Else if IE-1 DOLASTWK1 - DOLASTWK9 = 3
(R was on paternity leave or family leave from job)
then LABORFOR = 4
-- Else if IE-1 DOLASTWK1 - DOLASTWK9 = 4
(R was unemployed, laid off, or looking for work)
then LABORFOR = 5
-- Else if IE-1 DOLASTWK1 - DOLASTWK9 = 7
(R was going to school)
then LABORFOR = 6
-- Else if IE-1 DOLASTWK1 - DOLASTWK9 = 5
(R was keeping house)
then LABORFOR = 7
-- Else if IE-1 DOLASTWK1 - DOLASTWK9 = 8
(R was on permanent disability)
then LABORFOR = 8
-- Else if IE-1 DOLASTWK1 - DOLASTWK9 = 6
(R was taking care of family)
then LABORFOR = 9
-- Else if IE-1 DOLASTWK1 - DOLASTWK9=9
(R responded “something else”)
then LABORFOR = 10

Imputation note: If there is insufficient information to define LABORFOR (i.e., if IE-1
DOLASTWK1 in (98,99), then impute LABORFOR.

User Note: The original LABORFOR recode, as defined above, was collapsed for public use
from 10 categories to 9. The full-detail variable called INLABORFOR is available
through the NCHS Research Data Center.

Note: The original 9 categories for the raw variables DOLASTWKnn were collapsed for public-
use into 6 categories (refer to VARIABLES SUPPRESSED OR MODIFIED FOR
PUBLIC USE in Appendix 7c of the User’s Guide for more detail). Therefore, the public-
use versions of LABORFOR and DOLASTWK cannot be aligned as given in the
specifications above. The full-detail variables of INDOLASTWKnn are available through
the NCHS Research Data Center.

Code categories and ranking for LABORFOR (public-use variable):
1 = Working full-time
2 = Working part-time
3 = Working, but on vacation, strike, or had temporary illness
4 = Working, but on maternity or family leave
5 = Not working but looking for work
6 = In school
7 = Keeping house
8 = Caring for family
9 = Other

Code categories and ranking for INLABORFOR (restricted-use variable):
  1 = Working full-time
  2 = Working part-time
  3 = Working, but on vacation, strike, or had temporary illness
  4 = Working, but on maternity or family leave
  5 = Not working but looking for work
  6 = In school
  7 = Keeping house
  8 = On permanent disability
  9 = Caring for family
10 = Other
Section J: Audio CASI

**POVERTY**: “Poverty level income”

Poverty level income is R’s combined family income from all sources in the calendar year before the interview (JI-3 TOTINC) divided by the weighted average threshold income of families whose head of household was under 65 years of age, for a family of the size of R’s family, based on the annual poverty levels defined by the U.S. Census Bureau (family size is calculated by adding 1 to the integer value of NUMFMHH, from Section A Recodes). If the value is 998 or greater, then POVERTY=998.

---

For this recode an exact family income is estimated by the midpoint of the reported range of annual family income (JI-3 TOTINC) as follows:

1 = $2,500  
2 = $6,250  
3 = $8,750  
4 = $11,250  
5 = $13,750  
6 = $17,500  
7 = $22,500  
8 = $27,500  
9 = $32,500  
10 = $37,500  
11 = $45,000  
12 = $55,000  
13 = $67,500  
14 = $87,500  
15 = $125,000

The annual poverty thresholds for each family size are:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>2012¹ (for 2013 interviews)</th>
<th>2013² (for 2014 interviews)</th>
<th>2014³ (for 2015 interviews)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,945</td>
<td>$12,119</td>
<td>$12,316</td>
</tr>
<tr>
<td>2</td>
<td>$15,450</td>
<td>$15,679</td>
<td>$15,934</td>
</tr>
<tr>
<td>3</td>
<td>$18,284</td>
<td>$18,552</td>
<td>$18,850</td>
</tr>
<tr>
<td>4</td>
<td>$23,492</td>
<td>$23,834</td>
<td>$24,230</td>
</tr>
<tr>
<td>5</td>
<td>$27,827</td>
<td>$28,265</td>
<td>$28,695</td>
</tr>
<tr>
<td>6</td>
<td>$31,471</td>
<td>$31,925</td>
<td>$32,473</td>
</tr>
<tr>
<td>7</td>
<td>$35,743</td>
<td>$36,384</td>
<td>$36,927</td>
</tr>
<tr>
<td>8</td>
<td>$39,688</td>
<td>$40,484</td>
<td>$40,968</td>
</tr>
<tr>
<td>9 or larger</td>
<td>$47,297</td>
<td>$48,065</td>
<td>$49,021</td>
</tr>
</tbody>
</table>
User Note: The original POVERTY recode, as defined above, was top-coded for public use at 500 to represent “500% of poverty level or more.” The full-detail variable called INPOVERTY is available through the NCHS Research Data Center.

Imputation note: If missing, the “DK follow-up” questions (JI-3a FMINCDK1, JI-3b FMINCDK2, JI-3c FMINCDK3, JI-3d FMINCDK4, and JI-3e FMINCDK5) are used as imputation bounds.

Code categories:

0 - 499 = 0-499 percent of poverty level

500 = 500 percent or more of poverty level

TOTINCR**: “Total income of R’s family”

TOTINCR = R’s income (if no family members in household) or combined income of R’s family from all sources in the calendar year before the interview (JI-3 TOTINC).

This variable is an imputed version of JI-3 TOTINC and is created for the purposes of creating/imputing POVERTY.

Code categories:

1-15 = under $5,000/year –$100,000 or more/year

Imputation note: If missing, the “DK follow-up” questions (JI-3a FMINCDK1, JI-3b FMINCDK2, JI-3c FMINCDK3, JI-3d FMINCDK4, and JI-3e FMINCDK5) are used as imputation bounds.

PUBASSIS**: “Whether R or any members of her family received public assistance in the calendar year before the interview”
PUBASSIS = 1 if:
R received public assistance/welfare, food stamps, WIC, help with transportation, childcare, or job training in the calendar year before the interview (JI-4 PUBASST = 1 or JI-6 FOODSTMP = 1 or JI-7 WIC = 1 or JI-8a HLPTRANS = 1 or JI-8b HLPCHLDC = 1 or JI-8c HLPJOB = 1).

PUBASSIS = 2 if:
if R did not receive public assistance/welfare, food stamps, WIC, help with transportation, childcare or job training in the calendar year before the interview (JI-4 PUBASST = 5 and JI-6 FOODSTMP = 5 and JI-7 WIC = 5 and JI-8a HLPTRANS = 5 and JI-8b HLPCHLDC = 5 and JI-8c HLPJOB = 5).

Imputation note:  PUBASSIS is imputed if one or more variables are 8 or 9 (DK/RF) and the remainder are 5 (no, did not receive this type of public assistance).

Code categories:
1 = Yes (R received public assistance in previous calendar year)
2 = No (R did not receive public assistance in previous calendar year)