APPENDIX 1 – QUESTIONNAIRE

Stratum: *1=Formal, 2=Informal, 3=Peri-urban, 4=Rural* **Study Number:**

QUESTIONNAIRE FOR INVESTIGATING FOETAL DEVELOPMENT AMONG WOMEN IN NORTH-WEST PROVINCE

- In completing the questionnaire, please tick the appropriate option or fill in the information or date, as required.
- Please note that throughout the questionnaire, when we talk about "your spouse/partner" we mean the father of your last child (or the partner that you had last time you became pregnant).
- *Before answering the questionnaire, please answer the screening questions (please tick the appropriate option):*
- *Interview is private, no people other than interviewee to be present*

SCREENING QUESTIONS

1. Have you ever been pregnant? **Yes** **No**

*IF **YES,** PLEASE. START WITH SECTION A*

*IF **NO**, PLEASE CONTINUE TO QUESTION 2.*

2. Have you ever tried to fall pregnant? **Yes** **No**

*IF **YES,** PLEASE START WITH SECTION A*

*IF **NO**, PLEASE STOP HERE. THANK YOU FOR YOUR TIME.*

THIS IS THE END OF THE SCREENING QUESTIONS.
ACCORDING TO THE RESPONSES YOU GAVE, PLEASE FOLLOW THE INSTRUCTIONS ABOVE AND COMPLETE THE APPROPRIATE SECTIONS OF THE QUESTIONNAIRE.

QUESTIONNAIRE FOR INVESTIGATING FOETAL DEVELOPMENT AMONG WOMEN IN NORTH-WEST PROVINCE

For Office Use

A. PERSONAL INFORMATION

A1. Age — A1.

A2. Race (for statistical purposes only): a. Black b. White c. Coloured d. Asian — A2.

A3. Compared to other women are you: a. short b. medium c. tall — A3.

A4. Compared to other women are you: a. slim b. medium c. fat — A4.

A5 Do you currently smoke Yes No — A5.

A6. Have you ever smoked Yes No — A6.

B. SOCIOECONOMIC STATUS

B1. What was the highest level of education that you finished? — B1.

No school Some Primary school

Completed Primary School (5 yrs) Some High School no Matric

High School with Matric (10 yrs) Tertiary eg. University

B2. Do you work for money or payment at the moment? Yes No — B2.

IF NO, PLEASE SKIP TO QUESTION B6
IF YES, PLEASE CONTINUE WITH QUESTION B3.

B3. Your current working place _____ — B3.

B4. Job title _____ — B4.

B5. When did you start doing your current job? MM / YYYY — B5.

B6. Is your husband/Partner working for money or payment? Yes No — B6.

B7. What is his job? _____ — B7

B8. Who or where does your husband/partner work for? _____ — B8

B9. What is your current household monthly income after tax (Please tick the correct option)? — B9

1	Less than R500	5	R1,501 – R2,000	11	R4,001 – R5,000
2	R500 – R750	6	R2,001 – R2,500	12	R5,000 – R7,000
3	R751 – R1,000	7	R2,501 – R3,000	13	R7,001 – R10,000
4	R1,001 – R1,500	8	R3,001 – R4,000	14	R10,001 & more

C. ENVIRONMENTAL FACTORS

For Office Use

C1. How many people live in your house? C1.

C2. What type of dwelling is your house? C2.

Formal house (brick) Formal house (wood)

Informal house or shack Flat

Hostel Other _____

C3. Do you have water in your house? Yes No C3.

C3.1. If no, where do you get water from? C3.1.

. Communal tap Well River/stream

C3.2. What do you keep/carry water in? C3.2.

New plastic container Re-used plastic container

Metal container

C4. Do you have electricity in your house? Yes No C4.

C4.1. What source of energy do you use for cooking? C4.1.

Electricity Gas

Paraffin Wood

Other _____

C5. Do you work in the garden/field? Yes No C5.

C5.1. Do you use pesticides or insecticides in garden/field? Yes No C5.1.

C5.2. How often do you use pesticides or insecticides in the garden/field? C5.2.

Usually (4x a week) Occasionally (1x a week)

Sometimes (1x a month) Never

C5.3. What is the name of pesticide or insecticide you use most often?

_____

*Ask to be shown the pesticide or insecticide container. Note name and active ingredient

C6. Do you use insecticides inside the house? Yes No C6.

C6.1. If yes, how often do you use insecticides in the house? C6.1.

Usually (4 x a week) Occasionally (1x a week)

Sometimes (1 x a month) Seldom (1-3 times a year)

C7. Do you keep any domestic animals? Yes No

C7.1. If yes, what animals do you keep?

Dogs Cats

Goats Sheep

Cattle Pig

Chickens Rabbits

C8. Do you use pesticides on your animals Yes No

C8.1 Do you ever apply, or help to apply pesticides to your animals? (dipping or spraying)

Yes No

C8.2 If yes, how often do you do this? _____

C9. What do you use on your garden or vegetables to remove the pests? _____

_____

_____

C10. What do you use in your house for the insects? _____

_____

_____

C11. Do you worry about anything in your environment?_____

_____

_____

* Interviewer can suggest examples like factories nearby and dust chemicals strange tastes or smells.

C12. Does anyone in your house smoke? Yes No

C12.1If yes how many people smoke in the house _____

C12.2How much do they smoke per day?

1-4 5-9 10-14 15-19 20+

*Interviewer tick relevant box

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C7.

C7.1.

C8.

C8.1.

C8.2___

C9.

C12.

C12.1

C12.2

REPRODUCTIVE HISTORY I

*The next two questionnaires are for people who have had at least one pregnancy. Please note that a pregnancy does not always end up with the birth of a child (e.g., some pregnancies may finish with a spontaneous or an induced abortion).

D1 When did you start trying to fall pregnant for your first pregnancy? MM/YYYY

Don't know Did not plan

D1.1 Were you using contraceptives before you started trying for a child? Yes No

D1.2 If yes, please specify which of the following you were using: * Name

Intra-uterine device (coil) Oral contraceptive (pill) _____

Spermicidal jelly, cream or foam Condoms

Injectable 3 month Injectable long term _____

Other (please specify: _____) e.g. abstinence, Rhythm, natural.

*Interviewer – give suggestions like condoms, injection, depravera, Yasmin, OC

D1.3 When did you stop using your contraceptives MM / YYYY

D1.4 How long had you used contraceptives

D 1.5 How often did you have sex

Usually (4x a week) Occasionally(1x a week) Sometimes (1 x a month)

D 1.6 Did you time your sex to your monthly cycle Yes No

D2. Did you become pregnant Yes No

D2.1 When did you fall pregnant MM / YYYY

D3 Did you receive any assistance to fall pregnant Yes No

D3.1 When did you receive this assistance MM / YYYY

D3.2 What treatment did you use _____

- Interviewer eg. fertility pills from the doctor

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D1._____

D1.1

D1.2

D1.3 _____

D1.4 _____

D1.5___

D1.6

D2

D2.1___

D3

D3.1_____

D3.2___

D4. Please complete Table 1 for all the children you have ever given birth to.

Please note:
Include all live born children, even the ones who died shortly after birth
Include stillbirths (dead newborns)
Count the multiple births (e.g. twins etc) as one child
Birth assistance 1-doctor, 2-nurse, 3-midwife , 4-family /village doulagh

Table 1

Child	**Date of birth** (dd /mm/yyyy)	**Birth weight** (kg)	**Live birth** (√)	**Still birth** (√)	**Birth assistance**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

* Please turn over the page if more space is needed.

D5 Have you ever had a miscarriage? Yes No

(Miscarriage=spontaneous abortion, including incomplete miscarriages which then require abortions But not a termination of pregnancy)?

D 5.1 If yes, please specify how many:

D 5.2 Please specify when you had the miscarriages and what the causes were:

Table 2

Miscarriage	**Date (mm/yy)**	**Cause**
1		
2		
3		
4		
5		

* Interviewer if causes are unknown state this

D6. Have you ever had a termination of pregnancy (induced abortion)? Yes No

D6.1 If yes, please specify how many.

D6.2 Please specify when you had a termination of pregnancy and why, in:

For Office Use

D8

D9 See Table

D9.

D9.1

D9.2 See Table

D8.

D8.1.

Table 3

Pregnancy	Date (mm/yyyy)	Reason
1		
2		
3		
4		
5		

D9. Was your last child born after January 1996? Yes No

If **Yes** please continue to the next page

If **No** please stop here

REPRODUCTIVE HISTORY II

HISTORY OF YOUR LAST (MOST RECENT) PREGNANCY

- The next set of questions is about the **last time you were pregnant**, about the progress of this last pregnancy and the way the pregnancy ended (e.g., with the birth of a child, with a spontaneous abortion, or an induced abortion?).
- When we talk about "your spouse/partner" we mean the father of your child (or the partner that you had when you became pregnant).
- Please tick the appropriate option or fill in the date, as required.

For Office Use

E1. Are you currently pregnant Yes No

E1.

E2. Were you using any contraceptives before you became pregnant with this child?

Yes No

E2.

E2.1 If yes, please specify which of the following you were using: * Name

E2.1

Intra-uterine device (coil) Oral contraceptive (pill) _____

Spermicidal jelly, cream or foam Condoms

Injectable 3 month Injectable long term _____

Other (please specify: _____) eg abstinence, Rhythm, natural.

E2.2 How long had you used contraceptives _____

E2.2_____

E3 How old were you when you fell pregnant

E3.

E4. How many times have you been pregnant before the last pregnancy ? (include miscarriages and abortions)

0 1 2 3 4 5 6 7 8 9 10

E4

more than ten, how many?_____

E5. How old was/is your previous child when this one was born (years and months)? .

E5.

E6. What was your weight at the beginning of the pregnancy (kg)? Don't know

.

E6.

E7.What was your weight at the time of your delivery (kg)? Don't know

E7.

E8. Was this a planned pregnancy? Yes No

E8.1 If yes, when did you start trying to fall pregnant? MM / YYYY

E 8.2 When did you fall pregnant? MM / YYYY

E8

E9. How often did you have sex ?

E8.1

_____

Usually (4x a week) Occasionally(1x a week) Sometimes (1 x a month)

E8.2_____

E10. Did you time your sex to your monthly cycle Yes No

E9.

E11 Did you receive any assistance to fall pregnant Yes No

E11.1 When did you receive this assistance MM / YYYY

E11.2 What treatment did you use _____

- Interviewer eg. fertility pills from the doctor

E12 How old was your spouse/partner when you became pregnant?

E13. Did you work during your last pregnancy? Yes No

If yes, please answer
If no, please move on to Section D.

E14. How many hours per week did you work on average during the last pregnancy?

E15. How many hours per day were you doing that job?

E16. Did you work in shifts during your last pregnancy? Yes No

E17. In which month of your pregnancy did you stop working?

E18. Which company did you work at during your last pregnancy?

_____

E19. What was your job description at this company?

_____

E20. On what date did you **start** doing this job at this company? DD / MM / YYYY

E21. On what date did you **stop** doing this job at this company? (if pregnancy current when will you stop) DD / MM / YYYY

E22. Table 4 lists various substances/conditions that one may encounter in working places. If you have been exposed to any of them during your last pregnancy, please tick the "Exposed" box and specify the time period of exposure (Start date to End date).

Table 4

Substances/conditions encountered in the workplace	**Exposed** (√)	**Time period of exposure**	
		Start (mm/yyyy)	**End** (mm/yyyy)
Anaesthetic agents (Operating Theatre)			
Antineoplastic agents (Oncology ward)			
Carbon monoxide (Heavy traffic)			
Ethylene oxide (Sterilizing at hospitals)			
Excessive physical activity**			

For Office Use

E11.
E11.1.
/
E11.2
_____

E12.

E13.

E14.

E15.

E16.

E17

E18

E19

E20.
/ /

E21.
/ /

E22 see table

Excessive psychological stress			
Hypobaric environment (high altitude)			
Ionising radiation			
Lead			
Mercury			
Microwave radiation (not microwave ovens)			
Noise (excessive eg drilling)			
Organic solvents(Disinfectants, factory work)			
Pesticides			
Video display terminals (Computer monitors, TV's more than 4 hours per day)			
Living below electricity pylons/substations			

** This means: Bending for more than 1 hour/day OR Standing for more than 6 hours a day OR Heavy lifting

E23.Did you use insecticides or herbicides (bug or weed killers, flea and tick sprays, collars, powders or shampoos) in your household during your last pregnancy? E23.

Yes No

E 23.1If yes, please specify what kind of chemicals: E23.1___

_____ __

E23.2 How often did you use these during your last pregnancy? E23.2

Usually (4 times a week) Sometimes (1 times a month)

Seldom (1-3 times a year)

E24. Did you smoke during your last pregnancy? Yes No E24.

E24.1 If yes, how many cigarettes did you smoke per day? E24.1

more than 20 11-20 5-10 1-5

E25. Did your spouse/partner smoke at home during your last pregnancy? Yes No E25

E25.1 If yes, how many cigarettes did he smoke per day? E25.1

more than 20 11-20 5-10 1-5

For Office Use

E26. Table 6 lists various types of alcohol.
For each of the drinks, please indicate how much you drank per week during your last pregnancy?

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E26. See Table

TABLE 6

Drink	Number of drinks per week
Beer (bottle)	
Wine (glass)	
Spirits: whisky, brandy (tot)	
Other (Specify:_____)	

E27. Have you ever been diagnosed with high blood pressure? Yes No

E27.

E27.1 If yes, please specify the date of diagnosis: MM / YYYY

E27.1_____

E20.1. What treatment did you receive? _____

E28 Did you experience excessive stressing your last pregnancy like a death in your family, divorce or loss of income?

E28.

Yes No

E29 Have you ever been diagnosed with diabetes ("sugar")? Yes No

E29.

E29.1 If yes, please specify the date of diagnosis: MM / YYYY

E29.1_____

E29.2 What type of diabetes do you have

E29.2

Insulin dependent Insulin independent

E29.3What treatment did you receive for the diabetes?

E29.3

Injections Tablets None

E30 Have you ever been diagnosed with any disorders of the womb (uterus)? Yes No

E30.

Don't know

E30.1 If yes, please specify the Date of diagnosis: MM / YYYY

E30.1_____

E30.2 What disorder were you diagnosed with? _____

E30.1_____

E31. Have you ever been diagnosed with any hormonal disorders? Yes No

E31.

E31.1_____

E31.1 If yes, please specify the Date of diagnosis: MM / YYYY

E31.2_____

E31.2 What disorder were you diagnosed with? _____

E31.3_____

E31.3 What treatment did you receive? _____

E32 Table 7 lists various infections that may occur during pregnancy.

If you had any of these during your last pregnancy, please tick the "Yes/No" box and specify the date of diagnosis (mm/yy) and the month of pregnancy in which you got the infection.

TABLE 7

Infection	**Yes/No** (√)	**Date of diagnosis** (MM/YY)	**Month of pregnancy**
Rubella (German measles)			
Mumps			
Herpes simplex infection			
Varicella (chickenpox)			
Zoster (shingles)			
HIV infection			
Toxoplasmosis (toxoplasma gondii infection)			
Genital Mycoplasma infections			
Syphilis			
Any uterine infection			
High fever (over 41°C)			

E33 Did you receive any antenatal care during your last pregnancy? Yes No

E33.1 If yes, in which month of your last pregnancy did the antenatal care start?

_____

E34 How many weeks were you pregnant for in your last pregnancy?

E35 What was the outcome of your last pregnancy?

Live birth Still birth Miscarriage (spontaneous abortion)

Abortion (voluntary termination of pregnancy)

Other (please specify: _____)

*If the pregnancy outcome was a **live birth** or **stillbirth**, please specify the following:*

E36. Multiple birth (e.g., twins, triplets etc) Yes No

*If **yes to multiple birth**, please specify the following for one child only.*

E37. Place of Birth (which medical facility): _____

E38. Province of birth: _____

E39. Date of Birth: DD / MM / YYYY

For Office Use

E32. See table 7

E33

E33.1____

E34

E35.

E36.

E37

_____

E38_____

_

E39_____

_

E40. Gender: Male Female

E41. Birth Weight (grams): g

E42. With respect to the due date of the baby, which of the following applies:

The baby was born premature The baby was born at term

The baby was born after the due date

E43. Was the baby born with any malformations (deformity/abnormality)? Yes No

*If the pregnancy outcome was a **miscarriage**, please answer the following questions*

E44. Date of miscarriage: DD / MM / YYYY

E45. Were you examined by a doctor after the miscarriage? Yes No

E46 If yes to E45, what was the diagnosis (the reason for the miscarriage)?

_____

For Office Use

E40

E41

E42

E43

E44 / /

E45

E46 _____

THIS IS THE END OF THE QUESTIONNAIRE.

Thank you for your time and patience in completing this questionnaire

Should you have any further questions, please do not hesitate to ask your interviewer.

REPRODUCTIVE HISTORY III

* This page is people who have tried but have had no pregnancy. Please note that a pregnancy does not always end up with the birth of a child (e.g., some pregnancies may finish with a spontaneous or an induced abortion).

D1 When did you start trying to fall pregnant for your first pregnancy? MM/YYYY

Don't know Did not plan

D1.1 Were you using contraceptives before you started trying for a child? Yes No

D1.2 If yes, please specify which of the following you were using: * Name

Intra-uterine device (coil) Oral contraceptive (pill)

_____

Spermicidal jelly, cream or foam Condoms

Injectable 3 month Injectable long term

_____

Other (please specify: _____) e.g. abstinence,

Rhythm, natural.

*Interviewer – give suggestions like condoms, injection, depravera, Yasmin, OC

D1.3 When did you stop using your contraceptives MM / YYYY

D1.4 How long had you used contraceptives

D 1.5 How often did you have sex

Usually (4x a week) Occasionally(1x a week) Sometimes (1 x a month)

D 1.6 Did you time your sex to your monthly cycle Yes No

D2 Are you still trying to fall pregnant? Yes No

D2.1 If no, how long did you keep trying to fall pregnant before you gave up?

_____

D2.2 Why did you give up?

_____

D3 Did you seek medical advice Yes No

For Office Use

D1._____

D1.1

D1.2

D1.3 _____

D1.4 _____

D1.4 _____

D1.6

D2

D2.1_____

D3

D4 ____

D5

D6

D7

D4 What was the outcome of the doctors visit?

_____

_____

___

* Interviewer doctors diagnosis

D5 When you first started trying to fall pregnant, were you a smoker? Yes No

D6 When you first started trying to fall pregnant, was your partner a smoker? Yes No