***University of the Witwatersrand***
*Department of Paediatrics and Child Health*

**BIRTH TO TWENTY BABIES**
**6 MONTH CORE QUESTIONNAIRE**

**DATE:** **Day** ☐☐ **Month** ☐☐ **Year** ☐☐☐☐

**BTT ID NUMBER:** ☐☐☐☐☐☐☐

**BONE STUDY ID NUMBER:** ☐☐☐

**Name of Clinic:** _____

**Research Assistant name:** _____

**Language:** **Research Assistant:** _____

**Respondent:** _____

## PRIMARY CAREGIVER RELATIONSHIP TO THE CHILD

1. Are you the biological mother/father of this child? ☐

2. If **NO**,
   What is your relationship to the child? *(For example: child's mother's sister, paternal grandmother etc.)*

   ☐ ☐☐

3. Who is the primary caregiver of the child? (*Who lives with the child, who looks after the child most days and nights, and makes decisions around the child?)*

   ☐ ☐☐

**Interviewer's Notes:**

- If the biological mother is not the primary caregiver, where is the mother? (Contact details, whereabouts, and reason for not being the primary caregiver)

- Biological mother whereabouts: _____
  _____
  _____
  _____

- Contact details:
  Physical address: _____
  _____
  _____
  Telephone contact 1: _____
  Telephone contact 2: _____
  Telephone contact 3: _____

- Reason for not being the primary caregiver: _____
  _____
  _____
  _____

4. Approximately how much money does this household spend on food per wee

   Most | | |

   Least | | |

   Most: R_____ Least: _____ Don't know: _____

5. Who usually takes care of this child during the day? (eg childminder, relative etc)

   | | |

   If not the mother, for what reason?

   | | |

6. What is the highest school standard the caregiver has passed?

| | |
|---|---|
| 1 = no formal education | 6 = grade 10 |
| 2 = grade 1/grade 2 | 7 = grade 11 |
| 3 = grade 3-5 | 8 = grade 12 (matric) |
| 4 = grade 6-7 | 9 = post matric |
| 5 = grade 8-9 | 10 = don't know |

7. Where has the baby routinely spent most of its time since birth? (please tick)

| | **With biological mother** | **Other** | |
|---|---|---|---|
| | | **WHOM?** (specify relationship and reason) | **WHERE? (physical address)** |
| During the week day | | | |
| Evenings during the week | | | |
| During weekends | | | |

8. Has the baby been living in a different place for more than one week?

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

If YES,

| **WHERE? (physical address)** | **WHOM? (relationship to baby)** | **For how long (in weeks)** |
|---|---|---|
| | | |
| | | |
| | | |

9. What languages is this baby exposed to?

1. _____
2. _____
3. _____
4. _____

10. What is the highest school standard the baby's maternal grandmother has passed?

| | |
|---|---|
| 1 = no formal education | 6 = grade 10 |
| 2 = grade 1/grade 2 | 7 = grade 11 |
| 3 = grade 3-5 | 8 = grade 12 (matric) |
| 4 = grade 6-7 | 9 = post matric |
| 5 = grade 8-9 | 10 = don't know |

11. What is the highest school standard the baby's maternal grandfather has passed?

| | |
|---|---|
| 1 = no formal education | 6 = grade 10 |
| 2 = grade 1/grade 2 | 7 = grade 11 |
| 3 = grade 3-5 | 8 = grade 12 (matric) |
| 4 = grade 6-7 | 9 = post matric |
| 5 = grade 8-9 | 10 = don't know |

## BIOLOGICAL MOTHER INFORMATION

1. After being admitted for the birth of your baby was there anyone with you during labour or delivery other than the nursing or medical staff?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If **YES**, who was with you?

| | |
|---|---|
| 1. | Father of the baby |
| 2. | Mother |
| 3. | Mother in law |
| 4. | Other family member |
| 5. | Friend |
| 6. | Other:<br>Specify_____ |

2. How many times have you been pregnant?

| | | |
|---|---|---|
| 1. | Total number of pregnancies | |
| 2. | Total number of live births | |
| 3. | Total number of stillbirths | |
| 4. | Total miscarriages/abortions | |

3. Have any of your children died? (i.e livebirths)

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If **YES**,

| **Age** | | **Cause of death/ symptoms** | **Year of death** |
|---|---|---|---|
| **Years** | **Months** | | |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

4. Does/did anyone in the family have difficulty with:

a. Speaking

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

b. Hearing

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

If **YES** to any of the above,

| **Who (relation to baby)** | **What is the problem** |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

5. When you first realized you were pregnant with this baby, were you still at school?

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

If **YES**,

a. Did you return to school after having the baby?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

b. If you have not returned to school yet, do you still plan to go back to school?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

6. Are you living with the father of your child?

| Always | Most of the time | Some of the time | Not at all |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

**CONTRACEPTION**

1. Do you intend having another baby?

| Yes | No | Unsure |
|---|---|---|
| 1 | 2 | 3 |

If **YES**, when?

| | |
|---|---|
| Pregnant at present | 1 |
| As soon as possible | 2 |
| Within 1 year | 3 |
| Within 2 years | 4 |
| Within 5 years | 5 |
| Unplanned (anytime) | 6 |
| In the far future (more than 5 years) | 7 |

2. Are you using contraception at the moment?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If **YES**, which type?

| | |
|---|---|
| Sterilization after delivery | 1 |
| Oral contraception | 2 |
| IUCD (loop) | 3 |
| Injection | 4 |
| Condom | 5 |
| Diaphragm | 6 |
| Spermicidal cream only | 7 |
| Withdrawal | 8 |
| Rhythm method | 9 |
| Abstinence | 10 |
| Herbal medicine | 11 |

## FEEDING

1. Have you ever breastfed this baby?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If **YES**,

a. Are you still breastfeeding this baby?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If **NO**,

i). How old was your baby when breastfeeding was discontinued?

| | | | |
|---|---|---|---|
| **Months** | | **Weeks** | |

2. Have you introduced bottle feeds?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If **YES**,

a. How old was the baby when you started this?

| | | | |
|---|---|---|---|
| **Months** | | **Weeks** | |

b. At the moment, how many bottle feeds do you give in 24 hours? ☐

c. How much milk per bottle? _____ml

d. What type of milk are you using?

| | | |
|---|---|---|
| Powder milk<br>Name: _____ | | 1 |
| Cows milk | Full cream | 2 |
| | Skimmed milk | 3 |
| Other milk<br>Specify: _____ | | 4 |

3. Were there any feeding difficulties (eg. Sucking, swallowing, milk coming through the nose) during bottle or breast feeding?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If **BOTTLE FEEDING**,

Which of the following reasons (one or more) did you have for starting bottle feeding?

| | |
|---|---|
| Going back to work/school | 1 |
| Not enough milk or not strong enough | 2 |
| Problems with breasts/nipples | 3 |
| Difficulty with getting the baby to take the breast | 4 |
| Baby preferred bottle | 5 |
| Medical reasons (mother or baby) | 6 |
| Breast milk did not agree with the baby<br>Specify: _____ | 7 |
| Mother prefers bottle feeds<br>Specify: _____ | 8 |

ADVISED OR INFLUENCED BY:

| | |
|---|---|
| Father of baby | 1 |
| Other relative<br>Specify: _____ | 2 |
| Friends | 3 |
| Health worker<br>Specify: _____ | 4 |
| Advertising | 5 |
| Other | 6 |

If any OTHER reasons, please describe:

_____
_____
_____

4. Have you regularly given your baby food other than milk?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES,

a. How old was the baby when started?

| | | | |
|---|---|---|---|
| **Months** | | **Weeks** | |

b. What food did/do you give your child?

| | **Yes** | **No** |
|---|---|---|
| Baby porridge/cereal | 1 | 2 |
| Fruit/fruit cereal | 1 | 2 |
| Processed baby food | 1 | 2 |
| Vegetables (home prepared) | 1 | 2 |
| Mealie pap | 1 | 2 |
| Eggs | 1 | 2 |
| Tea | 1 | 2 |
| Other | 1 | 2 |

If other, Describe

_____

c. If any salt is added to the baby's solids, state how much per day:

| **None** | **A pinch** | **¼ teaspoon** | **½ teaspoon** | **1 teaspoon** |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

5. In the first 2 months, did you feed your baby by:

| | Yes | No |
|---|---|---|
| Demand | 1 | 2 |
| Schedule | 1 | 2 |

## HEALTH STATUS AND USE OF HEALTH SERVICES

1. Before the birth of this baby, did you receive any antenatal care? (eg visited a clinic/doctor)

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES,

a. From whom did you receive antenatal care?

| | |
|---|---|
| Antenatal clinic | 1 |
| Private doctor/obstetrician | 2 |
| Other<br>Specify: _____ | 3 |

b. How many times did you receive antenatal care? ☐

c. At how many weeks of pregnancy did you start attending/receiving antenatal care?

_____ weeks

2. How long did the mother stay in hospital/clinic after the delivery?

| | | | |
|---|---|---|---|
| | **hours** | | **days** |

3. How long did the baby stay in hospital after birth?

| | | | |
|---|---|---|---|
| | **hours** | | **days** |

4. Was there anything wrong with the mother after delivery?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES, what?

_____

_____

_____

5. Was there anything wrong with the baby after delivery?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES, what?

_____
_____
_____

6. Was the baby admitted to an intensive care unit?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES, for how long? _____ days

7. Did you go for a check-up yourself (postnatal visit) 6 weeks after delivery?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

8. In the last two weeks (14 days) has your child had any of the following?

| **SYMPTOM / SIGN** | **Yes = 1 No = 2** | **ACTION TAKEN (please tick)** | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | **0 = none** | **1= home remedy** | **2 = chemis** | **3 = trad. healer** | **4 = pvt doctor** | **5 = public clinic** | **6 = wel baby clinic** | **7 = hospital** |
| a. Sneezing | | | | | | | | | |
| b. Runny / stuffy nose | | | | | | | | | |
| c. Eye problems (red / itching eyes) | | | | | | | | | |
| d. Dry cough | | | | | | | | | |
| e. Wet cough | | | | | | | | | |
| f. Hoarseness | | | | | | | | | |
| g. Difficulty breathing | | | | | | | | | |
| h. Noisy breathing | | | | | | | | | |
| i. Rapid breathing | | | | | | | | | |
| j. Wheezing | | | | | | | | | |
| k. Runny ears | | | | | | | | | |
| l. Vomiting | | | | | | | | | |
| m. Diarrhoea (3 or more loose / watery stools in 24 hours) | | | | | | | | | |
| n. Colic | | | | | | | | | |
| o. Fever | | | | | | | | | |
| p. Poor appetite | | | | | | | | | |
| q. Rash | | | | | | | | | |
| r. Allergy | | | | | | | | | |
| s. Other health problem | | | | | | | | | |
| | | | | | | | | | |

If other, please specify: _____

9. Is this baby covered by a medical aid?

| Yes | | No | | Don't know | |
|---|---|---|---|---|---|
| 1 | | 2 | | 3 | |

10. In the past 6 months, has your child ever had any of the following conditions?

| SYMPTOM / SIGN | Yes = 1 No = 2 | ACTION TAKEN (tick where applicable) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 0 = none | 1= home remedy | 2 = chemist | 3 = trad. healer | 4 = pvt doctor | 5 = public clinic | 6 = well baby clinic | 7 = hospital |
| a. Pneumonia (diagnosed by a doctor) | | | | | | | | | |
| b. Bronchitis (diagnosed by a doctor) | | | | | | | | | |
| c. Asthma ( diagnosed by a r doctor) | | | | | | | | | |
| d. Other sever chest illnesses | | | | | | | | | |
| e. Croup | | | | | | | | | |
| f. Wheezing | | | | | | | | | |
| g. Runny ears | | | | | | | | | |
| h. Eye problems (red/swollen /discharge) | | | | | | | | | |
| i. Allergies | | | | | | | | | |
| j. Measles | | | | | | | | | |
| k. Fits/convulsions | | | | | | | | | |
| l. Injuries | | | | | | | | | |
| m. Operation | | | | | | | | | |
| n. Heart condition | | | | | | | | | |

11. For your usual Well Baby Clinic…….

a. How long does it take you to get there?

| | **hours** | | **minutes** |
|---|---|---|---|
| | | | |

b. How do you get there? _____

c. On average, how much time do you spend there?

| | **hours** | | **minutes** |
|---|---|---|---|
| | | | |

d.

| | Yes = 1 | No = 2 |
|---|---|---|
| In general are you satisfied with the service? | | |
| In general are you happy with the amount of time spent there? | | |
| Have you ever been upset about something that happened to you or your baby at the clinic? | | |

If YES, specify: _____

**ROAD TO HEALTH CARD**

1. Do you have your baby's Road to Health Card here with you?

| 1 = Yes | | 2 = No | |
|---|---|---|---|

For interviewer, "MAY I PLEASE SEE IT?"

INFORMATION FROM ROAD TO HEALTH CARD:

| Vaccination | Date given | Weight (grams) |
|---|---|---|
| BCG / MOPV (polio) | date / month/ year | |
| DWT 1 / POLIO 1 | date / month/ year | |
| DWT 2 / POLIO 2 | date / month/ year | |
| DWT 3 / POLIO 3 | date / month/ year | |
| MEASLES | date / month/ year | |

INFORMATION FROM CLINIC RECORDS

| Vaccination | Date given | Weight (grams) |
|---|---|---|
| BCG / MOPV (polio) | date / month/ year | |
| DWT 1 / POLIO 1 | date / month/ year | |
| DWT 2 / POLIO 2 | date / month/ year | |
| DWT 3 / POLIO 3 | date / month/ year | |
| MEASLES | date / month/ year | |

2. Why do you have your baby immunized?

_____
_____
_____

## HEAD INJURIES

1. Has your baby ever hit its head by:

| | Yes | No |
|---|---|---|
| Falling from the bed, carrycot or pram | 1 | 2 |
| Falling while being fed, changed or bathed | 1 | 2 |
| Had an object falling on his/her head | 1 | 2 |
| Been hit on the head | 1 | 2 |
| Been involved in a car accident as a passenger while being wheeled/caried | 1 | 2 |

If YES to any of the above,

a. After the incident, did the child suffer from:

| | Yes | No |
|---|---|---|
| Loss of consciousness | 1 | 2 |
| Vomiting | 1 | 2 |

b. What kind of action was taken?

| | Yes | No |
|---|---|---|
| None | 1 | 2 |
| Home remedy | 1 | 2 |
| Chemist/pharmacy | 1 | 2 |
| Traditional healer | 1 | 2 |
| Pricate doctor | 1 | 2 |
| Public clinic | 1 | 2 |
| Well baby clinic | 1 | 2 |
| Hospital | 1 | 2 |

## PRE SPEECH DEVELOPMENT

| | Yes | No |
|---|---|---|
| a) Does the child turn immediately towards mother/caregiver's voice? | 1 | 2 |
| b) Does the child babble repetitively? e.g say a-a, muh, goo, atar, er leh | 1 | 2 |
| c) Does the child laugh and squeal aloud in play? | 1 | 2 |
| d) Does the child scream with annoyance? | 1 | 2 |
| e) Does the child cry when uncomfortable or annoyed? | 1 | 2 |

## ENVIRONMENTAL HEALTH

Water, Sanitation, refuse and fuel

1. Does your household have sole us of, share with another household or not have any of the following?

| Water | Sole Use | Shared | No Access |
|---|---|---|---|
| Indoor running hot + cold water | 1 | 2 | 3 |
| Indoor running cold water only | 1 | 2 | 3 |
| Outside tap only (inside yard) | 1 | 2 | 3 |
| Street tap | 1 | 2 | 3 |
| Water from other sources | 1 | 2 | 3 |

If you get water from other sources,
Specify nature of source: _____

Type of container used: _____

Is the inside of the container painted?

| 1 = Yes | | 2 = No | |
|---|---|---|---|

2. Access to toilet facilities

| Toilet | Sole Use | Shared | No Access |
|---|---|---|---|
| Flush toilet inside the home | 1 | 2 | 3 |
| Flush toilet outside the home | 1 | 2 | 3 |
| Pit latrine | 1 | 2 | 3 |
| Bucket System | 1 | 2 | 3 |
| Other (specify): _____ | 1 | 2 | 3 |

If pit latrine/bucket system, how many times on average per month is waste removed?

| _____times/month |
|---|

3. How is your refuse normally disposed of? (please tick all methods used)

| | |
|---|---|
| Own garbage bin | 1 |
| Own refuse heap | 2 |
| Communal refuse heap | 3 |
| Leaving it in the street | 4 |
| Other (specify): _____ | 5 |

4. How often is your refuse removed?

| | |
|---|---|
| Once a week | 1 |
| Once every 2 weeks | 2 |
| Once a month | 3 |
| Hardly ever | 4 |
| Never | 5 |

5. What type of fuel do you normally use for cooking?

| | |
|---|---|
| Electricity (ESKOM or City Power) | 1 |
| Own power conductor | 2 |
| Coal | 3 |
| Gas | 4 |
| Paraffin | 5 |
| Wood | 6 |
| Brazier | 7 |
| Other (specify): _____ | 8 |

If additional fuel, specify: _____

Is this the same for summer?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If NO, Please specify:

_____
_____

6. What type of fuel did you use fir heating your home during the past winter?

| | |
|---|---|
| Electricity (ESKOM or City Power) | 1 |
| Own power conductor | 2 |
| Coal | 3 |
| Gas | 4 |
| Paraffin | 5 |
| Wood | 6 |
| Brazier | 7 |
| Other (specify): _____ | 8 |

If additional fuel, specify: _____

7. Which of the following do you use for heating your home?

| | Yes | No |
|---|---|---|
| Coal stove | 1 | 2 |
| Wood stove | 1 | 2 |
| Open fireplace | 1 | 2 |
| Primus | 1 | 2 |
| Gas heater | 1 | 2 |
| Electric heater | 1 | 2 |
| Other, specify: _____ | 1 | 2 |

8. Is your home linked to an electricity supply?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

Do you currently use electricity?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If NO, why not (please elaborate)

_____
_____
_____

**HOUSING**

1. Do you have a chimney in this dwelling?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

2. Do you have a separate kitchen for cooking purposes only?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

3. Is your house painted?

| | Yes | No |
|---|---|---|
| Inside | 1 | 2 |
| Outside | 1 | 2 |

If YES to any of the above, is the paint peeling or flaking from the….

| | Yes | No |
|---|---|---|
| Inside walls / windowsill / doors | 1 | 2 |
| Outside walls / windowsills / doors | 1 | 2 |

4. Does your home have…..

| | Yes | No |
|---|---|---|
| A leaking roof | 1 | 2 |
| Cracked walls | 1 | 2 |
| Broken door/s | 1 | 2 |
| Broken window/s | 1 | 2 |
| Anything else that needs repairing | 1 | 2 |

5. How would you describe the current status of your home?

| Good | Fair | Poor |
|---|---|---|
| 1 | 2 | 3 |

6. Does your house have a ceiling?

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

7. Do you often find dust to be a problem in your house?

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

8. What material is your house made of?

| _____ | 1 | Don't know | 2 |
|---|---|---|---|

9. Have any members of your household done any work on the roof in the last 6 months, which involved cutting or sawing of surfaces?

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

If YES, were you aware of excessive dust being created by such activity?

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

10. How old is your house?

| | |
|---|---|
| Less than 10 years | 1 |
| 11 – 20 years | 2 |
| 21 – 40 years | 3 |
| More than 40 years | 4 |
| Don't know | 5 |

11. Have you had any problems with mould or mildew appearing on the indoor surfaces (walls, ceilings, curtains, etc) of your home?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES, Specify

| | |
|---|---|
| In which rooms? | |
| What months of the year? | |

12. Have you had any problems with leaks or water damage to your home?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES, specify

| | |
|---|---|
| In which rooms? | |
| When? | |

13. In the past month, have you been troubled by?

| | Yes | No |
|---|---|---|
| Flies | | |
| Rats | | |
| Lice | | |
| Bed bugs | | |
| Cockroaches | | |

14. Do you have any pets in your home?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES,

| | |
|---|---|
| What pets? | |
| How many? | |

15. How many people live in the place where you stay at present? [ ]

Specify (including and starting with yourself)

| | Age | Sex<br>1 = Male; 2 = Female | Relationship to you |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |
| 15 | | | |
| 16 | | | |
| 17 | | | |
| 18 | | | |
| 19 | | | |
| 20 | | | |

16. How long have you stayed at your current address?

| | **years** | | **months** |
|---|---|---|---|
| | | | |

17. Do you think air pollution is a problem in your area?

| Yes = 1 | No = 2 | Don't Know = 3 |
|---|---|---|

If YES, what is the problem?

_____

_____

18. Do you think your child's health is affected by air pollution?

| Yes = 1 | No = 2 | Don't Know = 3 |
|---|---|---|

19. Are you aware of anything in your house that contains asbestos?

| Yes = 1 | No = 2 | Don't Know = 3 |
|---|---|---|

If YES, What?

_____
_____

20. Do you think asbestos in the house can adversely affect you or your child's health?

| Yes = 1 | No = 2 | Don't Know = 3 |
|---|---|---|

21. Do you have any comments on asbestos?

_____
_____
_____

22. Are there members in your household who currently smoke?

| Yes = 1 | No = 2 | Don't Know = 3 |
|---|---|---|

If YES,

| | |
|---|---|
| How many? (including yourself) | |
| How many smoke more than 20 cigarettes per day? | |
| Don't know | |

**WORK**
MOTHER

1. Are you working now?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If YES,

| | | | | | |
|---|---|---|---|---|---|
| a) | Describe the job you are doing | | | | |
| b) | What is your title/position | | | | |
| c) | What is the name of the company? | | | | |
| d) | What type of business does this company do? | | | | |
| e) | Do you work full time or part time? | Part time | 1 | Full time | 2 |
| f) | Do you work shifts or normal office hours? | Normal office hours | 1 | Shifts | 2 |
| g) | Is this the same job you had before you were pregnant? | Yes | 1 | No | 2 |
| h) | How old was the baby when you began working again? | _____ months | | | |

**FATHER**

2. Is your husband/father of your baby working now?

| | | |
|---|---|---|
| Yes = 1 | No = 2 | Don't Know = 3 |

If YES,

| | | |
|---|---|---|
| a) | Describe the job he are doing | |
| b) | What is his title/position | |
| c) | What is the name of the company? | |
| d) | What type of business does this company do? | |

## SMOKING AND DRINKING HABITS

1. Have you ever smoked daily for 6 months or more?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If Yes, do you smoke now?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If Yes, how often?

| | |
|---|---|
| At least 1 per day | 1 |
| Occasionally | 2 |
| Not at all | 3 |

2. How often do you smoke alcohol?

| | |
|---|---|
| Daily | 1 |
| Several times per week | 2 |
| Once a week | 3 |
| Several times per month | 4 |
| Once a month | 5 |
| A few times per year | 6 |
| Never | 7 |

3. Does your husband/partner smoke alcohol?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

**PIT DEPRESSION SCALE**

1. At the present time:

| | Yes | No | Don't know |
|---|---|---|---|
| 1. Do you sleep well? | 0 | 2 | 1 |
| 2. Do you easily lose your temper? | 2 | 0 | 1 |
| 3. Are you worried about your looks? | 2 | 0 | 1 |
| 4. Have you a good appetite? | 0 | 2 | 1 |
| 5. Are you as happy as you ought to be? | 0 | 2 | 1 |
| 6. Do you easily forget things? | 2 | 0 | 1 |
| 7. Have you as much interest in sex as ever? | 0 | 2 | 1 |
| 8. Is everything a great effort? | 2 | 0 | 1 |
| 9. Do you feel ashamed for any reason? | 2 | 0 | 1 |
| 10. Can you relax easily? | 0 | 2 | 1 |
| 11. Can you feel the baby is really yours? | 0 | 2 | 1 |
| 12. Do you want someone with you all the time? | 2 | 0 | 1 |
| 13. Are you easily woken up? | 2 | 0 | 1 |
| 14. Do you feel calm most of the time? | 0 | 2 | 1 |
| 15. Do you feel that you are in good health? | 0 | 2 | 1 |
| 16. Does food interest you less than it did? | 2 | 0 | 1 |
| 17. Do you cry easily? | 2 | 0 | 1 |
| 18. Is your memory as good as ever? | 0 | 2 | 1 |
| 19. Have you less desire for sex than usual? | 2 | 0 | 1 |
| 20. Have you enough energy? | 0 | 2 | 1 |
| 21. Are you satisfied with the way you are coping with things? | 0 | 2 | 1 |
| 22. Do you worry a lot about the baby? | 2 | 0 | 1 |
| 23. Do you feel unlike your normal self? | 2 | 0 | 1 |
| 24. Do you have confidence in yourself? | 0 | 2 | 1 |

**POLITICAL VIOLENCE**

I would like to ask you some questions about the political/township violence.

1. Have you been personally affected by political violence? (e.g injury)

| **1 = Yes** | | **2 = No** | |
|---|---|---|---|

If Yes, please explain

_____
_____
_____

2. Have you had any difficulty obtaining health care for your child because of political violence?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If Yes, please explain

_____
_____
_____

3. Has any household member died as a result of violence?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If Yes, how is the person related to the child?

_____

4. Has any household member been injured as a result of the political violence?

| | | | |
|---|---|---|---|
| **1 = Yes** | | **2 = No** | |

If Yes, How is the person related to the child?

_____

Who completed this questionnaire?
(e.g mother, maternal grandmother etc)

_____

**THANK YOU VERY MUCH FOR YOUR CO-OPERATION**

**NAMES AND ADDRESSES**

MUST BE COMPLETED BY ALL PARTICIPANTS

**INFORMATION ON MOTHER**

MAIDEN NAME : _____
SURNAME : _____
FIRST NAME : _____

RESIDENTIAL ADDRESS

HOUSE NO. : _____
STREET NAME : _____
SUBURB : _____
ZONE : _____ POSTAL CODE : _____
TELEPHONE: HOME: _____ WORK: _____

---

**INFORMATION ON CHILD**

SURNAME : _____

FIRST NAME : _____

RESIDENTIAL ADDRESS

HOUSE NO. : _____

STREET NAME : _____

SUBURB : _____

ZONE : _____ POSTAL CODE : _____

TELEPHONE: DAYTIME: _____

---

**CONTACT ADDRESSES** OTHER THAN OWN

1. SURNAME : _____

   FIRST NAME : _____

   RELATIONSHIP TO MOTHER: _____

   RESIDENTIAL ADDRESS

   HOUSE NO.: _____

   STREET NAME : _____

   SUBURB : _____

   ZONE : _____ POSTAL CODE : _____

   TELEPHONE NO. : HOME : _____WORK: _____

---

**CONTACT ADDRESS** OTHER THAN OWN

2. SURNAME : _____

   FIRST NAME : _____

   RELATIONSHIP TO MOTHER: _____

   RESIDENTIAL ADDRESS

   HOUSE NO.: _____

   STREET NAME : _____

   SUBURB : _____

   ZONE : _____ POSTAL CODE : _____

   TELEPHONE NO. : HOME : _____WORK: _____

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