Mother's Name _____

BTT ID | | | | | | | |

BIRTH TO TEN 5-YEAR INTERVIEW CHECKLIST

ITEM	CHECKED
1. Sign Consent Form	
2. Apply EMLA Cream	
3. Insert Pink Form	
4. Complete Blue Form	
5. Sign For R5	
6. Complete Core Questionnaire	
7. Measure Child Growth	
8. Measure Maternal Weight/Height	
9. Complete Nutrition Survey	
10. Complete Smoking Questionnaire	
11. Assess Developmental Status	
12. Record Blood Pressure	
13.Collect Blood Sample	
14. Complete Dental Survey	

University of the Witwatersrand
Department of Paediatrics and Child Health

BIRTH TO TWENTY
FIVE YEAR QUESTIONNAIRE

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

BTT ID NUMBER: ☐☐☐☐☐☐☐

BONE STUDY ID NUMBER: ☐☐☐

RELATIONSHIP TO THE CHILD:

1. Are you the mother of the child? | Yes=1 | No=0 |

IF YOU ARE NOT THE MOTHER:

2. What is your relationship to the child? _____

NOTES OR COMMENTS BY THE INTERVIEWER:

_____
_____
_____
_____
_____
_____
_____
_____

Interviewer: _____

Date of interview: _____/____/1995
Day Month

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Complete **Table A, Household Composition and Demography**
(find attached at back of questionnaire)

3. Are there any children younger than the BTT Child?

Yes=1	No=0

IF YES: Specify dates of birth:

Child 1 _____/_____/19___
Child 2 _____/_____/19___
Child 3 _____/_____/19___

4. Is BTT mother **pregnant** now?

Yes=1	No=0

5. Did the mother use any **Contraceptives** in the **past year**?

Yes=1	No=0

IF NO:
Has the mother been sterilized

Yes=1	No=0

IF YES:
Which method is being used

Pill	IUD	Injection	Condom	Other
1	2	3	4	5

IF OTHER: Please list _____

CHILD CARE:

6. Where does the child spend **most of the day** during the **week**?

Home	1	Childminder	3
Relatives	2	Creche	4
Neighbour or friend			5

7. Who looks after the child **most** of the **time**?

Mother	1	Childminder	3
Adult relative	2	Creche staff	4
Neighbour or friend			5

8. Does another child ever look after the BTT child?

Yes=1	No=0

COMPLETE 9(a) to 9(g) ONLY IF THE CHILD IS IN DAYCARE
(i.e. not cared for by the mother)

9.(a) If the BTT child is in **daycare** what kind?

Creche: formal	1	Playgroup	2
Backyard crèche/garage	3	Child minder	4
Other			

(b) What made you decide to choose this kind of care for your child?

_____

_____

(c) How much do you **pay per month** (in Rands) for this care? R _____

(d) How many hours per day is the child in their care?

5 Hours or less	1	8 Hours or less	2	More than 8 hours

(e) Does your child ever spend part of or the whole night at the crèche or childminder?

Yes=1	No=0

(f) About how many other children are at the child minder or crèche?

5 or less	1	6 to 10	2
11 to 20	3	More than 20	4

(g) During the last year, have you changed the arrangements or place of your child's care?

Yes=1	No=0

IF YES: What were your reasons for making the change?

PRESCHOOL SOCIAL AND EMOTIONAL ADJUSTMENT:

I'd like to ask you about your child's behaviour. Please respond for the following behaviours with a YES, NO or SOMETIMES

Does your child or is your child…

10. Wet the bed at night?

Yes=1	No=0	Sometimes=2

11. Difficult to manage, throw temper tantrums, disobedient?

Yes=1	No=0	Sometimes=2

12. Cry, Whine, moan and seem unhappy a lot of the time?

Yes=1	No=0	Sometimes=2

13. Daydream, get lost in his/her own thoughts?

Yes=1	No=0	Sometimes=2

14. Fearful, has specific fears (e.g. dark, dogs, insects)?

Yes=1	No=0	Sometimes=2

15. Eat poorly, have a poor appetite?

Yes=1	No=0	Sometimes=2

16. Seem clumsy, knock things over, walk into things trip frequently?

Yes=1	No=0	Sometimes=2

17. Stutter?

Yes=1	No=0	Sometimes=2

18. Speak badly, immaturely for his/her age?

Yes=1	No=0	Sometimes=2

19. Have habits like nail biting, scratching, nose picking, thumb, teeth grinding?

Yes=1	No=0	Sometimes=2

20. Spend a lot of time alone, not get on well with other children?

Yes=1	No=0	Sometimes=2

21. Aggressive with or bullying other children?

Yes=1	No=0	Sometimes=2

22. Are there any things about your child's behaviour (that haven't been mentioned above) that bother you?_____
_____

23. Has your child been or have you ever suspected that your BTT child has been physically or sexually abused by somebody?

Yes=1	No=0	Not sure=2

IF YES:
Who? _____

What happened or what did you think happened?
_____
_____

24. Do you think your child is ready to start school next year?

Yes=1	No=0	Not sure=2

IF NO or NOT SURE:
What are your reasons for saying that? _____
_____

Complete **Table B, C & D** **(find attached at back of questionnaire)**

PRIOR RESIDENCE HISTORY OF BTT CAREGIVER AND PARTNER CURRENT and RECENT RESIDENTIAL MOBILITY of ALL HOUSEHOLD MEMBERS

25. Do you participate in a saving scheme?

Yes=1	No=0

IF YES:

Stokvel	1	Burial Society	2	Savings Club	3
Bank/Building Society	4	Other (specify)			5

26. Do you have immediate family members that live elsewhere and are dependent on receiving remittances (money or goods) from your household?

Yes=1	No=0

How are they related to the head of this household?

_____

Where do they live? _____

27. If anyone was listed in Table C as being away from your dwelling for at least one week during the past 12 months:

What does your household member take to that household, if anything?

_____

How does your household member help those that he/she visits?

_____

28. If anyone has visited your household for at least a week during the past 12 months:

What does your visitor(s) bring to your household, if anything?

_____

How does your visitor(s) help when he/she visits?

_____

29. How would you describe your **home**?

Shack/Zozo	1	House	3	Shared house	5
Flat/Cottage	2	Hostel	4	Room/Garage	6

30. Does your household own this dwelling (i.e. built, bought or buying)?

Yes=1	No=0

31. How many rooms does your household use for sleeping in this dwelling?

(**including** any attached nearby shack, kitchens, lounges and dining rooms, bedrooms _____

32. Which of the following do you have in your home at the present time?

Electricity	Yes	1	No	0	
Television	Yes	1	No	0	
Radio	Yes	1	No	0	
Motor vehicle	Yes	1	No	0	
Fridge	Yes	1	No	0	
Washing machine	Yes	1	No	0	
Telephone	Yes	1	No	0	
Children's toys	Yes	1	No	0	

MEDICAL CARE OF THE CHILD

33. Do you have medical insurance that includes the BTT child? | Yes=1 | No=0 |

GENERAL HEALTH OF THE CHILD

34. Compared to other children of this child's age, would you sat this child's health is:

Good=1	Fair=2	Poor=3

IF POOR: Please explain _____
_____

SERIOUS MEDICAL OR DEVELOPMENTAL PROBLEMS

35. Does the BTT child have, or has the child had, any serious **medical or developmental problems**?

Yes=1	No=0

IF YES: please list the:
(a) **problem,**
(b) the **type of treatment** and
(c) the **place** where the child is or has been treated.
(d) If you have a **clinic, outpatient or hospital record number** could we have that and may we look the record up?

Problem 1 (a) _____

Treatment (b) _____

Place (c) _____

Record # (d) _____

Problem 2 (a) _____

Treatment (b) _____

Place (c) _____

Record # (d) _____

Problem 3 (a) _____

Treatment (b) _____

Place (c) _____

Record (d) _____

36. Do any of the household members have problems such as club foot, loss of sight, deafness, etc.

Yes=1	No=0

IF YES:
Who and what is the problem? _____
_____

Who and what is the problem? _____
_____

Who and what is the problem? _____
_____

37. Has the child or any of the household members had treatment from:

	Who	Problem		
Occupational therapist			Yes=1	No=0
Physiotherapist			Yes=1	No=0
Speech Therapist			Yes=1	No=0
Psychologist			Yes=1	No=0
Psychiatrist			Yes=1	No=0

INJURIES

38. Has the BTT child been **<u>seriously hurt</u>** or **<u>injured</u> during the past year?**
(Do not include minor scrapes, cuts and bruises, but **<u>do</u>** include **burns, road accidents**)

Yes=1	No=0

IF YES:

<u>Inj 1</u> (a) What was the type of injury?_____
_____

(b) How **old** was the child? _____ months

(c) What type of treatment did the child receive? _____
_____

(d) **Where** was the child treated? _____

IF AT HOME: <u>What</u> was the treatment and **why** did you treat the child at home? _____
_____

(e) If the child was taken to a clinic or hospital could we have the **record number**?
_____

(f) Who was **taking care** of the child at the time of the injury and how old was that person?

Relationship to child _____ **Age** _____ **Yrs**

<u>Inj 2</u> (a) What was the type of injury? _____
_____

(b) How **old** was the child? _____ months

(c) What type of **treatment** did the child receive?
_____

(d) Where was the child treated? _____

IF AT HOME: <u>What</u> was the treatment and **why** did you treat the child at home? _____
_____

(e) If the child was taken to a clinic or hospital could we have the **record number?** _____

(f) Who was taking care of the child at the time of the injury and how old was that

person?

Relationship to child _____**Age** _____Yrs

Inj 3 (a) What was the **type of injury**? _____
_____

(b) How **old** was the child? _____ months

(c) What type of treatment did the child receive? _____
_____

(d) **Where** was the child treated? _____
IF AT HOME: What was the treatment and **why** did you treat the child at home**?** _____
_____

(e) If the child was taken to a clinic or hospital could we have the **record number?** _____

(f) Who was taking care of the child at the time of the injury and how old was that person?

Relationship to child _____ **Age** _____Yrs

HOSPITALIZATION: (Including chest illnesses)

39. Has the BTT child been admitted to a clinic, nursing home or hospital during the past year? (including a drip room, sleep over or ward 36B at Baragwanath)

Yes=1	No=0

IF YES:

Age (months)	**Duration (days)**	**Reasons**	**Clinic hosp #**
1.			
2.			
3.			
4			
5.			

CHILDHOOD ILLNESSES:

40. Has the BTT child had any of the following since birth?

	Yes	No	Age (months)
Measles	1	0	
Mumps	1	0	
Chickenpox	1	0	
German Measles (Rubella)	1	0	
Tuberculosis	1	0	
Whooping cough	1	0	

FITS:

41. Has the child had any fits since birth? Yes=1 | No=0

If YES: Is he/she on regular treatment? Yes=1 | No=0

Age at first fit (months) _____

Cause _____

How many or how frequent _____

POISONING:

42. Has the child ever been treated for poisoning? Yes=1 | No=0

IF YES: type of poisoning _____

Age: _____

Is he/she attending a clinic regularly for special treatment? Yes=1 | No=0

Give details:

_____

43. Does anyone in the household ever use paraffin? Yes=1 | No=0

IF YES: What do you use it for? _____

44. How do you store the paraffin?

Container _____
Place _____

FREE TREATMENT FOR UNDER 6 YEAR-OLDS:

45. Do you have to pay for the treatment of the BTT child at the clinic that you use?

Yes=1	No=0

IF YES

Which clinic _____

TREATMENT:

46. During the past six months, how many times has the BTT child receive treatment from the following people or places?

(LIST ANYTHING THAT YOU HAVE NOT YET MENTIONED IN THIS INTERVIEW including less serious problems e.g. colds or stomach problems)

What was the **reason** for the treatment and/ or **what** was the **treatment**?

	Times	Reasons	Treatment
Self medication			
Faith healer			
Homeopath			
Nyanga			
Sangoma			
General practitioner			
Clinic			
Hospital			
Pharmacist			

MEDICAL CONDITIONS OF RELATIVES:

44. Does the BTT child have a close relative (father, mother, brother, sister, aunt, uncle, grandmother or grandfather) who has or had any of the following conditions?

	Yes	No	Unsure
High blood pressure	1	0	2
Diabetes (sugar in the blood)	1	0	2
Heart attack/angina (heart cramp)	1	0	2
Heart attack/angina (heart cramp before the age of 50)	1	0	2
Stroke	1	0	2
High blood cholesterol (bloodfats)	1	0	2

SMOKING:

The following questions should be answered by the child's primary caregiver

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

Yes=1	No=0

49. Do you smoke now?

Yes, daily=1	Yes, occasionally=2	Not at all=3

50. If your partner lives in the same house as the BTT child, does he/she smoke?

Yes, daily=1	Yes, occasionally=2	Not at all=3

IF YES: How many cigarettes does he/she smoke per day? _____

51. Are any other members of your household regularly smoking?

Yes=1	No=0

52. Altogether, how many regular smokers are there in the household (including yourself) _____

53. Does any other person who looks after the child for two or more hours per day smoke while the child is in their care (including childminder)

Yes=1	No=0

SOCIAL SUPPORT:

In order for us to be able to understand your particular circumstances better, we would like to know how much help and support you feel you get from your family and friends.

54. If you had a really big problem and needed help, with money, the children, accommodation, and so on, are there people who could help you?

Nobody=1	Maybe, unsure=2	A number of people=3

55. Can you talk to your parents, other family members or a friends about any problems you may have?

Nobody=1	Maybe, unsure=2	A number of people=3

56. Can you talk to your husband or partner about any problems you might have?

Never=1	Sometimes=2	Always=3

57. Do you feel that the father of your child or your partner makes things harder for you because of the way he acts?

Never=1	Sometimes=2	Always=3

58. Do you belong to a church group or any other organization? | Yes=1 | No=0 |

59. How often do you go to meetings?

Once a week=1	Once a month=2	Irregularly=3

60. Do you have a friend with a child about the same age as your BTT child?

Yes=1	No=0

IF YES:

61. How often do you see her?

Once a week=1	Once a month=2	Irregularly=3

STRESS AND VIOLENCE:

Sometimes one's life and that of one's close family, goes through periods of being very stressful. I'd like to ask you some questions about any stress you might have experienced in the last few months.

62. During the last 6 months, have you or a member of your close family been in real danger of being killed? | Yes=1 | No=0 |

63. During the last 6 months has any household member died as a result of violence in the areas where you live or work? | Yes=1 | No=0 |

64. During the last 6 months, has any household member been a victim of a violent crime (like armed robbery, you live or work? | Yes=1 | No=0 |

65. During the last six months, has any household member been a victim of a violent crime (like armed robbery, assault, rape etc)? | Yes=1 | No=0 |

66. During the last 6 months, did you witness a violent crime (e.g. murder, robbery, assault, rape)? | Yes=1 | No=0 |

67. During the last 6 months, has violence in the areas where you live or work affected your ability to obtain health care for any of your children? | Yes=1 | No=0 |

68. During the last six months, have you found that you are in so much debt that you don't know how you will repay the money? | Yes=1 | No=0 |

69. During the last six months, have you or your close family | Yes=1 | No=0 |

ever had too little money for basics, such as food, rent, clothes?

70. Have you or one of your close family not been able to find a job more than six months? | Yes=1 | No=0

71. During the last six months, have you or anyone in your close family been seriously ill? | Yes=1 | No=0

72. During the last six months, did any member of your close family die? | Yes=1 | No=0

73. Is there anyone in your close family with a serious disability (for example, epilepsy, mental retardation,deafness,blindness, mental illness) | Yes=1 | No=0

74. Is there anyone in your close family that has a problem with drugs or alcohol? | Yes=1 | No=0

75. During the last six months, have you had a break-up with your husband or partner? | Yes=1 | No=0

76. During the last six months, has your husband or partner hit or beaten you? | Yes=1 | No=0

77. During the last six months, have you had any serious fight or alienation from members of your family or your close neighbours? | Yes=1 | No=0

78. During the last six months, have you or any member of your close family been arrested, had to go to court, or consulted a lawyer on a non-routine matter? | Yes=1 | No=0

79. During the last six months, have you given help (money, accommodation etc) to close family or friends in need? | Yes=1 | No=0

80. During the last six months, have you been separated unwillingly, from any of your child/ren (excluding holidays) | Yes=1 | No=0

81. During the last six months, have you experienced any problems with your child or children (such as schools closing, failure at school, problem behavior, drugs etc.) | Yes=1 | No=0

IF YES: Specify problem: _____

BIRTH TO TEN: FIVE YEAR QUESTIONNAIRE 1995

BTT ID NUMBER: | | | | | | | |

MOTHER'S NAME AND SURNAME:

_____

NAME OF CHILD:

_____

ASK THE FOLLOWING QUESTIONS FROM THE CAREGIVER

1. How much does your child fidget with his hands or feet or by squirming in his/her seat?

Never=0	Not usually=1	Quite often=2	A lot=3	Always=4

2. How long would your child remain seated when required to do so?

As long as left=0	A short time=1	For some time=2	A lot=3	Not at all=4

3. How much would an extraneous stimulus such as a sound distract your child?

Not at all=0	Just a little=1	Somewhat= 2	A lot=3	A very great deal=4

4. To what extent can your child await his/her turn in games or group activities?

Very well=0	Quiet well=1	Somewhat=2	Just a little=3	Not at all=4

5. To what extent does your child blurt out answers to questions before they have been completed?

Never=0	Not usually=1	Somewhat=2	A lot=3	Always=4

6. How well does your child follow through on instructions from others e.g. complete a chore or play activity?

Always=0	Usually=1	Somewhat=2	Just a little=3	Not at all=4

7. How much does your child shift from one uncompleted activity to another? completes a task.

Always=0	Usually=1	Sometimes=2	Seldom=3	Never=4

8. How often does your child play quietly, alone?

Always=0	Very often=1	Often=2	Occasionally=3	Continuously=4

9. How much does your child talk?

Very little=0	A little=1	A fair amount=2	A great deal=3	Continuously=4

10. How readily would your child interrupt or intrude in others e.g. butt into other children's game

Never=0	Very seldom=1	Sometimes=2	A lot=3	Always=4

11. How often does your child not seem to listen to what is being said to him/her?

Never=0	Very seldom=1	Occasionally=2	A lot=3	Always=4

12. How often does your child sleep in the afternoon?

Always=0	Very often=1	Sometimes=2	Occasionally=3	Never=4

13. How readily does your child go to bed at night?

Very easy=0	Occasionally difficult=1	As often with difficulty as ease=2	Occasionally with ease=3	With great difficulty=4

14. How much does your child wake up during a typical night's sleep?

Not at all=0	A little=1	A fair amount=2	A lot=3	A very great deal=4