REPRODUCTIVE HEALTH CARE AND HYGIENE PRACTICES
(A study in Slums of Anantapuramu Municipal Corporation, A.P)

Name of the Respondent : 

Name of the Slum : 

I Personal Data

1. Age : 

2. Marital Status : 

3. Religion : 

4. Caste : 

5. Education : 

6. Major Occupation : 

7. Annual Income : 

8. No. of persons in the family: 

9. Type of family (Joint / Nuclear) : Joint / Nuclear

II Family Background

<table>
<thead>
<tr>
<th>Relationship with respondent</th>
<th>Age</th>
<th>Sex</th>
<th>Marital Status</th>
<th>Education</th>
<th>Occupation</th>
<th>Income</th>
<th>Place of residence</th>
<th>Worker/Non worker</th>
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</table>
III Housing Characteristics & Standard of Living

20. Type of House : Kutcha / Semi-Pucca /Pucca

21. House Electrified : Yes / No

22. Source of Lighting : Electricity/Gas light/ Kerosene light

23. Source of drinking water : Spring/canal/Tank/openwell/Borewell/ Public Tap/Tap in house

24. Fuel for cooking : Wood/ Gas/ Kerosene /Others (specify)

25. Sanitation in House : No toilet facility / Public community toilet / Own open toilet /Own flush toilet / Open field

House hold Assets:

26. Fan : Yes / No

27. Radio / Transistor : Yes / No

28. T.V : Yes / No

29. Sewing Machine : Yes / No

30. Telephone : Yes / No

31. Mobile : Yes / No

32. Bicycle : Yes / No

33. Moter bike / Scooter : Yes / No

34. Jeep / Car : Yes / No

35. Tractor : Yes / No

36. Bullockcart : Yes / No

IV Socio-Economic Status:

37. Do you have Ration card : Yes / No

38. Color of the card : White / Pink

39. Do you have Voter identity card : Yes / No
40. Did you vote in the last election : Yes / No

41. Do you hold position in any of the institution / organization : Yes / No
   Local bodies
   If yes specify

42. Do you own land : Yes / No
   If yes please give details

V Service Facilities:

Please indicate the distance and mode of transport from your residence to the following:

<table>
<thead>
<tr>
<th>Service</th>
<th>Distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>43. Primary School</td>
<td>:</td>
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<td>44. High School</td>
<td>:</td>
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<td>45. College</td>
<td>:</td>
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<td>46. Bus stand</td>
<td>:</td>
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<tr>
<td>47. Railway station</td>
<td>:</td>
</tr>
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<td>48. Doctor</td>
<td>:</td>
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<td>49. ANM / Nurse</td>
<td>:</td>
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<td>50. Health worker</td>
<td>:</td>
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<tr>
<td>51. Private health facility</td>
<td>:</td>
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<tr>
<td>52. Government health facility</td>
<td>:</td>
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<tr>
<td>53. Anganwadi</td>
<td>:</td>
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<tr>
<td>54. Primary health centre</td>
<td>:</td>
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<tr>
<td>55. Health sub centre</td>
<td>:</td>
</tr>
<tr>
<td>56. Hospital (Govt.)</td>
<td>:</td>
</tr>
<tr>
<td>57. Anganwadi centre</td>
<td>:</td>
</tr>
</tbody>
</table>
VI Do you Face any problems During Menstrual Cycle?

1. Menstrual problem
   Yes          No
2. Backache
   Yes          No
3. Headache
   Yes          No
4. Stomach ache/colon spasm/constipation
   Yes          No
5. General body pains( fullness of breasts, abdomen, face and feet).
   Yes          No
6. Tiredness/weakness/laziness/heavy feeling
   Yes          No
7. Irritation/fear/anxiety
   Yes          No
8. Anguish cannot cope/changing behavior
   Yes          No
9. Difficult urination
   Yes          No
10. Any other
    Yes          No

VII. Menstrual Hygiene:

1. What type of menstrual protection do you used
   a. Soiled cloth
   b. Washed cloth
   c. Sanitary napkin
   d. Menstrual Pads
2. How often do you change the cloths in a menstrual cycle?
   Number of times in a day
3. Do you use same cloth after washing for the other days of menstruation?
   Yes          No
4. Do you keep the same cloths for future use that is subsequent menstruation?
   Yes          No
5. Do you get white discharge due to use of same old cloth?
   Yes          No
6. Do you keep yourself away from domestic and other activities during menstruation?  
   Yes  No  
   If Yes, Who will cook the food in the house? 

7. Do you think menstruation is necessary for women?  
   Yes  NO  
   If yes give reasons  
   a. Necessary for women hood to cause children  

8. What is your idea about menstruation?  
   a. Monthly burden  
   b. removes bad blood  

21. Please give the foods that are avoided during menstruation days  

22. Do you work during menstruation days  
   Yes  No  

VIII Reproductive Health Status: (please indicate the year/s if possible. For example 2001 etc.)  
58. Age at Marriage  Respondent:  Husband:  
59. Age at first conception  
60. No. of living children  1\textsuperscript{st}  2\textsuperscript{nd}  3\textsuperscript{rd}  4\textsuperscript{th}  5\textsuperscript{th}  
61. Number of  
   Conceptions  Live Births  Still Births  Abortions  

<table>
<thead>
<tr>
<th>Conceptions</th>
<th>Live Births</th>
<th>Still Births</th>
<th>Abortions</th>
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</table>

62. Age at last conception
IX Awareness of Reproductive track infections:

63. Are you currently menstruating?  
   Yes / No pregnant / No menopause/ No Amehoria

64. During last three month did you have any Menstruation problem: Yes / No

65. What was the problem:  
   1. No periods  
   2. Painful periods  
   3. Frequent / short periods  
   4. Delayed periods  
   5. Prolonged bleedings  
   6. Excessive Bleeding  
   7. Scanty Bleeding  
   8. Inter Menstrual Bleeding  
   9. Any other problem (specify)

66. Since how long you have this problem?

67. Whom & Where did you go for consultation?

68. Are you aware of R.T.I symptoms?  
   1. Itching over vulva
   2. Boils / ulcer / warts around vulva
   3. Pain in lower abdomen not related to menses
   4. Pain during sexual inter course
   5. Bleeding after/ during sexual inter course
   6. Painful passage of urine
   7. Mass coming out of vagina
   8. Any involuntary escape of urine while coughing / sneezing
   9. Swelling in breast

69. Whom & Whom did you go for consultation for the above problem. Yes/ No

70. Did you experience any abnormal vaginal discharge during the last three months?  
   Yes / No

71. If yes does the discharge wet / stain the clothes.

72. If yes what is the color: Colourless/green/yellow/blood stained/white

   Texline: Sticley/frothing/cur doosh/pum lilea

   Odour: Foul odour/ No.odour

73. Since how long did you have this problem?
X Reproductive Health Care:

Please give the details of Antenatal care during the pregnancy:

**Antenatal Tests:**

<table>
<thead>
<tr>
<th>Test</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Measurement</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
</tr>
<tr>
<td>Height Measurement</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
</tr>
<tr>
<td>Blood pressure checkup</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<td>urinal tested</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<tr>
<td>Abdomen Examined</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<tr>
<td>Internal examined</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<tr>
<td>X ray</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<tr>
<td>Ultra sound</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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</table>

**Antenatal Check ups**

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<thead>
<tr>
<th>Pregnancy</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
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<tbody>
<tr>
<td>ANC checkup</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
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<tr>
<td>T.T. Injection</td>
<td>Nil</td>
<td>Yes/No</td>
<td>Yes/No</td>
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<td>One</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<td>Two</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<td>More</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<tr>
<td>IFA Tablets</td>
<td>One regularly</td>
<td>Yes/No</td>
<td>Yes/No</td>
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<tr>
<td>Two a regularly</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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<tr>
<td>100 tablets during pregnancy</td>
<td>Yes/No</td>
<td>Yes/No/NA</td>
<td>Yes/No/NA</td>
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</table>
4. Full ANC (3 visits +T.T+IFA) Yes/No Yes/No Yes/No 1st 2nd 3rd

5. Delivery at (Home/private hospital/Govt.hospital/PHC)

6. Delivery complication (Specify)

7. Post Delivery complication (Specify)

8. Who assisted the delivery?

9. Whom did you consult for complication?

10. Where did you go for consultant?

11. Did you receive Medical care for the complication Yes/No Yes/No Yes/No

XI Utilization of services:

1. Place of Antenatal check ups consultations:
   At home/subcentre/PHC/Govt. Hospital/Private Clinic/Private Hospital/Any other

2. Source of ANC: ANM Nurse/Govt.Doctor/Private Practiesner/RMP/Anyother

3. Please give Reasons for Not seeking ANC (Probe):

4. Please give reasons for not seeking/availing Medical interventions for complications :

5. Please give details of Antenatal Advice: Danger signs of Pregnancy
   Diet
   Delivery care
   New Born care
   Place of Delivery
   Type of Delivery

6. What are the problems/ difficulties you faced to receive A.N.C and assistance during the complications :
XII. Postnatal Care

1. What are Health problems of Post Natal Mother
   a. Puerperal sepsis    c. Fever
   c. Excessive bleeding   d. Depression

2. How many days vaginal discharge is present during Post-natal period?

3. What are the solutions used for perineal care
   a. Plain water only
   b. Hot water only
   c. Antiseptic solution solution (Dettol, savlon etc.)
   d. Not used any solution
   e. Other (specify)

4. What types of perineal pads are safe
   a. Old cloth
   b. Clean cotton cloth (care free/stay free etc.)
   c. Silk cloth
   d. Nothing

5. What are benefits to the mother for giving breast milk
   a. No benefit
   b. Act as contraceptive
   c. Breast feeding is harmful
   d. Cracked nipple
   e. Others (specify)

6. Did you give first milk from breast (colostrums) to baby
   Yes   No

7. What are the benefit of colostrums?
   a. Colostrums should not be given
   b. It is harmful
   c. Diarrhea
   d. Improve immunity
   e. Other (specify)

8. When should mother start her first breast feeding?
   (Time)

9. Did ever receive any vaccination to prevent him from getting diseases
   Yes   No
10. If Yes, give details
    a. BCG
    b. Polio
    c. DPT