

Follow Up Visit Questionnaire for Women

Section A: To be completed by the Receptionist

1 Unique Study ID: □□□□□□□□

First, I would like to ask you if your contact information has changed since your last visit. If someone else answers the phone, we will not tell them any information about the study. I would like to remind you that your involvement in the study is completely confidential.

2 Address of residence: _____

3 Village of residence: _____

4 District of residence: _____

5 Telephone: _____

6 Other contact/next of kin: _____

CHECKED BY RECEPTIONIST:

Signature: _____ Date: **(DD/MM/YYYY)** ____/____/____

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Section B: To be completed by the Nurse

Thank you for participating in this study. I will be conducting your interview today and it will last about 10 minutes. I ask all participants in this study the same questions. All of your answers are confidential. I will mark a response to every question, but if you are not comfortable answering any question, you can tell me to mark “no answer”. You can also ask me to go back, or repeat any questions. Are you comfortable proceeding with the interview now?

Now, I would like to ask you a few questions about the time since we last saw you.

7 *Since your last study visit*, do you have any **new** health problems?

- 01** - Yes
- 02** - No **SKIP TO 9**
- 88** - Don't know/not sure **SKIP TO 9**
- 99** - Refused **SKIP TO 9**

8 If yes, please specify the new health problems you are experiencing.

MARK ALL THAT APPLY.

Symptom	Yes	No	Refused
General (<i>fevers, weight loss, loss of appetite, feeling tired</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems (<i>itching, ocular redness, eye lid inflammation, blurred vision, complete loss of vision</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (<i>loss of strength in arms, or legs, inability to balance</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems (itching, spots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric problems (hallucinations, delusions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (e.g loss of hair) SPECIFY _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9 *Since our last meeting*, has anyone in your home/household or any of your close contacts (*such as sexual partners or family*) gotten Ebola?

- 01** - Yes
- 02** - No **SKIP TO 11**
- 88** - Don't know/not sure **SKIP TO 11**
- 99** - Refused **SKIP TO 11**

10 If yes, please specify their relationship to you, and if they recovered or died.

Nurses should capture information on sexual partners, siblings, and children. If more than one spouse, sibling or child, please list one per row. Write “refused” under relationship if participant refuses to specify relationship.

No.	Relationship	Outcome			Did this person have Ebola before or after you?		
		<i>Recovered</i>	<i>Died</i>	<i>Refused</i>	<i>Before</i>	<i>After</i>	<i>Refused</i>
1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11 *Since our last meeting*, have you participated in sexual activity? Sexual activity includes oral, vaginal, or anal sex.

01 - Yes

02 - No **SKIP TO 13**

99 - Refused **SKIP TO 13**

12 If yes, how often did you use a condom during sex? **Choose one.**

01 - Never

02 - Some of the time

03 - Every time

88 - Don't know

99 - Refused

13 How often have you engaged in sexual activities *since your last visit*?

01 - Every day

02 - 3 or more time a week

03 - 2 times a week

04 - Once per week

05 - Once per month

06 - Once

99 - Refused

14 Since the last visit, have you stopped breastfeeding? **Choose one.**

01 - Yes

02 - No **SKIP TO 16**

99 - Refused **SKIP TO 16**

15 If you stopped breastfeeding, why? **MARK ALL THAT APPLY**

- 01 - I ran out of/stopped producing breast milk
- 02 - I was worried about infecting my baby with Ebola
- 03 - My husband/partner/family member/community leader told me not to breastfeed
- 04 - My doctor told me not to breastfeed.
- 05 - My child was old enough to wean
- 06 - Other → SPECIFY: _____
- 88 - Don't know
- 99 - Refused

16 Since your last visit, have you started your menstrual period?

- 01 - Yes
- 02 - No **SKIP TO 17**
- 03 - Other → SPECIFY _____ **SKIP TO 17**
- 88 - Don't know/not sure **SKIP TO 17**
- 99 - Refused **SKIP TO 17**

16a If yes, when was the first day of your period?

First day of bleeding: (DD/MM/YYYY) ____ / ____ / ____ Estimated

If refused date, put 99/99/9999

17 Do you know if you are pregnant today?

- 01 - Yes, I am pregnant
- 02 - No, I am not pregnant today. **SKIP TO 18**
- 88 - Don't know/not sure **SKIP TO 18**
- 99 - Refused **SKIP TO 18**

To all women: We will also offer you the possibility of a pregnancy test as a part of this study; you can accept or decline the test as you like.

17a If you are pregnant today, how many months pregnant are you? Estimated

If refused, mark 99

18 Thank you very much for participating in the survey today. Do you have any other comments or concerns you would like to share about these topics?

19 Result of questionnaire:

- 01 - Completed
- 02 - Partially completed
- 03 - Participant refused
- 04 - Other → Specify: _____

CHECKED BY NURSE:

Signature _____

Date: ____/____/____
(DD / MM / YYYY)

CHECKED BY RESEARCH ASSISTANT:

Signature _____

Date: ____/____/____
(DD / MM / YYYY)