PAN Asia Pacific
For a just and pesticide-free future

HANDBOOK FOR COMMUNITY BASED PESTICIDE ACTION MONITORING, CORPORATE ACCOUNTABILITY AND INTERNATIONAL ADVOCACY

Pesticide and Community Health

Members of CSO and community workers congregated at Zwe Bar Village, Kawa Towship, Bago Division, Myanmar recently to participate in the Community Pesticide Action Monitoring survey session. The members of CSO briefed the farmers from Zwe Bar on the purpose of the survey.

Questionnaire 1: Part B. Pesticide and Community Health

This part should be used only if you have medical or community health training, or are accompanied by a health worker.

HEALTH HISTORY		
Q	**Question**	**Category**
1.	Have you visited someone for health care in the past month?	☐ Yes ☐ No
1.a	If yes, how many times	[______]
1.b	Where did you go? Tick (or fill-in) one or more of the following	☐ Plantation medical facility ☐ Government hospital ☐ Private hospital ☐ Private clinic ☐ Other, specify [________________]
1.c	From who did you seek consultation? Tick (or fill-in) one or more of the following	☐ General practitioner ☐ Medical specialist ☐ Alternative medicine practitioner (Herbalist, traditional healer, etc) ☐ Other, specify [________________]
1.d	Was this related to your contact with a pesticide?	☐ Yes ☐ No
1.e	What was the doctor's diagnosis and advice?	[______________________________]
1.f	If no, do you have access to a doctor or health practitioner?	☐ Yes ☐ No

2. Do you have any of the following illnesses?

Indicate your illness and if there is a family history of the same illness

Tick (or fill-in) one or more of the following

Illness	Yourself	Family members
Hypertension	☐	☐
Diabetes Mellitus	☐	☐
Ischemic heart disease	☐	☐
Kidney disease	☐	☐
Asthma	☐	☐
Liver disease	☐	☐
Tuberculosis	☐	☐
Thyroid disease	☐	☐
Allergy (specify)	☐ [__________]	☐ [__________]
Cancer (specify)	☐ [__________]	☐ [__________]
Psychiatric disease (specify)	☐ [__________]	☐ [__________]
Autoimmune disease (specify)	☐ [__________]	☐ [__________]
Other (specify):	☐ [__________]	☐ [__________]

3. Are you taking any medication at the moment?

[ ] Yes

[ ] No

3.a If yes, list the names of the medicine (including contraceptives)

[______________________________]

[______________________________]

[______________________________]

OBSTETRICAL AND GYNECOLOGIC HISTORY (FOR FEMALE RESPONDENTS)

4. Have you been sexually active for the past 5 years?

Note: his question is relevant to understanding cervical cancer, if this condition is a problem.

- ☐ Yes
- ☐ No

5. Age of first menstruation [____]

5.a Subsequent menstrual period

- ☐ Regular
- ☐ Irregular

5.b Indicate your cycle

- ☐ 26 days
- ☐ 28 days
- ☐ 30 days
- ☐ Other, specify [____________________]
- ☐ Don't know

5.c Duration of menses per cycle [_____]

5.d History of dysmenorrhea

- ☐ Yes
- ☐ No

5.e History of

- ☐ Increased menstrual flow
- ☐ Decreased menstrual flow

6. Pregnancy (Please indicate any pregnancies below)

Age (of mother at pregnancy)	Number of pregnancy (1st, 2nd, etc.)	Outcome (full term, term, premature, aborted, stillborn)

SOCIAL HISTORY

7.	Do you smoke?	☐ Yes ☐ No
7.a	If yes, how many cigarette sticks per day?	[_____]
7.b	Do you smoke while you work?	☐ Yes ☐ No
7.c	How many years did you smoke?	[_____]
8.	Do you drink alcohol?	☐ Yes ☐ No
8.a	If yes, how many drinks per day?	[_____]
9.	Do you chew tobacco?	☐ Yes ☐ No
10.	Do you chew betel nut?	☐ Yes ☐ No
11.	Others (e.g. drugs, neutriceuticals)?	☐ Yes. Specify [_____] ☐ No
12.	How many meals do you eat per day?	[_____]
13.	Where do you get your drinking water?	[______________________________]

ENVIRONMENTAL HISTORY

14.	Length of stay in present address	[________] years
15.	Distance of residence from plantation/ workplace	[________] km [________] m
16.	Have you ever changed your residence or home because of a health problem?	☐ Yes ☐ No
16.a	If yes, please describe the circumstance	[______________________________]
17.	Do you do things at home that involve the use of any chemical?	☐ Yes ☐ No

17.a	If yes, please describe	[________________________]
18.	Does your spouse or any other household member have any contact with chemicals at work or at home?	☐ Yes ☐ No
18.a	If yes, please describe the activity	[________________________]
18.b	Give the name of the chemical	[________________________]
19.	What do you use for cooking at home Tick (or fill-in) one or more of the following	☐ Wood ☐ Gas stove ☐ Clay stove ☐ Electric stove ☐ Charcoal ☐ other, specify [________________]
20.	Do your burn your rubbish	☐ Yes ☐ No
21.	Distance of house from street or road where vehicles pass by	[___] kms [___] meters

PESTICIDES AND YOUR HEALTH

22.	During the past 12 months, did you come sick or have any health complaints because of pesticides?	☐ Yes ☐ No ☐ Unknown
23.	If yes, how many times?	[_____]
24.	Do you have access to a doctor or health practitioner?	☐ Yes ☐ No
24.a	How far away are there?	[____________________]
24.b	Do you have transport to get there?	☐ Yes ☐ No
24.c	Do you have medical insurance?	☐ Yes Who provides it? Own or employer? ☐ No

25. If you are employed by a plantation, do your employers provide regular check-ups?

- ☐ Yes
- ☐ No

26.a Can you provide the doctor's report?

- ☐ Yes
- ☐ No

26.b Could you afford the medical costs?

- ☐ Yes
- ☐ No

27. If yes, please identify

Tick (or fill-in) one or more of the following

General

- ☐ Weakness
- ☐ Easily fatigued
- ☐ Muscle pains
- ☐ Weight loss
- ☐ Fever
- ☐ Chills
- ☐ Loss of appetite
- ☐ Change in taste
- ☐ Other (specify): [_________]

Respiratory system

- ☐ Coughing
- ☐ Breathlessness
- ☐ Noisy breathing
- ☐ Difficulty in breathing
- ☐ Pain on deep breathing
- ☐ Cyanosis
- ☐ Pulmonary secretions
- ☐ Blood in the sputum
- ☐ Other (specify): [_________]

Ears, Eyes, Nose, Throat

- ☐ Eye pain
- ☐ Eye redness
- ☐ Eye tearing
- ☐ Eye itchiness
- ☐ Blurring of vision
- ☐ Photophobia
- ☐ Earache
- ☐ Alopecia
- ☐ Pallor
- ☐ Sweating
- ☐ Jaundice
- ☐ Nail changes
- ☐ Other (Specify): [_________]

Genito-urinary system

- ☐ Blood loss in the urine
- ☐ Pain on urination
- ☐ Increased urination
- ☐ Decreased urination
- ☐ Other (specify): [_________]

Neurologic

- ☐ Confusion
- ☐ Dizziness
- ☐ Headache
- ☐ Vertigo
- ☐ Paresthesias
- ☐ Fasciculations (local)
- ☐ Fasciculations (general)
- ☐ Convulsions
- ☐ Loss of consciousness
- ☐ Paralysis
- ☐ Ataxia
- ☐ Hallucinations
- ☐ Drowsiness
- ☐ Tremors
- ☐ Other (specify) [__________]

- ☐ Deafness/hearing impairment
- ☐ Tinnitus
- ☐ Nasal secretion
- ☐ Nose bleed
- ☐ Nasal congestion
- ☐ Hoarseness
- ☐ Neck mass
- ☐ Other (specify): [________]

Cardiovascular system

- ☐ Chest pain
- ☐ Palpitations
- ☐ Exertional dyspnea
- ☐ Arrhythmia
- ☐ Tachycardia
- ☐ Pillow orthopnea
- ☐ Calf pains
- ☐ Syncope
- ☐ Bradycardia

Integument/Skin

- ☐ Skin discolouration
- ☐ Easy bruising
- ☐ Skin rashes
- ☐ Skin itchiness
- ☐ Blisters
- ☐ Skin lesions

Gastrointestinal system

- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Abnormal masses
- ☐ Salivation
- ☐ Throat irritation
- ☐ Heartburn
- ☐ Dyspepsia
- ☐ Difficulty swallowing
- ☐ Hematemesis
- ☐ Perforation of bowel
- ☐ Other (specify): [_________]

Obstetrical, gynaecological(F)

- ☐ Miscarriages
- ☐ Abnormal bleeding
- ☐ Amenorrhea
- ☐ Menstrual disturbances
- ☐ Abnormal vaginal discharges
- ☐ Other (specify) [_________]

Reporting

Name of interviewer: ____

Date of Interview ______________ **Time started** _______ **Time ended** _________

Organization/address ____

Return this questionnaire to: ____