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 Township, 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.

<table>
<thead>
<tr>
<th>Q</th>
<th>Question</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Have you visited someone for health care in the past month?</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ No</td>
</tr>
<tr>
<td>1.a</td>
<td>If yes, how many times</td>
<td>[_______]</td>
</tr>
<tr>
<td>1.b</td>
<td>Where did you go?</td>
<td>□ Plantation medical facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Government hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Private hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Private clinic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Other, specify</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[_____________________]</td>
</tr>
<tr>
<td>1.c</td>
<td>From who did you seek consultation?</td>
<td>□ General practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Medical specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Alternative medicine practitioner (Herbalist, traditional healer, etc)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Other, specify</td>
</tr>
<tr>
<td></td>
<td></td>
<td>[_____________________]</td>
</tr>
<tr>
<td>1.d</td>
<td>Was this related to your contact with a pesticide?</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ No</td>
</tr>
<tr>
<td>1.e</td>
<td>What was the doctor’s diagnosis and advice?</td>
<td>[_____________________]</td>
</tr>
<tr>
<td>1.f</td>
<td>If no, do you have access to a doctor or health practitioner?</td>
<td>□ Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ No</td>
</tr>
</tbody>
</table>
2. Do you have any of the following illnesses?

<table>
<thead>
<tr>
<th>Illness</th>
<th>Yourself</th>
<th>Family members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Kidney disease</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Asthma</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Liver disease</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Allergy (specify)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Cancer (specify)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Psychiatric disease (specify)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Autoimmune disease (specify)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other (specify):</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

3. Are you taking any medication at the moment? [ ] Yes [ ] No

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

[________________________]
[________________________]
[________________________]
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Have you been sexually active for the past 5 years?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Note: This question is relevant to understanding cervical cancer, if this condition is a problem.</td>
<td></td>
</tr>
<tr>
<td>5. Age of first menstruation</td>
<td></td>
</tr>
<tr>
<td>5.a Subsequent menstrual period</td>
<td>Regular, Irregular</td>
</tr>
<tr>
<td>5.b Indicate your cycle</td>
<td>26 days, 28 days, 30 days, Other, specify, Don't know</td>
</tr>
<tr>
<td>5.c Duration of menses per cycle</td>
<td></td>
</tr>
<tr>
<td>5.d History of dysmenorrhea</td>
<td>Yes, No</td>
</tr>
<tr>
<td>5.e History of</td>
<td>Increased menstrual flow, Decreased menstrual flow</td>
</tr>
<tr>
<td>6. Pregnancy (Please indicate any pregnancies below)</td>
<td></td>
</tr>
<tr>
<td>Age (of mother at pregnancy)</td>
<td>Number of pregnancy (1st, 2nd, etc.)</td>
</tr>
</tbody>
</table>
## 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

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**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: ________________________________________________