

## Questionnaires

**Research title:** Persistent hypertension among postpartum women with comorbid HIV and preeclampsia in Zambia

Visit number \_\_\_\_\_ Participant id \_\_\_\_\_ Date \_\_\_\_\_

**Note!** Before answering the questionnaires on return visits, participants should reread the information sheet as a guide to this questionnaire.

### **Instructions:**

Please answer the following questions for each part of the questionnaire. Your responses are strictly confidential and anonymous. It will take you 20 to 30 minutes to complete. The questionnaire has 5 parts (Part A to E). Each part addresses a specific characteristic to help us classify you to a correct group in our study. You may skip questions or parts you do not feel comfortable with. You may discontinue participation/ answering the questionnaire at any time without penalty, or loss of benefits to which you are otherwise entitled. Furthermore, there is no requirement to provide a reason for withdrawing and any data collected from you will in default be destroyed unless you expressly consent to its retention.

Please fill in the following relating to you so that we can know more about you. If this is a return visit and nothing has changed, kindly indicate so in the question column and proceed to part A

Appendix 3. Questionnaires

Visit number \_\_\_\_\_ Participant id \_\_\_\_\_ Date \_\_\_\_\_

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**Instructions:**

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Please fill in the following relating to you so that we can know more about you. If this is a return visit and nothing has changed, kindly indicate so in the question column and proceed to part A

No.	Question	Response options (tick/write what applies to you)
1	Residential address	_____
2	Email address	_____
3	Cell number	_____
4	Marital status	<input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> never married <input type="checkbox"/> other
5	Education	<input type="checkbox"/> no education <input type="checkbox"/> primary <input type="checkbox"/> secondary <input type="checkbox"/> tertiary
6	Housing type	<input type="checkbox"/> unplanned <input type="checkbox"/> low cost <input type="checkbox"/> medium cost <input type="checkbox"/> high cost
7	Household income (Kwacha)	_____
8	Religion	<input type="checkbox"/> Christian <input type="checkbox"/> Muslim <input type="checkbox"/> hindu <input type="checkbox"/> other
9	Household size (# who stay in the house)	_____

**Part A: An alcohol screening tool - Self-Report Version**

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question. You can skip this part if you feel uncomfortable answering any questions

Do you drink any form of alcohol?  yes  no  
 If no, then move to part B

Circle the response option that best suits you

AUDIT-C Question	Response options					
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never or	Monthly	less 2-4 times per month	2-3 times per week	4+ times per	
How many drinks containing alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more drinks on one occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
<b>(Score) To be completed by research staff</b>						

**Part B: Smoking: Nicotine Dependence for Daily and Nondaily Smokers – Short Form 4a**

1. Do you smoke any form of cigarettes?  yes  no

If no, then move to part C

2. How many cigarettes do you smoke?

A) > one cigarette/day and lasts more than six months

B) I stopped smoking

3. Please respond to each question or statement by marking one box per row

<b>Question</b>	<b>1.Never</b>	<b>2.Rarely</b>	<b>3.Sometimes</b>	<b>4.Often</b>	<b>5.Always</b>
When I haven't been able to smoke for a few hours, the craving gets intolerable					
find myself reaching for cigarettes without thinking about it					
I drop everything to go out and buy cigarettes					
I smoke more before going into a situation where smoking is not allowed					
<b>(Score) To be completed by research staff</b>					

**Part C: Hospital Anxiety and Depression Scale (HADS)**

Tick the box beside the reply that is closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate is best.

D	A		D	A	
		<b>I feel tense or 'wound up':</b>			<b>I feel as if I am slowed down:</b>
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		<b>I still enjoy the things I used to enjoy:</b>			<b>I get a sort of frightened feeling like 'butterflies' in the stomach:</b>
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite often
3		Hardly at all		3	Very often
		<b>I get a sort of frightened feeling as if something awful is about to happen:</b>			<b>I have lost interest in my appearance</b>
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		<b>I can laugh and see the funny side of things:</b>			<b>I feel restless as I have to be on the move</b>
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		No at all		0	Not at all
		<b>Worrying thoughts go through my mind:</b>			<b>I look forward with enjoyment to things:</b>
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		<b>I feel cheerful</b>			<b>I get sudden feelings of panic</b>
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		<b>I can sit at ease and feel relaxed:</b>			<b>I can enjoy a good book or radio or TV program:</b>
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

**For research staff use:**

Total score: Depression (D) \_\_\_\_\_ Anxiety (A) \_\_\_\_\_

**Part D: Food security (Household Hunger Scale)**

This section will ask you questions on how secure you are with food requirements for yourself and family. You may respond by ticking/ circling your best response option provided.

No.	Question	Response Option (circle your choice)	Code
Q1	In the past [4 weeks/30 days], was there ever no food to eat of any kind in your house because of lack of resources to get food?	0 = No (Skip to Q2) 1 = Yes	<input type="checkbox"/>
Q1a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than 10 times)	<input type="checkbox"/>
Q2	In the past [4 weeks/30 days], did you or any household member go to sleep at night hungry because there was not enough food?	0 = No (Skip to Q3) 1 = Yes	<input type="checkbox"/>
Q2a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than 10 times)	<input type="checkbox"/>
Q3	In the past [4 weeks/30 days], did you or any household member go a whole day and night without eating anything at all because there was not enough food?	0 = No (Skip to the next section) 1 = Yes	<input type="checkbox"/>
Q3a	How often did this happen in the past [4 weeks/30 days]?	1 = Rarely (1–2 times) 2 = Sometimes (3–10 times) 3 = Often (more than 10 time)	<input type="checkbox"/>
<b>(Score) To be completed by research staff</b>			

**Part E: Socioeconomic status (Wealth index assessment) using principal component analysis (PCA)**

This part will assess your wealth index. Please select all that applies to you by ticking the option in the response column

Question No.	Characteristic	Response options
1	Source of drinking water	<input type="checkbox"/> Piped into dwelling, <input type="checkbox"/> piped into compound, <input type="checkbox"/> piped to neighbour, <input type="checkbox"/> piped to kiosk, <input type="checkbox"/> public tap, <input type="checkbox"/> borehole, <input type="checkbox"/> protected dug well, <input type="checkbox"/> unprotected dug well, <input type="checkbox"/> protected spring water, <input type="checkbox"/> unprotected spring water, <input type="checkbox"/> rainwater collection, <input type="checkbox"/> tanker-truck, <input type="checkbox"/> cart with small tank/drum, <input type="checkbox"/> surface water, <input type="checkbox"/> bottled water <input type="checkbox"/> , other
2	Type of toilet	<input type="checkbox"/> Flush to sewer, <input type="checkbox"/> flush to septic tank, <input type="checkbox"/> flush to pit latrine, <input type="checkbox"/> flush to somewhere else, <input type="checkbox"/> flush to unknown, <input type="checkbox"/> ventilated improved pit latrine, <input type="checkbox"/> pit latrine with slab, <input type="checkbox"/> open pit latrine, <input type="checkbox"/> composting toilet, <input type="checkbox"/> bucket, hanging latrine, <input type="checkbox"/> no facility
3	Type of floor	<input type="checkbox"/> earth/sand, <input type="checkbox"/> dung, <input type="checkbox"/> wood planks, <input type="checkbox"/> parquet or polished wood, <input type="checkbox"/> vinyl or asphalt strips, <input type="checkbox"/> ceramic tiles, <input type="checkbox"/> cement, <input type="checkbox"/> carpet
4	Type of roof	<input type="checkbox"/> No roof, <input type="checkbox"/> grass/thatch, <input type="checkbox"/> dung/mud, <input type="checkbox"/> iron sheet, <input type="checkbox"/> tin cans, <input type="checkbox"/> asbestos sheet, <input type="checkbox"/> concrete, <input type="checkbox"/> tiles
5	Type of wall	<input type="checkbox"/> No walls, <input type="checkbox"/> cane/palm/trunks, <input type="checkbox"/> dirt, <input type="checkbox"/> bamboo with mud, <input type="checkbox"/> stone with mud, <input type="checkbox"/> uncovered adobe, <input type="checkbox"/> plywood, <input type="checkbox"/> cardboard, <input type="checkbox"/> reused wood, <input type="checkbox"/> cement, <input type="checkbox"/> stone with lime/cement, <input type="checkbox"/> bricks, <input type="checkbox"/> cement blocks, <input type="checkbox"/> covered adobe, <input type="checkbox"/> wood planks/shingles, <input type="checkbox"/> others
6	Type of cooking fuel	<input type="checkbox"/> Electricity, <input type="checkbox"/> liquefied petroleum gas (LPGAs), <input type="checkbox"/> Natural gas, <input type="checkbox"/> biogas, <input type="checkbox"/> kerosene, <input type="checkbox"/> coal, <input type="checkbox"/> charcoal, <input type="checkbox"/> wood, <input type="checkbox"/> straw/shrubs/grass
7	Use of electricity	<input type="checkbox"/> Yes, <input type="checkbox"/> No
8	Possession of radio	<input type="checkbox"/> Yes, <input type="checkbox"/> No
9	Possession of TV	<input type="checkbox"/> Yes, <input type="checkbox"/> No
10	Possession of refrigerator	<input type="checkbox"/> Yes, <input type="checkbox"/> No
11	Possession of Washing machine	<input type="checkbox"/> Yes, <input type="checkbox"/> No
12	Availability of landline phone	<input type="checkbox"/> Yes, <input type="checkbox"/> No
13	Possession of mobile phone	<input type="checkbox"/> Yes, <input type="checkbox"/> No
14	Possession of bicycle	<input type="checkbox"/> Yes, <input type="checkbox"/> No
15	Possession of motorcycle/ scooter	<input type="checkbox"/> Yes, <input type="checkbox"/> No
16	Possession of watch	<input type="checkbox"/> Yes, <input type="checkbox"/> No
17	Possession of computer	<input type="checkbox"/> Yes, <input type="checkbox"/> No
18	Possession of car/ truck	<input type="checkbox"/> Yes, <input type="checkbox"/> No
19	Possession of animal drawn cart	<input type="checkbox"/> Yes, <input type="checkbox"/> No
20	Type household dwelling	<input type="checkbox"/> Own, <input type="checkbox"/> Rent, <input type="checkbox"/> Squatter/stay for free/others
21	Help from employed person	<input type="checkbox"/> Yes, <input type="checkbox"/> No
22	Agricultural land ownership	<input type="checkbox"/> Yes, <input type="checkbox"/> No
23	Livestock ownership	<input type="checkbox"/> Yes, <input type="checkbox"/> No

*This is the end of this questionnaire. Thank you for your responses.*

Date questionnaire completed \_\_\_\_\_