

- Hepatitis C Tuberculosis Parasitosis (es. malaria, toxoplasmosis, giardia, schistosomiasis, taenia, ecc.)
 STD (eg. syphilis, gonorrhea, HSV, etc.) Other (*please, specify* _____)

C) Health risk habits

C.1. Tobacco use

C.1.1. Have you smoked at least 100 cigarettes in your entire life? No (→C.2.1.) Yes

C.1.2. Do you now smoke cigarettes: Some days (*specify n°*) Every day (*specify n°*) Never (→C.2.1.)

C.1.3. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking? No Yes

C.2. Alcohol consumption

C.2.1. During the past 30 days, did you have at least one drink of any alcoholic beverage such as beer, wine or liquor? No (→D.1.) Yes

C.2.2. During the past 30 days, how many days per month did you have at least one drink of any alcoholic beverage?

C.2.3. During the past 30 days, on the days when you drank, approximately how many drinks did you drink on average?

Wine Beer Liquor

D) Prevention and screening

D.1. Immunization

D.1.1. Which of the following vaccinations have you had? (more than one option allowed)

Diphtheria Tetanus Pertussis Polio
 Hepatitis B Mumps Rubella Measles
 Chicken pox Haemophilus B Pneumococcal Meningococcal
 Influenza None/I don't know Other (*please, specify* _____)

(If participant answered Yes to the question A.3.2. skip to question D.1.2.. If participant answered No to the question A.3.2. skip to question D.2.1.)

D.1.2. Have your children received vaccinations included in the national programs? No I don't remember Yes (→D.1.4.)

D.1.3. Why have they not received children's vaccinations? (more than one option allowed)

I was not aware of their availability Vaccinations are not useful Vaccinations are dangerous
 Religious reasons Lack of time Other (*please, specify* _____)

D.1.4. Do you remember which of the following vaccinations your children have had?

Mandatory vaccinations (diphtheria, tetanus, polio, hepatitis B) Pertussis Measles, mumps and rubella
 Chicken pox Haemophilus B Pneumococcal Meningococcal
 Influenza None/I don't know Other (*please, specify* _____)

D.2. Screening

D.2.1. Have you ever had Pap test?

No Yes, for control Yes, for problems

D.2.2. When was the last time you had a Pap test? (years)

<1 yr ago 1-2 yrs ago 2-3 yrs ago 3-5 yrs ago ≥5 yrs ago

D.2.3. Have you had a hysterectomy? No Yes

D.2.4. Have you ever had a mammography?

No Yes, for control Yes, for problems

D.2.5. When was the last time you had a mammography? (years)

<1 yr ago 1-2 yrs ago 2-3 yrs ago 3-5 yrs ago ≥5 yrs ago

E) Utilization of maternal health services

(If participant answered Yes to question A.3.1. skip to question E.1.. If participant answered No to question A.4.1. end interview.)

E.1. How many times have you given birth since you've been in Italy? None (*spec. n°*)

E.2. How many times have you had a miscarriage? None I don't remember (*spec. n°*)

E.3. How many times have you had an abortion? None I don't remember (*spec. n°*)

(If participant answered None to question E.1. end interview. Otherwise, complete interview with all following questions referred to last pregnancy.)

E.4. Who was mainly monitoring your pregnancy/ies? None General practitioner
 Gynecologist Midwife Other (*please, specify* _____)

E.5. How many prenatal visits did you attend during each pregnancy?

- None 1 >1 (*spec. n°*)
- E.6. When did you receive your first pregnancy appointment?** I don't remember (*please, specify weeks of pregnancy*)
- E.7.1. How many prenatal ultrasound checks did you have during your pregnancy?** (*spec. n°*)
- E.7.2. Do you remember in which weeks of pregnancy you had these prenatal ultrasound checks?** (*more than one option allowed*) None
- <8 8-12 13-16 17-20 21-24 25-28 29-32 ≥33
- E.8. Did you know that prenatal visits and ultrasound checks are free?** No Yes
- E.9. Did you have any prenatal diagnostic testing?** (*max. 4 options*) No Yes, maternal serum markers
- Yes, chorionic villus sampling Yes, amniocentesis Yes, nuchal translucency Other (*please, specify* _____)
- E.10. Have you ever participated in a prepartum course/prenatal class?** No Yes
- E.11. Overall, do you believe you have had difficulties of access to and use of prenatal services during your pregnancy?** (*max. 3 options*) No
- Yes, I don't know system's organization Yes, for language barriers Yes, for long waiting times for access to health-care services
- Yes, lack of time Yes, for my poor socioeconomic situation Other (*please, specify* _____)
- E.12. Did you ever smoke during pregnancy?** No, I don't smoke No, I stopped
- Yes, I continued to smoke the same number of cigarettes Yes, but I decreased the number of cigarettes
- E.13. Did you have a postnatal visit within 12 months after delivery?** No Yes
- E.14. What was your chosen infant feeding method?** Breastfeeding only (→E.17.) Bottle-feeding only
- Breastfeeding and other (water, tisane, or other infusion) Breastfeeding and bottle-feeding
- E.15. Who advised you regarding the formula milk?** Nobody, I decided Pediatrician
- Family/Friends Physician of hospital ward Other (*please, specify* _____)
- E.16. What is the reason for the formula milk?** (*max. 3 options*) I don't have enough milk I stopped breastfeeding
- The baby was not gains weight The baby couldn't latch on well
- I had painful nipples, and/or mastitis I had acute health problems My child had acute health problems
- I had to resume work shortly I had to moved my child abroad I was tired
- I took some drugs (*please, specify* _____) Other (*please, specify* _____)
- E.17. Who gave you information about infant feeding?** None I know
- Midwife of hospital ward Midwife of family planning center Pediatrician Family/Friends
- Other (*please, specify* _____)
- E.18. Do you believe it is possible to get pregnant during the period of breastfeeding?**
- No, it's not possible I don't know Yes, it's possible
- E.19. Who counseled you on postpartum contraceptive methods?**
- None (→E.21.) Family/Friends General practitioner
- Specialist Midwife of family planning center Other (*please, specify* _____)
- E.20. Do you believe this counseling has been sufficient?**
- Yes, I believe it has No, I would like to know more
- E.21. At the resumption of sexual relations, are you thinking of using contraception?**
- No I don't know yet Yes (*please, specify* _____)
- E.22. Do you know a family planning center?**
- No (→E.24.) Yes, but I never used it Yes, I have used it (→ E.24.)
- E.23. Why have you never used a family planning center?** (*please, specify one or more reason*) _____
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- E.24. Are you accessing any healthcare services since discharge?** No (→E.26.) Yes
- E.25. Please, specify one or more of following healthcare services:**
- Pediatric planning center Family planning center Advice center Specialist clinic
- Emergency Department Hospital Other (*please, specify* _____)
- E.26. Whom have you selected as the child's physician?** None Specialist
- Physician of family planning center Physician of hospital ward Pediatrician Other (*please, specify* _____)