STUDY PROTOCOL

Ambient and Indoor Air Pollution in Pregnancy and the risk of Low birth weight and Ensuing Effects in Infants (APPLE): A cohort study in Bangalore, South India [version 1; peer review: awaiting peer review]

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Abstract

Background: Exposure to air pollution (IAP) from the combustion of solid fuels is a significant cause of morbidity and mortality in developing countries. Pregnant women exposed to higher pollutant levels are at higher risk of delivering a low-birth-weight (LBW) baby. There is a lack of standardized data regarding the levels and types of specific pollutants and how they impact LBW. We aim to prospectively assess the association between ambient and indoor air pollution levels in pregnancy and low birth weight and understand the subsequent risk of adiposity in these infants.

Methods: We will conduct a prospective cohort study of 516 pregnant women recruited before 18 weeks of gestation in the urban slums of Bangalore, who have voluntarily consented to participate. We will estimate the level of air pollutants including coarse particulate matter 10 μg/m3 (PM10), fine particulate matter 2.5 μg/m3(PM2.5) and carbon monoxide (CO) parts per million (ppm) levels in both indoor and ambient environment. The follow-up of the delivered children will be done at delivery until the infant is two years old. The association between pollutants and LBW will be evaluated using logistic regression adjusting for potential confounders. Further, we will explore the mediation role of LBW in the hypothesized causal chain of air pollution and adiposity. Nested within a larger Maternal Antecedents of Adiposity and Studying the Transgenerational role of Hyperglycemia and Insulin (MAASTHI) cohort, we can estimate the absolute risk of having low birth weight caused by air pollution and other variables.

Discussion: Understanding the association between exposures to ambient and indoor air pollution and low birth weight is essential in India. LBW babies have a higher risk of developing obesity and Non-Communicable Diseases
(NCDs) during adulthood. The results from this study can inform the efforts for controlling the air pollution-related chronic diseases in India.

**Keywords**
Ambient air pollution, indoor air pollution, low birth weight, adiposity, Non-communicable disease

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**List of Abbreviation**

AQI: Air Quality Index  
ATP: Adenosine TriPhosphate  
BMI: Body Mass Index  
CO: Carbon Monoxide  
CSV: comma separated values  
DNA: Deoxyribose Nucleic Acid  
HBsAg: Hepatitis B Surface Antigen  
HIV: Human Immunodeficiency Virus  
IAP: Indoor Air Pollution  
LBW: Low Birth Weight  
NCD: Non-Communicable Disease  
PM10: Particulate matter 10 micrometre  
PM2.5: Particulate matter 2.5micrometer  
PPM: parts per million  
RH: Relative Humidity  
SES: Socio-Economic Status  
SO2: Sulphur Dioxide  
SD: Secure Digital  
T2DM: Type 2 Diabetes Mellitus  
US EPA: The United States Environmental Protection Agency  
USB: Universal Serial Bus  
VDRL: Venereal Disease Research Diagnostic  
XLSX: Excel Microsoft Office Open XML Format Spreadsheet file

**Introduction**

The developmental origins of health and disease (DOHaD) hypothesis deals with exploring the causal role of intrauterine circumstances to the origins of diseases in adults. The initial studies have revealed that undernutrition during pregnancy is an important determinant of adult cardiac and metabolic disorders due to fetal programming. This was hypothesized to be mediated via altering the fetus’ structure, function, and metabolism (Gluckman et al. NEJM 2008). Since then, development of fetal origins of adult disorders has remained an essential focus of researchers in the exploration of causal mechanisms for hypertension, coronary heart disease, and non-insulin-dependent diabetes. The collation of the prospective evidence using the DOHaD approach helps in assessing and modifying the impact of determinants of health from the life-course perspective. While the evidence regarding nutritional pathways of LBW is available, other antecedents such as air pollution and psychosocial stress are less investigated.

Globally, nearly three billion people use traditional biomass fuels as their primary source of energy comprising of wood, charcoal and agricultural wastes. In India, nearly 67% of the population use biomass as a primary source of fuel for cooking. As a result, exposure to indoor air pollution (IAP) from the combustion of these fuels has emerged as an important cause of morbidity and mortality. Air pollution is contributing to the second-highest associated risk factor for mortality and morbidity. Even a low-dose exposure to pollutants in utero can result in disease, disability and death in childhood. There is evidence that air pollution is associated with the burden of several diseases including respiratory infections, chronic obstructive pulmonary disease, cataracts, cardiovascular events, low birth weight and all-cause mortality. Further, meta-analysis by Stieb et al. indicates that the decrease in birth weight is proportional to higher pollutant concentration.

The putative role of exposure to air pollution during pregnancy resulting in LBW has been assessed in several studies. The suggested mechanisms mediating this path include oxidative stress resulting in placental and endothelial dysfunction, and damage in the DNA productivity due to an imbalance between reactive oxygen species. Specifically, exposure to particulate matter during pregnancy induces changes in multiple placental compartments, including the maternal vascular space, fetal capillaries, and surface exchange areas. These alterations in placental function were associated with a higher incidence of LBW among exposed fetuses. The poor nutrition accentuates the propensity of a baby to be LBW and subsequent inadequate development of pancreatic beta cell mass resulting in a higher risk of development of type 2 diabetes in future. These include greater insulin resistance and storage of fat as compared to children with normal weight. Intrauterine malnutrition and other fetal constraints induce insulin deficiency (lack of the growth-promoting activities of insulin) and a postnatal state of regulatory insulin resistance, which leads to a rapid postnatal increase of adipose tissue that remains stable throughout life.

Available evidence suggests that several environmental factors induce intra uterine growth retardation (IUGR) and subsequent LBW in newborns. These include diet, diabetes, hormone exposure, air pollution, psychosocial stressors and hypoxia. Our ongoing, MAASTHI birth cohort study characterises the impact of these factors, including exposure to higher glucose levels during pregnancy, in the intrauterine milieu on the fetus, barring the effect of air pollution. A cohort study is an efficient study design to assess the association between prenatal exposure to air pollutants and infant health outcomes.

**Objectives**

We aim to evaluate the association between prenatal exposure to ambient and indoor air pollutants and low birth weight in newborns (Figure 1 and Figure 2). We will also be exploring the mediation role played by LBW in the causal path between air pollution in pregnancy and adiposity in infancy. (Figure 3 and Figure 4).

1. To explore the association of prenatal exposure to indoor air pollutants in pregnancy and low birth weight at birth.

   **Hypothesis 1:** Prenatal exposure to indoor air pollution increases the risk of low birth weight

2. To explore the association of prenatal exposure to ambient air pollutants in pregnancy and low birth weight at birth.
Figure 1. Directed acyclic graph displaying the causal pathway of indoor air pollution during pregnancy with low birth weight.

Figure 2. Directed acyclic graph displaying the causal pathway of ambient air pollution during pregnancy with low birth weight.

Figure 3. Directed acyclic graph displaying the causal pathway of showing the mediating effect of low birth weight due to indoor air pollution during pregnancy on adiposity.
Hypothesis 2: Prenatal exposure to ambient air pollution increases the risk of low birth weight.

3. To evaluate the association between prenatal exposure to indoor air pollutants in pregnancy and adiposity in infants, mediated through low birth weight.

Hypothesis 3: Low birth weight at birth mediates the effect of indoor air pollution in pregnancy on adiposity in children (Figure 3).

4. To examine the association between prenatal exposure to ambient air pollutants and adiposity in infants, mediated through low birth weight.

Hypothesis 4: Low birth weight mediates the effect of ambient air pollution in pregnancy on adiposity in children (Figure 4).

Methods
Study design
A prospective cohort study is planned in the urban slums of Bangalore. The study duration is three years. In this regard, a pilot study was carried out in September 2017. Subsequently, the recruitment and follow-up visits are scheduled between August 2018 and December 2020. The study population comprises of households with pregnant women. All the pregnant women in the study population will be followed up until delivery, and their infants will be followed up further irrespective of the exposure status. The follow-ups will be performed at delivery, at six months, and eighteen months of age. Infant anthropometry, morbidity, feeding practices, and child developmental milestones will be assessed during each follow-up visit.

Setting
The study area is located in the slums of east and west zones of urban Bangalore. The selected areas are Srirampura, Kodandarampura, Shirdi Saibaba Nagar, Subasnagar from the West Zone, and DJ Halli, Bagalur Layout and Pulikeshinagar from the East Zone (Figure 5). A slum is defined as an area comprising of at least 60-70 households living in poorly built congested tenements along with the neighbouring well-built houses (see data from the Karnataka Slum Development Board).

Participants
The study participants will be selected from the Bruhath Bangalore Mahanagara Palike (BBMP) health centres. Permissions have been obtained from the Chief Health Officer, Bangalore to conduct the study in the selected BBMP urban health centres. The selected centres are, Ramachandrapura Urban family welfare centre (UFWC), Subash Nagar urban health centre (UHC), Shirdi Saibaba UHC, Kodandarampura UHC from the west zone and DJ Halli, Bagalur Layout, Robertsonpet and KG Halli UHCs from the east zones of BBMP. The research staff will screen the eligible respondents in the health centre and in the community. Only eligible respondents will be enrolled in the study after obtaining their informed consent.
Eligibility criteria: Pregnant women aged between 18–45 years with a gestational age of under 18 weeks who reside in the slums and plan to deliver at the study locations are eligible for recruitment in the study. Women with severe co-existing illness and those who plan to move out of the study location during the study period will be excluded. Women who are mentally or physically not capable of voluntarily consenting or participating in the study will be excluded (Figure 6).

Ethical considerations
Institutional Ethics Committee: Ethical clearance for the proposed study has been obtained from the institutional review board (IEC) at Bangalore, IIPH-H (Approval Number IIPHHB/TRCIEC/121/2017 Dated 27 July 2017).

Written informed consent will be obtained from participants before the start of the study. They will be informed in detail about the study and their voluntary agreement to participate in the research will be obtained.

Variables
The list of variables used for exposure, confounder, intermediate and outcome assessment are provided in Table 1.

Exposure assessment. We will assess the level of air pollutants namely, fine particulate matter (PM$_{2.5}$) and coarse particulate matter (PM$_{10}$) and carbon monoxide (CO). All these pollutants will be measured both indoor and in the ambient environment using air quality monitors. Personal sampling monitors will be used to measure the individual exposure level of PM$_{2.5}$, PM$_{10}$ and CO at the household level. The eligible participants will be required to wear a personal sampling device for one entire day during each trimester. The samplers will be kept inside a small fully ventilated, appealing sling bag that they can wear while carrying out the routine household chores (Figure 7). The samplers record the data continuously for 24-hours, and are connected to a portable outlet power source or power bank. The data will be stored in the memory card in the sampler which is then transferred and stored safely in a hard disk later by the research staff. The exposure data will be measured twice during pregnancy, during the second and the third trimester of pregnancy. A tentative schedule for the distribution of the monitors is provided in Appendix 1 (Supplementary Table 1, Supplementary File 1). The ambient air quality monitor will be kept outside the house in a protected environment, within 5 km radius from the respective participant’s house to assess live ambient data on all three pollutants (PM$_{2.5}$, PM$_{10}$ and CO) for 24 hours. The device will
be about five feet above the ground level provided with a shelter to secure the device from direct sunlight and rain. We will also obtain the readings of the ambient air pollutant levels from the nearby ambient air quality monitoring devices and stations installed by the pollution control board (monitored via Eprolytics).

Together, we will assess the ambient exposure level of that particular area. This data will be considered as a proxy for ambient data for each household in that area.

**Covariates.** We will assess socioeconomic and demographic variables, current and previous obstetric history, fuel used for cooking and heating, and the location of the kitchen, using pre-tested questionnaires (Supplementary File 1). The information on other sources of pollution such as burning of agarbatti/dhoop (Incense sticks); and use of mosquito repellents and candles will be collected. The duration of exposure to indoor as well as outdoor air pollution will be collected. (Detailed in Supplementary Table 1, Supplementary File 1). Trained research staff will...
record the height and weight of the participants by using SECA 213 (seca Precision for health) stadiometer and digital Omron HN-283 (Omron Healthcare Co., Ltd.) weighing scale. The scale will be placed on a level ground, the research staff will check for a ‘zero’ reading, and after ensuring that the respondent has removed heavy outer clothing and shoes, two readings to the nearest 10 grams will be recorded. A portable stadiometer will be used for measuring height to the nearest 0.1 cm; measured with the participant standing straight with her feet together, the head plate of the stadiometer will then be pulled down to ensure that it rests on the crown of the head. Blood pressure will be measured using OMRON HEM-7203 (Omron Healthcare Co., Ltd.) automated blood pressure monitor. We will also measure the fasting and 2-hour post-prandial blood glucose levels (Oral glucose tolerance test) and haemoglobin during the day as markers of hyperglycaemia and anaemia in pregnant women who complete their 24 weeks of gestation (Table 2). The tests will be conducted by Medall Healthcare Pvt. Ltd. using fully automated analyzer, non-cyanide methods for hemoglobin estimation and glucose will be estimated using Glucose oxidase (GOD)-preoxidase (POD) colorimetric method. The procedure has been detailed further in the laboratory analysis and sample storage section. The field staff will assess for obstetric morbidity and hospitalization during the monitoring visits.

Household temperature and the status of anaemia will be considered as an intermediate factor between indoor and ambient air pollution and its association with low birth weight\(^23\). A list of known effect modifiers will be made and collected using a structured questionnaire (Supplementary File 1) and later considered during analysis. (Eg; the age of the respondent, occupational exposure\(^25\)). Season, socioeconomic status, smoking history and exposure to second-hand smoke, traffic roadways, maternal stress and social support have been considered as confounders\(^26\). As we cannot identify the relative contribution of tobacco smoke to the indoor or ambient air pollution, we will obtain data using the structured questionnaire. Psychosocial stress data will be collected using the standard Edinburgh Postnatal Depression Scale (EPDS), a widely used self-reporting questionnaire explicitly developed to screen women for perinatal depression\(^22\). EPDS has been validated by Fernandes et al. for prenatal depression in South India at a cut-off of ≤13 (sensitivity = 100%, specificity = 84.90%, and area under the curve = 0.95)\(^31\). Social support will be measured using a questionnaire that has been used and developed by St. John’s Research Institute to evaluate a broad range of social support (i.e., emotional, instrumental, informational, and appraisal)\(^34\). This questionnaire has a total of 12 items, and each item is scored between 0 (definitely not enough) to 3 (definitely enough). The highest score being 36 means excellent social support and 0 meaning very low social support.

**Outcome variables.** Birth weight, length and skinfold thickness of the baby at birth, 6 and 18 months are the outcomes of interest. Feeding practices, morbidity, and child development milestone will be assessed during the follow-up visits. (Table 2). The Trivandrum Developmental Scale will be used to measure the developmental milestones\(^35\). The 51-items of Trivandrum Developmental Screening Chart for children of 0-6 y [TDSC (0–6 y)] is a simple, reliable and valid screening tool in the community to identify children between 0–6 years with developmental delay.

For assessment of weight, the baby will be placed naked on the digital SECA 354 weighing scale and readings will be taken to the nearest 0.5g. For measuring infant length, the baby’s head will be held against the end of the head plate of the SECA 417 infantometer, and the foot plate will be bought up to the heels ensuring that the feet and knees are flat.
Chasmors body circumference tape will be used to measure the circumferences. Mid-upper-arm (MUAC) will be recorded with the arm bent, allowing the measurement to be taken with the baby in its natural position. An ink mark will be made on the anterior and posterior side of the arm to locate the point for biceps and triceps estimation. Head circumference will be measured with the baby’s head on the side. The tape will be placed on the forehead. Waist circumference will be taken by placing the tape around the abdomen immediately above the umbilicus at the end of expiration. Chest circumference will be measured by placing the tape around the chest at the end of expiration.

Skinfold thickness will be measured on the left side of the body using the Holtain Calipers. Three readings to the nearest 0.2mm will be taken. For triceps skinfold thickness, the tape will be placed around the upper arm at the level of the mark done at the posterior side while measuring mid-upper arm circumference (MUAC). With the tape in position, a horizontal line will be drawn on the skin at the level of the mark. The point at which the fold is to be measured will then be marked; the skin will be lifted over the posterior surface of the triceps muscle, above the marked point and the calipers will be applied below the fingers. For subscapular skinfold thickness, the inferior angle of the scapula will be identified, and the skin will be marked immediately below the angle. The skinfold will be picked up above the mark, and the caliper jaws will be applied below the fingers, at the apex of the fold.

**Adiposity**

We define adiposity as the sum of the skinfold thickness namely biceps, triceps and subscapular measuring above the 70th percentiles are classified as at risk to obese and more than 85th percentiles are classified as obese.

The skinfold thickness equation for body fat composition measurement by Holtain Caliper is correlated and validated against dual-energy x-ray absorptiometry (DEXA) which is a standard gold method for body fat estimation and reported a reasonable validation with DEXA. The list of exposure, outcome and potential confounders will be explained in detail below (Table 1)

**Laboratory analysis and sample storage**

Medall Healthcare Pvt. Ltd (MEDALL), a centralized and nationally accredited laboratory will be engaged to carry out all the tests including haemoglobin and oral glucose tolerance test (OGTT). The pregnant women will be advised by the research staff to visit the hospital after overnight fasting state for at least 7–8 hours. A trained phlebotomist will draw the fasting and postprandial sample 2 hours following a 75 g oral load of glucose. The blood from the fasting sample will be centrifuged within 30 minutes of collection at 3500rpm for about 5 minutes in a REMI Medico centrifuge C-854/6 portable centrifuge. The sample will be transferred into a cold box at 2–8°C and will be transferred to the central laboratory, where assays will be carried out. An aliquot of plasma will be made by centrifuging the fasting Sodium Flouride tube and haemoglobin processed EDTA samples for 3500rpm for 5 min. The remaining sediment of packed red cells will be centrifuged at high speed at 4500rpm for 5–10 min to extract the buffy coat samples. The plain tube containing 6ml of blood will be made to stand for 40 minutes to clot then centrifuged at a speed of 4500rpm for 5–10min to extract the buffy coat samples. The blood from the fasting sample will be centrifuged at high speed at 4500rpm for 5–10 min to extract the buffy coat samples. The plain tube containing 6ml of blood will be made to stand for 40 minutes to clot then centrifuged at a speed of 4500rpm for 5–10 minutes. Totally, six aliquots of serum will be separated from 6ml of a plain blood sample each holding 0.5ml of serum. 4 aliquots of plasma of 0.5ml each, 3 aliquots of buffy coats (0.1 – 0.5ml) will be stored for the future analysis. The aliquots will be stored in a bio-repository at the research centre (Indian Institute of Public Health, Public Health Foundation of India-Bangalore), wherein the samples will be stored in a stepwise manner (2 – 8 °C, -20 °C deep freezer and -80 °C deep freezer) for future analysis. The samples are planned to be stored long term will be moved to a -80 °C, ultra low deep freezer.

**Sample size**

A research study by Kalpana Balakrishna et al. showed that a population-weighted mean of annual PM10 exposure in India

### Table 2. Proposed measurements at baseline and follow up in the APPLE study.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Measurement/tests</th>
<th>Frequency</th>
<th>N</th>
<th>Time points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women</td>
<td>$\text{PM}<em>{2.5}$, $\text{PM}</em>{10}$ and CO concentration of both indoor and ambient level.</td>
<td>Two times</td>
<td>516</td>
<td>Once in 2nd and 3rd trimester</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>Blood glucose estimation, Haemoglobin, Height and weight, Blood Pressure, Socio-demographic characteristics, current obstetric history, psychosocial stress, social support</td>
<td>Once</td>
<td>516</td>
<td>During 24–32 weeks of gestation</td>
</tr>
<tr>
<td>Newborn</td>
<td>Anthropometry of the child (Skinfold thickness (Biceps, triceps and subscapular) and circumferences (Head, chest, waist, hip and mid-arm circumference)</td>
<td>Once</td>
<td>516</td>
<td>At birth</td>
</tr>
<tr>
<td>Infants</td>
<td>Skinfold thickness (Biceps, triceps and subscapular) and circumferences (Mid-upper arm, Head, chest, waist and hip circumference), morbidity and feeding practices, child developmental milestones</td>
<td>Two times</td>
<td>516</td>
<td>6th month</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18th month</td>
</tr>
</tbody>
</table>

PM – particulate matter
has increased from 59.8 µg/m³ to 79.9 µg/m³ (1990–2016). The study also reported that more than 80% of the Indian population were exposed to PM₂.₅ of more than 40µg/m³. Delhi has the highest populated weighted mean of PM₂.₅ (>150 µg/m³) followed by Uttar Pradesh, Bihar and Haryana. We plan to recruit 516 pregnant women over a period of one year with a hypothesized (based on the evidence in India) 20% of LBW in this population⁶⁰, accounting for the design effect (DEFF) of (for cluster surveys- 1.5, for 95% confidence interval, the sample size required is 369. Further, due to the transient nature of pregnant women from the slum population, the sample size required is 516 accounting for 40% loss to follow-up⁶⁰.

The sample size has been estimated using a formula, 

\[ n = \frac{Z^2 \cdot P(1-P)}{d^2} \]

where \( n \) is the sample size, \( Z \) is the statistic corresponding to the confidence interval, \( P \) is the expected prevalence and \( d \) is the precision. The sample size of 246 has been estimated using 20% of expected prevalence of LBW at 95% confidence interval and 5% precision. The two zones of the study area considered as a cluster and accounting for the design effect of 1.5 the sample size came out to be 369. Further, due to the transient nature of pregnant women from the slum population, the sample size required is 516 accounting for 40% loss to follow-up.

**Data sources and measurements**

The study instruments used in this study have been developed by research team using previous research finding. The questionnaire has been piloted and validated before administration in the field (Supplementary File 1). The research staff will administer the questionnaire, conduct blood investigation, and record the anthropometric measurements at the health centre. The air monitoring device with power bank will be distributed to pregnant women by the field staff of the respective area and taken back after the 24 hours estimation is done. The post-monitoring assessment will be performed using a structured questionnaire assessing the cooking practices and activity of the participants during the monitoring period. The enrolled pregnant women due for delivery will be tracked through periodic phone calls by tracking respondent based on their estimated due date (EDD) and scheduling follow-up visits.

**Ambient and indoor air quality monitor**

We will use the VAYUSESNE (later renamed as VAYUCARE) device for assessing the outdoor and indoor air pollutants. This is designed by Ambience Monitoring India private limited based in Delhi marketed through their selling partner “I love Clean Air”. It is a portable device that can operate for 24 hours with 10,000mAh external power bank (Figure 7). The devices provide real-time monitoring of particulate pollution PM₁₀, PM₂.₅ and CO. It has air sensors to produce details on air quality. The data will be saved in an SD card. The downloaded data can be viewed in comma-separated values (CSV) and Excel Microsoft Office Open XML Format Spreadsheet file (XLSX) format. The monitors are calibrated, tested and then installed⁶¹. Upon installation, the monitor will assess the indoor air quality data automatically. The particulate matter is measured in µg/m³, and CO is measured in ppm. The temperature is measured in degree Celsius, and relative humidity (RH) is expressed as a percentage.

**Bias**

Specific attention will be paid to limit bias by controlling for confounding, minimizing selection bias and measurement errors. In order to prevent any differential misclassification of outcome, the data from laboratory investigations and air pollutant estimation is accessed only by the key research staff who are not involved in data collection. The field team will be trained and certified on anthropometric measurements by St. John’s Research Institute and any possible measurement error will be minimized. Accuracy and inter-observer reliability of their measurements will be assessed at the outset and subsequently for every six month. To control for confounding, information about the potential confounders (Table 1) will be obtained and controlled during the analysis stage.

**Statistical methods**

Descriptive statistical estimates of the individual exposure will be reported. Frequencies and percentages will be reported for all the variables. The exposure data distribution will be checked for normality. The mean and standard deviation will be reported for quantitative variables. The minimum and maximum level of exposure will be reported. The prevalence of low birth weight will be calculated. The fasting and postprandial glucose will be categorized based on the WHO recommended cut off levels (fasting glucose of ≥92mg/dl and 2-hr values of ≥153mg/dl) are considered as hyperglycemia⁶⁵. The anaemia status will be categorized as normal when the Hemoglobin (Hb) is >11gm/dl, mild anaemia when Haemoglobin 10 – 10.9gm/dl, moderate anaemia when Hemoglobin 7– 9.9gm/dl and severe when the Hemoglobin level is less than 7gm/dl⁶⁶⁻⁶⁸. The outcomes (birth weight and adiposity) will be modeled both as a continuous and binary indicator variable. The exposure of interest (PM₂.₅, PM₁₀ and CO) will be taken as a continuous scale measure for analysis. The exposure value will then be categorized in terms of quartiles and the lower quartile of the exposure will be taken as the reference category for each pollutant for further analysis. The odds ratio with confidence interval will be reported. We will also report the dose-response relationship between maternal exposure to indoor and ambient air pollutants (PM₂.₅, PM₁₀ and CO) and birth weight will be assessed through sensitivity analysis⁶⁹⁻⁷⁰. Mediation analysis will be used to test the hypothesized causal chain for third and fourth objectives; involving low birth weight as an intermediate in the association between air pollution and adiposity.

**Dissemination of information**

The findings of the study will assist the efforts of the Government to counter climate change. The data from the study will pave way for future research and policy-making agendas of the government. We have engaged key stakeholders like health officers and Slum board official to increase their sense of awareness towards the impact of air pollution on health.
Discussion

There is a lack of standardized data for the confluence of risk factors including the levels and roles of specific pollutants and how they are associated with low birth weight and adiposity in India. By collecting high-quality prospective data on exposures in pregnant women, this study can provide insights into the environmental causes of low birth weight and obesity in childhood. The results from our study may provide evidence regarding the adverse effects of air pollution in pregnancy, and thereby can help in improving the neonatal and child health outcomes. The results can inform policy regarding limiting air pollution and designing interventions for use in future studies.

Supplementary material

Supplementary File 1: File contain the study questionnaire along with the following Supplementary Tables:
Click here to access the data

Supplementary Table 1: Tentative schedule for using the air pollution monitoring devices for exposure assessment
Supplementary Table 2: Description on variables

References

5. INDIA PROFILE. In.: Institute for Health Metrics and Evaluation; 2016.