

QUESTIONNAIRE (Phase I)**Introduction:**

“My name is... We are interviewing people in Mbarara district, Uganda about family planning methods and condom use. Have you been interviewed in the past few weeks for this study?”

If the respondent has been interviewed before, do not interview this person again. Tell them you cannot interview them a second time, thank them, and end the interview. If she has not been interviewed before, explain the study using the information sheet.

If the respondent agrees to participate, ask her the following questions.

Screening question:

- | | | | |
|--|-----|---|----|
| 1. How old are you? <i>Check yes if she is between 18-49 years old.</i> | Yes | • | No |
| 2. Do you have a husband or partner living together over 3 months? | Yes | • | No |
| 3. Have you had sexual intercourse with him in the past 3 months? | Yes | • | No |
| 4. Do you want to avoid pregnancies in the next 12 months? | Yes | • | No |
| 5. Are you using any family planning methods such as pills, implants, and injectables? | Yes | • | No |
| 6. Do you have a working telephone number? | Yes | • | No |
| 7. Are you pregnant or infertile? | Yes | • | No |
| 8. Are you either a health worker, political or religious leader, or teacher? | Yes | • | No |

If the respondent answers yes to 1-6 and no to 7-8, she is eligible for this study, ask her to give the informed consent and start the interview.

If the respondent has proved not to be eligible for the study, tell her you cannot interview her, thank her, and end the interview.

Identification:

Date	<u>DD</u> / <u>MM</u> / <u>YYYY</u>
Facility	
Interviewer	
Field editor	

QUESTIONNAIRE

Date: DD/MM/YYYY
 Facility: _____
 Interviewer: _____
 Field editor: _____

A) BACKGROUND INFORMATION

	Questions	Responses	Skin																																																									
A-1	What is your purpose of visiting this health center today?	<input type="checkbox"/> ₀ To initiate family planning <input type="checkbox"/> ₁ To continue family planning <input type="checkbox"/> ₂ To receive family planning counselling <input type="checkbox"/> ₃ Other ()																																																										
A-2	How old are you? (Completed year)	Age in completed years..... <input type="checkbox"/> ₈ Don't know																																																										
A-3	What is your ethnicity?	<input type="checkbox"/> ₁ Banyankole <input type="checkbox"/> ₂ Baganda <input type="checkbox"/> ₃ Bakiga <input type="checkbox"/> ₄ Batoro <input type="checkbox"/> ₅ Acholi <input type="checkbox"/> ₆ Other ()																																																										
A-4	What is your religion?	<input type="checkbox"/> ₁ Roman catholic <input type="checkbox"/> ₂ Protestant/other Christian <input type="checkbox"/> ₃ Muslim <input type="checkbox"/> ₄ No religion <input type="checkbox"/> ₅ Other ()																																																										
A-5	What is the highest level of school you have attended?	<input type="checkbox"/> ₀ Never <input type="checkbox"/> ₁ Incomplete primary school <input type="checkbox"/> ₂ Complete primary school <input type="checkbox"/> ₃ Incomplete secondary school <input type="checkbox"/> ₄ Complete secondary school <input type="checkbox"/> ₅ Higher than secondary school																																																										
A-6	What is your occupation?	<input type="checkbox"/> ₀ Unemployed <input type="checkbox"/> ₁ Agriculture <input type="checkbox"/> ₂ Government worker <input type="checkbox"/> ₃ Private sector <input type="checkbox"/> ₄ Own business <input type="checkbox"/> ₅ Students <input type="checkbox"/> ₆ Other ()																																																										
A-7	Does your household have:	<table border="1"> <thead> <tr> <th></th> <th>NO</th> <th>YES</th> </tr> </thead> <tbody> <tr><td>a) Electricity</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>b) A radio</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>c) A television</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>d) A mobile phone</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>e) A non-mobile phone</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>f) A refrigerator</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>g) A solar panel</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>h) A table</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>i) A chair</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>j) A sofa</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>k) A bed</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>l) A cupboard</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>m) A clock</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>n) A microwave oven</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>o) A DVD player</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>p) A cassette or CD player</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>q) A car or truck</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> <tr><td>r) A bicycle</td><td><input type="checkbox"/>₀</td><td><input type="checkbox"/>₁</td></tr> </tbody> </table>		NO	YES	a) Electricity	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	b) A radio	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	c) A television	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	d) A mobile phone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	e) A non-mobile phone	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	f) A refrigerator	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	g) A solar panel	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	h) A table	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	i) A chair	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	j) A sofa	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	k) A bed	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	l) A cupboard	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	m) A clock	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	n) A microwave oven	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	o) A DVD player	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	p) A cassette or CD player	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	q) A car or truck	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	r) A bicycle	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	
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A-8	What is your marital status?	<input type="checkbox"/> ₁ Single <input type="checkbox"/> ₂ Married <input type="checkbox"/> ₃ Cohabiting <input type="checkbox"/> ₄ Widow <input type="checkbox"/> ₅ Divorced																																																										
A-9	Are you currently married or living with a man with whom you have a sexual relationship?	<input type="checkbox"/> ₁ Currently married, living with a spouse <input type="checkbox"/> ₂ Currently married, living with another sexual partner <input type="checkbox"/> ₃ Currently married, not living with a spouse or any other sexual partners <input type="checkbox"/> ₄ Not married, living with a sexual partner <input type="checkbox"/> ₅ Not married, not living with a sexual partner	→A-11 →Check Criteria																																																									
A-10	Does your husband have other wives?	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₈ Don't know																																																										
A-11	Have you ever given birth?	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes	→A-15																																																									
A-12	Have you ever had an unintended pregnancy?	<input type="checkbox"/> ₀ No <input type="checkbox"/> ₁ Yes																																																										
A-13	How many children have you ever delivered? IF NONE, RECORD '00'. □□																																																										
A-14	How many living children do you have? IF NONE, RECORD '00'. □□																																																										
A-15	Would you like to have (a/another) child in the future, or would you prefer not to have any (more) children?	<input type="checkbox"/> ₀ No more <input type="checkbox"/> ₁ Have (a/another) child <input type="checkbox"/> ₂ Undecided																																																										
A-16	Would your husband / live-in sexual partner like to have (a/another) child in the future, or would he prefer not to have any (more) children?	<input type="checkbox"/> ₀ No more <input type="checkbox"/> ₁ Have (a/another) child <input type="checkbox"/> ₂ Undecided <input type="checkbox"/> ₈ Don't know																																																										

B) CONTRACEPTIVE USE and HIV/STIs

	Questions	Responses	Skip
B-1	Did you use a male or female condom the last time you had sexual relations with your husband or live-in sexual partner?	<input type="checkbox"/> _0 No <input type="checkbox"/> _1 Yes, male condom <input type="checkbox"/> _2 Yes, fe male condom	
B-2	Apart from condoms, have you been using any other forms of protection against pregnancy during the past two months?	<input type="checkbox"/> _0 No <input type="checkbox"/> _1 Yes	→Check Criteria
B-3	Which method have you been using?	<input type="checkbox"/> _1 Injectables <input type="checkbox"/> _2 Implants <input type="checkbox"/> _3 IUD <input type="checkbox"/> _4 Pill <input type="checkbox"/> _5 Female sterilization <input type="checkbox"/> _6 Male sterilization <input type="checkbox"/> _7 Other method ()	
B-4	Since what month and year have you been using (METHOD ON LIST IN B-3) without stopping?	Month <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _88 Don't know month Year <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _88 Don't know year	
B-5	How often did you and your partner use a male or female condom during the past two months?	<input type="checkbox"/> _0 Never <input type="checkbox"/> _1 Sometimes <input type="checkbox"/> _2 Almost every time <input type="checkbox"/> _3 Every time <input type="checkbox"/> _8 Don't know <input type="checkbox"/> _9 No response	
B-6	Have you ever been told by a health care provider that you had HIV and STIs such as chlamydia, gonorrhea, or trichomonas infections?	<input type="checkbox"/> _0 No <input type="checkbox"/> _1 Yes <input type="checkbox"/> _8 Don't know <input type="checkbox"/> _9 No response	