Appendix VIII: Questionnaire - English

Version: 2.0, October 18, 2022

Instructions: Tick in the box provided on the left only answers of the respondent's choice that apply and not more than one option can be chosen. Additional answers may be added in the spaces provided.

Section A: Socio Demographic Data

1. Age_____[Years]

2. Which religion are you?

   a) Christian

   b) Muslim

3. What is your country of Origin?

……

4. What is your tribe?

……..

5. What is your education level?

   a) No education

   b) Primary

   c) Secondary and beyond

6. What is your occupation?

   a) Not working

   b) Working

7. What is your average monthly income? _____[UGX/Month]

8. Do you have any media exposure? (tick all that apply)

    a) Reads newspaper.

    b) Listens to radio.

    c) Watch television.

    d) Owns a mobile phone.

    e) None of the above

9. What is the sex of household lead?

    a) Male

    b) Female

10. What is your relation to household lead?

    a) Husband / Spouse

    b) Parent

    c) Relative

11. Have you ever had sex?

    a) Yes

    b) No

12. If yes, what was your age at first sex debut _____ [Age in years]

Section B: Pregnancy

13. Do you have the Intention-to-get pregnant in the next 12 months.

    a) Yes

    b) No

14. Do you have friends within the same age bracket who are pregnant?

    a) Yes

    b) No

15. Have you ever got peer pressure to get pregnant?

    a) Yes

    b) No

16. Have you ever gotten pregnant?

    a) Yes

    b) No

17. If yes, How many times? _____ [Number of pregnancies]

18. What was the outcome of pregnancy (tick all that apply)

    a) Live births [ ]

    b) Abortions [ ]

    c) Still birth [ ]

    d) Ectopic [ ]

19. If births, what was the mode of delivery? (tick all that apply)

    a) SVD

    b) C/S

20. If live births, did your baby get any neonatal complications?

    a) Yes

    b) No

21. If Yes, _____ [specify]

Section C: Marriage

22. Do you have friends within the same age bracket who are married?

    c) Yes

    d) No

23. Have you ever got peer pressure to get married?

    a) Yes

    b) No

24. What is your marital status?

    a) Married

    b) Unmarried

25. If married, what was your mode of marriage?

    a) Forced / Arranged.

    b) Willingly

Section D: Contraception

26. Have you ever used modern contraceptive methods

    a) Yes

    b) No

27. If Yes, which one (select all that applies)

    a) Pills

        i. Emergency pills

        ii. Combined oral contraceptive pills

    b) Condoms

c) Implants

d) Injectables

e) IUDs

f) Others _____ [specify]

28. Are you currently using modern contraceptive methods (within the last 3 months)

a) Yes

b) No

29. If yes, which one (select all that applies)

a) Pills

i. Emergency pills

ii. Combined oral contraceptive pills

b) Condoms

c) Implants

d) Injectables

e) IUDs

f) Others _____ [specify]

Section D: Other factors

30. Do you have both parents?

a) Yes

b) No

31. Have you ever received sex education from home (parents)?

    a) Yes

    b) No

32. Have you ever received contraceptives use training from home (parents)?

    a) Yes

    b) No

33. Have you ever received sex education from school (teachers)?

    a) Yes

    b) No

34. Have you ever received contraceptives use training from school (teachers)?

    a) Yes

    b) No

35. Have you ever been health educated about the dangers of teenage pregnancies?

    a) Yes

    b) No

36. Have you ever been sexually abused?

    a) Yes

    b) No

37. If Yes, who was the perpetrator?

    a) Parents

    b) Relatives

    c) Strangers

38. Have you ever been physically abused?

    a) Yes

    b) No

39. Do you take alcohol?

    a) Yes

    b) No

Depression Screening

PHQ-9 modified for Adolescents (age 12-17)

Over the last 2 weeks, how often have you been bothered by any of the following:

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, irritable or hopeless?	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired or having little energy?	0	1	2	3
5. Poor appetite, weight loss or overeating?	0	1	2	3
6. Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work, reading or watching TV?	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way?	0	1	2	3
If response to question 9 is in shaded squares, answer question 10 below. If response to question 9 is 0 → **STOP**.				

10. Have you had thoughts of actually hurting yourself?	YES	NO
Staff: Add score for 9 questions. Enter all information in PHQ-9 doc flowsheet. If question 10 response if YES, a **P4 ASSESSMENT IS NEEDED**.		

Additional Questions				
In the past year have you felt sad or depressed most days, even if you felt okay sometimes	YES		NO	
If you are experiencing any of the problems listed on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
Has there been a time in the past month when you had serious thoughts about ending your life?	YES		NO	
Have you **EVER** in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?	YES		NO	

Thank you for participating