



BTT ID

*University of the Witwatersrand  
Department of Paediatrics and Child Health*

**BIRTH TO TWENTY SITE: 16<sup>TH</sup> YEAR  
ADOLESCENT QUESTIONNAIRE  
SELF-COMPLETION**

TODAY'S DATE : Day  Month  Year

**THIS IS A CONFIDENTIAL QUESTIONNAIRE**

**Please carefully read through the following sets of questions and answer as truthfully as possible.**

**If you need any assistance with the understanding of the procedure or questions, please do not hesitate to contact a research assistant.**

**Your responses will be confidential, and your name will not appear anywhere on the questionnaire.**

**Once you have completed the questionnaire, please place it in the unmarked envelope and deposit it in the questionnaire box.**

**SECTION 1**

**FOR ALL QUESTIONS PLEASE TICK (✓) THE APPROPRIATE BOX**

**Question 1**

Have you ever tried or experimented with cigarette smoking, even 1 or 2 puffs?

<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
<b>If YOU TICK (✓) “NO”: go to page 5</b>	<b>If YOU TICK (✓) “YES”:</b> please answer the following question How old were you when you first tried a cigarette? <input type="text"/> years

**Question 2**

During the past **month (30 days)** did you smoke cigarettes?

<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
<p><b>If YOU TICK ( <math>\checkmark</math> )“NO”: go to page 5</b></p>	<p><b>If YOU TICK ( <math>\checkmark</math> )“YES”: please answer the following questions</b></p> <p>1. How often do you smoke? (Choose only <b>ONE</b> option)</p> <p>Every day <input type="checkbox"/> YES <input type="checkbox"/> NO how many cigarettes a day? <input type="checkbox"/></p> <p>A few times a week <input type="checkbox"/> YES <input type="checkbox"/> NO how many cigarettes a week? <input type="checkbox"/></p> <p>A few times a month <input type="checkbox"/> YES <input type="checkbox"/> NO how many cigarettes a month? <input type="checkbox"/></p>

2. Where do you usually smoke? (TICK AS MANY AS APPLY)

At home	
At school	
At work	
At friends' houses	
At social events (parties)	
In public spaces (eg parks, outside shopping centres)	
Other, please specify	

3. Where do you get the money to buy cigarettes?  
(TICK AS MANY AS APPLY)

Use pocket money	
Receive payments for work	
Lift/steal money from people in the house	
Lift/steal cigarettes from people in the house	
Bum cigarettes off friends	
I buy loose cigarettes one at a time	
Remix stompies	
Other, please specify	

4. Have you ever tried to quit smoking? NO  YES

**Question 3**

Do any of your main caregivers smoke?

father/male Caregiver	YES	NO
mother/female Caregiver	YES	NO

**Question 4**

Do you think you will smoke cigarettes or continue to smoke when you are an adult (18 years or older)?

No	
Yes	
Not sure	

**Question 5**

If one of your best friends offered you a cigarette, would you smoke it?

Definitely Not	
Probably Not	
Probably Yes	
Definitely Yes	

**Question 6**

Do any of your closest friends smoke cigarettes?

None of them	
Some of them	
Most of them	
All of them	

**Question 7**

Has anyone in your family discussed the risks of smoking with you?

YES	NO
-----	----

During the past 6 months at school were you taught in any of your classes about the risks of cigarette smoking?

YES	NO
-----	----

**Question 8**

In the last **month (30 days)** have you had **3** or more drinks in one sitting?

YES	NO
-----	----

In the last **month (30 days)** have you had more than **1** occasion where you have had **3** or more alcoholic drinks?

YES	NO
-----	----

**Question 9**

Have **YOU** ever used the following drugs in the last month (**30 days**)?

Marijuana (weed, dagga, grass)	<b>NO</b>	<b>YES</b>
Cocaine (coke/crack/rocks)	<b>NO</b>	<b>YES</b>
LSD, Magic Mushrooms, Acid	<b>NO</b>	<b>YES</b>
Sniffing Glue, Petrol, Thinners	<b>NO</b>	<b>YES</b>
Ecstasy	<b>NO</b>	<b>YES</b>
Speed (tik,tik)	<b>NO</b>	<b>YES</b>
Mandrax (pinks)	<b>NO</b>	<b>YES</b>
Other	<b>NO</b>	<b>YES</b>

**SECTION 2**

**Question 1**

Have you ever carried a weapon for protection or for any other reason?

<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
<b>If YOU TICK ( <math>\checkmark</math> ) “NO”: go to Question 2</b>	<b>If YOU TICK ( <math>\checkmark</math> ) “YES”: please answer the following question</b>  1. What type of weapon? Gun <input type="checkbox"/> Knife / blade <input type="checkbox"/> Stick / knobkerrie <input type="checkbox"/> Other <input type="checkbox"/>



**Question 2**

Do you know of a friend who has carried a weapon?

<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
<b>If YOU TICK ( <input checked="" type="checkbox"/> ) “NO”: go to Question 3</b>	<b>If YOU TICK ( <input checked="" type="checkbox"/> ) “YES”:</b> please answer the following question  1. What type of weapon? Gun <input type="checkbox"/> Knife / blade <input type="checkbox"/> Stick / knobkerrie <input type="checkbox"/> Other <input type="checkbox"/>

**Question 3**

Have you ever been physically hurt by -

friend	<b>NO</b>	<b>YES</b>
boyfriend / girlfriend	<b>NO</b>	<b>YES</b>
peers at school	<b>NO</b>	<b>YES</b>
family	<b>NO</b>	<b>YES</b>
strangers	<b>NO</b>	<b>YES</b>
others (please specify)		

**Question 4**

Have you ever been in trouble with the law?

 NO YES

### SECTION 3

#### Question 1

Have you ever discussed sex and/or contraceptive methods with the following people in the **last month (30 days)**:  
 (Please answer **EACH** item – use a tick  $\surd$  for **the appropriate answer**.)

	<b>Sex</b>		<b>Contraceptive Methods (condom, pill etc)</b>	
Your parents / caregivers	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Your friends	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Your teacher, counsellor or coach	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Your doctor or clinic nurse	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Others (please specify who)	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES
	Who _____		Who _____	

**Question 2**

Have you ever engaged in **foreplay** or **heavy petting** (kissing, fingering, romancing, NOT going "all the way") in the past **month (30 days)**?

<input type="checkbox"/> <b>NO</b>	<input type="checkbox"/> <b>YES</b>
<p><b>If YOU TICK ( <input type="checkbox"/> ) "NO": go to Question 5</b></p>	<p><b>If YOU TICK ( <input type="checkbox"/> ) "YES": please answer the following questions</b></p> <p>1. How old was the person you engaged with? <input type="text"/> Years</p> <p>2. Was this something you wanted to do? <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b></p>

**Question 4**

Have you engaged in **ORAL** sex in the **last month** (penis inserted into mouth,, open mouth kissing of the vagina)?

<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
<b>If YOU TICK ( √ )“NO”: go to Question 5</b>	<b>If YOU TICK ( √ ) “YES”:</b> please answer the following questions  3. How old was the person you engaged with? <input type="text"/> Years  4. Was this something you wanted to do?. <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>  5. Did you make use of a male condom / rubber / female condom? <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>  4. Did your partner make use of a male condom / rubber / female condom? <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>

**Question 4**

Have you ever had **SEX** (made love/ gone all the way/ penis inserted in vagina or anus)?

<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;"><b>NO</b></td> <td style="width: 30px; height: 20px;"></td> </tr> </table>	<b>NO</b>		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 10px;"><b>YES</b></td> <td style="width: 30px; height: 20px;"></td> </tr> </table>	<b>YES</b>						
<b>NO</b>										
<b>YES</b>										
<p><b>If YOU TICK ( <input type="checkbox"/> ) “NO”:</b> go to Question 6</p>	<p><b>If YOU TICK ( <input type="checkbox"/> ) “YES”:</b> please answer the following questions</p> <p>1. How old were you in years when you had sex? <table border="1" style="display: inline-table; border-collapse: collapse; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td></tr> </table> years</p> <p>2. How old was your first partner? <table border="1" style="display: inline-table; border-collapse: collapse; vertical-align: middle;"> <tr><td style="width: 20px; height: 20px;"></td></tr> </table> years</p> <p>3. Was this something you wanted to do? <table border="1" style="display: inline-table; border-collapse: collapse; vertical-align: middle;"> <tr> <td style="padding: 2px 10px;"><b>NO</b></td> <td style="padding: 2px 10px;"><b>YES</b></td> </tr> </table></p> <p>6. Did you make use of a male condom / rubber / female condom? <table border="1" style="display: inline-table; border-collapse: collapse; vertical-align: middle;"> <tr> <td style="padding: 2px 10px;"><b>NO</b></td> <td style="padding: 2px 10px;"><b>YES</b></td> </tr> </table></p> <p>5. Did your partner make use of a male condom / rubber / female condom? <table border="1" style="display: inline-table; border-collapse: collapse; vertical-align: middle;"> <tr> <td style="padding: 2px 10px;"><b>NO</b></td> <td style="padding: 2px 10px;"><b>YES</b></td> </tr> </table></p>				<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>
<b>NO</b>	<b>YES</b>									
<b>NO</b>	<b>YES</b>									
<b>NO</b>	<b>YES</b>									

**Question 5**

Have you had **SEX** in the **last month** (made love, gone all the way, penis inserted in vagina or anus)?

<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
<b>If YOU TICK (√) “NO”: go to Question 7</b>	<b>If YOU TICK (√) “YES”:</b> please answer the following questions  1. How old was your partner? <input type="text"/> years  2. Was this something you wanted to do? <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>  3. Did you make use of a male condom / rubber / female condom? <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>  4. Did your partner make use of a male condom / rubber / female condom? <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b>

**Question 6**

Do you know anyone who has been forced to have sex against their will in the last 6 months?

<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
	<p><b>If YOU TICK ( <input checked="" type="checkbox"/> ) “YES”: please answer the following question</b></p> <p>Who is this person you know has been forced to have sex against their will?</p> <p>1. Family member, sister, brother, cousin <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b></p> <p>2. Good friend at home or school <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b></p> <p>3. Someone you know or heard about <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>YES</b></p>



**Question 7**

Have you ever engaged with someone of the **same sex** as you in the following way:

(Please answer **EACH** item – use a tick ✓ for **the appropriate answer**.)

	Often	Sometimes	Once	Never
<b>Foreplay</b> or <b>heavy petting</b> (kissing, fingering, romancing, NOT going "all the way")				
<b>SEX</b> (made love/ gone all the way/ penis inserted in vagina or anus)				
<b>ORAL</b> sex (penis inserted into mouth, open mouth kissing of the vagina)				

**Section 4**

Are you male or female?

<b>Male</b>	<b>Female</b>
If you are <b>Male</b> complete  <b>Questions 7-12</b> (on page 25-30)	If you are <b>Female</b> complete  <b>Questions 1-6</b> (on page 19-24)

**Question 1 (Females only)**

Have you ever been pregnant?

<table border="1"><tr><td data-bbox="170 475 331 532"><b>No</b></td><td data-bbox="331 475 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1050 475 1213 532"><b>Yes</b></td><td data-bbox="1213 475 1381 532"></td></tr></table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( √ )“NO” please go to Question 6</b></p>	<p><b>IF YOU TICK ( √ )“YES” please go to the next page.</b></p>				

**Question 2 (Females only)**

Have you ever terminated (aborted) a pregnancy?

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"><b>No</b></td> <td style="width: 50%;"></td> </tr> </table>	<b>No</b>		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"><b>Yes</b></td> <td style="width: 50%;"></td> </tr> </table>	<b>Yes</b>					
<b>No</b>									
<b>Yes</b>									
<p><b>IF YOU TICK ( √ ) “NO” please go to Question 3</b></p>	<p><b>IF YOU TICK ( √ ) “YES” please answer the following questions</b></p> <ol style="list-style-type: none"> <li>1. How old were you when it happened? <input style="width: 40px; height: 25px;" type="text"/> years</li> <li>2. How old was the father of the child? <input style="width: 40px; height: 25px;" type="text"/> years</li> <li>3. Did the father of the child know? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="padding: 2px 10px;"><b>NO</b></td><td style="padding: 2px 10px;"><b>YES</b></td></tr></table></li> <li>4. Was this something you wanted to do? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="padding: 2px 10px;"><b>NO</b></td><td style="padding: 2px 10px;"><b>YES</b></td></tr></table></li> <li>5. Did your parents know? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="padding: 2px 10px;"><b>NO</b></td><td style="padding: 2px 10px;"><b>YES</b></td></tr></table></li> <li>6. Was this something your parents wanted you to do? <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="padding: 2px 10px;"><b>NO</b></td><td style="padding: 2px 10px;"><b>YES</b></td></tr></table></li> </ol>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>
<b>NO</b>	<b>YES</b>								
<b>NO</b>	<b>YES</b>								
<b>NO</b>	<b>YES</b>								
<b>NO</b>	<b>YES</b>								

**Question 3 (Females only)**

Have you ever miscarried a baby (lost your baby during pregnancy)?

<table border="1"><tr><td data-bbox="170 472 331 532"><b>No</b></td><td data-bbox="331 472 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1045 472 1213 532"><b>Yes</b></td><td data-bbox="1213 472 1381 532"></td></tr></table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( ✓ ) “NO” please go to QUESTION 4</b></p>	<p><b>IF YOU TICK ( ✓ ) “YES” please answer the following questions</b></p> <p>1. How old were you when it happened? <input data-bbox="1692 760 1766 837" type="text"/> years</p> <p>2. How old was the father of the child? <input data-bbox="1692 889 1766 967" type="text"/> years</p> <p>3. How many weeks pregnant were you? <input data-bbox="1692 1019 1766 1097" type="text"/> weeks</p>				

**Question 4 (Females only)**

Have you ever given birth to a baby (alive or stillborn)?

<table border="1"><tr><td data-bbox="170 472 331 532"><b>No</b></td><td data-bbox="331 472 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1045 472 1213 532"><b>Yes</b></td><td data-bbox="1213 472 1381 532"></td></tr></table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( <math>\checkmark</math> ) “NO” please go to QUESTION 5</b></p>	<p><b>IF YOU TICK ( <math>\checkmark</math> ) “YES” please answer the following questions</b></p> <p>1. How old were you when it happened? <input data-bbox="1703 808 1780 885" type="text"/> years</p> <p>2. How old was the father of the child? <input data-bbox="1703 927 1780 1003" type="text"/> years</p>				

**Question 5 (Females only)**

Are you currently pregnant?

<table border="1"><tr><td data-bbox="170 472 331 532"><b>No</b></td><td data-bbox="331 472 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1047 472 1209 532"><b>Yes</b></td><td data-bbox="1209 472 1381 532"></td></tr></table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( <math>\checkmark</math> ) “NO” please go to Question 6</b></p>	<p><b>IF YOU TICK ( <math>\checkmark</math> ) “YES” please answer the following questions</b></p> <p>1. How old is the father of the child? <input data-bbox="1711 768 1787 842" type="text"/> years</p> <p>2. How many weeks pregnant are you? <input data-bbox="1711 893 1787 967" type="text"/></p> <p>3. Have you decided to have the baby?</p> <table border="1"><tr><td data-bbox="1287 1105 1430 1174"><b>NO</b></td><td data-bbox="1430 1105 1575 1174"><b>YES</b></td></tr></table>	<b>NO</b>	<b>YES</b>		
<b>NO</b>	<b>YES</b>				

**Question 6 (Females only)**

If not pregnant, are you currently using contraception?

<table border="1"><tr><td data-bbox="170 479 331 532"><b>No</b></td><td data-bbox="331 479 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1050 479 1213 532"><b>Yes</b></td><td data-bbox="1213 479 1381 532"></td></tr></table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( √ ) “NO”</b> please place the questionnaire in the envelope and place it in the box!!</p> <p style="text-align: center;">Thank You!</p>	<p><b>IF YOU TICK ( √ ) “YES”</b>, what method of contraception is being used by you or your partner:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Injectable contraception (the injection)</li><li><input type="checkbox"/> Oral contraceptives (the pill)</li><li><input type="checkbox"/> Male condom</li><li><input type="checkbox"/> Female condom</li><li><input type="checkbox"/> Intra Uterine Device (the loop)</li><li><input type="checkbox"/> Rhythm</li><li><input type="checkbox"/> Withdrawal</li><li><input type="checkbox"/> Other (Please specify)</li></ul> <p>Please place the questionnaire in the envelope and place it in the box!!</p> <p style="text-align: center;">Thank You!</p>				



**Question 7 (Males only)**

Have you ever made a partner pregnant?

<table border="1"><tr><td data-bbox="170 470 331 532"><b>No</b></td><td data-bbox="331 470 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1050 470 1213 532"><b>Yes</b></td><td data-bbox="1213 470 1381 532"></td></tr></table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( <math>\checkmark</math> ) “NO” please please go to Question 12</b></p>	<p><b>IF YOU TICK ( <math>\checkmark</math> ) “YES” please go to the next page.</b></p>				

**Question 8 (Males only)**

Has a partner ever terminated (aborted) a pregnancy?

<table border="1"><tr><td data-bbox="170 472 331 532"><b>No</b></td><td data-bbox="331 472 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1045 472 1213 532"><b>Yes</b></td><td data-bbox="1213 472 1381 532"></td></tr></table>	<b>Yes</b>			
<b>No</b>							
<b>Yes</b>							
<p><b>IF YOU TICK ( <math>\checkmark</math> ) “NO” please go to Question 9</b></p>	<p><b>IF YOU TICK ( <math>\checkmark</math> ) “YES” please answer the following questions</b></p> <p>1. How old were you when it happened? <input data-bbox="1717 808 1791 881" type="text"/> years</p> <p>2. How old was the mother of the child? <input data-bbox="1717 898 1791 971" type="text"/> years</p> <p>3. Was this something you wanted to do? <table border="1" data-bbox="1612 1011 1896 1084"><tr><td data-bbox="1612 1011 1753 1084"><b>NO</b></td><td data-bbox="1753 1011 1896 1084"><b>YES</b></td></tr></table></p> <p>4. Did your parents know? <table border="1" data-bbox="1612 1125 1896 1198"><tr><td data-bbox="1612 1125 1753 1198"><b>NO</b></td><td data-bbox="1753 1125 1896 1198"><b>YES</b></td></tr></table></p> <p>5. Was this something your parents wanted you to do? <table border="1" data-bbox="1612 1239 1896 1312"><tr><td data-bbox="1612 1239 1753 1312"><b>NO</b></td><td data-bbox="1753 1239 1896 1312"><b>YES</b></td></tr></table></p>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>
<b>NO</b>	<b>YES</b>						
<b>NO</b>	<b>YES</b>						
<b>NO</b>	<b>YES</b>						

**Question 9 (Males only)**

Has a partner ever miscarried a baby (lost your baby during pregnancy)?

<table border="1"><tr><td data-bbox="170 472 331 532"><b>No</b></td><td data-bbox="331 472 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1045 472 1213 532"><b>Yes</b></td><td data-bbox="1213 472 1381 532"></td></tr></table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( √ ) “NO” please go to QUESTION 10</b></p>	<p><b>IF YOU TICK ( √ ) “YES” please answer the following questions</b></p> <p>1. How old were you when it happened? <input data-bbox="1692 764 1766 841" type="text"/> years</p> <p>2. How old was the mother of the child? <input data-bbox="1692 894 1766 971" type="text"/> years</p> <p>3. How many weeks pregnant was she? <input data-bbox="1692 1024 1766 1101" type="text"/></p>				

**Question 10 (Males only)**

Has a partner ever given birth to a baby (alive or stillborn)?

<table border="1"><tr><td data-bbox="170 470 331 532"><b>No</b></td><td data-bbox="331 470 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1050 470 1213 532"><b>Yes</b></td><td data-bbox="1213 470 1381 532"></td></tr></table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( √ ) “NO” please go to QUESTION 11</b></p>	<p><b>IF YOU TICK ( √ ) “YES” please answer the following questions</b></p> <p>1. How old were you when it happened? <input data-bbox="1696 808 1772 883" type="text"/> years</p> <p>2. How old was the mother of the child? <input data-bbox="1696 938 1772 1013" type="text"/> years</p>				

**Question 11 (Males only)**

Is your partner currently pregnant?

<table border="1"><tr><td data-bbox="170 472 331 532"><b>No</b></td><td data-bbox="331 472 453 532"></td></tr></table>	<b>No</b>		<table border="1"><tr><td data-bbox="1045 472 1213 532"><b>Yes</b></td><td data-bbox="1213 472 1381 532"></td></tr></table>	<b>Yes</b>			
<b>No</b>							
<b>Yes</b>							
<p><b>IF YOU TICK ( √ ) “NO” please go to Question 12</b></p>	<p><b>IF YOU TICK ( √ ) “YES” please answer the following questions</b></p> <p>1. How old is the mother of the child? <table border="1"><tr><td data-bbox="1688 764 1766 841"></td></tr></table> years</p> <p>2. How many weeks pregnant is she? <table border="1"><tr><td data-bbox="1688 857 1766 933"></td></tr></table></p> <p>3. Has she decided to have the baby? <table border="1"><tr><td data-bbox="1619 959 1766 1029"><b>NO</b></td><td data-bbox="1766 959 1913 1029"><b>YES</b></td></tr></table></p> <p>4. Has she decided to keep the baby? <table border="1"><tr><td data-bbox="1619 1052 1766 1122"><b>NO</b></td><td data-bbox="1766 1052 1913 1122"><b>YES</b></td></tr></table></p>			<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>
<b>NO</b>	<b>YES</b>						
<b>NO</b>	<b>YES</b>						

**Question 12 (Males only)**

If not pregnant, is your partner currently using contraception?

<table border="1"> <tr> <td data-bbox="170 479 331 532"><b>No</b></td> <td data-bbox="331 479 453 532"></td> </tr> </table>	<b>No</b>		<table border="1"> <tr> <td data-bbox="1050 479 1213 532"><b>Yes</b></td> <td data-bbox="1213 479 1381 532"></td> </tr> </table>	<b>Yes</b>	
<b>No</b>					
<b>Yes</b>					
<p><b>IF YOU TICK ( √ ) “NO”</b> please place the questionnaire in the envelope and place it in the box!!</p> <p style="text-align: center;">Thank You!</p>	<p><b>IF YOU TICK ( √ ) “YES”</b>, what method of contraception is being used by you or your partner:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Injectable contraception (the injection)</li> <li><input type="checkbox"/> Oral contraceptives (the pill)</li> <li><input type="checkbox"/> Male condom</li> <li><input type="checkbox"/> Female condom</li> <li><input type="checkbox"/> Intra Uterine Device (the loop)</li> <li><input type="checkbox"/> Rhythm</li> <li><input type="checkbox"/> Withdrawal</li> <li><input type="checkbox"/> Other (Please specify)</li> </ul> <p>Please place the questionnaire in the envelope and place it in the box!!</p> <p style="text-align: center;">Thank You!</p>				