QUESTIONNAIRE: ADOLESCENT MOTHERS

Please answer each question by placing a cross (x) in the correct box for each question

SECTION A

1 How old were you at your last birthday?

11	
12	
13	
14	
15	
16	
17	
18	
19	

2 What is your race group?

African	
Coloured	
Indian	
White	

3 What is your home language?

Zulu	
Swazi	
English	
Afrikaans	
Xhosa	
Other: specify	

4 Highest school grade passed?

Grade 1-3	
Grade 4-6	
Grade 7-9	
Grade 10-12	
Other: specify	

5 What is your household monthly (30 days) income?

R0-R999	
R1 000-R1 999	
R2 000-R2 999	
R3 000-R3 999	
R4 000-R4 999	
R5 000-R5 999	
R6 000 and more	

SECTION B

6 How old were you when you had sex for the first time?

11	
12	
13	
14	
15	
16	
17	
18	
19	

7 Why did you have sex for the first time?

Did not know	
Love for partner	
Requested by partner	
Peer pressure	
Other: specify	

8 How many children do you have?

1	
2	
3	
4	
5	

9 How old were you when your first child was born?

11	
12	
13	
14	
15	
16	
17	
18	
19	

10 At what age did you receive information about?

Information	**Age**
Menstruation	
Sexual intercourse	
Pregnancy	
Contraceptives/family planning	

11 From whom did you receive information? Please cross on all relevant.

Mother	
Father	
Teacher	
Friend	
Clinic nurse	
Television	
Radio	
Magazine/newspaper	
Other: specify	

12 How was the information presented?

Book	
Video	
Lecture	
Personal discussion	
Other: specify	

SECTION C

13 Have you ever visited the clinic for contraceptives/family planning?

Yes	
No	

14 Have you ever used contraceptives/family planning?

Yes	
No	

15 Which contraceptive/family planning method?

Pills	
Injectables	
Intra-uterine contraceptive device (IUCD)	
Condoms	
Other: specify	

16 Were you allowed to choose a method at the clinic?

Yes	
No	

17 Have you ever used traditional family planning methods?

Yes	
No	

18 Which traditional contraceptive/family planning method?

Tying a rope around the waist	
Mixing medicines with menstrual blood	
Drinking traditional medicines	
Other: specify	

19 Did you experience any problems with receiving contraceptives/family planning or information?

Yes	
No	

20 If yes to question 19, please explain.

_____
_____
_____
_____
_____

21 Did you have knowledge about contraceptives/family planning before you became pregnant?

Contraceptive type	**Yes**	**No**
Emergency contraceptives (EC)		
Oral contraceptives/pills		
Injectables: Depo-provera		
Nur-isterate		
Intra-uterine contraceptive device (IUCD)		
Condoms		
Other: specify		

22 Did you actually use contraceptives before you became pregnant?

Yes	
No	

23 If yes to question 22, which one?

Emergency contraceptives (EC)	
Oral contraceptives/pills	
Injectables: Depo-provera	
Nur-isterate	
Intra-uterine contraceptive device (IUCD)	
Condoms	
Other: specify	

24 Have you experienced side-effects of contraceptives used, which one?

Spotting or bleeding between periods	
Nausea/vomiting	
Headaches	
Weight gain	
Amenorrhoea (absence of menstruation)	
Other: specify	

25 What was the reason for stopping contraceptives?

_____
_____
_____
_____
_____

26 Do you use contraceptives since baby's birth?

Yes	
No	

27 Which contraceptive/family planning?

Emergency contraceptives (EC)	
Oral contraceptives/pills	
Injectables: Depo-provera	
Nur-isterate	
Intra-uterine contraceptive device (IUCD)	
Condoms	
Other: specify	

28 Did you receive knowledge about side-effects of contraceptives?

Yes	
No	

29 If yes to question 28, from whom?

Mother	
Father	
Teacher	
Friend	
Clinic nurse	
Television	
Radio	
Magazine/newspaper	
Other: specify	

30 Are contraceptives available at your nearest clinic?

Always	
Sometimes	
Unknown	
Not available	
Other: specify	

31 Advice received at clinic during visit for contraceptives/family planning.

Condoms	
HIV/AIDS	
Other: specify	

32 How far is the distance from home to the nearest clinic?

0-5 km	
5-10 km	
15-20 km	
20 km and more	

33 What type of clinic do you use?

Fixed clinic (07:00-16:00)	
Mobile clinic (once a month)	
Community health center (24 hours)	
Other: specify	

34 What are the clinic operating days of the week? Please cross on all relevant.

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

35 Are contraceptive services offered at your nearest clinic?

All the time	
On specific days	
On specific times	
Other: specify	

36 How can you rate the clinic staff?

Very friendly	
Friendly	
Unfriendly	
Extreme unfriendly	

37 Was the clinic staff respectful?

Yes	
No	

38 What are your beliefs about contraceptives?

_____
_____
_____
_____
_____

SECTION D

39 Have you heard about termination of pregnancy (TOP)?

Yes	
No	

40 What do you know about TOP?

_____
_____
_____
_____
_____

41 Have you ever had an abortion?

Yes	
No	

42 If yes to question 41, reason.

_____
_____
_____
_____
_____

43 Where did the abortion take place?

Hospital/doctor	
Clinic	
Traditional healer	
Home	
Other: specify	

44 If you could access TOP services, would you use TOP services for another unwanted pregnancy?

Yes	
No	

45 Do you experience problems with TOP services?

Yes	
No	

46 If yes to question 45, explain.

_____
_____
_____
_____
_____

Comments or problems.

_____
_____
_____
_____
_____

WE TRUST THAT THE INFORMATION YOU SHARED WITH US WILL HELP TO ENABLE MORE YOUND ADOLESCENTS TO MAKE BETTER INFORMED DECISIONS.

THANK YOU!!