## Questionnaire (English Version)

**General information**

For each question, make a circle around the spelling that corresponds to the answer; fill the blanks with the answer or mark “x”.

1. Participant’s code number: \_\_\_\_\_\_\_\_\_\_\_\_

**CASE Positive CONTROL Negative**

**Part 1: Socio-demographic characteristics**

|  |  |  |  |
| --- | --- | --- | --- |
| S.No | Question | Response | Skip |
| 1.1 | How old are you? (completed years) | \_\_\_\_\_\_\_\_\_\_\_ |  |
| 1.2 | What is your level of education? | 1. Don’t write and read 2. Only read and write 3. Primary (1-4) 4. Primary (5-8) 5. Secondary (9-10) 6. Preparatory (11-12) 7. Diploma or technical/vocational 8. Higher (bachelor degree and above) |  |
| 1.3 | What is your marital status? | 1. Single 2. Married   C. Widowed  D. Divorced  E. Separated |  |
| 1.4 | How old were you when you first marriage? (If she is already married once) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 1.5 | How much is your family average monthly income(ETB) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 1.6 | What is your current occupation status? | A. House wife  B. Merchant  C. Daily laborer  D. Governmental employee  E. Private/NGO employee  F. Others (specify\_\_\_\_\_\_\_\_\_\_) |  |
| 1.7 | What is your religion? | A. Orthodox Christian  B. Muslim  C. Protestant  D. Catholic  E. Others(specify\_\_\_\_\_\_\_\_\_\_) |  |

**Part 2: Questions related to reproductive health factors**

|  |  |  |  |
| --- | --- | --- | --- |
| 2.1 | Do you ever use contraceptive? | 1. Yes 2. No | 2.4 |
| 2.2 | If answer for Q 2.1 yes, which type of contraceptive do you use? (you can choose more than one choice) | A. Pill  B. Injectable (Depo)  C. Implant  D. Others (specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |
| 2.3 | For how long have you been using contraception? |  |  |
| 2.4 | How old were you when you menarche? | \_\_\_\_\_\_\_\_\_\_\_ |  |
| 2.5 | How was your menstrual history? | A. Regular  B. Sometimes irregular  C. Always irregular  D. No menses, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 2.6 | Have you ever-experienced post coital bleeding? | 1. Yes B. No |  |
| 2.7 | Have you ever give birth? | 1. Yes B. No | 2.11 |
| 2.8 | If answer for Q 2.12 yes, how many times? | \_\_\_\_\_\_\_\_\_\_\_ |  |
| 2.9 | How old were you when you first birth? | \_\_\_\_\_\_\_\_\_ |  |
| 2.10 | What is the average birth interval between your births? (if she has two or more births) | \_\_\_\_\_\_\_\_\_ |  |
| 2.11 | Have you ever-experienced abortion? | 1. Yes B. No | 2.13 |
| 2.12 | If answer for Q 2.17 yes, how many times? | \_\_\_\_\_\_\_\_\_\_\_ |  |
| 2.13 | Do you have family (mother or sister) history of cervical cancer? | 1. Yes B. No |  |
| **Part 3: Questions related to lifestyle and sexual behavior factors** | | |  |
| 3.1 | Have you ever been screened for cervical cancer before? | 1. Yes B. No | 3.4 |
| 3.2 | If answer for Q 3.1 yes, when were you screened for the last time? | \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 3.3 | What was the result of that screening test? | A. Positive B. Negative |  |
| 3.4 | Have you ever smoke? | A. Yes B. No | 3.6 |
| 3.5 | If yes, how long you have been smoke? | \_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 3.6 | How old were you when you first had sex? | \_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 3.7 | Do you use condom whenever you are having sex? | 1. Always B. Sometimes   C. Never |  |
| 3.8 | Have you ever been told you that you had a pelvic infection or treated by health professionals? | A. Yes B. No |  |
| 3.9 | Have you had a sexually transmitted infection in your lifetime? | A. Yes B. No |  |
| 3.10 | Does your partner ever have history of STIs? | A. Yes B. No |  |
| 3.11 | Do you ever have history of genital ulcer or swelling? | A. Yes B. No |  |
| 3.12 | Does your partner ever have history of genital ulcer or swelling? | A. Yes B. No |  |
| 3.13 | Have you been tested for HIV before? | 1. Yes B. No | 3.16 |
| 3.14 | If answer for Q 3.20 yes, what was the result? | 1. Positive B. Negative   C. Unknown |  |
| 3.15 | If answer for Q 3.21 positive, did you start antiretroviral therapy? | 1. Yes B. No |  |
| 3.16 | How many sexual partners have you had in your lifetime? | \_\_\_\_\_\_\_\_\_\_\_ |  |
| 3.17 | Does your partner have other partners? | A. Yes B. No |  |
| 3.18 | If answer for Q 3.24 yes, how many? | \_\_\_\_\_\_\_\_\_\_\_ |  |

**Thank you!**