

STUDY ID: _____ - ____ - _____

Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

Date: ____ / ____ / ____

D D M M M Y Y Y Y

Staff Administered: _____

MALE PARTNER Enrollment Questionnaire

City: _____

Clinic: _____

First, I will start with some questions about you.

1. What is your birthdate?

____ / ____ / ____ ₇₇ *Don't know* ₈₈ *Refused*
D D M M M Y Y Y Y

2. What is the highest level of education that you have completed?

₁ Less than primary ₂ Primary ₃ Secondary ₄ Technical ₅ University or more ₀ None
 ₇₇ *Don't know* ₈₈ *Refused*

3. What type of health insurance do you have?

₁ Contributory ₂ Subsidized ₃ Not insured ₄ Specialized ₅ Exception
 ₆ Indeterminate / independent ₇₇ *Don't know* ₈₈ *Refused*

4. What is the name of your health insurance provider?

Name: _____ ₇₇ *Don't know* ₈₈ *Refused*

The next questions are about mosquito bites.

5. In the past 7 days, how many mosquito bites did you get?

₀ None ₁ Less than 20 ₂ 20 or more, or too many to count ₇₇ *Don't know* ₈₈ *Refused*

6. In the past 7 days, how often have you done the following things? Response options include never, some of the time, or always.

| | Never ₀ | Some of the time ₁ | Always ₂ | <i>Don't know</i> ₇₇ | <i>Refused</i> ₈₈ |
|------------------------------|--------------------|-------------------------------|---------------------|---------------------------------|------------------------------|
| Worn long pants that covered | | | | | |

| | | | | | |
|---|--|--|--|--|--|
| your legs | | | | | |
| Worn shirts or jackets with long sleeves that covered your arms | | | | | |
| Kept your ankles and feet completely covered | | | | | |
| Used mosquito repellent | | | | | |

The next questions are about what you might have heard about Zika virus.

7. Do you think it's possible for a person to get Zika virus in your community?

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

8. Do you think that everybody with Zika virus has symptoms?

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

9. Do you know anyone who has had Zika virus?

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

↳ Have you had Zika virus?

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

10. How worried have you been about getting Zika virus during your partner's current pregnancy?

₃ Very worried ₂ Somewhat worried ₁ Not at all worried
₇₇ *Don't know* ₈₈ *Refused*

11. Momentarily, I will give you a number of statements about Zika virus; we ask that you respond if you consider it to be "very likely", "somewhat likely", or "impossible" that Zika can be transmitted by any one of these means.

| | Very likely ₂ | Somewhat likely ₁ | Impossible ₀ | <i>Don't know</i> ₇₇ | <i>Refused</i> ₈₈ |
|---|--------------------------|------------------------------|-------------------------|---------------------------------|------------------------------|
| Being bitten by an infected mosquito | | | | | |
| Having vaginal sex with a woman who has Zika without using a condom | | | | | |
| Kissing someone on the mouth who has Zika | | | | | |
| Shaking hands with someone who has Zika | | | | | |
| Being coughed or sneezed on by someone who has Zika | | | | | |
| Receiving a blood transfusion with Zika in it | | | | | |
| Being in utero if a mother has Zika during pregnancy | | | | | |

12. Momentarily, I will give you a number of statements about the possible effects on a baby if their mother was infected with Zika during her pregnancy; we ask that you respond if you consider it to be “very likely”, “somewhat likely”, or “impossible” that a baby could be born with the following conditions:

| | Very likely ₂ | Somewhat likely ₁ | Impossible ₀ | Don't know ₇₇ | Refused ₈₈ |
|--|--------------------------|------------------------------|-------------------------|--------------------------|-----------------------|
| Microcephaly (a small sized head) | | | | | |
| Other birth defects | | | | | |
| Intrauterine growth restriction (small baby) | | | | | |
| Miscarriages/stillbirths | | | | | |

The next questions are about Zika symptoms you might have had.

13. In the past 3 months, have you had symptoms of Zika virus? Symptoms of Zika virus means being sick with 2 or more of fever, rash, red eyes, and joint pain that are not explained by other causes.

₁ Yes ₀ No ₇₇ Don't know ₈₈ Refused

↳ When?

₇₇ Don't know ₈₈ Refused
 _ _ / _ _ _ / _ _ _ _
 D D M M M Y Y Y Y

14. At any time, has a doctor or healthcare provider ever told you that you might have Zika virus?

₁ Yes ₀ No ₇₇ Don't know ₈₈ Refused

↳ When?

₇₇ Don't know ₈₈ Refused
 _ _ / _ _ _ / _ _ _ _
 D D M M M Y Y Y Y

Next I'll ask you some questions about your job.

15. In the past 3 months, have you worked at a job? Include jobs in which you don't have a formal employer, such as selling goods or providing services.

₁ Yes ₀ No ₇₇ Don't know ₈₈ Refused

↳ Have any of your jobs in the past 3 months involved the following:

| | |
|--|---|
| Battery manufacturing or battery recycling | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused |
| Electronic waste recycling | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused |
| Gold mining or gold processing | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused |
| Other metal mining (for example, uranium, nickel, or cobalt) | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused |
| A job in which you or your coworkers use lead | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused |
| A job in which you or your coworkers use mercury | <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ Don't know <input type="checkbox"/> ₈₈ Refused |

Now I'll ask you about your health.

16. Have you ever had...?

16a. Yellow fever

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

└─→ When?

| | | | | |
|------------------------|---|--|--|---|
| Less than 3 months ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| Between 3-6 months ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| 7-12 months ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| 13 months-5 years ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| More than 5 years ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |

16b. Dengue

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

└─→ When?

| | | |
|------------------------|---|--|
| Less than 3 months ago | <input type="checkbox"/> ₁ Yes ─→ <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> | Was it hemorrhagic? <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> |
| Between 3-6 months ago | <input type="checkbox"/> ₁ Yes ─→ <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> | Was it hemorrhagic? <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> |
| 7-12 months ago | <input type="checkbox"/> ₁ Yes ─→ <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> | Was it hemorrhagic? <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> |
| 13 months-5 years ago | <input type="checkbox"/> ₁ Yes ─→ <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> | Was it hemorrhagic? <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> |
| More than 5 years ago | <input type="checkbox"/> ₁ Yes ─→ <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> | Was it hemorrhagic? <input type="checkbox"/> ₁ Yes <input type="checkbox"/> ₀ No <input type="checkbox"/> ₇₇ <i>Don't know</i> <input type="checkbox"/> ₈₈ <i>Refused</i> |

16c. Chikungunya

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

└─→ When?

| | | | | |
|------------------------|---|--|--|---|
| Less than 3 months ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
|------------------------|---|--|--|---|

| | | | | |
|------------------------|---|--|--|---|
| Between 3-6 months ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| 7-12 months ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| 13 months-5 years ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| More than 5 years ago | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |

17. Have you ever been vaccinated for yellow fever?

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

18. In the past 3 months, have you smoked cigarettes?

₁ Yes ₀ No ₇₇ *Don't know* ₈₈ *Refused*

These next few questions are about your recent sexual experiences. You do not have to answer any questions if they make you uncomfortable.

19. In the past 3 months, how many women have you had sex with?

₀ None **→ End of questionnaire**
₁ 1
₂ 2
₃ 3 or more
₇₇ *Don't know* **→ End of questionnaire**
₈₈ *Refused* **→ End of questionnaire**

20. In the past 3 months, how often have you had vaginal sex with a woman? Choose the best answer.

₁ Once a day or more (7 times or more per week)
₂ 2-6 times a week
₃ Once a week (4 times per month)
₄ 2-3 a month
₅ Once a month
₆ Less than once a month
₀ Never **→ Go to question #22**
₇₇ *Don't know* **→ Go to question #22**
₈₈ *Refused* **→ Go to question #22**

21. When you had vaginal sex in the past 3 months, how often have you used a condom?

₂ Always ₁ Sometimes ₀ Never ₇₇ *Don't know* ₈₈ *Refused*

22. In the past 3 months, have you...?

| | | | | |
|--------------------------------|---|--|--|---|
| Received oral sex from someone | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| Performed oral sex on someone | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |
| Had anal sex | <input type="checkbox"/> ₁ Yes | <input type="checkbox"/> ₀ No | <input type="checkbox"/> ₇₇ <i>Don't know</i> | <input type="checkbox"/> ₈₈ <i>Refused</i> |

23. Since you found out that your partner was pregnant, have you changed how often you use condoms during sex with your partner?

₁ Yes, I use them more often
₂ Yes, I use them less often

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- ₃ No, I haven't changed how often I use condoms
- ₄ No, we don't use condoms
- ₀ I haven't had regular sex with my partner
- ₇₇ *Don't know*
- ₈₈ *Refused*

Thank you for answering this questionnaire. Do you have any questions?