CONFIDENTIAL QUESTIONNAIRE ADOLESCENTS AND YOUTH
AGE 10 – 24 YEARS

CHIVA SOUTH AFRICA
MENTORING. PARTNERING. SAVING LIVES.

Thank you for taking the time to share your opinions with us about adolescent and youth services at this clinic. Your answers will remain confidential and will only be used for the purpose of improving services provided to all young people at the clinic.

Are you: **Male** ☐ **Female** ☐ **Transgender** ☐ **Other** _____

How old are you? _____ **Years**

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1. What service(s) do you use at the clinic? (Please tick all that apply)

TB Treatment ☐ HIV Testing Services ☐ HIV Treatment ☐ Information ☐

Mental Health ☐ Pregnancy Prevention/Family Planning ☐ Pregnancy Care ☐

STI Treatment ☐ Smoking Support ☐ Alcohol Support ☐ Drug Abuse Support ☐

Physical Abuse/Violence ☐ Sexual Abuse/Assault ☐ Other (please specify) _____

2. What makes this clinic a good place for adolescents/youth to attend? What is good about this clinic?

_____
_____
_____
_____
_____

3. What are the challenges for adolescents/youth using this clinic? What do you not like about this clinic?

_____
_____
_____
_____
_____

PLEASE TURN OVER

4. Please tell us how important the following are for you (please tick <u>one</u> for each issue)

	Most important	Very important	A little important	Not important	Not sure
Confidentiality					
Clinic open in evenings/at weekend					
Family planning					
Respect from staff					
Staff attitude					
Distance from home/school					
Support group					
Chill Room					
Counselling services					
Happy Hour					

5. What suggestions do you have to improve the service for adolescents/youth using this clinic?

_____
_____
_____
_____
_____
_____

6. Any other comments you would like to tell us?

_____
_____
_____
_____
_____
_____

Thank you for helping us to improve services to adolescents and youth attending this clinic!