



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

**BIRTH TO TWENTY: 15<sup>TH</sup> YEAR  
ADOLESCENT QUESTIONNAIRE  
MOBILE SELF-COMPLETION**

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.**

### **Question 1**

Have you ever discussed sex and/or contraceptive methods with the following people:  
(Please answer **EACH** item – use  $\surd$  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)       |                             |                              |   |                              |

**Question 2**

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

| <b>NO</b>                              | <b>YES</b>   |
|--|--|
| <b>If YOU ✓ “NO”: go to Question 3</b> | <b>If YOU ✓ “YES”: please answer the following questions</b><br><br>1. How old were you in years when this first happened? <input data-bbox="1766 680 1908 751" type="text"/><br>2. How old was your first partner? <input data-bbox="1766 751 1908 823" type="text"/><br>3. How old was, or is, your most recent partner? <input data-bbox="1766 823 1908 886" type="text"/><br>4. Was this something you wanted to participate in; you were not forced?<br><br><input data-bbox="978 1097 1121 1169" type="checkbox"/> <b>NO</b> <input data-bbox="1358 1097 1501 1169" type="checkbox"/> <b>YES</b> |

**Question 3**

Have you ever engaged in **ORAL** sex (penis inserted into mouth)?

| <b>NO</b>                              | <b>YES</b>   |
|--|--|
| <b>If YOU √ “NO”: go to Question 4</b> | <b>If YOU √ “YES”: please answer the following questions</b><br><br>1. How old were you in years when this first happened? <input data-bbox="1764 722 1911 787" type="text"/><br>2. How old was the first person you engaged with? <input data-bbox="1764 795 1911 860" type="text"/><br>3. Was this something you wanted to do; you were not forced?<br><br><input data-bbox="976 1015 1123 1079" type="checkbox"/> <b>NO</b> <input data-bbox="1354 1015 1501 1079" type="checkbox"/> <b>YES</b> |

**Question 4**

Have you engaged in **ORAL** sex in the last month (penis inserted into mouth)?

| <b>NO</b>                              | <b>YES</b>  |
|--|---|
| <b>If YOU ✓ “NO”: go to Question 4</b> | <b>If YOU ✓ “YES”: please answer the following questions</b><br><br>1. How old was the person you engaged with? <input data-bbox="1766 751 1906 824" type="text"/><br><br>2. Was this something you wanted to do, and you were not forced?<br><br><input data-bbox="978 971 1121 1044" type="checkbox"/> <b>NO</b> <input data-bbox="1360 971 1503 1044" type="checkbox"/> <b>YES</b> |

**Question 5**

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

| <b>NO</b>                              | <b>YES</b>  |
|--|---|
| <b>If YOU ✓ “NO”: go to Question 5</b> | <b>If YOU ✓ “YES”: please answer the following questions</b><br><br>1. How old were you in years when you had sex? <input data-bbox="1766 766 1906 837" type="text"/><br>2. How old was your first partner? <input data-bbox="1766 837 1906 909" type="text"/><br>3. Was this something you wanted to participate in; you were not forced?<br><br><input data-bbox="978 1055 1121 1127" type="checkbox"/> <b>NO</b> <input data-bbox="1358 1055 1501 1127" type="checkbox"/> <b>YES</b> |

**Question 6**

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

| <b>NO</b>                              | <b>YES</b>   |
|--|--|
| <b>If YOU ✓ “NO”: go to Question 5</b> | <b>If YOU ✓ “YES”: please answer the following questions</b><br><br>1. How old was your partner? <input data-bbox="1766 789 1913 862" type="text"/><br><br>2. Was this something you wanted to participate in; you were not forced?<br><br><input data-bbox="978 1013 1121 1086" type="checkbox"/> <b>NO</b> <input data-bbox="1358 1013 1501 1086" type="checkbox"/> <b>YES</b> |

**Question 7**

Do you know anyone who has been forced to have sex against their will?

| <b>NO</b> | <b>YES</b>   |  |  |  |
|-----------|--|--|--|--|
|           | <p><b>If YOU ✓ “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> <ol style="list-style-type: none"><li>1. Family member, sister, cousin</li><li>2. Good friend at home or school</li><li>3. Someone you know or heard about</li></ol> <table border="1" data-bbox="1766 808 1913 1027"><tr><td></td></tr><tr><td></td></tr><tr><td></td></tr></table> |  |  |  |
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