

Acknowledgements

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Suzanne Borgelin

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Abstract (English)

Background

There are approximately 1,8 billion young people in this world, with 200 million living in Africa, making it the youngest continent in the world. Children and youth are commonly seen as the hope for the future, and youth is usually associated with good health. However, in low and middle-income countries, poverty and lack of access to education is a challenge. Many young people enter into sexual activities, some of which are non-consensual, without sufficient information or access to protective services. Thus it is imperative that young people have access to health services, which are specifically targeted to their needs. In 2015, the World Health Organisation launched eight global standards for quality health care services for adolescents, aiming to improve the quality of health care services to be more suitable for adolescents. Hence they will find it easier to promote, protect and improve their own health and well-being.

Objective

The main aim of this thesis was to develop an understanding of young people's perceptions of, and access to, adolescent friendly health care in Western Cape, South Africa; to what extent they perceived the quality and "friendliness" of health care services, and how this relates to the WHO global standards for quality health care services for adolescents. In addition, the thesis aims to discuss the implications of the study findings for the development of effective interventions.

Method

A mixed methods approach was used with data from the PREPARE study. Two separate studies with two different groups of participants. One source of data is questionnaires among grade eight students and the other comes from data gathered from in-depth interviews with students, health and social workers. The theory of triadic influence was used as a guiding framework.

Results

Results showed that there were contradictions in how the young people in the study *perceived* the access to sexual and reproductive health care, and how *available* the access really was. Young people do have access to reproductive health services and there are laws and policies in place that support young people's sexual and reproductive rights; however, low levels of health literacy, self-confidence, IPV – low levels of trust in the community, stigma and

privacy and confidentiality issues were important factors that contributed to young people's perceptions of barriers to access.

Conclusion

The study confirms what earlier studies have shown when it comes to the importance of support and acceptance from society for young people's need for sexual and reproductive health services. Although there is an offer to sexual and reproductive health services for young people in Western Cape, South Africa, and there are laws and policies in place that support young people's right to reproductive health, access is inadequate and has several shortcomings compared with the World Health Organization's quality standards. Standard 2 which deals with support from the community went again as the main standard.

Key words: access; quality; friendliness; sexual and reproductive health; theory of triadic influence; adolescents; young people; WHO global standards

Sammendrag (Norsk)

Bakgrunn

Av verdens 1,8 milliarder unge mennesker, lever 200 millioner i Afrika – noe som gjør kontinentet til det yngste i verden. Barn og unge er vanligvis assosiert med å være håpet for fremtiden, og det å være ung sees ofte i sammenheng med å ha ideell helse, men virkeligheten for mange unge mennesker betyr i realiteten økt sårbarhet og en tid med økt risiko. Mangelfull informasjon om beskyttelse mot seksuelt overførbare sykdommer og dårlig tilgang til seksuelle og reproduktive helsetjenester, fører til at de kommer i situasjoner med økt risiko for seksuelt overførbare sykdommer, uønskede eller uplanlagte svangerskap, seksuell mishandling, trakkassering og mentale helseproblemer assosiert med disse potensielle risikoene.

Hensikt

Hovedmålet med denne studien er å skape en forståelse av unge menneskers opplevelse av og tilgang til seksuelle og reproduktive helsetjenester i Western Cape, Sør – Afrika. Det var også et mål og undersøke i hvilken grad unge mennesker oppfattet vennligheten og kvaliteten ved helsetjenestene, og undersøke funnene i lys av verdens helseorganisasjons standarder på kvalitet i helseklinikker for ungdom. Til slutt var målet å undersøke hvilke implikasjoner som fantes for å kunne utvikle effektive intervensjoner.

Metode

Studien er basert på kvalitative dybdeintervjuer av studenter, helsearbeidere og sosialarbeidere samt kvantitative data innhentet via spørreskjema blant 8. klassinger. Data fra spørreskjemaet ble i hovedsak brukt for å gi et overblikk over situasjonen, og dybdeintervjuene gav mulighet for å få en dypere forståelse av opplevelse av helsetjenestene. Modellen, Theory of Triadic Influence, ble brukt som rammeverk.

Resultater

Resultatene viste at det var motsetninger i hvordan ungdommene i studien opplevde tilgangen og hvor tilgjengelig tilgangen til helsetjenestene egentlig var. Lav helseforståelse, lav selvtillit, vold i nære relasjoner og lave nivåer av tillit i samfunnet, stigmatisering og konfidensialitet var viktige faktorer som bidro til unge menneskers oppfatninger av barrierer for tilgang. Andre årsaker var ventetider, åpningstider og personvern og konfidensialitet

Konklusjon

Studien bekrefter det tidligere studier har vist når det gjelder viktigheten av støtte og aksept fra samfunnet for ungdommers behov for seksuelle og reproduktive helsetjenester. Selv om det finnes et tilbud til seksuelle og reproduktive helsetjenester for ungdom i Western Cape, Sør Afrika, og det er lover og retningslinjer på plass som støtter unges rett til reproduktive helsetjenester, er tilgangen utilstrekkelig og har flere mangler sammenliknet med verdens helseorganisasjon sine kvalitets standarder. Standard 2 som omhandler støtte fra samfunnet gikk igjen som en den viktigste standarden.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
CEDAW	Convention for the Elimination of Discrimination Against Women
CRC	Convention of the Right of the Child
HIV	Human Immunodeficiency Virus
ICDP	International Child Development Program
ICPD	International Conference of People Development
IPV	Intimate Partner Violence
NGO	Non Governmental Organization
NYP	National Youth Policy
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
TB	Tuberculosis
TOP	Termination of pregnancy
TTI	Theory of Triadic Influence
UDHR	Universal Declaration of Human Rights
UNFPA	United Nations Population Fund
WHO	World Health Organization

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1 Introduction

With focus on describing the relevance and importance of adolescent sexual and reproductive health as a public health matter and why additional research is needed, this first chapter introduces general background information, followed by previous research on young people's access to sexual and reproductive healthcare (SRH). Additionally, important key terms and concepts used in the thesis will be discussed, followed by a presentation of the rationale of this study. Next, the research questions behind the study are presented, followed by a description of the thesis structure.

There are 1,8 billion young people in the world today. With it's 200 million people aged between 15 and 24 years, Africa is the continent with the youngest population in the world, and the number is expected to rise from 18 % in 2014 to 30 % in 2050 (Ighobor, 2013; United Nations, 2014). Children and youth are commonly seen as the hope for the future, and youth is associated with ideal health. However, for many of today's youth the reality is different, not only do they face challenges with the changes happening to their bodies, but they also become vulnerable to human rights abuses, particularly in the fields of sexuality, marriage and reproduction (UNFPA, 2014a).

In low- and middle-income countries, where poverty and lack of access to education are a challenge, many adolescents enter into sexual activities, some of which are non-consensual. Without sufficient information or access to protective services, young people thereby position themselves in a time of even greater risk of negative lifelong consequences for health and well-being (Sundby, 2006).

The risk of sexual transmitted infections (STIs), unwanted or unplanned pregnancies, sexual abuse, harassment, and mental health related issues are all matters that needs to be assessed, and it is imperative that adolescents have access to health service which are specifically targeted to their needs (Sundby, 2006).

The Guttmacher Institute (2010) estimates that there are 2.2 million unintended pregnancies in sub-Saharan Africa each year. 92% of the induced abortions occur among those who are using no contraceptive method or a traditional one¹. According to the world health organization (WHO (2014c) the prevalence of intimate partner violence (IPV)² among girls 15 to 19 years old in Africa is 40 % and is a number of substantial public health concern

¹ In Wood and Jewkes (2006) study on contraceptive use among adolescent girls in Limpopo, South Africa

² IPV is defined by WHO (2012b) as "to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship." (WHO 2012, p. 1)

due to the potential negative impacts violence in its various forms can have for the victim in terms of risk of injury, early pregnancy, human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and mental health problems such as post-traumatic stress syndrome and depression (WHO, 2012b). In sub-Saharan Africa almost two-thirds of all the world's young people are living with HIV/AIDS, with southern Africa being the worst affected region in the world (WHO, 2014c). Reportedly only 10% of young men and 15% of young women aged 15 to 24 in sub-Saharan Africa are aware of their HIV status (WHO, 2014a).

There is a large body of literature and research that has focused on adolescent's access to reproductive and sexual health. Several times over the year, the WHO has called for the development of youth friendly health services worldwide (WHO, 2002, 2009, 2012a, 2014c), however, there are a multitude of reasons why the issue of young people's access to SRH services has been so contentious and challenging.

Several studies highlights that the denial of young people's sexuality and rights by conservative and traditional forces, often underpinned by various religious and cultural beliefs, has contributed substantially to restricting access (Glasier, Gülmezoglu, Schmid, Moreno, & Van Look, 2006; Shaw, 2009). Even when governments are progressive, cultural taboos present challenges to policies at the community level (Shaw, 2009).

The belief that teaching young people about sexual and reproductive health will encourage them to engage in sexual behaviour is a strong belief in many conservative societies and religious cultures. However, it is proven however by Kohler, Manhart, and Lafferty (2008) that teaching about contraceptives was not associated with increased risk of adolescent sexual activity or STIs. On the contrary, the study found that those who received comprehensive sex education had a lower risk of pregnancy than adolescents who received abstinence only education programs or no sex education (Kohler et al., 2008).

1.1 Rationale for the thesis

As the above introduction reveals, much has been over the past two decades about barriers faced by young people in accessing reproductive and sexual health care, and a debate about how health services can be made more youth friendly has emerged. In spite of this increased appreciation that young people are in need of services that are sensitive to their unique stage of biological, cognitive, and psychosocial change into adulthood, the provision

of adequate and quality health services still fall short (Denno, Hoopes, & Chandra-Mouli, 2015; Tylee, Haller, Graham, Churchill, & Sanci, 2007).

Several studies find that the structural barriers that exist on societal, cultural, political and economic levels are crucial to address when working to improve adolescent access to SRH (Marston & King, 2006; Nair et al., 2015; Shaw, 2009; Svanemyr, Amin, Robles, & Greene, 2015). There is also a broad consensus that laws and policies that promote and protect the human rights in relation to adolescents and their SRH needs to be in place and implemented (Shaw, 2009; Sundby, 2006; Svanemyr et al., 2015; WHO, 2015a).

According to Marston and King (2006), the challenge is to design locally tailored programmes that address these important factors of social influences on behaviour for each setting. In order to do this in an acceptable and most effective manner, WHO (2015a) emphasizes that risks and needs must be examined locally, and local adolescent members of the key population³ must be consulted and actively involved in the situational analysis and the development of effective interventions to improve both access, and the quality of health services for adolescent sexual and reproductive health.

1.2 The research questions

The main objective of the research was to develop an understanding of young people's perceptions of, and access to, adolescent friendly health care in Western Cape, South Africa, and what the implications are for the development of effective interventions.

The primary questions that guided this study were:

- *To what extent do young people access, and perceive they have access to sexual and reproductive health services in Western Cape, South Africa?*
- *To what extent do young people perceive the quality and 'friendliness' of the health care services? How does this relate to the WHO's global standards on adolescent health - care service?*

To develop a broad understanding of the issues young people face regarding access to SRH services, the Theory of Triadic Influence is utilized as a guiding framework. In addition,

³ Refers to defined groups that are at increased risk of HIV due to specific higher-risk behaviour and they often has legal and social issues that increase their vulnerability. Examples of key member are men who has sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people. Adolescent members of the key population are at even greater risk (WHO, 2015, p. viii).

the WHO's global standards are used to reflect on the study findings in relation to the perceived friendliness and quality of young people's SRH services. Specifically, the aim was to compare selected standards to the findings to understand how perceptions of young people SRH in in Western Cape relate to the global standards and in turn give implications for improvement.

1.3 Thesis Structure

The thesis consists of five chapters. The first chapter has introduced the theme and discussed the rationale for the study and presented the research questions. In the second chapter, the theoretical framework that will be applied in understanding the study findings will be presented together with an overview of the Western Cape, South Africa context. After describing the research design and methods in chapter three, empirical data collected from the Western Cape, South Africa will be examined and the findings will be linked up with the theory of triadic influence and presented in chapter four. Finally, there will be a concluding discussion of the thesis, including implications for improvement, reflections on future research needs and a methodological discussion of the thesis in chapter five.

2 Background

Having introduced the background, the rationale of the study, and the research questions guiding it, this chapter will present the necessary background information related to young people's access to SRH services.

First in this chapter some concepts used throughout this thesis will be clarified, followed by presenting young people's rights to SRH services and an introduction to WHO's global standards for quality health care services. Successively, a presentation of the study setting will follow with the focus of providing this thesis with the necessary background information of young people's SRH in Western Cape, South Africa. At last in this chapter the theory of triadic influence (TTI) will be presented.

2.1 Clarification of concepts

2.1.1 Young people, youth and adolescence

The WHO defines young people as those who are between the ages of 10 and 24 years, whereas adolescence is defined as those from 10-19 years and, youth is defined as those between 15-24 years of age (WHO, 2014c, 2015a). The participants in this study were in the age of 12-23, which positions them as young people according to the WHO definition.

However, in the South African National Youth Policy 2015-2020 (NYP) the definition of young people encompasses people aged between 15-35 years old⁴. In this study, the WHO's definition of young people (10-24 years) is adopted, to coincide with the South African definition. However, the terms "young people" and "adolescence" are used interchangeably throughout the thesis due to the fluidity of these categories, and because of the broad age spectrum found in the literature.

2.1.2 Health

Health is defined in many different ways, but the most widely known definition was set by WHO in 1946 as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (WHO 1946, p. 100). However, in contrast with the biomedical definition where the meaning of health represent absence of disease or illness, it is a positive definition that has been criticized for being too utopian and far from reality. The

⁴ The same definition can be found in the African Youth Charter which defines youth as those between the ages of 15 and 35 years." (Department of Health, 2015)

definition encompasses the holistic view of health, and coincides with this study because the definition includes the different dimensions of health which all needs to be considered in health prevention and promotion (Naidoo & Wills, 2009).

2.1.3 Sexual and reproductive health

The definition of reproductive health is derived from WHO's definition of health and is adapted from the International Conference of Population and Development (ICPD)⁵. Here, reproductive health means that "people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." (UNFPA, 2014b, p.18).

Adopted from both the ICPD⁶ and the WHO⁷, UNFPA (2014b) defines sexual health as that which:

Deals with the enhancement of life and personal relations, not merely counseling and care related to reproduction and sexually transmitted diseases. It refers to the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love (UNFPA 2014b, p.19).

2.1.4 Help-seeking behaviour

In a literature review by Barker (2007) on adolescent health and development, he found that "help-seeking" and "health-seeking" are used interchangeably. While "health-seeking" generally more narrowly refers to seeking services for a specific condition or illness, "help-seeking" refers to the use of health and other services in the case of mental health issues, including substance use, depression and suicide (Barker, 2007). In this study the term help-seeking, as defined by Barker (2007), is used because it suggests using a more comprehensive approach focusing on both the individual and on the sources of help available: "Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way" (Barker, 2007,p.2).

⁵ International conference on Population and Development (ICPD). Program of Action, UN Doc. A/CONF.171/13, 1994, chap. 7.A.

⁶ ICPD, UN Doc. A/CONF. 171/13 1994, Para. 7.3.

⁷ WHO. "Defining sexual health: Report of a technical consultation on sexual health. 28-31 January 2002, Geneva

2.2 Young people's rights to reproductive and sexual health services

The essential foundation of securing young people the sexual and reproductive health services they need, is to ensure their rights to receive such information. This is enshrined in national and international declarations and laws. The rights for adolescents and young people can mainly be found in the Convention of the Right of the Child (hereinafter CRC)⁸ and the Universal Declaration of Human Rights (hereinafter UDHR)⁹.

Reproductive and sexual rights are not a separate set of rights; they are both embedded within the UDHR and the CDC. The understanding that reproductive health is based on these rights was made at the International Conference on Population and Development (ICPD) in 1994 in Cairo. Here, the responsible governments acknowledged that they had to ensure that these rights were translated into national laws and policies (Cottingham et al., 2010).

In addition to the CRC and the UDHR, there is also the Convention on the Elimination of Discrimination Against Women (CEDAW), that sets out the rights of women and girls to health and adequate health care (WHO, 2014a).

Some examples of basic rights relevant to young people's access to sexual and reproductive health:

- The right to the highest attainable standard of health
Article 24, CRC and Article 12, ICESCR
- The right to survival and development
Article 6, CRC
- The right to educational and vocational information and guidance
Article 28, CRC
- The right to non-discrimination
Article 2, CRC
- Respect for the views of the child
Article 12, CRC

Sources: (Cottingham et al., 2010; Shaw, 2009; United Nations, 1989)

Since the ICPD in 1994 however, there are still struggles to implement the rights of sexual and reproductive health especially concerning young people, young girls and women. These difficulties are traced all the way up to the United Nations and the MDGs and SDGs

⁸ Convention on the right of the Child (CDC) was founded in 1989. A "child" is defined as a person under 18 years of age (United Nations, 1989). Ratified by South Africa in 1995.

⁹ Universal Declaration of Human Rights (UDHR) 1948(United Nations, 1948)

(Haslegrave, 2014; Starrs, 2015). In the Global Goals for Sustainable Development (SDGs), furthering the Millennium Development Goals (MDGs), article 3.0 aims to: "*Ensure healthy lives and promote well-being for all ages*", including, article 3.7, with the goal of ensuring universal access to SRH services by the year 2030 (United Nations, 2013). Reproductive health is also mentioned in article 5.6 under Goal 5, that aims to "*achieve gender equality and empower women and girls*" which together with article 3.7 address access to SRH information, education and services (Haslegrave, 2014; United Nations, 2013). In retrospect, the MDG's focus on maternal health is said to have been at the expense of the wider agenda of SRH (Hill, Huntington, Dodd, & Buttsworth, 2013) and further it has been seen as a setback to SRH when the goals to the implementation of SRH were removed in year 2000 for then to be reinstated in 2007 after a sustained campaign by advocates (Haslegrave, 2014; Starrs, 2015).

The SDGs are also now facing critique for being too narrow in relation to SRH and rights (Starrs, 2015). Although it is an improvement compared to the MDGs, the indicators¹⁰ for SRH are limited to family planning and the rights to SRH services (especially for women from the age of 15), but does not include other important elements like safe abortion, non-discrimination based on sexual orientation or gender identity, and the importance of high-quality, confidential, and timely sexual and reproductive health services (Starrs, 2015).

There are several WHO-documents on how to ensure a human rights based - approach in providing health services, such as "*Ensuring human rights in the provision of contraceptive information and services. Guidance and recommendations*" (WHO, 2014b).

Applying a human rights based approach to the provision of health services aims to ensure fully informed decision-making, dignity, autonomy, privacy and confidentiality, and sensitivity to the needs and perspectives of young people. This lens is also employed in the quality and friendliness of health services that will be elaborated upon in the next section, where the WHO's global standards for quality health care services will be presented.

2.3 Quality, friendliness and the WHO's global standards

As mentioned in the introduction, the WHO has made several attempts to improve the health services for young people. Tylee et al. (2007) utilized the framework adapted from WHO (2005) and WHO (2001) in their review article in: *Youth-friendly primary care*

¹⁰ <http://unstats.un.org/unsd/statcom/47th-session/documents/2016-2-IAEG-SDGs-E.pdf>

*services: how are we doing and what more needs to be done?”*¹¹ This framework consisted of different points of delivery and the barriers young people face when accessing primary health care services related to the equity, accessibility, acceptability, appropriateness and effectiveness of the health services. Through a comprehensive review of studies worldwide, several countries in Africa included, they found a large gap between the nature of what young people seek from primary health services, what services the clinics had to offer, and the actual major burden of disease that young people endure (Tylee et al., 2007).

The latest attempt to improve the quality and friendliness of health care facilities to young people is the development of the new WHO (2015a) set of “*Global standards for quality health-care services for adolescents*”. The background for these standards is an analysis of published and unpublished systematic reviews and meta-analyses from January 2000 to June 2013 on existing initiators and barriers to improving the quality of health care for adolescents and some of these analysis are presented here (Nair et al., 2015). On the basis of a literature review, two online surveys and an analysis of 26 national standards from 25 countries, the global standards were developed (WHO, 2015a).

The aim of the global standards is to improve the quality of health care services, so they will be more suitable for adolescents. Hence, they will find it easier to promote, protect and improve their own health and well-being (Nair et al., 2015). These surveys also informed the global report “Health for the world’s adolescents: a second chance in the second decade” (WHO, 2014c).

There are eight global standards that outline the required level of quality in the delivery of services and each standard reflects an important part of quality services (Table 1).

The WHO states also that to meet the needs of adolescents, all standards need to be met (WHO, 2015a). Under each standard there are criteria for measurement. The criteria are again divided into “input”, “process” and “output” whereas the “input” is the characteristics of the health services, “process” is the quality of implementation of the services, and “output” is accomplishing the defined standard (Nair et al., 2015). The WHO standards also include actions at the national level requiring authorities to review laws and policies to ensure that young people’s rights to a comprehensive quality health care are in place and implemented (WHO, 2015b).

¹¹ The review included all studies between 2000-2005 that assessed the effects of different service models of health care provision for young people in primary care or community health settings (Tylee et al., 2007).

Due to the scope and focus of this seven out of the eight standards were investigated with respect to how they relate to young people's perceptions of quality and "friendliness" of health care services. These standards will be elaborated upon after Table 1, which provides an overview of all the standards.

Adolescents' health literacy	Standard 1. The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Community support	Standard 2. The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Appropriate package of services	Standard 3. The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach. ¹
Providers' competencies	Standard 4. Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Facility characteristics	Standard 5. The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Equity and non-discrimination	Standard 6. The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Data and quality improvement	Standard 7. The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Adolescents' participation	Standard 8. Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

Table 1:WHO's Global standards for quality health care services for adolescents (WHO, 2015a).

2.3.1 Standard 1. Adolescents' health literacy

There were two global online surveys conducted by WHO in 2013 by Nair et al. (2015) which were used to assess needs among primary health care providers and adolescents from 104 countries. Five main themes emerged, whereas one was addressing adolescents'

understanding of the importance of health, meaning that there is an increasing demand for information about health and health care (Nair et al., 2015).

For the adolescents to be able to understand when, how and where to seek help regarding their health, they need to develop health literacy skills. The WHO defines health literacy as something that “means more than being able to read pamphlets and successfully make appointments”, and that “by improving people’s access to health information and their capacity to use it effectively, health literacy is critical to empowerment” (WHO, 2015, p.5).

This definition reflects upon the types of literacy described by Nutbeam (2000) as interactive and critical literacy, which again indicates that health literacy may have both personal and social benefits. This requires that the content of health education also raise awareness of the social determinants of health, so that people are enabled to act upon them. Improving health literacy implies greater autonomy and personal empowerment among a greater proportion of the population, and contribute to the development of social capital which is very similar to the “critical consciousness” style of education by Paulo Freire from 1973 (Nutbeam, 2000). One of the input criteria of the WHO standard involves the health care provider’s competency to educate and communicate to adolescents about health (WHO, 2015a).

The ability to read and write is an integral part of health literacy; schools therefore play a central role in this development (Manganello, 2008). The standard of health literacy is therefore also connected with Standard 2 because health education is carried out in the community as well.

2.3.2 Standard 2. Community support

Support from community members, like parents, teachers and community organizations will strengthen the integral position of reproductive and sexual health services for young people. These gatekeepers¹² play an important role, and without their support the health programmes aimed at adolescents will not be effective (Denno et al., 2015; WHO, 2014c). In the study by Nair et al. (2015) they found that families are crucial for adolescents’ well-being and are often reported to have the most influence regarding health information.

This standard sets the expectations for the level of support for adolescent from the gatekeepers and impose that health facilities have a responsibility of informing community

¹² Gatekeeper(s) is defined as “ Adults that have influence over adolescent’s access to and use of services, e.g. parents and/or other family members, legal guardians, teachers and community leaders” (WHO, 2015,p.viii).

members about the importance and value of providing health services to adolescents. According to the intent of this standard, these facilities have to engage in partnerships with organisations and other community members to develop health education and communication strategies and materials, stressing the need of adolescents themselves in this part (WHO, 2015a).

2.3.3 Standard 3. Appropriate package of services

A needs assessment conducted by Ambresin, Bennett, Patton, Sanci, and Sawyer (2013) on youth-friendly health care indicators drawn from young people's perspectives, identified eight core domains of health care that were important to young people¹³ whereas health outcomes like pain management and mental health improvement was important, and also reducing pregnancy rates to enable young people to maintain a job hence their social connections.

A call for a more comprehensive care was also found, defined by meeting young people's needs regularly on a developmental level, assessing them on their disease status, life events and personal ambitions (Ambresin et al., 2013). The appropriate package of services includes mental health, counselling, diagnosis, treatment and care and reflect the wishes from young people themselves for a more comprehensive health care service (Ambresin et al., 2013). Adolescents also expressed that they need health services for their mental health, and not only to address sexual and reproductive health (Nair et al., 2015).

2.3.4 Standard 4. Providers' competencies

"Health care providers demonstrate the technical competence required to provide effective health services to adolescents" (WHO, 2015a, p.9). This implies that the health workers not only possess the medical competency like technical skills and procedures, they also provide a guideline-driven care that includes that the health care is confidential and autonomous (Ambresin et al., 2013). Young people have expressed that attitudes, knowledge and skills of health care providers are at the core of quality service provision, emphasizing the providers' communication skills and that the attitude of staff is respectful, supportive, honest, trustworthy and friendly (Ambresin et al., 2013).

¹³ The assessment included any study of young people (10-24 years of age), qualitative and quantitative, that focused on measuring their satisfaction or experience with health care or friendliness of services (Ambresin et al., 2013).

Many health workers feel uncomfortable, insecure and lack confidence when it comes to handling or talking about issues such as IPV, sexual relationships, nutrition and substance use, which points out the importance of that health-care providers get the necessary training that they need to provide the comprehensive care that is required (WHO, 2015a).

2.3.5 Standard 5. Facility characteristics

This standard encompasses convenient operating hours for adolescents, so that the waiting time and registration process are respectful of the adolescents time, and thereby designed to minimize waiting times (WHO, 2015a). Adolescents have expressed the importance of an age-appropriate environment with flexible appointments, separate physical space, cleanliness (which was highlighted in low-income countries) and privacy (Ambresin et al., 2013). Accessibility of health care in terms of cost and quality is also an important factor (Ambresin et al., 2013; Nair et al., 2015).

2.3.6 Standard 6. Equity and non-discrimination

This standard stresses that the health facility is providing quality care irrespective of the adolescents ability to pay, their age or sex, marital status, education, sexual orientation or ethnic origin (WHO, 2015a).

The standard also require that the health-care providers are aware and knows who the marginalized groups in their community is so to involve them in the planning and monitoring and evaluation of health services (WHO, 2015a).

Standard 6 also stress that equity of care concerns all the dimensions of quality of care outlined in all the standards - not only in levels of services, but in the level of respect and *involvement* of care (standard 8).

2.3.7 Standard 8. Adolescents' participation

The rationale for this standard is that adolescents usually have the best knowledge about their own needs and ignoring their views may lead to disengagement and loss of follow-up (WHO, 2015a). Young people wants to be involved in their own health care(Ambresin et al., 2013) The standard therefore emphasizes the adolescent's involvement in the planning, monitoring and evaluation of health services and also their participation in their own care (WHO, 2015a). Further the standard requires that the facility solicits adolescent's perceptions

of its services, and also gathers information from other agencies and organizations in the community to influence its programmes and services (WHO, 2015a).

The standards aim to improve the *quality* of care provided; hence the adolescents' rights to *accessible*, *acceptable* and *effective* care can be fulfilled. The next section seeks to address the status of health care services provided in the Western cape.

2.4 Young people's SRH in Western Cape, South Africa

2.4.1 Overview

Western Cape (Figure 1) is the 4th largest province in South Africa with its estimated 6.1 million people (as of 2014), and approximately 51% of the population is under 30 years of age (Statistics South Africa, 2014; The Western Cape Government, 2012). The province is divided into six district municipalities.

There are several official languages in Western Cape, the most wide-spread are Afrikaans (55.3%), Xhosa (23.7%) and English (19.3%). According to the most recent population census, the coloured demographic group represent more than 50% of the total population in the Western Cape; this is followed by the Black, White and Asian demographic and makes the Western Cape one of two provinces (the other being the Northern Cape) with a predominantly coloured population. The religious majority is Christian, followed by African

Independent Churches and Islam (The Western Cape Government, 2012).



Figure 1: Map of the Western Cape (The Western Cape Government, 2014)

2.4.2 Young people's sexual and reproductive health needs in South Africa

As stated in the National Youth Policy for 2015-2030, one of the biggest challenges for young people in South Africa is the issue of sexual and reproductive health (Department of Health, 2015). In the South African National HIV Prevalence, Incidence and Behavior Survey from 2012¹⁴, samples from grades 8, 9, 10 and 11 learners selected from public schools in the nine provinces, found that 36% of learners reported having had sex, and among these 18 % had been pregnant or made someone pregnant (Shisana, 2014). This sheds light on the fact that nearly one-quarter of women aged 15-19 years in South Africa report having been pregnant, despite its progressive health policies that permit young women from the age of 12 to independently decide on contraception and abortion, and the fact that teenage pregnancies in South Africa are reportedly (Department of Health, 2012; Hoopes, Chandra-Mouli, Steyn, Shilubane, & Pleaner, 2015).

¹⁴ The third Youth Risk Behavior Surveillance 2011/12 conducted by the Medical Research Council in collaboration with the Department of Health and Education (Shisana, 2014).

In primary health clinics and other health facilities pregnancy test are free, although they are not always available (Department of Health, 2013).

As mentioned in the introduction, HIV/AIDS is this still a major concern in South Africa, mainly among young girls and women. In 2012, 113,000 new infections occurred among women aged 15–24 years, which is more than four times more than among young men (Shisana, 2014). The main form of HIV transmission in South Africa is heterosexual intercourse and due to several biological reasons, women are more vulnerable to get transmitted with HIV (Bearinger, Sieving, Ferguson, & Sharma, 2007; Higgins, Hoffman, & Dworkin, 2010). It's not unusual that women and girls in South Africa often get infected with HIV almost as soon as they start having sex, and the younger the girl, the greater the risk, mainly because the lining of the neck of the womb is not fully developed (UNFPA).

The disproportionately high rate of HIV infection among women in South Africa also mirrors social and cultural challenges, such as gender dynamics, as the country is also reported to have one of the highest rates of sexual violence in the world (Hoopes et al., 2015; Petersen, Bhana, & McKay, 2005). A study by Jewkes, Dunkle, Nduna, and Shai (2010) found that power inequity and IPV increase risk of incident HIV infection among young South African women. A great concern in Western Cape, as well as in South Africa in general, is that 40% of young people in relationships have experienced intimate partner violence (IPV) (Jewkes et al., 2010).

There is overwhelming evidence in South Africa that IPV is a leading cause of reproductive health problems, including HIV, STI's and unwanted pregnancies (Aarø et al., 2014; Burton, 2008; Jewkes et al., 2010).

In their study on intimate partner violence in South Africa, Wubs, Aarø, Mathews, Onya, and Mbwambo (2013) found that women and girls were mostly affected because of their vulnerable social and economic position, and they were also more likely to have an early sexual debut, and to be coerced into sexual intercourse than those who do not experience such violence (Wubs et al., 2013). Experiencing forced sex at an early age can influence women's sexual behavior in later years and might have a negative impact on a young woman's ability to negotiate sexual relationships (Mosavel, Ahmed, & Simon, 2012).

Violence itself may be exacerbated by poverty and unemployment, or it may also be a result of images of masculinity embracing toughness and defence of honour (Department of Health, 2014b). Poverty might also impact transactional sex where adolescent girls face economic pressures to allow older men to be their 'sugar daddies,' exchanging sex for presents or money (Jewkes, 2002; Mosavel et al., 2012).

Heavy alcohol consumption or substance use is also a risk factor for IPV, and substance related problems have increased dramatically in South Africa over the past 10 years (van Heerden et al., 2009). Strengthening women educationally, socially and economically might therefore have a protective effect on IPV (Jewkes, 2002).

2.4.3 Young people's access to SRH care in Western cape, SA

The South African Department of Health acknowledges youth as a target audience in their National health promotion policy and strategy for 2015-2019 and “encourages health promoters to address risky sexual behaviour, including multiple sexual partners, sex without a condom, and the consequences of unwanted pregnancies” (Department of Health, 2015, p.18). This will be done, the policy states, by health promotion and early screening for health conditions and illnesses through the integrated school health program, and health promotion strategies and policies that empower communities to gain control over the main social determinants of health (Department of Health, 2014b).

Young people's access to sexual and reproductive health services in Western Cape, South Africa is delivered as an integrated part of the family health service delivery. Public health care is free of charge, and on their website the Department of Health refers to several primary care clinics throughout the province (Department of Health, 2016). There are also 11 reproductive clinics across the province that provide access to free counselling and contraceptives for adults and teenagers, and the website states their rights to use contraceptives without permission from parents and partners.

Shisana (2014) found that only one in seven learners reported having received HIV/AIDS education at school. This extremely low number sheds light on the integrated school health policy (2014) that was introduced in 2012 as the health sectors key component to strengthen the primary health care delivery and realizing children's rights to education by making school a center for learning, support and care (Department of Health, 2014a).

Although South Africa ratified the CRC in 1995 (the same year as the ICPD), children's school health programs have been neglected due to a historical lack of collaboration between the Department of Health and Basic Education (Department of Health, 2014a). This, the policy states, has resulted in a lack of consistency and poor quality of health services, such as insufficient basic equipment, lack of beneficial environment in classrooms for proper screening and examination, poor referral system to identified health needs, poor follow up because of just a annual visit by the nurse (Department of Health, 2014a).

The integrated school health policy includes provision of services to learners in all education phases, and that the package of services provided is more comprehensive and address not only barriers for learning but also other health conditions that affects morbidity and mortality among learners (Department of Health, 2014a).

Reproductive and sexual health care is emphasized as part of the curriculum of health education and in the service provided; the same applies to sexual, physical and emotional abuse. The policy states that all learners should receive counselling on sexual and reproductive health, and if learners are sexually active they should also get information about contraceptives, counselling and screening of STIs, either on-site or at a health facility.

The students below 18 years of age must have a written consent from their parents or caregiver to be provided with school health services, but if older than 14 years they may consent to their own treatment and are advised telling their parents/caregivers (Department of Health, 2014a)

"An Analysis of Adolescent Content in South Africa's Contraception Policy Using a Human Rights Framework" by Hoopes et al. (2015) found that youth-friendly services were described as a key element of service delivery and adolescents were highlighted throughout the policy as being at risk for discrimination or coercion.

Confidentiality of services for young people was emphasized, and laws protecting the rights of adolescents were cited. The study concluded that South Africa's contraception policy and guidelines were comprehensive and forward looking, nevertheless, they found gaps that may have left adolescents vulnerable to discrimination and coercion and created barriers to accessing contraceptive services. Areas to strengthen included the need for normative guidance, ensuring both availability of contraceptive information and services for young people and adolescent participation in development of community programs and services (Hoopes et al., 2015)in development of community programs and services (Hoopes et al., 2015).

2.4.4 Previous interventions and programs aiming at young people's sexual risk behaviour

There have been several initiatives and prevention programs aimed at young people's sexual and reproductive health in South Africa, and there are currently over a hundred organizations working with young people in different ways and with different focus areas at

national, provincial and district level that support health promotion interventions (Department of Health, 2014b).

Some of the previous interventions that focused on young people's sexual risk behaviour in South Africa raise the difficulties in changing this kind of behaviour, as the effects of interventions are generally rather small (Aarø et al., 2014)

In “The evaluation of PREPARE after-school behavioural HIV prevention programme” by Catherine Mathews et al. (2016), which also included a focus on IPV prevention, provided no evidence that it reduced sexual risk behaviour¹⁵. There were also no indication that students who attended a greater number of education sessions reported less sexual risk behaviour than those in the control group, however, a significantly greater reduction in rates of IPV victimization compared to the control group were found (Catherine Mathews et al., 2016). It was also observed that higher rates of attendance in education session had even greater impact on IPV victimisation (Catherine Mathews et al., 2016). The study implies that reducing HIV risk among adolescents requires interventions which address a greater range of structural, social and environmental barriers to behaviour that prevent HIV infection(Catherine Mathews et al., 2016)

Several studies focusing on young people's sexual behaviour and IPV in South Africa have called for a more comprehensive intervention and health promotion approach. Svanemyr et al. (2015) also discuss the importance of working within an ecological approach when dealing with adolescents' sexual and reproductive health in order to foster an enabling environment. This is due to the strong influences of a variety of social, cultural, political and economic factors and inequalities, and how these factors increase adolescent's vulnerability and pose barriers to their access to SRH information and services (Svanemyr et al., 2015). Thus, the field may benefit from adopting a broader theoretical perspective, which may be more sensitive to the diversity of determinants that affect individuals' help- seeking behaviour.

2.5 Theory of Triadic Influence (TTI) and help – seeking behaviour

After reviewing relevant health behaviour theories, the theory of triadic influence (TTI) was selected because the model represents health behaviour as influenced on multiple levels.

¹⁵ Meaning they were less likely to have their sexual debut, were more likely to use condoms or had fewer sexual partners than those in the comparison arm (Catherine Mathews et al., 2016)

It is a comprehensive theory that builds on all former health behaviour theories, such as Bronfenbrenner's socio-ecological model (Bronfenbrenner, 1979), social-cognitive theory (Bandura, 2003), and theory of planned behaviour (Ajzen, 1991). The TTI acknowledges the complexity of health behaviour, while at the same time providing a framework for a more comprehensive and better understanding of the studied behaviour (Flay & Petraitis, 1994). The TTI (Figure 1) provides a model for the hierarchy of associated factors or "determinants".

Theories and variables can be arranged by different *levels* of causation: *ultimate*, *distal* and *proximal*, and are divided into three *streams of influence* corresponding to *person*, *situation* and *environment*.

2.5.1 Streams of Influence

The three streams of influence all include two *sub-streams* each, whereas one sub-stream represents the *cognitive and rational* and the other represents the *affective or emotional*.

The *intra-personal influences* are interpersonal characteristics that contribute to one's self-efficacy regarding specific behaviours such as biology, personality and self control (Flay, Snyder, & Petraitis, 2009).

Social influences are the *social context* or *situations* that contribute to social normative beliefs about specific behaviours and includes family, parenting styles, peers clustering and social learning (Flay et al., 2009).

Cultural environmental influences are multiple sociocultural macro-environmental factors that contribute to attitudes toward specific behaviours, like poverty, laws and policies, general knowledge and cultural identity (Flay et al., 2009).

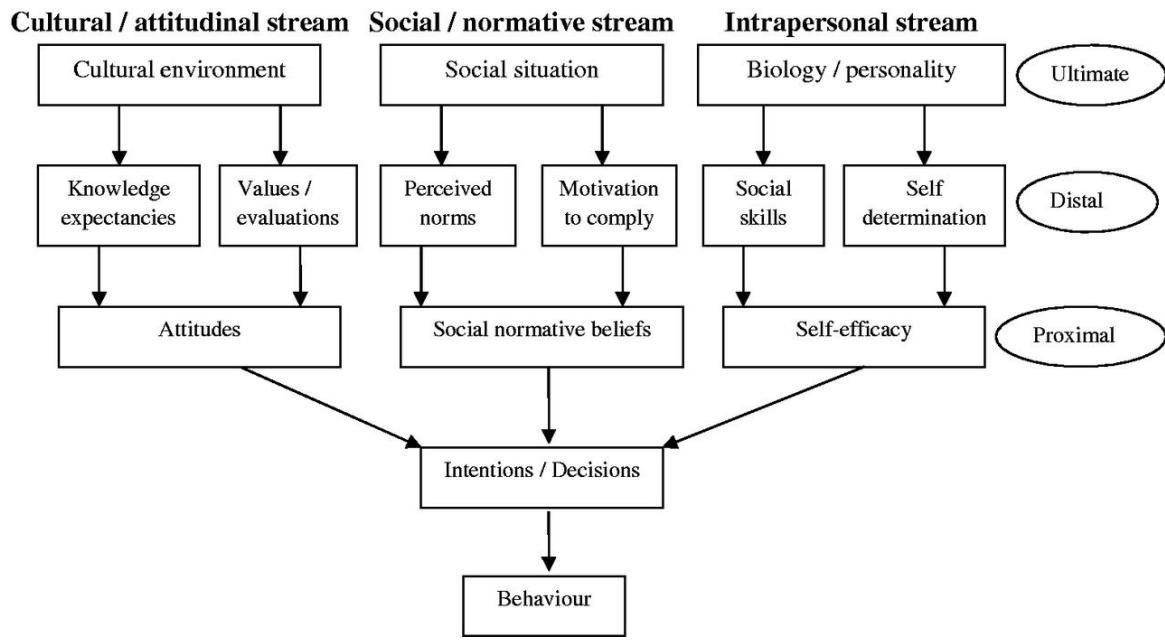


Figure 2: The theory of triadic influence (TTI) in Klein Velderman et al. (2015) adapted by Flay and Petraitis (1994).

2.5.2 Levels of causation

The **ultimate** or underlying determinants are furthest removed from behaviour, largely beyond the easy control of any individual and are relatively stable. This includes for example poverty rates, parenting styles and biological vulnerability. For example, the fact that girls are more vulnerable to get infected with HIV/AIDS (Higgins et al., 2010). The effects of these underlying determinants, however, are the most pervasive, and if they are changed it is likely that the effects will have the greatest and longest-lasting influence on a broad array of behaviours (Flay et al., 2009). For instance, changing poverty rates or empowering women economically would have substantial influence on their social situation, hence improve their health and reduce the occurrence of gender violence (Jewkes, 2002; Shaw, 2009).

Taking a step further towards behaviour, there are the **distal** influences divided into two levels. The first level is the social-personal nexus, meaning for example rebelliousness, religious participation, or bonding to parents or other role models (Flay et al., 2009). These variables reflect the quality and quantity of contact between the individuals and their sociocultural environments, social situations or personality; for example, young people might be influenced by their peers or partners to engage in risky sexual behaviour (Flay et al., 2009).

The second level of distal influences, called evaluations and expectancies, are a set of affective/cognitive influences (Flay et al., 2009).

Proximal influences are the general values, behaviour specific evaluations, general knowledge and specific beliefs that arise out of the contact between individuals and their surroundings (Flay et al., 2009). Young people's own perceptions and attitudes, social normative beliefs and their attitude towards accessing a health care facility is found at the proximal level of influences (Flay et al., 2009).

The model was first applied in order to understand tobacco use among adolescents, and has later been applied to several research studies on understanding youth outcomes and behaviour, such as violence and sexual abuse, mental health, positive youth development, dietary behaviours and sexual behaviours (Flay & Petraitis, 1994; Flay et al., 2009; Klein Velderman et al., 2015; Petersen et al., 2005). It has also been proven to be useful for mapping and designing an intervention to promote positive behaviour and resilience in youth (Segawa, Ngwe, Li, & Flay, 2005)¹⁶.

A large study on "Cultural, social and intrapersonal factors associated with clusters of co-occurring health-related behaviours among adolescents" by Klein Velderman et al. (2015)¹⁷, adds significant understanding on how health related behaviours such as smoking, excessive alcohol consumption and risky sexual behaviors are influenced of cultural, social and interpersonal factors. They suggest that by addressing common factors at the ultimate or distal level, such as parenting styles and descriptive norms, the health gains can be substantial (Klein Velderman et al., 2015).

Although the TTI has been more widely used over the last decade, it has not yet been utilized in a study of help-seeking behaviour. Flay and Petraitis (1994) however claims that the model can be utilized for understanding any behaviour.

The primary critique of the TTI model relates to its comprehensiveness, and the biggest challenge of the TTI is the complexity of the model, which makes it difficult to test the entire theory in one study (Flay et al., 2009). In the end, the model implicates not only understanding of the causes of behaviour but also the development of effective forms of health promotion.

¹⁶ Referring to Aban Aya youth project (AAYP), a project aiming to address multiple problem behaviors such as violence, substance abuse, crime and sexual activity in a long-term intervention specifically for African American youths in grades five through eight in Chicago, USA, between 1994 and 1998.

¹⁷ The study included a random sample of 898 adolescents; 12-18 years of age interviewed with a computer assisted face to face collection and Internet questionnaires (Klein Velderman et al., 2015).

3 Methodology

Having presented the background and theoretical framework, the aim of this section is to provide the reader with a comprehensive description of the methodological process. It will start with some background information on the research project where the data was gathered, followed by two separate sub-sections with descriptions of the methods used in this study, both quantitative and qualitative, with ethical considerations discussed in the end.

3.1 Background

This thesis is based on data from a EU-funded research project called Promoting sexual and reproductive health among adolescents in sub-Saharan Africa (PREPARE). The PREPARE project grew out of a consortium, which also conducted a multi-site intervention project in sub-Saharan Africa, the SATZ project¹⁸.

PREPARE's overall purpose was to develop and evaluate community-based (school delivered) interventions in four sites in sub-Saharan Africa that were effective in reducing the spread of STI's (including HIV) and unwanted pregnancies by changing sexual- and reproductive behavior and determinants of such behavior, and also to examine the utility of social cognition models in predicting sexual behavior in cultural contexts where there have been few studies examining their relevance (Aarø et al., 2014).

In Western Cape, South Africa, the aim was to develop and test a comprehensive school-based community prevention approach, to promote positive sexual practices, and reduce intimate partner violence among learners aged 12 to 14 years (Aarø et al., 2014).

There were three phases in this study. In the first phase, a formative study was conducted in order to develop a better understanding of the context to monitor the development and to revise the materials and methods to be used in the intervention, and in the process also taking aim of establishing collaboration with the selected schools (Aarø et al., 2014). The second phase consisted of developing, refining, and testing the content and materials, as the third and final part was a post-intervention phase, where data was collected from questionnaires (Aarø, Vries, Bastien, Mason - Jones, & Mathews, 2009). For a more detailed overview of the PREPARE study, see (Aarø et al., 2014)

¹⁸SATZ is an acronym for South Africa Tanzania. It studied the effect on young adolescent sexual risk behaviour of teacher-led school HIV prevention programmes in Cape Town, Mankweng and Dar es Salaam (C. Mathews et al., 2012). Primary outcomes were delayed sexual debut and condom use among adolescents aged 12–14 years.

3.2 Study design

All individuals bring with them different experiences, attitudes and knowledge into their profession, and as a researcher it is vital to acknowledge that my own perceptions are embedded in commitments to particular versions of the world (Brodkorb & Rugkåsa, 2009). Selecting research area, research questions, and the study design, are all highly connected with the researchers own point of view. My background in nursing and my deep interest for international public health challenges were the main reasons for me to choose this research topic.

To answer the research questions in this thesis, a mixed method approach was adopted in using two sources of data from the PREPARE study, specifically from the Cape Town site. This included secondary data analysis of the formative research material that was collected in the first phase of the PREPARE study (as described above), and also data collected from the questionnaires in the post-intervention phase (control schools only). These two components will be described separately later on in this section.

Using mixed methods or triangulation in public health research is useful because it is useful to both describe and understand communities given the complexities of modern public health problems (Baum, 2006).

Methodological triangulation has been a target of criticism, as some methodologists argue that combining the two paradigms is not possible. However, the counterpart's argument is that in the field of public health it is important to adopt a social view of health and bridge the different views to make public health research more comprehensive, which might lead to the development of more effective interventions (Baum, 2006).

Marston and King (2006) emphasize qualitative research in the paradigm of behaviour change, as this helps describe and find the reason for behaviour and its social context. Further, the article also claims that by gathering qualitative and quantitative data relevant to themes, policymakers can build a local profile of possible influences on sexual behaviour, and that this systematic exercise may highlight gaps in local knowledge and shortcomings in existing programs.

The purpose of applying triangulation is to provide understanding and insight that might have been missed if only a single method was used, and it might also strengthen a study by overcoming the weaknesses of the other (Johnson & Onwuegbusie, 2006).

There is certainly not only strengths to consider when utilizing a mixed methodology, the possible weaknesses are that it can be difficult to comprehend both qualitative and

quantitative research for just one researcher as he/she needs to learn and master them both and it can also be more expensive to implement and more time consuming (Johnson & Onwuegbusie, 2006).

The rationale for including both sets of data in this study, was, first of all, due to the limitation of information on the researched topic in each dataset. While there was rich information gathered from the health and social workers in the formative research, the information gathered from the students' perspectives was less rich, hence the questionnaire data was used to contribute to describing how young people experienced health services – though in a very broad sense.

The findings from the questionnaire are used to set the stage for getting a sense of how many of the participants that have visited a health worker or nurse, and how many times they have done this during the last 6 months. There were also variables which investigated students' experiences of using a health care service, for instance if they found the service helpful, if they felt respected and if they felt listened to.

The data was gathered from two different participants and sources, and the qualitative data then provided an opportunity to explore the deeper meaning behind the results from the quantitative data, thus providing a broader perspective that again generated a more comprehensive understanding.

3.3 Questionnaire data

The quantitative data used in this thesis comes from the post-intervention questionnaires collected in control schools at the follow-up data in the third phase of the PREPARE project.

3.3.1 Sampling

The study population included Grade eight learners attending public high schools in the Western Cape province. There were 42 schools (intervention and control) randomly selected on the basis that they were representative of schools on that site (Aarø et al., 2014). A statistician then "blindly" and randomly allocated the schools into intervention and control schools, and they were then matched with schools that are similar in terms of demographic and socio-economic characteristics (Aarø et al., 2014).

One school from each pair was randomly selected to receive the intervention, while the matched school was to serve as a control school. There were approximately 200 eligible learners per school, giving a total of 6244 invitations to learners to participate in the study.

After signed parental/care-giver consent forms were returned, 3451 participants were included in the study(Aarø et al., 2014). In order to avoid confounding the findings by including the intervention group, this study only included the control schools giving the total population study N= 1715. Figure 3 illustrates the flow of participant inclusion.

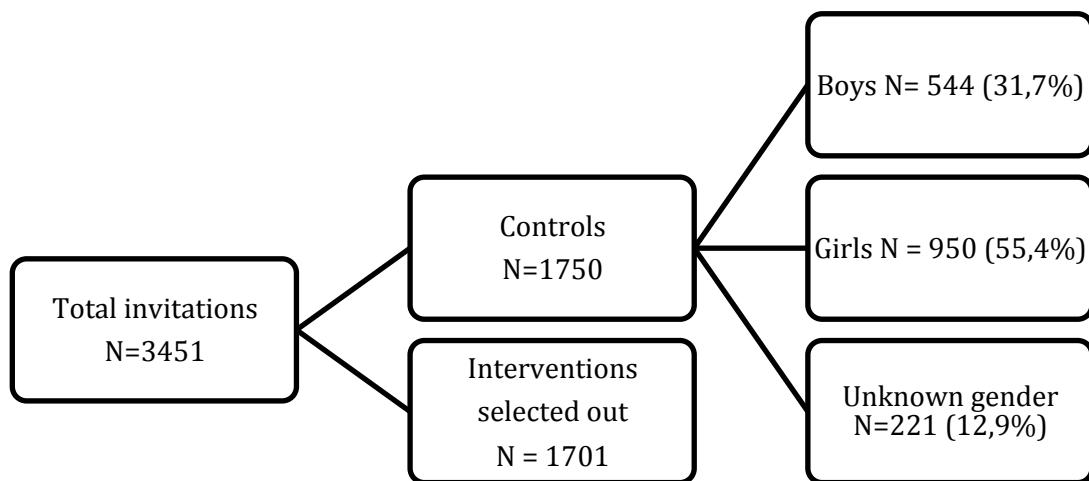


Figure 3: Flow chart of participant inclusion.

3.3.2 Questionnaire

The questionnaires included common questions for all sites and are partly based on a set of social cognition models previously applied to the study of HIV-preventive behaviours (Aarø et al., 2014). There were 10 variables from the questionnaire that focused on access to health care and these variables are relevant for this thesis (see Appendix 1-4). The questionnaire was printed in full color in an adolescent-friendly format resembling a “teen magazine” rather than an examination paper (Aarø et al., 2014).

There were two, three, or five different response options using a Likert type scale, dependent on the questions that are asked. Two response options consist of either yes or no, three response options are either yes, no or never, and five response options depends on the amount of times the incidence has happened or never happened.

Social desirability bias is a reliability problem when utilizing questionnaires, because there is a risk that participants do not answer honestly, mainly because they do not want to feel judged or make a bad impression (Fisher, 1993).

3.3.3 Analyses

The analysis was carried out using the SPSS statistical software (IBM SPSS Statistics 23). Descriptive statistics were computed in order to provide information on the characteristics of the study. Proportions were calculated for categorical data, and means and standard deviations for continuous and interval data. Frequencies and crosstabs were used to look at differences between the sexes and chi-square tests were used to describe the sample participants.

3.4 Formative research data

The qualitative data used in this thesis stems from data which was collected in the formative research done in the first phase of the PREPARE project. The formative data was collected in one school in each of six local communities that were already identified due to their participation in an IPV and HIV prevention research-based intervention (3 as intervention schools, 3 as matched controls) (Aarø et al., 2014).

These schools represent the 3 main language groups found in the Western Cape, and also comprise of students from across ethnicity and socio-economic spectrums (Aarø et al., 2014). In each school and community, individual in-depth interviews with teachers, social workers, learners, parents, principals, health workers, and police officers were conducted in September-December 2010.

The aim of the interviews was to gain insight into community norms and dynamics, when it comes to violence in general and more specifically intimate partner violence (Aarø et al., 2014). Perspectives on barriers and motivators to change concerning sexual behaviour and violence, and opinions on materials utilized in related interventions in Cape Town was sought (Aarø et al., 2014).

3.4.1 Participants and recruitment

Learners were recruited with the assistance of teachers, and the participation was voluntary (Aarø et al., 2014). The interviews with learners were equally represented with respect to both sexes. Due to the sensitive nature of the topics covered in the interviews, and due to privacy concerns, the inclusion criteria for learners were that they have had their sexual debut, and that they were 18 years of age or older (Aarø et al., 2014).

Health care workers were recruited from four different primary clinics within the study area (Aarø et al., 2014). One of the interviews was completed as a focus group

discussion with four health workers, of which one male and three females. At the other three clinics, each interview was conducted one on one, with all three of them being female health workers. The social workers were recruited because of their involvement with four of the represented schools in the study(Aarø et al., 2014).

3.4.2 Interviews

Each in-depth interview was conducted individually and face-to-face by trained interviewers (Aarø et al., 2014). Female interviewers performed all the interviews. The duration of each interview varied from 30-60 minutes. Participants were given the option of speaking the language of their choice, which was Xhosa, Afrikaans or English. The participants were also advised to respond to questions according to their own comfort level, and advised prior to participation that they had the right to withdraw from the study or refuse answering questions at any time (Aarø et al., 2014).

The interviews utilized a narrative approach to draw out participants' perspectives and experiences. The aim of this approach was to generate scripts, which might shed light on the factors and processes leading up to sexual debut, what happens afterwards, and in regard to on-going sexual behaviour and relationships, including condom use, patterns and behaviour (Aarø et al., 2014). Narrative interviewing typically involves an open-ended approach. The interviewer encourages the respondent to let their story unfold, but the interviewer may also assist the respondent to produce a coherent story or narrative (Kvale, Brinkmann, Anderssen, & Rygge, 2009). In this study, a semi-structured interview guide was used to ensure that key topics were addressed in the interviews (see Appendix 5-7).

All interviews were tape-recorded, and they were already transcribed and translated into English. Given the large number of interviews, and also the wide range of topics discussed in the interviews, each transcript was first reviewed to assess whether or not it was relevant for inclusion in the analysis.

The identification strategy focused first on the learners, then supplemented in the following order with the health care workers and social workers. Starting with the students, the total amount of interviews was 26, and 8 interviews were omitted due to no collected information on the related topics. With the health and social workers the total number of participants were 29.

This next section describes the analysing process utilizing systematic text condensation as a guidance to get to the meaning of the material.

3.4.3 Systematic text condensation

The interviews were analysed with the data tool NVIVO FOR MAC Version 11.1.1 (1551). NVIVO was a useful tool for keeping track of the sources in the data at all times, so that it was possible to track the meaning units origin, especially when you have so many pages of transcripts. When using NVIVO, the data is coded by sorting pieces of text into different nodes and makes editing of the existing nodes easy.

Systematic text condensation is rooted in Giorgi's psychological phenomenological method (modified by Malterud (2012)), and consists of four steps; getting a total impression, identifying and sorting meaning units, condensation, and synthesizing. Every step of the analysis is described as followed:

Step 1: Getting a total impression

The first step in the data analysis process consisted of reading through all the transcribed data in the following order; learners, health care workers and social workers. In this step, the goal was to establish an overview, looking for initial themes associated with participants' perceptions of, and experience with, adolescence' reproductive and sexual health care. Due to the large volume of transcribed material and the scope of this thesis, the initial step in this study was to eliminate transcripts from the analysis that did not include relevant content regarding the research topic. After this, only relevant pieces of text remained, and this made the analysis more comprehensive.

The remaining pieces of the transcripts were then reviewed again, with an open mind, and without imposing themes or codes, but at the same time keeping the research question and theoretical framework as a guide when identifying new sections of text, and when sorting them into the different themes or "nodes" to get a better overview of the data (Malterud, 2012).

Themes were organized around recurring clusters in the data that were relevant for the researched topic, and sorted into a list. Attention was attracted by broad themes such as "HIV/STI - testing", "contraceptives", "sexual behaviour", "interpersonal violence", "barriers for access to health clinics", "social/cultural norms", and "link between school and health clinic".

Step 2: Identifying and sorting meaning units

The next step in the analysis consisted of reviewing the remaining transcripts line by line, in order to identify meaning units, which is a piece of the text that contains some information about the research question (Malterud, 2012).

This involves de-contextualization, temporarily removing parts of the text from their original context for cross-case synthesis, with the themes as road signs. Identifying meaning units involved giving them a label or a code that connects related meaning units into a code group (Malterud, 2012). In order to be true to the research topic, a selection of meaning units that provided any knowledge on perception of, and access to, adolescent sexual and reproductive health services/care, was selected into a suggested list of themes and sub-themes – this time using the theoretical framework of TTI and the WHO standards as a guide for names of themes and sub-themes according to the content.

Initially, some of the meaning units were coded several places, but later moved as the coding progressed, because it gave more meaning under another node. Also, sometimes the name originally chosen for a “node” was found to insufficiently accurate to describe the topic, and therefore changed or moved. The list of “nodes” in NVIVO needed to be sorted and revised several times, as the coding process endured, and the understanding of the data increased.

Memos were written to keep track of reflections and decisions through the process. Malterud (2012) expresses the importance of doing this to enable the researcher to report selected issues making the process more transparent.

After the meaning units had been sorted out, they were systematically read through to make sure that the code groups differed distinctively from one another, gathering the ones that were similar and splitting the ones that differed from one another (Malterud, 2012).

Step 3: Condensation

The third step of the analysis implies systematic abstraction of meaning units within each of the code groups established in the second step of analysis. The empirical data is reduced into a selection of meaning units across individual participants perceptions, experiences and thoughts on the researched topic (Malterud, 2012).

The meaning units from each theme were then sorted into sub-themes by writing what in Malterud (2012) terms is a “*condensate*”, which is taking a summary that contains every single meaning unit within a theme and transforming them into a more abstract format (Malterud, 2012). Finally, the analysis ended up with four themes and a total of 10 subthemes (Table 2).

After finishing a condensate, authentic illustrative quotation(s) were identified and moderated where it was necessary, as to give them a written form in terms of taking away small word as “uhm”, “ah”, “um” or repetitions, pauses (Kvale et al., 2009).

Step 4: Synthesizing

The final step involved assembling all the components, developing descriptions and concepts, and making sure that the results reflected the validity of the original context. The descriptions and themes are presented in the next chapter.

Themes	Sub-themes
Perceptions of young people's access to health services and information	Privacy and confidentiality
Perceptions of young people's reproductive and sexual health problems	Lack of knowledge Intimate partner violence Self-confidence
Exploring the friendliness of clinics	Health workers knowledge and competence Provision of services Availability of the health clinic
Community support for young people's sexual and reproductive health	Parental support School and health clinic link Cooperation with NGOs

Table 2: Themes and sub -themes

3.5 Ethical considerations

There are always ethical issues to consider in research. Especially when doing research that involves sensitive topics and involves children or young people (Kvale et al., 2009). In this section, some of the moral concerns that are involved in this thesis are addressed.

3.5.1 Ethical approvals

The PREPARE study was approved by the Western Norway Regional Committee for Medical and Health Research Ethics (REC). Relevant committees in each of the African sites provided separate ethics approvals (see Appendix 8-9). In this case, for the Western Cape, approval was received from South Africa: Human Research Ethics Committee, Faculty of Health Sciences, University of Cape Town; Mankweng, Limpopo, South Africa: MEDUNSA (Medical University of Southern Africa) Research Ethics Committee (MREC).

3.5.2 Informed consent

Given that sexual behaviour as a research topic easily may turn out to be in conflict with ethical norms and values important for those concerned, all participation in the project was voluntary. Participants in the formative research were adults, eighteen years and older, so parental consent was not required; however, informed consent was required from all participants including learners, health workers, and social workers (Aarø et al., 2014).

Regarding the questionnaires, information forms were sent home with learners to parents, as they were under the age of 18, which also provided an opportunity for parents to withdraw their child from the study. If parents were not literate, learners were instructed to describe the information form to their parents. In the event that parents chose to withdraw their child, they could sign the form indicating their refusal, or they could telephone one of the research team, teachers or principals. If refusal was not indicated, it was assumed that parents had given consent to participate. They were also informed of their right to withdraw their child at any time during the study (Aarø et al., 2014).

This procedure is consistent with a previous study by Catherine Mathews et al. (2005), where it was found that actively written consent unethically restricts access to research and may skew study findings by overestimating interventions due to volunteer bias. It was also noted that obtaining communal consent might be more culturally appropriate to the cultural context, rather than individual consent alone. All participation in the study was voluntary, and all groups involved were carefully informed about intervention plans as well as research components (Aarø et al., 2014).

3.5.3 Confidentiality

The focus groups and in-depth interviews were audio taped and transcribed with the participant's permission, and the audiotapes were destroyed after the transcription were completed (Aarø et al., 2014). Names were not linked to any of the data in any of the data collections. In this thesis the names of schools have been given a number and clinics have been given a letter to keep them separate (Aarø et al., 2014).

All the data utilized in this study have been kept on a computer with a log-on security system, which is password protected.

3.5.4 Consequences

As the themes of the interviews were very sensitive topics, and one being questions related to IPV, directions were given for which a student volunteered information that they had been victim of abuse by a perpetrator within the school setting, the principal and the Department of Education would be informed (Aarø et al., 2014).

The research staff that conducted the interviews were carefully trained on all aspects of confidentiality (Aarø et al., 2014). If a student were to divulge information about any illegal activity, the information would not be shared with anyone; if, however, a student reported being exposed to violence of a serious nature, they would be assisted with reporting their experiences to the appropriate agency (Aarø et al., 2014). If the student was unwilling to report it and they remained at high risk, the research staff would report it to the appropriate agency as per South African Law (Aarø et al., 2014).

3.5.5 The researchers role

In qualitative interviews, ethical issues typically arise because of the asymmetrical power relation between interviewer and the interviewee. p.76 (Kvale & Brinkmann, 2009).

Although I, the researcher, did not take part in conducting the interviews, there are some ethical issues for me to address regarding the performance of the interviews, especially because one of the groups interviewed were young adults. When interviewing children or teenagers, it is important that the interviewee try avoiding being associated with classroom teachers, as well as conveying expectations that there is one right answer to a question (Kvale & Brinkmann, 2009). In some transcripts the student addressed the interviewer as “Miss” throughout the interview, indicating that the student might have felt this asymmetry.

There were female adults that conducted the interviews, and as the students were both boys and girls, this might be a disadvantage especially across sexes. Boys might be more at ease talking to the same sex, especially when it comes to subjects as interpersonal violence and sexual behaviour, as studies demonstrates how this problem is deeply connected with gender norms in South Africa (Jewkes et al., 2010; Mosavel et al., 2012). Boys might be less comfortable talking to a woman about these issues; however, it might be an advantage as well, as a woman might appear more caring and responsive allowing the boys to open up about feelings and thoughts that are not that accepted in the masculine world.

By reviewing the transcripts, there were both rich and less rich information gathered from both sexes, indicating that in the end the interviewer’s qualifications and personal skills

in terms of his or her knowledge, experience, honesty, and fairness is imperative (Kvale & Brinkmann, 2009).

In this context, this also applies to the role I have as an interpreter. As every culture creates a tradition of knowledge and understanding, we all develop a set of values and concepts that we use to interpret and understand the world with, and these values and concepts are not necessarily common or universal. It is vital as my role as a researcher that I acknowledge that my interpretation or explanation of an event or phenomenon in one society might be interpreted or understood quite different in another (Brodtkorb & Rugkåsa, 2009).

4 Empirical findings

This chapter presents the results in two sections; first, the results from the questionnaire data, and then the findings from the formative data in relation to the main objective of the research, which was to develop an understanding of adolescent's perceptions of, and access to, adolescent friendly health care – in particular with respect to quality and 'friendliness' in Western Cape, South Africa. In the discussion chapter, the results from the questionnaire data will be compared and contrasted with the formative results.

4.1 Findings from the questionnaire data

Due to scope, time limit and focus of this thesis, the data from the questionnaire was primarily intended to give an overview of health care access and perceptions among young people, and thereby contribute to the overall comprehensive understanding of adolescent sexual and reproductive health in this setting. The findings here include an overall demographic overview of the participants, and their responses concerning access and perceptions of health services.

Table 3: Demographic overview of participants (N=1715)

	N	SD/Mean
Sex	1494	
Male	544	
Female	950	
Age (Mean; SD)	1659	13.7 (1.06)
12-15 years	1544	
16-23 years	90	
SES¹⁹ (Mean; SD)	1715	5.95 (1.71)

The study population included 1715 adolescents between 12 to 23 years of age, and are presented in table 3.

The mean age of participants was 13.7 years (SD 1.06) after a total response rate of 96.7%. Socio economic status (SES) was measured by using an adapted version from the family affluence scale, and are questions regarding things in their family that the students were likely to have knowledge about (Boyce, Torsheim, Currie, & Zambon, 2006). Students were

¹⁹ The results were summed to create a scale that signifies the amount of assets they had access from "no households items" (0) to "8 household items".

asked to indicate whether they had access to any of the following assets at their home: tap water, a toilet, electricity, a house telephone, a mobile telephone, a fridge, a television, or a car (Aarø et al., 2014).

Table 4: Descriptions of participant's access to, and perceptions of health care (N=1715)

	N	Male	Female
Have you ever had sex? (Vaginal intercourse)(<i>p=0.001</i>)	1352		
Yes		26.9% (132)	7.1%(61)
Are there a health worker or nurse that you can visit at school? (<i>p=0.006</i>)	1586		
Yes		34.2% (206)	29.8% (293)
No		32.9% (198)	29.4% (289)
I don't know		32.9% (198)	40.9% (402)
Visited nurse or health worker at school in the past 6 months? (<i>p=.245</i>)	1498		
Yes, I have once		18.2% (110)	15.3% (153)
No		75.7% (458)	79.3% (793)
Visited nurse or health worker outside school in the past 6 months?(<i>p=.860</i>)	1554		
Yes, I have once		24.6% (144)	27.1% (262)
No		59% (346)	57.6% (558)
Ever been treated (at a clinic or hospital) for an injury as a result of violence caused by anyone in the last 6 months? (<i>p=0.001</i>)	1415		
Yes, I have once		29.5% (176)	20.7% (205)
No		56.4% (337)	72% (712)
The last time you visited a nurse or health worker (at school or elsewhere) was it helpful? (<i>p=0.086</i>)	1590		
Yes		61.8% (371)	56.4%(558)
No		6.2%(37)	5.9%58
Did the nurse or health worker listen carefully to you? (<i>p=.316</i>)	1502		
Yes		82.8% (480)	80.7%(744)
No		17.2% (100)	19.3% (178)
Did you feel respected by the nurse or health worker? (<i>p=0.016</i>)	1293		
Yes		84.8% (419)	79.5% (635)
No		15.2% (75)	20.5% (164)
Going to a clinic to get a condom is...(<i>p= 0.001</i>)	1450		
Very difficult for me		19.7% (119)	26.4%(256)
Very easy for me		27.8% (168)	17.9% (173)

4.1.1 Access to and perceptions of health care

Table 4 provides an overview of the students' answers related to access, and perceptions of health care services.

With a 76,7% response rate, significantly more boys than girls reported to ever having had vaginal sex ($p=.001$).

When asked if there were health workers they could visit at their school, 282 (16,4%) said yes, 426 (24,8%) answered no, and 752 (43,8 %) answered, "I don't know".

No differences were found between the sexes in relation to visitations of clinics, either *at school* or *outside* school. Within the last six months, there were a total of 16.4% students that had visited a health worker *at school*, while 26.1% had visited a clinic *outside* school. The reason for consulting a nurse or a health worker is uncertain.

More boys (29.5%) than girls (20.7%) had been to a clinic or a hospital in the past 6 months, due to injury as a result of violence caused by anyone.

There was also a significant ($p=.001$) difference between boys and girls as to how they felt about going to a clinic for a condom. Among the girls, 17.9% answered "very easy", compared to 27.8% of the boys.

The last time they visited, both girls and boys (81.5%) seems to have felt that they were listened to by the health care workers, and this also applied for to what extent they felt respected by the nurse or health care worker (81.5%). However, here there was a slight difference between boys and girl, whereas boys felt a little more respected than the girls ($p=.016$).

A difference also applied for the knowledge of existing health care services at school, where girls (40.9%) answered, "I don't know", more frequently than boys (32.9%).

Based on the questionnaire data, this overview and insight of students provides a foundation for understanding issues related to access and perceptions of health care. In the next section, a deeper insight to these issues can be obtained by investigating what the participant's perspectives revealed during the formative phase of the study.

4.2 Findings from the formative data

As a part of the systematic text analysis, this section presents the findings of the formative study. The sub-themes related to access and perceived quality in Table 2 are presented and discussed according to the three streams of influence based on the TTI model, including the environmental stream, the social stream, and the personal stream (Table 5).

Within each stream, the results are subsequently presented according to levels of influence, including the ultimate, distal and proximal. However, the findings do not necessarily address all the levels within one stream, but this will be accounted for as the findings unfold.

Streams of influence	Sub-themes
Cultural- environmental stream	Health workers knowledge and competence Perceived availability of the health clinic School and health clinic link Cooperation with NGOs Lack of knowledge
Social/normative stream	IPV Parental support Privacy and confidentiality
Intrapersonal stream	Self-confidence

Table 5: Streams of influence and subthemes

4.2.1 Cultural/environmental stream

This stream refers to an individual's cultural environment, and involves interactions with social institutions, information and opportunities that are predictive of values, expectation, knowledge and expectancies, that again are predictive of an individual's attitude towards that behaviour. In relation to cultural-environmental influences, the findings from interviews conducted with health and social workers provide an opportunity at *the ultimate level* to explore the health clinic's cooperation with schools and non-governmental organizations, what was working, what were the barriers and implications of how to improve the situation so to strengthen the cooperation.

The *ultimate level* represents the underlying causes that are furthest away from the behaviour and that the individual has little control over (Flay et al., 2009).

All of the health workers and social workers interviewed in the formative research were positive to different degrees of fostering a ***link between schools and the health clinics***. It was also widely agreed that the school is a good place for adolescents to learn about sexuality and sex-related issues. However, the link was reportedly in need of improvement. From the health workers' perspective, one of the reasons behind the lack of connection was

the continuous shortage of health clinic staff. One health worker expressed that there was a demand from the schools in the area, but they didn't have the capacity to meet the demand.

"I think there's a need because lots of schools phone and say, can't you do a program? (...) We don't have the staff or the capacity to go and do that. We don't have anybody to send. It's either doing this, they come into the clinic, or you do that. One's got to suffer."
(Health worker, female, clinic A)

Downsizing and lack of cooperation with the Department of Education, not being able to get in touch with the necessary support system in the community, and lack of consistency was the main findings among health workers perceptions.

Other difficulties they had to strengthen or to develop this link were the school requirements, paperwork, and waiting for permission for the health workers to enter and work in the schools. Whether the school was open to do a program and whether the parents agreed was stated as barriers.

However, one clinic seemed to have a better link to the schools than the other clinics, and said they'd send out a nurse,(a Health Promotion Officer) two times a year, and they also said they've got some schools in the area that referred students to them.

Among the social workers, some described not having any contact, calling the system "not functioning".

"I have no direct contact with them (health clinic) at all, no, because I wouldn't personally take a child there. So that, if, all we do is give the child information and make sure there is some kind of support system to take the child. In terms of legal implications it would be very dicey, for example, for me to take someone there for a pregnancy test."
(Female social worker, school 2)

And others described a link that seemed instable regarding the continuity:

"(..) You know, this year it didn't go as like last year, but last year they had a very good relation in terms of the clinics, because even the nurses they would come, even at the beginning of this year, they would come because they know that learners they don't want to go there to the clinic for contraceptives, so they came to them ..() They would be here for two, three hours."
(Female social worker, school 5)

When discussing what could be done differently in order to strengthen the school and health clinic link, a health forum where they could meet frequently with the schools was brought up. Words like "reach out more", "need to take action", and "communicating" were frequently used to express what needed to be done to improve the linkages.

It varied between the clinics on how much they *cooperated with NGOs* in their areas. None of the clinics seemed to have any consistent contact with organizations. At one clinic it happened every once in a while. If they had a young person they were concerned about, they could send them to a clinic they collaborated with and that were active in the community. Currently they had some programs on drug abuse and teenage pregnancy:

"If, ah, if there's a new project that, happens there, then they always inform us about it, and they, ah, concentrate on the, a lot on pregnancy amongst the teen mothers and so forth, so they have asked us to work with them on that also."

(Health worker, female, clinic B)

Another clinic had collaborated closely with an NGO nearby that had been involved in all clinics in the area with after school programs, where young people were teaching other young people about sex and HIV/AIDS. However, due to lack of funding, they had not been around for the last six months. The other two clinics reported not to have much contact with other organizations:

"We don't have anything at the moment. Um, we only have the sisters incorporated up the road here that does, um, unwed pregnant mommies and there's a new one opened in XX, at the moment? So we'll be in contact but not...no, we don't have much outside contact with organizations."

(Health worker, female, clinic C)

Health workers' training and competence relates to the culture-environmental stream in different levels, as this includes the health workers' knowledge and values that they have towards young people, hence this will affect both their own attitudes as well as young people's attitudes towards the clinic.

The training the health workers have had in dealing with young people's reproductive and sexual health varied substantially. One nurse had participated in a course about young people's sexuality ten years ago, some other nurses had been attending a course a couple of years ago. Another nurse had just recently participated in a course on adolescents and sexual behavior. None of the health workers had any training as to how to deal with young people in relation to interpersonal violence or sexual abuse.

At one clinic, in the focus group, one special problem came up, and this was a subject that the participants seemed very frustrated about. More concrete, they expressed difficulties when a couple came in for HIV-testing or something else, and it came out that one in the couple was HIV-positive and the other wasn't, and the one that was positive didn't want the

health worker to tell their partner. Due to confidentiality, they couldn't do anything, and they felt very frustrated about not being able to protect their other patient (or others) in their community.

"It's not on and something needs to be changed, because really you can't have, where does it stop, where does it begin? The one is positive, the other is still coming back for window period, and that is what we're sitting with. How do I protect the one that's still in the window period²⁰, and negative? How do I protect that one?"
(Health worker, female, Clinic A)

Confidentiality, privacy, and non-discrimination are shown in studies to be of great importance for young people's quality measures in their meeting with health workers and other staff members (Ambresin et al., 2013; Nair et al., 2015).

There were concerns among some students about being discriminated. This could be fear of being discriminated by a nurse, because of being sexually active and under a certain age, or discriminated during examination by the opposite sex.

"If you go for contraceptives to the clinic at the age of... if let's say you are below the age of 18 years, the nurses throw negative comments at you."

(Student, male, 18 years, School 5)

The **provision of services** are closely linked to the competence and knowledge of health workers in the cultural-environmental stream as this might influence young people's experiences of the health clinic at the *distal level*. If the services do not offer the services young people need, or the services provided doesn't meet their expectations, this might in turn influence their attitude at the *proximal level* (Flay et al., 2009).

The services mostly provided for young people was HIV-testing, contraceptives, pregnancy, referral for abortions, "morning after pill", and sometimes STI testing and TB-testing. Counselling in relation to HIV-testing seemed like a procedure at all clinics. Only one of the clinics tried to have a specific day for a teenage clinic that they tried to accomplish once every week, but emphasized that this was way too little, among other things this was because they said they'd experienced an increase in teenage pregnancies and cases of abuse that they didn't have the capacity to handle, and so they had to refer them to a NGO nearby.

There was also a problem that other patient groups didn't respect that those days were for teenagers, and they couldn't turn them away because they would then get in trouble with the management.

One clinic said there used to be a clinic across the street where young people usually went because it was especially for teenagers, but it was closed down some years ago by the government.

The ***perceived availability of the health clinic*** also represents the same *ultimate level* as the ***services provided*** and the ***competence and knowledge among health workers***. The availability might influence young people's access, knowledge and expectancies towards the clinic at a *distal level*. This again might influence their attitude, and in the end their decision, to access the health clinic at the *proximal level*.

Among health workers, school hours and clinic hours were one of the reasons why young people didn't go to the clinics. There was a unified opinion among the health workers that more should be done to make the clinics more available for young people, but they felt that they didn't have the capacity. As one health worker expressed:

But then also considering, you know, we do TB everyday, we have the STI clinic, we have the Baby clinic, we have different things that we need to do every day and we don't even have enough staff just to man what we're supposed to be doing here on a clinic basis.

(Health worker, female, clinic A)

From a social workers' perspective, the notion wasn't that different; however, this statement was carried out regarding lack of counseling in conjunction with TOPs:

The counselling services I'm not sure what, um, if it's sheer numbers, that they can't cope with it, or there's a lack of staff, I'm not sure what the problem is, but I'm picking up that the counselling doesn't always happen. Maybe just part of it happens but not the... To me there's a gap somewhere.

(Social worker, female, school 2)

Mostly, there were positive reflections and suggestions on how to foster improvements. Health workers focused mainly on the importance of education, giving moral support, and empowering the young, and they felt that they had a lot to teach young people. The health workers came up with suggestions like group sessions, workshops, raising awareness in the community, regular health-awareness runs, and generally interacting more with young people, and finding out about their thoughts and knowledge. Campaigns were also mentioned, but it had to be something regular, to ensure sustainability and continuity that again would contribute to building relationships.

"There's a lot more that we don't know about and, imagine having a big group and interacting, you know, in groups, in workshops with them. That would be great, sharing experiences, if they do. And you find once people... young people start talking they tend to want to tell, if they're in their own, sort of, groups rather than one on one. It's not always easy."

(Health worker, female, clinic B)

In terms of education, ***lack of knowledge*** stood out when participants spoke about the challenges regarding young people's reproductive and sexual health in their communities.

Within the cultural-environmental stream, knowledge is connected with the cognitive sub-stream at the *distal level*, which are associated with information, opportunities and interactions with social institutions, such as for example schools and health facilities. These social institutions are again associated with young people's values, expectations, knowledge and experiences, which again have a predisposing influence on attitude at the *proximal level* (Flay et al., 2009).

In the interviews, participants touched on several themes, like lack of knowledge on contraceptive use, inconsistent condom use, more teenage pregnancies, and younger and younger people transmitted with HIV/AIDS as some of the main problems facing young people's sexual and reproductive health. Ignorance and lack of knowledge was the most consistent concern articulated by the health and social workers. There was a feeling of frustration in their testimonials on how little young people actually knew, and their attitudes towards the knowledge that they possessed:

"They've been taught about AIDS and all kinds of things about sexuality, but when you actually sit and talk to a child who's in trouble the lack of knowledge is sometimes astounding."

(Social Worker, female, school 2)

There was a sense of powerlessness, especially among the health care workers:

"Oh, a lot of them are misinformed. So we try to kind of see where they're coming from, and try to put their thoughts into perspective, but not that it helps much."

(Health worker, female, clinic C)

In relation to HIV/AIDS, health and social workers both expressed that they got the impression that young people knew "everything" about the disease, but they didn't see it as something that could happen to them, indicating low levels of risk perception, which again is predicted by the information and knowledge an individual possesses (Flay et al., 2009).

Some had experiences with young people telling them that oral sex was common because they thought there wasn't any risk of transmission involved. One social worker expressed that she was under the impression that sex wasn't a big deal among young people

today, and told stories about students participating in binge drinking and risky sexual games not thinking about consequences:

“People know it is dangerous but they don’t really know or they don’t think (..) It’s not something that will ever happen to me, you know. It’s out there it’s not here.”

(Social worker, female, school 3)

The students themselves didn’t touch the issues in the same detailed way that the social worker did, and most talk around sexual issues were very superficial. It seemed with many of the participants that they were influenced by norms, and that they were polite in answering, but many of the answers were short and limited to “yes”, “no” or “I don’t know”. They seemed to be answering what was expected of them, pleasing the interviewer.

This also seemed present when asked about condom use, and if they talked about HIV/AIDS with their partner or friends, almost everyone that said they have had sexual intercourse said they almost always used a condom. Some girls reported going on contraceptives. Most of the students seem to have discussed HIV/AIDS, pregnancy and other sexual matters with their friends or girlfriend/boyfriend. Most of this was about the use of condoms to prevent themselves from either pregnancies, STI’s or HIV/AIDS.

“When I was talking about the condom we mentioned it to prevent pregnancy, we did not focus much on HIV/AIDS because sometimes the HIV/AIDS issue came last in our minds because we used to think since we are children we are not going to get HIV, and forgot that HIV spreads to anybody, so what we talked about the most regarding the condom was to prevent unwanted pregnancy.”

(Student, male, 18 y, when talking about discussing condom use with his girlfriend)

Some students talked about the fear of getting infected with HIV/AIDS:

I’m always so afraid because you like... you can’t really pick up on it, and if he cheats or if I cheat you’re like, what if he didn’t use a condom. And you don’t know if that person has HIV or Aids, or even like an STD, it’s like the same thing, the fact that you don’t know, um, what that person has, you don’t know that person. So we only keep to ourselves, and it’s better that way; that’s part of having a relationship (Student, female, 18y, school2).

Fear of HIV/AIDS relates to the cultural-environmental stream at the *proximal level*, and according to the TTI fear may be one of several predictive factors of knowledge and expectancies, and this might reflect how young people think about HIV/AIDS. This again might be a result of information and interactions with social institutions at the *distal level* (Flay et al., 2009).

A few of the students also mentioned that people didn't go to clinics because they were afraid of testing for STIs in fear of what the results might show. One said his friends were scared of getting a HIV- positive result, because this meant that their life was over, and the conclusion was that they'd rather not go test themselves.

Even though there were barriers in relation to SRH services, many of the students expressed that talking more openly, educating young people, and creating greater awareness about relationships, teenage pregnancy, HIV/AIDS, violence, drugs and alcohol abuse, and sexuality would be a way to make things better among youth in their community:

"(..) So as the youth it could be better if in every area we have access to community centers where we can meet at stipulated times to talk about such issues like teenage pregnancy, HIV/AIDS, and maybe if a child is involved in a relationship they must use a condom when they decide to engage in sex to avoid teenage pregnancy and HIV/AIDS".

(Student, boy, 18 years, School 6)

School was suggested to be a good place to raise awareness, because it reached children on an every day basis. One student also suggested educating parents to take their children to a clinic, and teach them how to protect themselves.

Other suggestions were education through advertisements in newspapers, posters and TV-programs. Continuity was also brought up, not just short programs that lasted for a certain amount of time. They wanted community programs with activities for children and a place where young people could come together and talk about what bothered them:

"...I think I will talk more about people, about violence, or I will try to make people more aware about violence (...)

That's the mindset of people that just has to be changed, and I think the subjects should be in that for, you know, more life orientation. We don't do that much; um, we just do HIV, which we obviously all know about: it's like, yes, don't do this, don't have sex; and so it's like that, just the basic."

(Student, female, 18 years, school 2)

This last quote not only reflects this young girl's thoughts on how to make people more aware about violence, it also reflects her attitude towards what she learns at school, and you get the impression that it is not very inspirational, nor that it is something she believes in.

4.2.2 Social/normative stream

In the social/normative stream of TTI, perceptions of intimate partner violence, sexual abuse and rape were linked to perceived gender norms, lack of role models, and young people

or their parents' drug and alcohol abuse at the *distal level* that is associated with social normative beliefs at the *proximal level*.

All participants recognized **intimate partner violence** in relationships as a major problem facing young people's reproductive and sexual health in the community, and this mirrors previous research that is pointing out the problem of violence in South Africa (Burton, 2008; Jewkes et al., 2010; Catherine Mathews et al., 2016; Mosavel et al., 2012; Petersen et al., 2005).

Although not every participant had experienced any form of violence close up, there was a notion that incidents of rape, sexual abuse and assault was a commonality. Most of the learners knew someone who had been involved in some sort of intimate partner violence or sexual abuse. Health and social workers reported that among young people the most common type of sexual violence was rape and abusive relationships, whereas the boy forced the girl to have sex either by threatening or hitting her.

Poverty was seen as the root to this problem, which again led to younger people engaging in relationships with older men and/or women because of the financial gain. Both younger boys and girls were mentioned in this context, but the girls in particular were seen as easily influenced by older men. Many of the participants mentioned this sort of behaviour, often referred to as transactional sex in the literature (Mosavel et al., 2012), where the girls received gifts and money, and they didn't know (or they ignored) that they in reality were victims of abuse or rape. Women were said to be dependent of their men, and some said this was due to unemployment.

"Obviously the, the teenagers are sexually active, the teenagers are, ... they're attracted to older men, because of the financial gain that they can get and (...), because of the poverty in our specific area, how they will do anything, and, (...) because drugs and things are so rife, how they would, ah, use sex as the, ah, for financial gain."

(Health Worker, female, Clinic C)

Thoughts on these difficulties from a male student's own perspective:

"Falling in love with a person your own age is very difficult because the person your own age (...) she expects you to have money that you will give to her every now and then, including buying airtime to phone her, if you do not call her then you are in trouble, she forgets that you are actually a student just like her,
(...) ...in some cases you approach a girl and she replies to you by saying "you are too young for me" you see." (Student, male, 18 years, school 5)

Parents' role was seen as passive and non-supportive in this regard, which emphasizes the notion of how deeply entrenched violence is in some of the communities.

Parents are a part of young people's social situation in the TTI's social stream, where the interpersonal bonding at the *distal level* represents young people's relationships with their parents or other immediate social relationships (Flay et al., 2009). Further the parent's behaviors and attitudes are associated with young people's normative perceptions (Flay et al., 2009).

They also think that it's normal, do you know what I'm saying. What are you complaining about? What is the issue here, you know? When... and we see it often especially amongst the black communities, when the guy has money, it's a huge problem. When the guy has money you see the girl. She'll come in with her mom. Maybe she's pregnant. She comes in with her mom and you can see she's not happy. She... and the mom will just want to get rid of everything and push it under the mat and whatever because money is power, hey. To lots of people money is power.

(Health worker, female, Clinic D)

As in other studies, the parents were perceived to have a strong influence on young people among the participants (Nair et al., 2015). Both health and social workers emphasized that parents were the best source of information, but around the sexuality subject very little or no communication seemed to take place, mainly because it was a taboo subject.

"I always feel that the best place to get information from is the parents, but it's the area where very little or no communication takes place whatsoever. It's still very much with our children's parents it's a taboo subject. It's a subject you just... you don't talk about it at home."

(Social Worker, female, School 1)

Both health workers and social workers also felt strongly that parents were often a barrier to a child's access to a clinic or educational services regarding sexuality, because they were reluctant to the idea of their child being sexually active, and if they starting to talk about it with their children or took them to a clinic it would mean that they encouraged their sexual behavior.

"Sometimes parents are aware that their children are sexually active but they won't take them, and I'll be like, you know, you know your daughter is sexually active. You need to take her to the clinic. You need to have tested, get her a pregnancy test and an HIV test, and you need to get her onto a contraceptive. Oh no, because that means I'm giving her permission."

(Social worker, female, School 1)

At the same time, the participants stressed the importance of getting through to parents, involving them in a positive way, so that they may boost their children's self confidence and ability to negotiate healthy sexual relationships.

The main barrier for the adolescents to access a health care clinic was due to ***privacy and confidentiality issues***, as reported by both boys and girls. They feared being recognized

by someone in their community, and they were afraid that someone would tell or ask their parents or guardians why they had seen them going to the clinic, which again would give them explanation problems.

Within the social stream of the TTI, the decision or intention of young people not to access a clinic because they fear social repercussions can be related to perceptions of norms, that again are influenced by others behaviour and attitudes toward this behaviour (Flay et al., 2009).

Some adolescents claimed that they didn't show up at the clinic because there were people there that knew their relatives and knew whom they were, as one female student expressed when talking about going for an HIV-test.

"I didn't know really where to go and I didn't want to go to the clinic because like people know me there, so I didn't want to go to that, so it's like a big hassle...."

(Student, female, 18 years, school 2)

One perceived norm was that going to the clinic meant that you were sexually active, or maybe sleeping around, or that you were infected with a STI, such as HIV. It was also proclaimed that because of the stigma around sexuality, young people would rather not use condoms instead of getting them for free at the clinic.

At one of the clinics, the health worker expressed that due to the greater demands of the community, adolescents had to sit for longer in the waiting area, which resulted in less and less adolescents coming to the clinic.

"So how the heck are you going to get a teenager to sit comfortable, and wait for the family planning, or for the STI, or anything teenager related if you're sitting next to, possibly, your neighbour, or your Mother's friend, or whoever. You're not going to come back; quite honestly, you're not going to come back. I wouldn't come back."

(Health worker, female, Clinic A)

In juxtapose, one health worker thought that some young people seemed comfortable accessing the clinic and that it wasn't a problem, especially if they went to a clinic outside their community. Most health and social workers agreed that it was threatening for young people to be seen by somebody heading for the clinic, but other than that they had no problem. Some said that the services itself were very accessible and that the adolescents knew where to go and that it was more a matter of the young peoples' attitude and choice:

(..) Some of them feel that some of the clinics in their areas are not, they don't always want to access the one in the area, because it's obviously a little bit threatening to be seen by somebody, so they sometimes prefer to go to the one perhaps nearer school, or in a friend's area, or something like that, but I think they do access the Clinic quite easily, yes, without any, um, embarrassment these days, yes.

(Social worker, female, School 2)

These statements might seem conflicting, but rather just represent two different perspectives on access. From one point of view, there is the objective access, and on the other side you have the perceived access. These two views represent a very important point in terms of improving access for young people, and will be elaborated upon in the discussion chapter.

4.2.3 Intrapersonal stream

Within the streams of influence, the intrapersonal stream focuses on an individual's personality, resilience and self-control at the *ultimate level*. Young people, especially during time of adolescence, are still in development of their personal identity that makes them more psychologically vulnerable. This influences their sense of self, self-control and social competence, which is associated with the self determination, social and general skills at the *distal level*, which again leads to the self efficacy and the behavioural control at the *proximal level* (Flay et al., 2009).

The intrapersonal stream is also a remainder of the importance of the individuality in this context, as 'young people' is an inclusive term (Wood et al., 2006).

Thoughts emerged among some participants over young people not being encouraged enough to express themselves regarding their sexuality, because it was a taboo subject. A social worker said that young people, especially those that were not sure of their own identity, might isolate themselves and become depressed or suicidal, and expressed that she was concerned about this development.

Thoughts on lack of self-confidence was shared by one young participant:

"All that I can add is that many people in, in the community and so, we doubt too much in, we doubt ourselves too much, we don't think - like many of them don't think little of themselves but many of them think "I cannot do that" or so.

The 'self confidence' is not high, the self- confidence."
(Student, male, 18 years, school 4)

As the participants expressed it, the lack of encouragement from others was seen as a reason for these emotions, which highlights that interactions between the different streams exist, and this will be explained in the next section.

4.2.4 Flows and interactions within the TTI

As the findings were presented within each stream of influence with referrals to the different levels, as mentioned in section 2.5, it is important to note that there is causal connections between the three streams of influence, and that factors in one stream might influence factors in another stream (Flay et al., 2009).

In the case of fear of HIV/AIDS among young people, for instance, is related to the cultural-environmental stream, because it can be a predictive factor of one's knowledge, although it might also affect the individual's sense of self and self-control at the distal level in the intrapersonal stream, which again can be associated with the self-determination of a person that affects his or hers self efficacy and behaviour control at the *proximal level*.

The perceptions of interpersonal violence in the community is another example is, although here presented under the social stream of influence, it is also strongly connected with the cultural-environmental stream, because the social situation or context in which the violence occur, is highly connected with the broader social environmental situation where a young person grows up and lives (Flay et al., 2009).

There are many aspects of these findings that could be elaborated on and deeply investigated with the TTI as framework; however, the goal of this thesis is the perceived quality and access to health services among young people, and the findings above have provided rich insights to the situation of Western Cape, South Africa, and have further given a solid ground for discussing these issues.

5 Discussion

The findings of this study suggest that there are indeed multiple influences that affect young people's access to sexual and reproductive health care services in the Western Cape, South Africa, and that there *is* room for improvement in the quality and friendliness of the sexual and reproductive health care that is provided.

This chapter will discuss the findings from both the questionnaire data and the formative study, merging the findings together with theory and how it relates to the WHO global standards. The discussion will be structured to the same, different streams of influence as in the findings chapter, and by doing this the research questions that has guided this study will be answered.

5.1.1 Structural barriers and community support

Being positive to the idea of cooperating with schools, health workers experienced some barriers in achieving this; downsizing, not having enough staff, and lack of cooperation with the Department of Education emerged as the main reasons, which also resulted in a lack of consistency in communication with the schools. Other barriers were school requirements, the amount of paperwork, and waiting for permission to get access.

Schools' openness towards cooperation was also mentioned as a barrier, and parents were given some fault, due to schools being required to get permission from parents on sexual education.

On the other hand, social workers also mentioned inconsistency, that the system was dysfunctional, and that overall there seemed to be room for improvement. Among the students in the formative research, some reported to have had HIV/AIDS-tests at school, but the impression was that external health workers or organizations carried this out. The WHO's standard 2 weighs the importance of the health care facilities to reach out, and that it is vital for health workers to engage in partnerships with other community organizations and schools, in order to address the value of providing health services to young people. Hence, by doing this, the output will be that the community organizations support the provision and utilization by young people (WHO, 2015a).

Data from the questionnaire showed that many of the students didn't have access to a health worker or nurse at school, and many more students didn't know if there were any.

This reflects the historical lack of collaboration, stated in the South African integrated school health policy (2014), between the Department of Health and basic education.

However, with the new policy in place, policies are now targeting to promote young people's health by collaboration with the department of health and also organizations. Hopefully this will lead to improvement of schools' health services, and also make the link between school and primary health clinics better.

Community support from, and cooperation with, organisations, was reportedly varying a lot, and had no solid compound. Health workers implied that the clinics seemed to have knowledge in somewhat degree about organizations in their community; this is very strange considering the fact that many organizations focus on adolescents, and could be a huge resource for the primary health clinics.

The WHO's standard 2 focuses, as mentioned, on the health clinics' *responsibilities* to outreach. However, they are in fact dependant of being met with the will to cooperate. Likewise, they need to have enough staff to carry out this standard. Among all the health workers, shortness of staff was reported as an issue that restrained them in their work.

Ultimately, economy and finances are in fact important influences of all the WHO standards, and it might seem that even though the government creates comprehensive and forward-looking policies that promotes young people's access to SRH services, the question is how to prioritize the allocation of the resources required for the implementation of such policies (WHO, 2015b).

As research has shown, even though governments do their part, cultural taboos might still present challenges in the community, and it is important to address these underlying causes that affect young people's behaviour in such a drastic way (Shaw, 2009). Accordingly, WHO states in standard 2, community support, that without gatekeepers the health programmes will not survive (Nair et al., 2015).

5.1.2 Quality and friendliness

Knowledge and competence of young people's reproductive and sexual health among the health workers in the formative research were very distinct from each other, especially in relation to the training that they'd received. However, they seemed pretty updated on what kind of problems young people were facing, due to their experiences and interactions with them, and the community in general.

One problem that emerged among the health workers, was the confidentiality that one group discussed in relation to HIV/AIDS. Out of this, they seemed to have a high work ethic

and maintained their patient confidentiality clause, although they found it very hard and controversial.

The attitude health workers have towards young people is important. It is important to be respectful, supportive, honest, trustworthy and to communicate in a friendly way, and in previous studies this is at the core of quality service provision among young people (Ambresin et al., 2013; WHO, 2015a).

The WHO's standard 4 on providers' competencies, emphasize *inter alia* that health workers and clinic staff must show young people respect, and that they must protect and fulfil young people's rights to information, privacy, confidentiality and non-discrimination.

Health workers' knowledge and values are also incorporated in standard 4, this also represent the health workers' attitude towards young people (Ambresin et al., 2013; WHO, 2015a).

None of the health workers in the formative research had any training on how to deal with violence and sexual abuse, which is quite alarming given that South Africa has the highest rates of violence in the world, high rates of rape and abuse, and the overwhelming evidence that IPV lead to SRH issues and unwanted pregnancies (Denno et al., 2015; Mosavel et al., 2012).

Correspondingly, the WHO's standard 3, appropriate package of services, encompasses how the provision of comprehensive care shall fulfil the needs of all young people (WHO, 2015a). Services that were provided for young people in the clinics of this study were mostly HIV-testing, contraceptives, pregnancy-testing and abortion referrals, indicating a lack of comprehensiveness in the provision of quality health care for adolescents (WHO, 2015a).

Lack of counselling in relation to TOPs was seen as a major problem since very young girls were left to themselves and their feelings. South Africa's laws on TOP gives girls from the age of 12 the right to decide for themselves, but there is no such policy as to ensure that these young girls get the support and counseling they need (Chandra-Mouli, McCarraher, Phillips, Williamson, & Hainsworth, 2014).

In the formative research, health workers implied that one barrier for young people was trouble with time, so they had to miss a couple of hours at school to attend to the clinic. At one clinic they tried to have a day once every week for teenagers, but found difficulties because of orders to prioritize other patients and therefore the teenage clinic was put on hold. Another problem with this clinic was that other members of the community came on those

days, and the health workers weren't allowed to refer them to the next day, and so the teenager day was no longer exclusively for teenagers.

In relation to the WHO's standard 5, facility characteristics, which emphasizes accessibility and operating hours that are suitable for young people, the health clinic is here trying to be more adolescent friendly, however they are hindered because of structural barriers (WHO, 2015a).

In the TTI, a feedback loop (immediate feedback of good or bad experience) adds to first hand knowledge about a specific behaviour (Flay et al., 2009). Accordingly, if what young people gain from a health visit is worth overcoming their mentioned barriers, or if a health facility takes measures to make the visit for young people friendlier and enhance quality in terms of waiting time and privacy, it will probably make their experience with the health service good, and they will be more likely to use it again.

Among students from the questionnaire, a substantial number were positive when asked about their perception of feeling respected, listened to, and if the visit was helpful. This indicates that the quality and friendliness of the health clinic they visited relates to the WHO's standard 4, providers' competencies (WHO, 2015a).

Compared to the number of students that experienced respect and being listened to, there were fewer who experienced that the health visit was helpful. This might shed light on the previous research of the gap between the service offered at the health clinics compared to what young people actually need (Tylee et al., 2007), bringing the subject back again to the importance for young people's wish for more comprehensive care.

5.1.3 What you do not know...

A cluster related to lack of knowledge and ignorance emerged in the formative data. Health and social workers expressed their concerns that young people they'd interacted with both knew less than they thought they knew, and that they seemed ignorant and didn't understand the consequences of their behaviour. Although the last concern is quite usual when speaking about young people, it is vital that young people get more aware, especially in a country where there are so many potential risks.

The WHO's standard 1, adolescent health literacy, emphasize that a health facility implements systems to ensure that adolescents are knowledgeable about their own health, when and where they can get this, and that the health literacy is more than just being able to understand basic health information (Nair et al., 2015).

Improving people's health and their quality of life, and empowering them for a better future by education is nothing new, but as previous research highlights, the topic of comprehensive sexual education is still a contentious topic in many conservative and religious cultures (Nutbeam, 2000; Shaw, 2009). Among the participants, there was a sense that the sex education students get at school is only scratching the surface of a very current and desired subject that no one wants to talk openly about.

Here, the WHO's standard 2 manifests itself, again weighing the importance of cooperation with other community members and organisations, like schools, to inform and get acknowledgement for the vital knowledge of SRH. Without knowledge about diseases, health risks and the potential benefits of altered health behaviour, people lack the necessary tools to choose good health habits and protection (Bandura 2004).

This also connects to the WHO's standard 4, providers' competencies, and how their attitude, knowledge and skills are at the core of quality services provision (Ambresin et al., 2013; WHO, 2015a). Health workers in this study seemed very keen on engaging more in working with young people, and felt they had a lot to teach them. They also came up with suggestions like having group sessions to raise awareness, which in the process would allow them to get to learn young people's own perspective and get an idea of where they were coming from.

5.2 Social/normative stream

"Our learners are exposed to domestic violence a lot of the times but it's like part of life."
(Social Worker, female, school 3)

5.2.1 Intimate partner violence and transactional sex

Among the participants from the formative study, a cluster of intimate partner violence and perceived gender norms in the community emerged as a major problem regarding young people's sexual and reproductive health.

This actually seemed normal, as most students knew someone who had been involved in some sort of violence or sexual abuse, and this relates to the previous literature on violence from South Africa (Jewkes et al., 2010; Catherine Mathews et al., 2015; Mosavel et al., 2012; Wubs et al., 2013).

Findings from the questionnaire data showed that a substantial amount of students mainly boys, had been to a clinic in the last six months because of violence. Even if these numbers do not tell anything about what kind of violence they experienced, it is still

worrying numbers. Because these issues seem to be underreported, another concern is that these numbers may probably be underestimated. One reason could be that violence is so common that they do not go to the clinic unless it is bigger trauma involved, or that many young people do not know their rights when they get abused; on the other hand, those who do know, might be afraid to get repercussions if they report it (Mosavel et al., 2012).

This subject was also touched upon by health and social workers, where they expressed that girls didn't see it as rape if their partner forced themselves on them or coerced them into having sex. This leads to another cluster related to unhealthy relationships where violence and abuse emerged when the girl was a lot younger than the boy. The girl, given gifts and money from her older boyfriend, would position herself in a situation of risk of sexual abuse. Getting an insight to the perceived problems young people experience in their social situation that affects their sexual and reproductive life is important when assessing the *quality* and *friendliness* of the provision of health services and also to know what services to provide (WHO, 2015a).

Transactional sex is shown in previous studies to be a longstanding problem in South Africa (Jewkes, 2002; Mosavel et al., 2012). There is also substantial evidence that IPV is connected with the risk of getting HIV (Wubs et al., 2013).

In their standards, the WHO (2015a) use the term "key population" when referring to defined groups that have increased risk of being infected with HIV due to higher risk behaviour. Adolescents in this group are said to be in even higher risk, and therefore they have specific health related needs. However, in the South African context, there is a considerable amount of research that shows that women in general are a part of the "key population" (WHO, 2015a).

Among the health workers, they seemed to be upset that there are more and more young girls coming in transmitted with HIV, and there also seemed to be an increase in the amount of teenage pregnancies. Clearly, the health care workers knew a lot about these issues and they acknowledge that they are important for the SRH of young people, but again there seems to be structural barriers that keep the health facilities from providing an appropriate and comprehensive package of care (standard 3).

5.2.2 Parents and guardians, important for access and vital for change

Health and social workers revealed that there were certain restraints in relation to the parents of their students and patients. This resulted in problems like parents having too much

to deal with, and that they didn't have the capacity to get involved in their children's lives, or that they thought talking about sex or taking them to a clinic was tantamount with giving them permission to have sex. This sheds light of the importance of a comprehensive approach when improving the quality and access of SRH to young people, and that even though governments do their part and reinstate progressive policies to enhance young people's right to quality SRH services, cultural taboos still present challenges in the community (Shaw, 2009).

The family is very important for young people's health and wellbeing, and has reportedly the most influence regarding health information (Nair et al., 2015).

This notion was supported in the interviews with the health and social workers, as they all acknowledged the importance of parent support for young people, and they stated a wish for improvement in this area. However, most of the time they experienced lack of support or non-support, and they seemed very frustrated about this. In this sense, parents were also seen as role models that expressed bad behaviour that demonstrated bad behaviour to their children. One of these issues was gender norms, where a mother got abused by her partner, influencing the child to believe that this is "normal", which again can lead to a bad circle of violence and abuse, where the child, boy or girl, also engages in this sort of behaviour. In the WHO's standard 2, community support also includes the aim of implementing systems to ensure that parents and guardians recognize the value of providing health services, and support such provision to young people (WHO, 2015a).

5.2.3 Perceived access versus objective access

First of all, a cluster related to young people's fear of being recognized by other people in the community because of stigma when accessing a clinic, emerged as an important contributing factor and as a barrier for young people accessing SRH clinics in the formative data.

Interestingly, contradictions were found in statements of health and social workers. They claimed the services had good accessibility, and that the problem was more the young people's attitude and choice rather than the access. In reality it might seem that young people in the study have pretty good access, yet the young people's perceptions tell another story. This draws a clear connection to the WHO's standard 8, adolescents' participation. Consulting young people in the community will give an indication on how they perceive their

access to health care, which really is a key piece in the planning for, and development of, more youth friendly health clinics – especially with regard to SRH services (WHO, 2015a).

In the questionnaire data, there were a significant difference between girls and boys and how they felt about going to a clinic to get a condom. Boys perceived the task much easier than the girls, however, these perceptions conveys to the previous research where privacy and confidentiality is an important factor, indicated by young people all over the world (Ambresin et al., 2013; Tylee et al., 2007). Lack of confidentiality and fear of being recognized is also found in studies as a major reason for young people's reluctance to seek help (Tylee et al., 2007). This again highlights the need of the provision of the WHO's standard 2, as mentioned earlier in this discussion, that target the community, which also includes parents and other key members of the community to get support for young people's health care (WHO, 2015a).

5.3 Young people's “sense of self” in the intrapersonal stream

Emerging from the formative research, some young people, especially those that are insecure in relation to sexuality, seem to struggle more than others with sexuality being a taboo subject.

As mentioned in the findings, the term “young people” is a very general approach. There is still a huge diversity and variety within this term and in every context. Acknowledging this is fundamental in order to also be able to reach the marginalized and most vulnerable that so often fall outside in the more general approaches within public health promotion (Wood et al., 2006).

Here, drawing in the WHO's standard 6, equity and non-discrimination, might be useful because the standard stresses the importance that policies and procedures need to be in place for the provision of equitable care (WHO, 2015a). Further the standard emphasize the importance of reaching out to vulnerable and marginalized groups in the community, hence the output will be the involvement of vulnerable adolescents in the planning, monitoring and evaluation of the health services which then again will ensure equal experiences of care. This do however require actions on a higher level where governance need to advocate with district managers to ensure their ownership and support for key policies (WHO, 2015b).

5.4 Methodological discussion

As presented in the introduction of this thesis, the main purpose of writing on this topic was to shed light on young people's perceptions of, and access to, quality SRH services in Western Cape, South Africa. In this section the researcher attempts to address the limitations of the study and also answer questions in terms of validity.

In both quantitative and qualitative research there is validity and reliability measurements that needs to be accounted for. While the validity in social science is restricted to whether the researcher is measuring what the study is meant to measure and probability calculation, the qualitative validity concerns to what extent that a method investigates what it is supposed to investigate (Kvale & Brinkmann, 2009).

In this study, the weight has been on the formative data, and therefore the validity criteria have been selected accordingly, and the limitations and validity of the quantitative data has been accounted for where appropriate.

5.4.1 Limitations

Due to the scope and time limit of this thesis, there are some important limitations to address. First of all, it would have been possible to explore transcribed interviews from teachers, principals and police officers. With more time, it would have been interesting and valuable to also include teachers and principals to get their perspectives on the researched topic.

Because of the limits of time, the qualitative data was emphasized at the expense of the questionnaire data, which resulted in a limited data analysis. It would've been expedient to analyse differences in socioeconomic status and age, in addition to differences in sex. In addition, the data also allowed for studying several more variables on intrapersonal violence and sexual behaviour, which would have given a richer description of the study population.

Another limitation was that the data collections that included the young people's own perspectives (questionnaire data and interviews with students) were restricted to young people who were in school, excluding out of school youth that would possibly be more involved in sexual risky behaviour and violence (Aarø et al., 2014). On the other hand, health and social workers are in a position where they probably meet young people from all social backgrounds, hence enabling them to provide rich information of the situation in the community. At last there are limitations in the questionnaire data, where the questions asked

about health care visits just give a general impression of health care and not for sexual and reproductive health care.

5.4.2 Validity

Descriptive validity includes the researchers reporting of the collected data collections, and how the researcher interprets the study findings. The data were already transcribed and translated, and the transcriptions (that in fact are a part of the analysis itself) might be a concern due to the fact that important information and details such as cultural expressions and interpretations may have been lost (Kvale et al., 2009). However, some expressions were documented in the transcriptions, like laughter, hesitating, and over talking, and sometimes there were comments from the interviewer added at the end of the interview with comments from on how the interview went, which can be considered as a strength to support the descriptive validity of the study. In some of the quotes in the thesis, pieces of text were modified, and this may paradoxically give the reader another picture of the conversation than the original one. This might impair the validity, although the analysis is thoroughly described to strengthen the descriptive validity of this study (Kvale et al., 2009; Malterud, 2012).

In this study, the interviews were recorded with an audio player and transcribed shortly after the interviews took place; however, I did not utilize this. There are several issues important to address in this matter.

Interpretive validity evolves around the researchers knowledge, honesty, experience and fairness and how he or she interprets the participants statements, and to what extent the researcher gives a valid and true picture of the participants view of the studied phenomena (Maxwell, 1992). By not performing the interviews, the interpersonal communication is lost and in that sense the interpretive validity might be affected negatively; on the other hand, one may argue that it can strengthen the validity because the researcher is more objective when reading through the transcribed material and does not carry with her/him any personal emotions towards any of the participants (Kvale et al., 2009).

Theoretical validity includes to what degree the researcher has managed to explain the phenomenon adequately; thus it refers to the application of theory, and to what extent this theory is connected and “makes sense” to the studied phenomena (Maxwell, 1992). The reason for choosing the TTI as a framework is, as mentioned in chapter two, due to the

evidence in former research that points out the complexity of the field of young people's sexual and reproductive health.

There were equal gender representatives among the interviewed learners, and adding health workers and social workers in the analysis provided a rich variety of information.

External validity addresses whether the inferences made will be valid if applied to other persons or settings (also referred to as generalizability), and Maxwell explained it as "to what extent to which one can extend the account of a particular situation or population to other persons, times, or settings than those directly studied" (Maxwell 1992, p. 293). The variety and amount of data collected both quantitative and qualitative gave a more solid base of information on the researched topic.

Cultural differences are relative and hard to generalize; limiting the external validity is the specific context of South Africa, with its special history of violence that is entrenched in the society. However, with the aim of mapping the perceptions of access and quality versus the objective access and quality of SRH services for young people, the comprehensive approach enhances the external validity and demonstrates that the framework of TTI and the WHO standards can be utilized in another setting.

6 Concluding remarks

This section will summarize the main focus of the thesis and its findings in order to provide a brief overview of the thesis, followed by key recommendations for future research.

The findings of this study highlight young people's need for reproductive and sexual health care facilities that are adapted to their needs.

In Western Cape, South Africa, health and social policies are more or less in place and there have been several improvements on the area to secure young people's rights to sexual and reproductive health services however, experiences drawn from the health workers show another picture where downsizing, shortage of staff, and clinics closing down, is the reality of what is going on.

This study also reveals that all though there are clinics available for young people to attend to, there is a tension between young people's perceived access and the objective access. One of the most important barriers for this perceived access was young people's fear of being recognized while accessing health services because of stigma, lack of knowledge and ignorance.

Intimate partner violence and perceived gender norms in the community emerged as a major problem regarding young people's sexual and reproductive health among the participants. Lack of parent's support and presence was also seen as a more or less indirect barrier for young people's access to both SRH services and education.

After looking into how young people in Western Cape experiences the friendliness and quality of health care services and how this relates to the WHO global standards, the data indicated that students were overall satisfied with the providers' competencies, but the services provided could be more comprehensive.

Further there is a need for improvement of quality and friendliness at the health clinics on all areas, but by frequently returning to the WHO standard on community support clarifies the importance of cooperation, engaging key members of the community for a better future for young people and their right to live a life free of stigma, violence and life threatening disease. This is also highlighted by WHO as the one standard that is vital for the survival of health interventions (WHO, 2015a).

These findings substantiates previous research in the same field, where the emphasize lies on the importance of addressing the underlying determinants that hinders access by cooperating with various stakeholders such as parents, community members, and policy makers to enable the environment so that young people get aware of their SRH and human

rights (Marston & King, 2006; Catherine Mathews et al., 2016; Nair et al., 2015; Svanemyr et al., 2015).

This study also highlights the importance of including young people in the development of health services to obtain valuable insight to the world of young people in accordance with WHO, standard 8, and also that future research intervention should focus more actively on the participation of young people. Not only for mapping out how they perceive their access, but actively involve them in the planning, implementation and evaluation of future interventions (WHO, 2015a).

Another issue that came up among participants were the wish for programs that were consistent. Too many interventions and programs are beginning and ending after too short time, while studies have shown that working with behaviour change takes time before showing results (C. Mathews et al., 2012; Catherine Mathews et al., 2016). This is also why the main contributor should be the government, empowering primary health clinics to ensure that they have the resources and finances they need so that they can implement a provision of quality health care that encompasses all the standards of WHO. Only then can there be sustainable and durable SRH services for young people that is so urgently needed.

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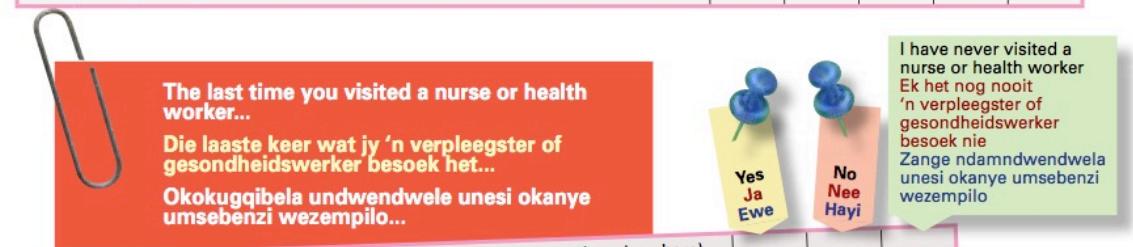
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Looking after your health

Om na jou gesondheid om te sien

Ukunakekela impilo yakho

		Very easy for me Baie maklik vir my Kulula kakhulu kum	Easy for me Maklik vir my Kulula kum	Nor sure Nie seker nie Andi qiru sekang'a	Difficult for me Moeilik vir my Kunzima kum	Very difficult for me Baie moeilik vir my Kunzima kakhulu kum
47	How easy or difficult is it for you to ask for help when you have painful thoughts, feelings and experiences? Hoe maklik of moeilik is dit vir jou om hulp te vra wanneer jy pynlike gedagtes, gevoelens en ervarings het? Kulula okanye kunzima kangakanani kuwe ukuba ucele uncedo xa unengcinga ezibuhlungu, uva kabuhlungu kwaye kuthe kwenzeka into ebuhlungu kuwe?					
48	How easy or difficult is it for you to deal/cope with painful thoughts, feelings and experiences? Hoe maklik of moeilik is dit vir jou om pynlike gedagtes, gevoelens en ervarings te hanter? Kulula okanye kunzima kangakanani kuwe ukuba udile/umelanee neengcinga ezibuhlungu; indlela oziva ngayo ebuhlungu kwakunye nento ethie yenzeka kuwe ebuhlungu?					
49	How easy or difficult is it for you to discuss your painful thoughts, feelings and experience with others? Hoe maklik of moeilik is dit vir jou om jou pynlike gedagtes, gevoelens en ervarings met ander mense te bespreek? Kulula okanye kunzima kangakanani kuwe ukuba uxoxe/uthethe ngengcinga zakho exibuhlungu; indlela oziva ngayo kwakunye nento ethie yenzeka kuwe ebuhlungu?					
50	How easy or difficult is it for you to ask for help from a counsellor or social worker when you have painful thoughts, feelings and experiences? Hoe maklik of moeilik is dit vir jou om hulp te vra van 'n berader of maatskap-like werker wanneer jy pynlike gedagtes, gevoelens en ervarings het? Kulula okanye kunzoma kangakanani kuwe ukuba ucele uncedo kwi khansila okanye unontlalo-ntle xa unengcinga ezibuhlungu; uva kabuhlungu kwaye kwenzeka into ebuhlungu kuwe?					
51	Have you EVER spoken to a counsellor? Het jy al OOIT met 'n berader gepraat? Ingaba wakhe watthetha ne counsellor?	Yes Ja Ewe	No Nee Hayi			
52	Have you EVER spoken to a social worker? Het jy al OOIT met 'n maatskaplike werker gepraat? Ingaba wakhe watthetha no nontlalo-ntle?			Yes Ja Ewe	No Nee Hayi	I don't know Ek wiet nie Andazi
53	Are there nurses or health workers that you can visit at school? Is daar verpleegsters of gesondheidswerkers wat jy kan besoek by die skool? Ingaba kukho oonesilamanesi okanye abasebenzi bezempilo ongakwazi ukubandwendwela esikolweni sakho?					

Looking after your health Om na jou gesondheid om te sien Ukunakekela impilo yakho	
	
	<p>In the past 6 months have you visited a nurse or health worker at your school?</p> <p>54 In die laaste 6 maande, het jy 'n verpleegster of gesondheidswerker by jou skool besoek? Kwinyanga ezintandathu ezidlulileyo ubukhe wandwendwela inesi okanye umsebenzi wezempilo esikolweni sakho?</p> <p>In the past 6 months have you visited a nurse or health worker at a clinic outside of your school?</p> <p>55 In die laaste 6 maande, het jy 'n verpleegster of gesondheidswerker by 'n kliniek buite die skool besoek? Kwinyanga ezintandathu ezidlulileyo ubukhe wandwendwela inesi okanye umsebenzi wezempilo kwikliniki ngaphandle kwasikolweni sakho?</p> <p>In the past 6 months have you spoken to a counsellor about problems?</p> <p>56 In die afgelope 6 maande, het jy met 'n berader gepraat oor probleme? Kwinyanga ezintandathu ezidlulileyo ubukhe watetha nekhansila malunga neengxaki?</p> <p>In the past 6 months have you spoken to a social worker about problems?</p> <p>57 In die afgelope 6 maande, het jy met 'n maatskaplike werker gepraat oor probleme? Kwinyanga ezintandathu ezidlulileyo ubukhe watetha nonontialonthe malunga neengxaki?</p>
	 <p>The last time you visited a nurse or health worker...</p> <p>Die laaste keer wat jy 'n verpleegster of gesondheidswerker besoek het...</p> <p>Okokugqibela undwendwale unesi okanye umsebenzi wezempilo...</p> <p>I have never visited a nurse or health worker Ek het nog nooit 'n verpleegster of gesondheidswerker besoek nie Zange nadamndwendwela unesi okanye umsebenzi wezempilo</p>
<p>58</p> <p>The last time you visited a nurse or health workers (at school or elsewhere) was it helpful?</p> <p>Die laaste keer toe jy 'n verpleegster of gesondheidswerker besoek het (by die skool of érens anders) het dit gehelp?</p> <p>Kwixesa lokugqibela undwendwala unesi okanye umsebenzi wezempilo (esikolweni okanye kwenye indawo) ingaba yaba luncedo lonto?</p>	
<p>59</p> <p>Did the nurse or health worker listen carefully to you?</p> <p>Het die verpleegster of gesondheidswerker mooi na jou geluister?</p> <p>Ingaba inesi okanye umsebenzi wezempilo uye wakumamela ngnonophelo?</p>	
<p>60</p> <p>Did you feel respected by the nurse or health worker?</p> <p>Het jy gevoel die verpleegster of gesondheidswerker het jou gerespekteer?</p> <p>Ingaba uye waziva uhlonitshiwe yinesi okanye umsebenzi wezempilo?</p>	
<p>61</p> <p>In the past year, have you received family planning from a health worker or a clinic?</p> <p>In die afgelope jaar, het jy gesinsbeplanning van 'n gesondheidswerker of 'n kliniek gekry?</p> <p>Kunyaka odlulileyo, ubukhe wafumana ukucwangcisa kumsebenzi wezempilo okanye ekliniki</p>	
<p>62</p> <p>In the past year have you received family planning from a health worker at your school?</p> <p>In die afgelope jaar, het jy gesinsbeplanning van 'n gesondheidswerker by jou skool gekry?</p> <p>Kunyaka odlulileyo ubukhe wafumana ukucwangcisa kumsebenzi wezempilo esikolweni sakho?</p>	



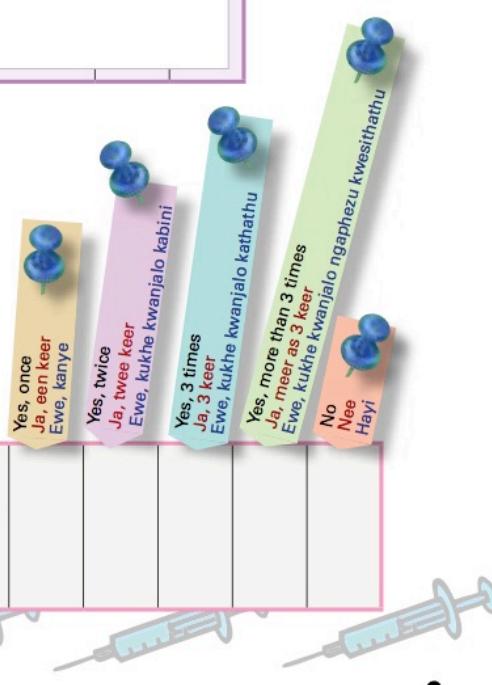
63 In the past year did you get a condom from any of the following places or people? (Yes/No for each response options)

In die afgelope jaar, het jy 'n kondoom van enige van die volgende plekke of mense gekry? (Ja/ Nee vir elkeen van die antwoord oopsies)

Kunyaka odulileyo ubukhe wafumana ikhondom kwenye yezindavo zilandelayo okanye abantu? (Ewe/ hayi kwiopshini yempendulo nganye)

Clinic or hospital Kliniek or hospitaal Kliniki okanye isibedlela		
School Skool Esikolweni		
Shop Winkel Evenkileni		
Pharmacy Aptek Ekhemesti		
Friends Vriende Abahlobo/iitshomi		
Parents Owers Abazali		
Family members Familielede Amalungu efemeli		
Public toilets Openbare toilette Kwizundlu zangasese zika wonke wonke		
Boyfriend/girlfriend Kérel/meisie Kwiqabane lakho (iowu okanye icherry yakho)		
Other (please describe) Ander (beskryf asseblief) Enye (Nceda ucacise)		

64 In the past 6 months, have you ever been treated (at a clinic or hospital) for an injury as a result of violence caused by anyone?
In die afgelope 6 maande, was jy al ooit behandel (by die kliniek of hospitaal) vir 'n besering as gevolg van geweld wat veroorsaak is deur iemand?
Kwezinyanga zintandathu zigqithileyo, wakhe wanyangwa (ekliniki okanye esibhedlele) ulimele ngenxa yomlo obuqalwe ngomnye umntu?



What do you think about condoms?

Wat dink jy oor kondome?

Ucinga ntoni ngekhondoms?

<p>Imagine what the people in your life would think about you using condoms.</p> <p>Verbel jou wat die mense in jou lewe daaroor sal dink dat jy kondome gebruik.</p> <p>Yibanomfanekiso-ngqondweni ukuba abantu abasebomini bakho bangacinga ntoni ngawe xa usebenzisa ikhondoms.</p>		Strongly agree Stem beslis saam Ndiyavuma Kakhulu	Agree Stem saam Ndiyavuma	Not sure Nie seker nie Andiqinisekanga	Disagree Verskil Andivumi	Strongly disagree Verskil beslis Andivumi Kakhulu
106	Most of my friends think that I should use a condom when I have sex. Die meeste van my vriende dink dat ek 'n kondoom behoort te gebruik wanneer ek seks het. Itshomi zam ezinanzi zicinga ukuba mandisebenzise ikhondom xa ndisabelana ngesondo.					
107	My parents/caregivers think that I should use a condom when I have sex. My ouers/vorsorgers dink dat ek 'n kondoom behoort te gebruik wanneer ek seks het. Abazali bam okanye abantu abandigcinayo bacinga ukuba mandisebenzise ikhondom xa ndisabelana ngesondo.					
108	Most of my other family members think that I should use a condom when I have sex. Die meeste van my ander familie-lede dink dat ek 'n kondoom behoort te gebruik wanneer ek seks het. Amalungu amaninzi efemeli/osapho lam acinga ukuba mandisebenzise ikhondom xa ndisabelana ngesondo.					
109	My boyfriend/girlfriend thinks that I should use a condom when I have sex. My kērel/meisie dink dat ek 'n kondoom behoort te gebruik wanneer ek seks het. I-owu/i-cherry Yam icinga ukuba mandisebenzise ikhondom xa ndisabelana ngesondo.					

How hard or easy is it for you?

Hoe hard of maklik is dit vir jou?

Kungazima okanye kungalula kangakanani kuwe?

<p>Even if you have never had sex, imagine what it would be like.</p> <p>Selfs as jy nog nooit seks gehad het nie, verbel jou hoe dit sal wees.</p> <p>Nokokuba zange wakhe wabelana ngesondo, yiba nomfanekiso ngqondweni ukuba bekunokuba njani.</p>		Very difficult for me Baie moeilik vir my Kungazima kakhlulu kum	Difficult for me Moeilik vir my Kungazima kum	Not sure Nie seker nie Andiqinisekanga	Easy for me Maklik vir my Kungalula kum	Very easy for me Baie maklik vir my Kungalula kakhulu kum
110	Using a condom when I have a steady partner is ... 'n Kondoom te gebruik wanneer ek 'n vaste maat het, is ... Ukusebenzisa ikhondom xa ndineqabane elisinginxia ku ...					
111	Using a condom when I feel sexually excited is ... 'n Kondoom te gebruik wanneer ek seksueel opgewonde voel, is ... Ukusebenzisa ikhondom xa ndisemdleni wokwabelana ngesondo kunga ...					
112	Using a condom when I am drunk is ... 'n Kondoom te gebruik wanneer ek dronk is, is ... Ukusebenzisa ikhondom xa ndisele utywala kunga ...					
113	Using a condom when I do not feel comfortable (when I am shy) is ... 'n Kondoom te gebruik wanneer ek nie gemaklik voel nie, (wanneer ek skaam is), is ... Ukusebenzisa ikhondom xa ndiziva ndingakhululekanga (xa ndinentloni) kunga ...					
114	Going to a clinic to get condoms is ... Na 'n kliniek te gaan om kondome te kry is ... Ukuya ekliniki ndiyofuna ikhondoms ku ...					

PREPARE-CAPE TOWN

INTERVIEWGUIDE
Interview with learners

Introduction

We would like you thank you for participating in this interview. The interview is part of ongoing research cooperation between several universities in Africa and Europe. The research project aims at developing effective school-based programmes for young people to postpone the onset of sexual activity and increase the use of safer sex practices.

The reason for interviewing you is to get a better understanding of young people's opinions and personal experiences so that the program can be better designed to suit your needs.

The interview will take about 45 minutes. If you feel that there are related issues that are relevant and important, you are mostly welcome to raise these issues during the interview. In any use of the interview material at a later stage, confidentiality will be ensured.

*

Socio-demographic information

- Age/sex
- Residence (parents, siblings, other family members, other)
- Relationship status (boy/girlfriend)
- Current grade in school

Young people and relationships

- Are many young people your age having sexual relationships?
- Are you currently in a relationship?
- Please tell me about your relationship with this person? (probes, how does it make you feel, what do you do together, how freely do you communicate, how long has it lasted, how serious is your relationship?)
- Can you describe what happened the first time you had sex with this person? (probes: How did it happen, how did you feel about it, did you discuss it beforehand, did you want to have sex? did you use a condom or discuss using one, how did you feel about it after it happened, were you or your partner drinking or using drugs at the time,?)
- Have you had other sexual relationships before? Can you describe them? Tell me about the first time you ever had sex. (probes: How did it happen, how did you feel about it, did you discuss it beforehand, did you use a condom or discuss using one, how did you feel about it after it happened, were you or your partner drinking or using drugs at the time, was it a long-term or short- term relationship?)
- Have your sexual relationships been positive experiences? Can you elaborate?
- Have you experienced any violence or fear in your relationships? Have you ever felt forced into doing things you did not want to do? Please tell us about this.

- Do you think it is difficult for young people in sexual relationships to discuss sex/condoms? Why or why not?
- Have you ever discussed HIV/AIDS or condoms with a sexual partner? Can you describe the circumstances (what was discussed, who started the discussion, ect)?
- How do you feel about carrying condoms? And how do you feel about being the person to take responsibility for producing condoms when you are going to have sex?

Violence

- Can you describe a time when you've personally experienced some form of violence?
- Have you ever experienced violence at home? Can you describe what happened?
- Have you ever experienced violence at school? Can you describe what happened?
- What do you think would work to help reduce violence between boyfriends and girlfriends? At school? At home? (prompts: Young people teaching each other/peer education, parents being involved at school, lessons/information taught by teachers/police/health workers/other outside people)

PREPARE

INTERVIEWGUIDE Interview with health workers

Introduction

We would like you thank you for participating in this interview. The interview is part of ongoing research cooperation between African and European universities. The research project aims at developing effective school-based programme for students to postpone the onset of sexual activity and increase the use of safe sex practices. We are also interested in understanding and preventing different forms of violence that take place in communities, schools and homes.

The reason for interviewing you and other health workers is to have your opinion on these issues as they related to young people. We are also interested to know how you understand the cause and consequences of violence and what you think can or should be done to improve the situation. In particular, we would like to know whether you think there is a role for health workers to participate in high school HIV and violence prevention programmes.

The interview will take about 45 minutes. If you feel that there are related issues that are relevant and important, you are welcome to raise these issues during the interview. In any use of the material at a later stage, confidentiality will be ensured.

*

Introduction:

- What is your profession and how long have you been working in it?
- How much of your job involves working with young people or schools?
- Have you had any specific training concerning working with young people?

Young people and sexuality:

- What do you think are the main problems young people today are facing when it comes to sexuality?
- What is your experience in discussing sexuality and related issues with young people?
- In your experience, are young people comfortable in accessing sexual and reproductive health services?
- Do you think the school is a good place for young people to learn about sexuality and sex-related issues?
- In your experience, are there strong links between schools and health care services?
- What do you think can or should be done to strengthen the linkages?
- What are the barriers to setting up links between schools and health care services?

- How do you feel about participating in school HIV and violence prevention programmes?

Violence and young people:

- What kinds of acts do you think count as violence?
- In your experience, how common is violence in this community?
- What forms of violence have you had to deal with in your job as a health care worker?
- Have you had any experience with young people that access health services as a result of violence?
- Is family violence typically reported by young people? Can you describe your experience (if any) in dealing with this issue?

Sexual violence/intimate partner violence:

- What acts do you think constitute sexual violence and intimate partner violence?
- Are these forms of violence common in your community? Why or why not?
- How are cases of sexual/intimate partner violence handled? What are your obligations as a health care worker?
- Do you think most cases of sexual/intimate partner violence are reported? Why or why not?
- Do such cases occur among young people? Do you have any experience with this?
- Have you received any specific training to deal with young people who have experienced sexual/intimate partner violence?

PREPARE

INTERVIEWGUIDE
Interview with teachers

Introduction

We would like you thank you for participating in this interview. The interview is part of ongoing research cooperation between African and European universities. The research project aims at developing effective school-based programme for students to postpone the onset of sexual activity and increase the use of safe sex practice. We are also interested in understanding different forms of violence that take place in communities, schools and homes.

The reason for interviewing you and other teachers is to have your opinion on these issues as they relate to young people. We are also interested to know how you understand the cause and consequences of violence and what you think can or should be done to improve the situation. We would also like to ask you about your feelings about the Respect4U intimate partner violence prevention research project your school has been participating in this year.

The interview will take about 45 minutes. If you feel that there are related issues that are relevant and important, you are welcome to raise these issues during the interview. In any use of the material at a later stage, confidentiality will be ensured.

*

Introduction:

- How long have you been a teacher? What subjects do you teach?
- Have you ever taught Life Orientation?
- Have you had any specific training concerning teaching about sexuality and sex-related topics to young people? Have you had any specific training about how to deal with violence at school?

Young people and sexuality:

- In your experience, are young people comfortable in discussing sex related topics in the class? Why or why not? Are there any gender differences?
- Are you comfortable teaching about sexuality and sex related topics?
- What do you think about teaching condom use skills at school? Who is the best person to teach such skills? Do you think there is a role for health workers?
- Do you think the school is a good place for young people to learn about sexuality and sex-related issues?

- Have there been any other outside programs (aside from LO) related to sexuality or HIV prevention in this school recently? What is your opinion of the program?
- In your experience, are there strong links between schools and health care services?
- What do you think can or should be done to strengthen the linkages?

Violence at school and home:

- How common is violence at this school? Can you describe any recent incidents?
- What forms of violence have you had to deal with in your job as a teacher?
- What are the procedures at this school for dealing with violence?
- What do you think causes violence at school?
- What are the consequences of violence at school?
- Are there any initiatives to reduce violence at school?
- What strategies do you think would be effective in reducing violence at school?
- Are there links between the local police force and the school to address violence?
- In your experience, is family violence an issue for young people at this school? Can you elaborate?

Sexual/intimate partner violence:

- Is sexual violence common at this school? Can you describe any recent incidents?
- How are cases of sexual violence at school dealt with? What are your obligations as a teacher?
- Have you received any specific training to deal with young people who have experienced sexual/intimate partner violence?
- What is your impression of the Respect4U program that has been ongoing at your school? What do you think of the materials the program uses? In your opinion, do students enjoy/benefit from the program? Do you think it can contribute to reducing IPV? What do you think could be done to improve the program? How can other teachers, parents or members of the community contribute to reducing IPV?

Appendix 8

UNIVERSITY OF CAPE TOWN



Faculty of Health Sciences
Human Research Ethics Committee
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6626 • Facsimile [021] 406 6411
e-mail: shuretta.thomas@uct.ac.za

29 July 2011

HREC REF: 268/2010

A/Prof C Mathews
Adolescent Health Research Unit
Department of Psychiatry

Dear A/Prof Mathews

PROJECT TITLE: PREVENTING SEXUAL RISK BEHAVIOUR AND INTIMATE PARTNER VIOLENCE AMONG ADOLESCENTS IN CAPE TOWN.

Thank you for your letter to the Faculty of Health Sciences Human Research Ethics Committee dated 4th July 2011.

The HREC has **approved** phase 3 of this study. Approval of this study is extended to 15 August 2012.

Please note the following comments:

1. All informed consent forms for students for the Photovoice project should also be signed by the researcher and dated as witness to the student's signature.
2. In respect of culture as mentioned on page 4, paragraph 1, vii, we see no need to include this point on culture-specific norms for the following reasons: the researchers produce no evidence that culture was a significant variable in the PREPARE study; no justification is made for the inclusion of a particular cultural group and finally no expert anthropologist has been included on the research team. We would therefore suggest that more harm than good might be done from this aim.

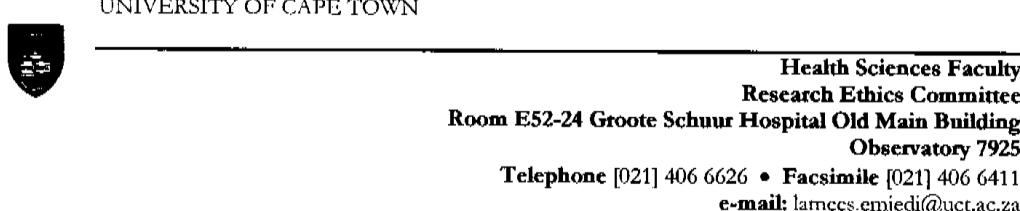
Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC. REF in all your correspondence.

Yours sincerely

Wesley Henley
PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

S Thomas



05 August 2010

HREC REF: 268/2010

A/Prof C Mathews
Child & Adolescent Psychiatry
Red Cross Hospital

Dear A/Prof Mathews

PROJECT TITLE: PREVENTING SEXUAL RISK BEHAVIOUR AND INTIMATE PARTNER VIOLENCE AMONG ADOLESCENTS IN CAPE TOWN

Thank you for your ethics response to the Faculty of Health Sciences Human Research Ethics Committee dated 09 June 2010.

It is a pleasure to inform you that the FHS HREC has **formally approved** the above-mentioned study.

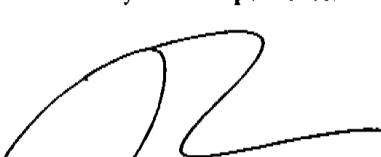
Approval is granted for one year until 15 August 2011.

Please send us an annual progress report (website form FHS 016) if your research continues beyond the approval period. Alternatively, please send us a brief summary of your findings so that we can close the research file.

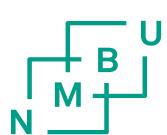
Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely


PROFESSOR M BLOCKMAN
CHAIRPERSON, HSF HUMAN ETHICS

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