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Kathryn Meagley Date

The Sociocultural Context of Help Seeking Behaviors of Youth in Soweto, South Africa

Kathryn Meagley

Master of Public Health
Behavioral Sciences and Health Education

_____

Kristin Dunkle, MPH, PhD
Committee Chair

_____

Kirk Elifson, MA, PhD
Committee Member

_____

Michael Windle, MA, PhD
Department Chair

The Sociocultural Context of Help Seeking Behaviors of Youth in Soweto, South Africa

By

Kathryn Meagley

Bachelor of Arts
Kenyon College
2011

Thesis Committee Chair: Kristin Dunkle, MPH, PhD

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Behavioral Sciences and Health Education
2013

Abstract

The Sociocultural Context of Help Seeking Behaviors of Youth in Soweto, South Africa
By Kathryn Meagley

Within the last couple of decades there has been an increased recognition that behaviors are a manifestation of social context and culture. However, there is a lack of understanding of how the community context and local culture affect general help seeking behaviors of young people, especially in South Africa. The present study was conducted in Soweto, South Africa, and explored the sociocultural context of help seeking behaviors among youth using in-depth interviews. We found that the process of seeking health information and services was indirectly affected by gender roles. Furthermore, the cultural context and gender roles played an even greater role when individuals were concerned about their sexual health. Social support networks formed as a result of gender norms. Young men and women choose to consult different individuals when they had specific health questions or concerns because their social support networks were unique. This has implications for the distribution and communication of health information among youth.

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ACKNOWLEDGEMENTS

There are a number of people that I would like to personally acknowledge and thank for their help and guidance throughout this process. Without their help, this thesis would not have happened or come together. I cannot express my gratitude enough.

I would like to first thank **Brittany Shriver** for bringing me onto this project. I could not have pictured a more amazing collaboration. GO TEAM FLUFFY UNICORN!

The entire Bt20 team, I feel honored to have been apart of this amazing group of people and am humbled by all of the work that you all put into this project. I cannot express my gratitude enough for your help with all of the logistics from preparing for the interviews to recruiting participants. Specifically, I would like to thank **Dr. Shane Norris** for inviting Brittany and I to join the team and providing us with this unique opportunity. **Rebecca Geary,** your encouragement and support while we designed and implemented the project was invaluable.

I am so thankful to have such a committed and supportive **Thesis Committee.** To **Dr. Kristin Dunkle,** my committee chair, and **Dr. Kirk Elifson,** my committee member, I would like you both to know how much I appreciated your immediate feedback and always being available to answer my questions. **Dr. Kristin Dunkle,** your comprehensive knowledge of the context and encouragement was instrumental in the helping me contextualize and interpret the results. **Dr. Kirk Elifson**, your extensive experience in qualitative methods and work in a variety of settings further helped us develop and adapt our methods within the cross-cultural context. Also, to **Dr. Dawn Comau** and **Becca Miller**, thank you so much for your thoughts on analysis and constructive feedback.

I am also grateful to have a mentor like **Kelly Callahan.** You have always had my back and I appreciate you encouraging me to pursue my Master in Public Health at Emory University. To my parents, **Leslie and Rich Meagley**, and little sister, **Lauren Meagley**, thank you for always supporting my crazy adventures and ideas. **Tatenda Uta** and **Catarina Oliveira**, you two always put life in perspective and I sincerely appreciated your feedback during the early stages.

To my **Roomies** and **Friends**, thank you for your support, offering endless laughs and telling me when it is time to just call it a night. As for my amazing **Rollins School of Public Health Family,** with a special shout out to my **Behavioral Sciences and Health Education (BSHE)** and **Master's International Brothers and Sisters**, it has been a wonderful last couple of years learning and growing with all of you. You are all inspiring and I wish you all the best.

Most importantly, I would like to especially thank and dedicate this investigation and thesis to ***the 25 young men and women of Soweto*** *who shared their stories and opinions. I admire you all for your strength and optimism, and I can only hope to exemplify the same kind of courage you all demonstrated. Schap Schap. Stay well.*

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CHAPTER 1: BACKGROUND AND SIGNIFICANCE

Receiving adequate help and appropriate healthcare is imperative in order to treat medical conditions effectively before they worsen. Within the last couple of decades there has been an increased recognition that behaviors are a manifestation of social context and culture (Adimora & Schoenbach, 2005; Airhihenbuwa et al., 2000; Airhihenbuwa & Webster, 2004; MacPhail et al., 2008; Remes et al., 2010; Weyers, et al., 2010). Societal norms are defined and constructed in a broader cultural context resulting in the formation and reinforcement of gender roles and norms within the societal structure and hierarchy. It is imperative to understand the specific sociocultural context, not only to provide culturally sensitive health services for the youth, but also to facilitate a higher sense of individual agency so that young people will seek help for their health concerns. There is currently a lack of understanding of how the community context and local culture affect general help seeking behaviors of young people, especially in South Africa (Barker, 2007; WHO, 2011).

In South Africa, men have been traditionally defined as the providers for the family while women have been defined as the caregivers (Jewkes, Morrell, & Christofides, 2009). The dominant hegemonic masculinity historically also meant that men were the head of the household and had multiple sex partners, while women had little power within the relationship and were expected to be submissive (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Pettifor, MacPhail, Anderson, & Marman, 2012). As a result of the stratified gender roles, men have had more access to social support outside of the home (Barker, 2007).

The individual internalization of these gender norms influences behaviors across a range of contexts. For example, to embody aspects of hegemonic masculinity associated with strength

and physical prowess, men have been less inclined than women to seek healthcare services since it is seen as sign of weakness (Lynch, Brouard, & Visser, 2010). Understanding the societal context in which help-seeking decisions are made is important to promote healthy behaviors and facilitate early detection, diagnosis, and treatment of diseases in order to maximize the overall health benefit (Meyer-Weitz et al., 2000).

To promote healthy behaviors, it is not enough to target individuals with health interventions. Social relations influence the formation and maintenance of personal health behaviors. Social networks and support have been found to be highly influential in adolescents' decisions to seek help and healthcare services (Barker, 2007; Fröjd, Marttunen, Pelkonen, von der Pahlen, & Kaltiala-Heino, 2007; Novins, Spicer, Fichenscher, & Pescosolido, 2012; Weyers, et al., 2010; Wu, Whitley, Stewart, & Liu, 2012). Social support is defined as interpersonal relations that are influential in personal wellbeing (Barker, 2007). Help seeking behavior encompasses the process of consulting both formal healthcare services and informal social networks. In recognizing that adolescents prefer to consult family and friends before pursuing formal health services, the World Health Organization (WHO) has suggested that strengthening social networks and facilitating community acceptance of behaviors could positively impact young people's help and healthcare seeking behaviors (Barker, 2007; World Health Organization, 2011).

Although it is well recognized that culture plays an important role, few studies have investigated how the social context and support networks manifest themselves in the help seeking behavior process of adolescents in South Africa. This study investigated the cultural and social contexts of help seeking behaviors of youth in Soweto, South Africa and examined the social networks, sources of health information, and the contextual factors. The main purpose was

to examine the process through which young people obtain health information and decide to utilize health services. This investigation was done in conjunction and collaboration with another qualitative study examining young people's perception of public, primary healthcare clinics.

CHAPTER 2: LITERATURE REVIEW

There is a lack of understanding of how the sociocultural context influences help seeking behaviors among South African youth. Help seeking behavior is defined as the process of consulting both formal healthcare services and informal social networks (Barker, 2007). In order to promote timely and effective treatment of medical conditions, it is important to understand and encourage expeditious help and healthcare seeking behaviors. Current research, public health interventions, and healthcare services have focused on the relationship between the patient and the provider and stressed the importance of the individual taking the initiative to maintain a healthy lifestyle (Airhihenbuwa & Webster, 2004). However, the lack of cultural sensitivity of the services and by staff has been cited as a primary reason why individuals do not use healthcare services in other international settings (Bailey, 1987; Barker, 2007; M. S. Richter & Mfolo, 2006). Furthermore, some research has noted differences in help seeking behavior between genders, but does not explore why there are gender behavioral differences or why individuals seek help from certain sources.

Understanding how sociocultural context shapes care seeking among youth is imperative to understand behavioral motivations and develop public health interventions that will encourage healthy behaviors. This literature review investigates the cultural and social context of help seeking behaviors internationally.

2.1 Key Elements of Sociocultural Context

Gender norms are constructed within a sociocultural context and influenced by external political and economic factors. Throughout sub-Saharan Africa, there are a number of commonalities that characterize gender identities.

In many sub-Saharan African societies, masculinity was traditionally defined by financial responsibilities and decision-making power within relationships. In order to assert their superiority and masculinity, young men aspired to pursue economic power (Hunter, 2005; Macia, Maharaj, & Gresh, 2011; Ragnarsson et al. 2009). However, as a result of high unemployment among youth, poverty, familial instability, and inadequate schooling opportunities, dominant masculinity evolved into an identity characterized by risk taking and violence (Parikh, 2007; Ragnarsson, et al., 2009; Walker, 2005; Walsh & Mitchell, 2006). In South Africa, the continued lack of employment has redefined masculinity. Less emphasis has been placed on being able to financially provide for one's family. Traditionally men paid a bride price to the families of their fiancé in gratitude. However, as a result of the historical racial segregation and the lack of employment opportunities, marriage has become too expensive for most young men. In 2001, less than 30% of men and women over the age of 15 years old were married among African populations in South Africa (Hunter, 2005).

Studies show that masculinity is defined by risky behaviors and is widely accepted as the gender norm. In many of the impoverished and slum areas where black South Africans live, death is an everyday part of life. As a result, young men have become desensitized to the meaning and implications of death. They have little motivation to protect their health since death is viewed as an everyday occurrence. This further perpetuates risky behaviors (Walsh & Mitchell, 2006). Similarly, a study in the United States also noted how the lack of economic

opportunities resulted in violent hegemonic masculinity among young men (Courtnay, 2000).

Another characteristic of masculinity is toughness. In order to demonstrate this ideal, it is widely accepted that men assert their dominance over women physically, sexually, and in decision-making processes (Coovadia, et al., 2009; Kaufman, Shefer, Crawford, Simbayi, & Kalichman, 2008; Parikh, 2007). Social status among adult men in Uganda and South Africa within peer groups was achieved through portraying sexual prowess (Govender, 2011; Parikh, 2007). In South Africa, adolescents value being sexually experienced and often ridicule those who they perceive as inexperienced (Govender, 2011). Similar findings were observed in Nicaragua in 1998. The authors also recognized that young adults' perception of their peers sexual experience strongly influenced their sexual behavior. However, girls held more negative views of premarital sex and were more frequently discouraged from having sex by family members than boys (Rani et al., 2003).

While men are culturally responsible for financially providing for their families and have the majority of the decision making power within their family, in most Sub-Saharan African cultures, women are obligated to fulfill domestic roles as caregivers and are expected to be submissive to men (Jewkes, et al., 2009; Mindry, 2010; Pettifor, et al., 2012). Men believe they have control over women's bodies for their sexual pleasure, and women are expected to be subordinate (Mankayi, 2008). There is the perception that women are expected to serve their male counterparts (Coovadia, et al., 2009). As the primary caretakers, mothers and grandmothers primarily make health-related decisions regarding children. One study in South Africa found that women thought that girls faced a double standard that allowed for it to be more socially acceptable for boys to engage in sexual behaviors (Francis et al., 2011).

Understanding gender roles and expectation placed by the community expectations on young men and women offers a framework for examining individual behaviors. Behaviors shaped by gender norms are reinforced by social networks (Adimora & Schoenbach, 2005; Airhihenbuwa et al., 2000; Airhihenbuwa & Webster, 2004; MacPhail et al., 2008; Remes, et al., 2010; Weyers, et al., 2010). Social support is defined as interpersonal relations that are influential in personal wellbeing (Barker, 2007), while sociocultural context refers to the interaction between cultural norms and social networks.

Ideas of masculinity and femininity are maintained through social networks, including familial structure and peer groups (Anteghini, Fonseca, Ireland, & Blum, 2001; Govender, 2011; Remes, et al., 2010; Underwood, Skinner, Osman, & Schwandt, 2011). Size and breadth of social networks is a result of gender roles. Therefore, it is important to understand the impact that social networks can have on individual choices about health, and how these dynamics may vary by gender.

2.1.1 Sources of Sexual Health Information

Sources of health information regarding sexual and reproductive health information are influenced by the sociocultural context. During adolescent development, social norms and taboos dictate which individuals are consulted.

In Sub-Saharan African societies, it is socially unacceptable to discuss sexual information across generations (Bastien, Kajula, & Muhwezi, 2011). Researchers in Mozambique, Botswana and Malawi found that adults felt uncomfortable discussing safe sex practices with their children due to the traditional norms opposing dialog surrounding sexuality with youth (Underwood, et al., 2011). A group of researchers in Tanzania identified similar responses. Parents and

adolescents felt that it was the responsibility of the parents to create an environment conducive to proper youth development. Parents were cited as an important role model and were responsible for their children's sexual behaviors. However, many parents did not feel like they had the resources or skills to have sensitive and meaningful discussions with their children about sex and HIV (Remes, et al., 2010).

Furthermore, researchers found that youth help seeking behaviors regarding sexual health depended heavily on cultural norms. In Nicaragua, young men consulted their peers (67%) about sex more often than their parents (24%), However, in Pakistan, young men consulted a wider variety of older male figures such as friends, fathers, and cousins for health information regarding puberty, sexual development, pre-marriage courtship, wedding and wedding night, and pregnancy. Nicaraguan women consulted both their parents (40%) and friends (37%) when they needed information regarding sex. Likewise, Pakistani women primarily sought out sexual and reproductive information from their mothers, older sisters or sister-in-laws, and older married friends (Hennink, Rana, & Iqbal, 2005; Rani, et al., 2003).

Interestingly, studies have shown that more young people are beginning to turn to the internet in order to get more information regarding sexual and reproductive health. Both Nicaraguan and Pakistani boys and girls identified media as an important source of information; however, boys sought information from the internet more often than girls (Hennink et al., Hennink, et al., 2005; Rani, et al., 2003). In contrast, a study with Zimbabwean men in 2008 found that men were more likely to go to personal relations rather than media sources when they had concerns regarding their sexual health (Pearson & Makadzange, 2008).

2.1.2 Gender and Help Seeking Behavior

Help seeking refers to the pursuit of both formal and informal medical information and assistance (Barker, 2007). This group of health practices varies greatly depending on the type of information required and cultural norms. Depending on the situation, help seeking behaviors have different connotations for men and women within societies. Understanding the societal context in which the youth decide to seek care is important to promote health services and facilitate early detection, diagnosis, and treatment of diseases in order to maximize the overall health benefit (Meyer-Weitz et al., 2000).

Strong social connections and networks can facilitate better health practices and influence whether or not people seek additional healthcare services (Khawaja, Abdulrahim, Soweid, & Karam, 2006). In Australia, researchers found that 44.4% of youth in clinics consulted someone about their health concerns prior to seeking additional care. They spoke with their mother, another health professional, their partner, or a nonmedical professional such as a coach. However, this study did not investigate why the participants chose to go to those individuals and for what health concerns (Haller, Sanci, Patton, & Sawyer, 2007).

The sociocultural context has been shown to be a significant factor in seeking treatment for especially sexually transmitted infections (STIs) among young South Africans. There have been various studies that have ascribed the cultural stigma and fear of being socially ostracized from peers as a barrier to getting tested and seeking healthcare services, especially HIV (Forrest et al., 2009; Kalichman & Simbayi, 2004; C. L. MacPhail, et al., 2008; Meyer-Weitz et al. 2000; Wood & Jewkes, 2006).

Seeking STI care has different social implications for men and women. One study found that men were more likely to seek healthcare services for STIs because having an STI

demonstrated their ability to attract women. However, women seeking STI services were more likely to be viewed as unfaithful and become ostracized (Meyer-Weitz et al. 1998). Although some studies have not reported a difference in healthcare seeking behaviors, negotiations surrounding condom use reflect similar concerns of partner infidelity (Meyer-Weitz et al. 2000).

MacPhail et al. also conducted focus groups to investigate how social norms in Johannesburg affected individual behaviors surround HIV testing. In 2008, the National AIDS Survey showed that while 57% of women had ever been tested for HIV, only 43% of men had ever been tested (Jewkes & Morrell, 2010). Social stigma and fear of being ostracized deterred adolescents from seeking health services. They were afraid that if they go to the clinic to get tested, staff and other patients would gossip about their HIV status and assume that they were HIV positive (C. L. MacPhail, et al., 2008). In addition to fear of gossip, studies with HIV positive men found that they delayed seeking healthcare because it was viewed as a sign of weakness, which was contrary to perceived social norms of masculinity (Dageid, Govender, & Gordon, 2012).

In Lusaka, Zambia, researchers found that the lack of community acceptance of youth seeking reproductive health services, STI testing and treatment had a significant impact on whether or not adolescents actually went to healthcare services. The results suggest that strengthening community acceptability of seeking reproductive health services for unmarried youth would facilitate healthcare seeking behaviors (Mmari & Magnani, 2003).

Social norms also influence who seeks reproductive health care. Across the United States, women with self-reported sexual dysfunction were more likely to seek formal healthcare services for distressing sexual problems if they had a supportive partner and a supportive social network (Shifren et al., 2009). In Mali, women often found support in their female-in-laws during

pregnancy and illness. Healthcare seeking behavior of pregnant women was mediated by their mother-in-laws who often escorted their daughter-in-laws to the delivery room. Husbands and sons played a limited role in maternal health, even though they were often major decision makers in their wives care (Bove et al., 2012).

2.2 Changing Sociocultural Context

Many African societies are witnessing transformation of gender identities. In many contexts, men are struggling to fulfill their traditional roles as financial providers in changing social and economic environments (Macia, et al., 2011; Parikh, 2007; Walker, 2005). As a result, studies have recorded a transformation of ideas of gender identity within these changing social contexts.

Researchers in the Kisii District of Kenya found that the migratory labor system constructed during the colonial period was associated with the reconstruction of gender norms. Men were forced to travel far from their place of origin in order to find stable employment to support their families. In the late 1980s with the absence of men in communities, women began to realize that they could not depend on their husbands for safety and food security and adapted to their new roles as both providers and caretakers of their family. As a result, men felt frustrated and devalued, which resulted in the adoption of destructive health behaviors, such as alcohol abuse (Silberschimidt, 1990).

More recent studies echo similar connections to male disempowerment and more destructive health behaviors. The reconstruction of masculinity within an economically poor area where there are few employment opportunities has fostered social environments where multiple concurrent relationships are common. In Uganda in 2007, the increasing number of unmarried

women was partially attributed to the lack of substantial employment for men. Since men's incomes were not sufficient, they could not pay the full bride price and establish themselves within a community. This resulted in a the delay of marriage and normalcy of premarital relationships (Parikh, 2007). In South Africa, the lack of employment has allowed men to avoid responsibility for the children that they father, leaving women with the burden of providing for and raising children (Hunter, 2005; Jewkes, et al., 2009; Varga, 2003). In 2001, less than 30% of men and women over the age of 15 years old were married among African populations in South Africa (Hunter, 2005). A couple of studies have found that women in urban settings are becoming more financially independent and asserting themselves in intimate relationships and becoming more financially independent (Kaufman, et al., 2008; Pettifor, et al., 2012).

It has been noted that the reconstruction of gender identities has the potential to increase healthcare seeking behaviors (MacPhail, 2003). In South Africa, social identity has been an important part of peer education programs surrounding adolescent health, especially STIs. Two South African peer education programs implemented in Summertown, a township outside of Johannesburg, and in the KwaZulu-Natal Province, have focused on changing social identities to promote protective behavior against STIs. By strengthening the social networks and targeting social norms, these programs seek to facilitate an honest discussion and provide accurate information while calling for a peer driven behavioral change. Unfortunately, both programs were not sustainable primarily because the economic context was not considered while designing the programs (Campbell & MacPhail, 2002; Gibbs, Campbell, Maimane, & Nair, 2010).

2.3 Summary of Literature Review

The ways in which individuals internalize societal norms and gender roles construct feminine and masculine identities and leads to differences in health behaviors (Airhihenbuwa & Webster, 2004; Weyers, et al., 2010). Men are less likely than women to adopt behaviors that promote wellbeing as a result of gender identities surrounding masculinity. Furthermore, these social norms are constructed and influenced by the broad sociocultural context. Due to the interaction between gender identities and the social context, many of these ideas are transforming. In order to ensure that public health interventions are effective, it is imperative that these interpersonal relations are understood.

CHAPTER 3: METHODS

3.1 Setting and Sampling

The location of this investigation was in Soweto, South Africa, the southwest township of Johannesburg. It is estimated that over 1.5 million individuals inhabit the area, most of who are black Africans (GeoNames). Although there is a range of housing situations, the area is primarily characterized by poor infrastructure and high unemployment. Soweto is most internationally known for it's historical political movements during the apartheid (Johannesburg).

The Birth to 20 (BT20) cohort and is the largest and longest running study of child and adolescent development on the African continent. During a seven week period in 1990, 3,273 children were born in public hospitals in the Johannesburg-Soweto area and recruited for a longitudinal study. Over the last 20 years, these children and their families have been monitored by research staff. Attrition over two decades has been comparatively low (30%), mostly occurring during children's infancy and early childhood. Approximately 2,300 children and their families remain involved with the study. The sample is roughly representative of the demographic parameters of South Africa with equal numbers of male and female participants (Richter et al., 2007).

The present study was conducted from May to July 2012 in Soweto, South Africa. Participants were purposively sampled from a subset of fifty BT20 cohort members who had been randomly selected and recently participated in the cohort's periodic Young Adolescent Health Survey (YAHS). Participants were chosen from this subset based on their gender (14 female/9 male), and whether or not they had utilized health services within the last six months

(13 users/10 non-users) (Table 1). All participants were either 21 or 22 years of age and were ethnically Zulu.

Table 1. Distribution of users and non-users among male and female participants.

	User	*Non-user*	**Total**
Male	4	5	**9**
Female	9	5	**14**
Total	**13**	**10**	**23**

3.2 In-Depth Interviews

An in-depth interview guide (Appendix A) was developed prior to the study. This interview guide covered social networks, definitions of health, and perception of health services and was developed through a thorough review of the literature as well, then modified through informational interviews with field staff in Soweto. The two principal investigators (PIs), who were young American women, conducted four interviews with South African research staff members in order to pilot the interview guide and determine if the questions were culturally appropriate.

Five pilot interviews were conducted with members from the YAHS subset of the Bt20 cohort to refine the interview method. Three interview methods were piloted: (a) semi-structured 1-on-1 interview between one of the PIs and the participant in English, (b) semi-structured 1-on-1 interview between a Zulu-speaking research assistant from the community and the participant in Zulu and English, and (c) interview between one of the PIs and the participant with the Zulu-speaking research assistant present for translation if participant felt more comfortable expressing themselves in Zulu during the interview.

A BT20 staff member contacted each participant by phone, explained the nature of the study, and invited subjects to come in for the interview (Appendix B). Interviews were held on-site at Chris Hani Baragwanath Hospital in private interview rooms. Informed consent was obtained from all of the individuals who participated in the study (Appendix C). The protocol was submitted and exemption granted by Emory University IRB (ID 58317; Appendix D). Local ethics approval was granted by the University of Witwatersrand under the BT20 approval (ID M120138).

The external pilot interviews indicated that participants were the most comfortable expressing their opinions in the semi-structured 1-on-1 in-depth interviews between the PI and the participant in English (option a). There was also noticeable difference in the answers that were given to the Zulu-speaking research assistant present, suggesting a social desirability bias in the presence of local study staff. During pilot interviews, more complete answers were elicited from the 1-on-1 in-depth interviews with the PI than with the Zulu speaking research assistant. Furthermore, during the interview between one of the PIs and the participant with the Zulu-speaking research assistant present, the participant's body language suggested that she was not completely comfortable sharing information.

The final interview guide were found to be sufficient for the purposes of the study, culturally appropriate, and understood by the participants. Because methodology was the only major change from the pilot to the data collection phase, the 1-on-1 pilot interviews between the PI and the participant in English (option a) were included in the data analysis.

All semi-structured in-depth interviews were conducted in English and varied in length between 45 minutes and two hours in length. Participants were encouraged to openly express their opinions and seemed to be comfortable conveying their thoughts and ideas. Interview guide

included questions regarding personal relationships, sources of health information, perceptions of healthy living, and help seeking behaviors. For example, “If you wake up and are not feeling your best, what do you do?” and “Where did you learn about condoms and STIs?” Participants were also asked to draw a picture to illustrate the people who were close to them. These relationship maps were used to facilitate a richer discussion of the important relationships and social context. Each participant was compensated for travel expenses (R50, which at the time was equivalent to approximately US $7) and provided with a snack.

Rapport was built by conversing in small talk prior to the interview. The PIs asked how the participant was doing, how did they find their way to the hospital, and asked about the weather. The interview was not initiated until the participant’s body language suggested that they were starting to relax (approximately 5-10 minutes). Referring to the interview guide or taking notes broke rapport between the interviewer and participant and the answers became abrupt. As a result, no notes were taken and the interview guide was on the table during the interviews, but was not referred to while the interview was being conducted. The PIs memorized the topics of interest and followed the lead of the participant to facilitate an open and comprehensive discussion.

3.3 Data Analysis

All interviews were digitally recorded and then transcribed verbatim. The PIs used modified grounded theory as described by to analyze the transcripts using MAXQDA10 Qualitative Analysis Software (Hennink, Hutter, & Bailey, 2011). Data were then read independently and codebooks were developed by the two PIs based on arising themes. The two codebooks were then synthesized and consolidated and code definitions were agreed on by both

PIs (Appendix E).

Inter-coder reliability was checked for three interviews. Discrepancies in coding were discussed and the remaining interviews were coded independently. Prior to analysis, the PIs merged the independently coded transcripts and recoded them so that they encompassed both of the PIs' coded segments. The relationship maps were then scanned and coded based on the corresponding themes identified in the interview. This manuscript focuses on the process of help seeking behavior among youth, while the perceptions of health services is covered in the co-PI's work.

CHAPTER 4: RESULTS

Help seeking behaviors were highly influenced by gender roles and social networks. For our participants, gender roles and division of responsibilities as defined by South African masculinity and femininity resulted in different social support networks.

4.1 Gender Roles and Division of Labor

The daily lives of young adults were shaped by familial responsibilities. Our participants talked about providing and caring for their family while balancing domestic obligations and personal relationships. Young men spoke less often of responsibilities, and described less intense domestic and economic commitments than young women.

4.1.1. Domestic Responsibilities

Many young women described how they spent a significant portion of their day doing domestic chores. A typical day for many of our female participants consisted of helping to maintain a clean living area and prepare meals. If they had time after completing chores, they talked about resting or watching TV. Of the 14 young women, one young woman was pregnant and six of the young women in the study had children. All of the young children were between the ages of two and four years old. The young women who had children talked about spending more time on their domestic responsibilities as compared to the young women who did not have children. In addition to maintaining a clean household, these young women also discussed feeding, bathing, watching and spending time with their young children. However, they and their

families were completely responsible for raising their children and none of them talked about sharing caretaking responsibilities with the fathers.

In general, our nine male participants talked about domestic responsibilities to a lesser extent than our 14 female participants. It was not a driving factor in their day and they said that after they finished their chores they spent time hanging out with friends, playing soccer or watching TV. Only one of our male participants talked about children he had fathered. At the time of the interview, he was unemployed and his girlfriend was six months pregnant. He spoke with us about how he planned to find a job to financially support his girlfriend and child. However, he did not talk about sharing childrearing responsibilities.

4.1.2 Financial Responsibilities

There was a difference in employment types between genders. There were six young women working, all in the formal job market at established companies. They had learnerships or fulltime positions that were the result of pervious learnerships[1]. There was one additional young woman who was working at part-time job while studying at a university. In contrast, of the six young men who considered themselves employed, only one was employed at a company. This individual was doing maintenance work. The remaining five were making money through their own entrepreneurial businesses. They talked about owning car washes, printing t-shirts, DJing on the weekends and running public call centers. However, these businesses were not stable and involved had irregular wages. Young men did not talk about their finances being shared while the young women talked about how their income went to providing food and other necessities for their family.

[1] Learnerships are equivalent to internships in the United States. It is on the job training for young professionals.

The young women with children talked about how they and their families were solely responsible for financially providing for their children. Among the six young women who had small children, the father was not frequently reported as being involved in the child's life, which put financial stress on the young women. Of the six young women with a child, three were employed. One young woman explicitly spoke about the pressures of financially providing for her family and taking care of her child:

> *I got the baby, neh. After getting a baby like… [my family] did nothing. They didn't help. I even failed my [high school exams]. Like, there was nothing, I had to stay and take [care] of the baby. I forgot it, you know. I misread it, […] My [baby's father], was…it didn't even matter that, dividing it to make sure that I balanced everything. Then about…yeah, I think my son was about 2 months, I got a job. I was making about [1400]. And the transport was 900. I was going to be left with 500. But my grandmother wanted me to buy food at home. I had to give [her] 300, and left with only 200.*
> *~21 year old female, formally employed, four year old son*

Women took on the role of financial provider more so than men. However, their domestic obligations did not decrease when they entered into the formal workforce.

4.2 Social Support Networks

The differences in time spent on domestic and financial obligations had implications for social support networks. In general, young men talked about having a larger social network of close relationships than young women, and young women talked about having to make a greater effort to maintain relationships with those who lived outside of their household.

4.2.1 Family Structure

All of the participants were living with their family and none were married. All but two of the households were comprised of two or more generations. The head of the household, defined as the eldest resident, was usually either one of the participant's parents or grandmother.

There were five individuals who lived with their married biological parents, while nine participants lived in a single parent household. Two of the young men did not live with their parents and lived with a younger cousin or brother. Of the remaining seven participants, grandmothers headed four households while one young woman lived with her great grandmother, one young man lived with both grandparents, and one young woman lived in a household headed by her aunt. Six of our participants mentioned that one of their parents had passed away. Our participants also talked about living with cousins and siblings. Four individuals also lived with their sisters' children.

The young women in our study discussed how much of their emotional support came from the individuals with whom they lived with at home. This was not discussed as much by our male participants. Much of the young women's immediate support was in the form of their caretaker, usually their mother or grandmother. When they had a personal problem or concern, they talked about consulting a family member. Who they approached was depended on the concern. If their problems concerned sexual relationships, they usually sought out an older sibling. However, parents and grandparents were often consulted for financial support and advice.

Four of our participants discussed how their fathers were absent from their childhoods. If their fathers were around, then they mainly provided financial support or business advice. The general lack of older male roles models within their social networks had significant implications for our male participants in particular. This 22 year old male explicitly discussed the personal consequences of being raised in a single parent household:

> *Interviewer: So, what sort of things would you have liked to have been able to talk to him about, that you can't talk to your mother or your grandmother about?*
> *Participant: Mmm, like…tool stuff, or male circumcision…'Cause I never had a role model in my life. Like, em…if I had a figure, someone I can say I look up to, 'cause, ah…got some stuff I'm*

> *missing. I can't talk to anyone, like if I had a problem with a woman…go and talk to them…'Hey, Papa. Where do I go from here?...I'm afraid that' Yeah. 'Cause like there…traditionally there are things that I don't talk to my mother to.*
> *~22 year old male, unemployed, raised in a single parent household by his mother*

Participants also lived with their siblings and a few said they lived with young children, either theirs or their sibling's. For the male participants who had younger siblings living in their household, they become the dominant male figure and talked about how they needed to inspire and empower their younger siblings.

4.2.2. Peers Groups

There was a difference in size of peer groups between the young women and men. Most of the peer groups and friendships that our informants discussed were formed in primary school or high school. While, four young women whom we spoke with were studying at a university, only one young man was a current university student at the time of the interviews. These individuals did not talk about forming any new close friendships with their peers. They mentioned that they had met their friends before attending university.

Most of the young women had a small circle of friends. Many of the young women talked about how they had known their friends for a long time and had met while still in primary or high school or were long-time family friends. However, out of their friend group, most of the young women only had one or two close friends with whom they could talk go to if they had a question or problem. This young woman expressed a concern about their peers gossiping.

> *Ok, I don't have friends that way. Just people I know and socialize together with at school. […] Girls talk a lot about you. They gossip. Too much drama. That's why I talk to my sister a lot. All of it.*
> *~21 year old female, unemployed, no children*

As a result, when something worried them, they were very deliberate about who they would tell. They seemed more likely to either keep the problems to themselves or consult a family member.

In contrast, young men spent more time with their group of friends than young women. Many of the young men talked about having peer networks that they would see on a daily basis and would meet up with them after completing their chores around the house. At these daily gathering, many of our participants talked about how they discussed the merits of the information they obtained before forming their own opinions. One young man recalled how when he needs advice he sought guidance from his peers:

> *I'm chilling with the friends, I'm asking just so so… 'if I'm doing this, like this'… 'no don't do that' 'ok' so sometimes like, me and my friends […] we get advice from someone and bring those things to the corner and talk about it and come back. You can just give advice just there at the corner.*
> *~21 year old male, unemployed, lives in a single parent household with mother*

Peer groups within the workplace differed between young women and men. Female participants did not talk about forming close and lasting relationships with individuals they worked with in the formal employment sector. There was only one instance where a young woman had met her current boyfriend at a previous learnership. In contrast, our male informants often started their entrepreneurial pursuits with their male peers, cousins, or siblings. Young men were not attempting to form new relationships. However, it worked to the young men's advantage if they were well connected. Two of the young men talked about how many of their DJing opportunities were obtained through word of mouth.

Romantic relationships were one of the few close relationships that many young women had outside of their family. None of our participants were married, but romantic relationships appeared to be a source of emotional and financial support, particularly for the women. This seemed to be relevant even for those young women who were aware that their boyfriends were

having concurrent relationships as well. Most of these romantic relationships had developed during high school. A few of the young women talked about their boyfriends providing money when to go to private doctors for reproductive health issues. A few of the young women said they went to their boyfriends if they had a problem because they trusted that their boyfriends would not gossip. This was explicitly stated by the young women who was also responsible for financially providing for her family:

> *Oh, my friend, my friend I don't talk to, I don't talk to her that much. 'Cause friends like, they like to gossip. You go and tell her something, then they take it to the other person. 'Cause my boyfriend is a guy. Guys don't do those things.*
> *~21 year old female, formally employed, four year old son*

Even though young women had a tendency to consult their boyfriends if they needed support, young men did not necessarily approach their girlfriends if they had personal concerns. One young man suggested that he did not consult his girlfriend because he did not see her a lot and so he saw his problems as his personal issues:

> *Participant: When I go and I'm in these relationship with girlfriend, she also has a place where she stays, so sometimes its only for a week sometimes its only […]But we never speak, like talk about life. It's just these short term so you can't just tell her things. I just keep it there (points to heart) cause with this girlfriend I know it's only fine. You never bring up that side, if you have a bad side she obviously can't be with you. That's why you leave your problems at home. And when he gets home that's when he tries with all his problems.*
> *~22 year old male, student, no children*

4.2.3 Religion

Religious practices did not appear to differ by gender, but there was variation in religiosity and beliefs. For some of the participants religion was a source of social support. A few participants also talked about how they had formed close relationships with peers in their religious institutions when they were younger and first started going to church. They remained close with that group and would regularly spend time with them outside of the church setting.

Also, a few young women talked about how they had been paired with older mentors for guidance. However, our informants said that they do not talk to these individuals as much as they did when they were younger, but did not explain why they had become more distant. Both young women and young men identified their pastors as confidants they could approach about problems at home.

4.2.4 Role of Technology and Social Media

Young women described a process of becoming socially isolated following high school due to their domestic and work responsibilities. Consequently, they had to consciously make an effort to maintain relationships. However, due to other time constraints at home and work, they only had limited time to catch up with old friends due to conflicting schedules. In order to maintain relationships, this female participant emphasized the importance of social media:

> *I used to have a lot of friends, eh, in high school. I'm still close to some of them. But we hardly see each other now, 'cause some of them don't live here anymore, some are always in school. But when I'm at work, they are at home. But, when I'm off they're at school, so we hardly see each other between…mostly talk through the phone…or WhatsApp…or Mix It, or Facebook.*
> *~22 year old female, formally employed, no children*

Only one male participant used social media to maintain relationships, but that was because his brother was currently incarcerated. Young men generally spent more time around their friends, either while "chilling" or doing business with them, and so, it was not necessary for them to use social media to maintain relationships.

4.3 Pathways of Help Seeking Behaviors

Our results focus on the pathways of help seeking behaviors, which includes individuals' search for health information and assistance through from both formal institutionalized healthcare services and informal sources including social networks (Barker, 2007). Both young men and women went to the clinics for general illnesses -- such as the flu -- and HIV/STI testing. The young women sought healthcare services for themselves as well as for others. When the young women went to clinics for themselves, it was mostly for birth control services. A few young women talked about going to the local clinics when they were experiencing reproductive health issues, including what was described to be a urinary tract infection and complications with birth control. Young women also talked about taking their young children to get vaccinated and helping their grandmothers go for annual check ups. The young men went to the clinic mainly for themselves. In addition to attending the clinic for general illness, our male informants also received tuberculosis treatment and circumcision services.

None of our participants sought healthcare from traditional healers. One male participant talked about how his grandmother encouraged him to go when he had a reoccurring dream, but decided not to consult the traditional healer. He said that he did not believe in the validity of this method.

4.3.1 General Health and Illness

The process of seeking help did not differ between young men and women for general health and common illnesses, such as the flu. The preferred source of help were older and knowledgeable about simple remedies. Figure 1 depicts the overall pathway for help seeking behaviors. When our participants had a question about their general health, both young men and

young women usually first sought the opinion of an older maternal figure, such as their mother or grandmother. If an individual woke up in the morning with the flu, they frequently sought help from their maternal support, who was also usually the head of the household. A few individuals also went to an aunt or a neighbor. Some participants said they would go to their fathers if they felt sick, but when probed, they said that they had learned all home remedies for common sickness from their mothers. Both young men and young women rationalized this as this was the person that raised them and so they know them best. If this individual did not have the answers or the symptoms persisted, then the participant would either seek out another maternal figure close to them (if such a person existed) or they would go to professional healthcare services, either at the local or private clinics. These two excerpts demonstrate how both young men and women valued their mother's knowledge when they were feeling sick:

> *Interviewer: Yeah, so if you wanted something like advice about your health, who would you go to first?*
> *Participant: My mom.*
> *Interviewer: Your mom. Why your mom?*
> *Participant: I think when it comes to… 'cause I would say she been the one who carried me until... until I was two years old. So… she knows what's best for me. What can I take… she knows how I look. She knows when I'm sick. So I go to my mom.*
> *~22 year old male, maintenance worker*

> *Interviewer: So, who would you go to if you had a question or you wanted advice about your health? Who would you talk to first?*
> *Participant: I would talk… I think I would talk to my mother.*
> *Interviewer: ok, why would you talk to your mother first?*
> *Participant: Because she's the older one and she's been through some things that I have went through so it's going to be much easier to ask her about such things.*
> *~22 year old female, university student, working part-time, lives with great grandmother*

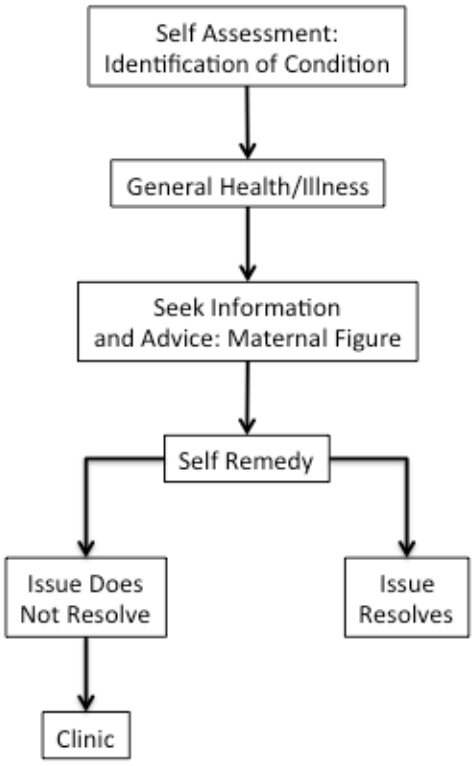


Figure 1. Help seeking pathway for general health and illness.

4.3.2 Condoms/STIs/Birth Control and Sexual Health

Unlike general health information and illness, cultural context and gender roles defined help seeking behaviors for sexual and reproductive health in very specific ways (Figure 2). Talking intergenerationally about sex was considered a taboo within this population, and both young men and young women found it very embarrassing and were uncomfortable discussing their sex lives with the parents, grandparents, or mentors. However, discussions surround sex with parents was slightly different for the young women who already had children. Having a child seemed to facilitate a more open discussion with young women's maternal figures about issues related to reproduction and sex. The young women acknowledged that their families were aware that they were using some form of birth control. Young women who did not have children seemed to be more reluctant to discuss pregnancy prevention with their families. However, even

though the young women talked about preferring to discuss their concerns with either their mother or grandmother, when asked for examples, they described situations in which they sought sexual and reproductive advice from a close friend or boyfriend.

Furthermore, no one talked about going to anyone they knew from church if they had a question or concern about relationships or their sexual health. This reluctance to consult religious figures is clear from the excerpt below:

> *Interviewer: So, what sort of questions can you go to your friend, but not the lady pastor?*
> *Participant: Eh. Boyfriends. (Laughs) Ok, only boyfriends. Eesh. I'll go to my friend, not my lady pastor. Yeah, 'cause she'll open the Bible, quoting verses, you know. It's a sin, dating and all that, eh. It's too much.*
> *~21 year old female, formally employed, no children*

Young women were not as likely to talk about sex and pregnancy prevention with their friends or family. When they had a question or concern regarding their sexual health, they were very cautious about whom they consulted. One of the main concerns of our participants was fear of gossip amongst their peers. When an issue came up regarding their sexual health, young women preferred to go to one person, preferably an older female, but no older than 10 years their senior. This person was usually a close friend, older sibling or older cousin. Young men also discussed seeking advice from an older male, but similar in age. This was rationalized as that this person was more experienced and therefore had more accurate information.

Another person that young women often went to was their boyfriend, if they were dating someone. Two of the young women described a past episode of what sounded like a urinary tract infection. Rather than going to their female counterparts, they chose to go to their boyfriends first with the concerns. Their boyfriends either escorted them to the clinic or provided them with money to go to a private doctor for medical assistance.

The young women we spoke with did not always trust the information that they got from their peers. The young women openly admitted that the information from their friends may not be correct and seemed more willing to seek out additional information either from the internet or from the health clinics than young men. This process of consulting different sources for health information can be seen below:

> *Participant: Even though [female cousin] may be… maybe two years [older]. Because it's easier to talk to her, I guess, like talk to her freely. Even though she's not going to give me that right answers that I need.*
> *Interviewer: What do you do when you want those right answers?*
> *Participant: Honestly, first I start going to the internet. Then I will check, check, check, check. Then… if its serious, if that thing is serious then I have no choice, I have to go to the clinic.*
> *~22 year old female, university student, working part-time, lives with great grandmother*

Although young men were encouraged to seek out healthcare services, their male peers influenced their behaviors. Young men sought out sexual health information about condoms and sex from slightly older male friends or their group of friends. Many young men said that they wanted multiple perspectives before making a decision. Since information was exchanged within a group setting, they strategically acquired different perspectives and opinions without having to actively seek out information about sexual and reproductive health. For young men, their male peers and ideas of masculinity primarily influenced their health behaviors. One male participant recounted how he felt pressure from his circumcised friends to have the procedure:

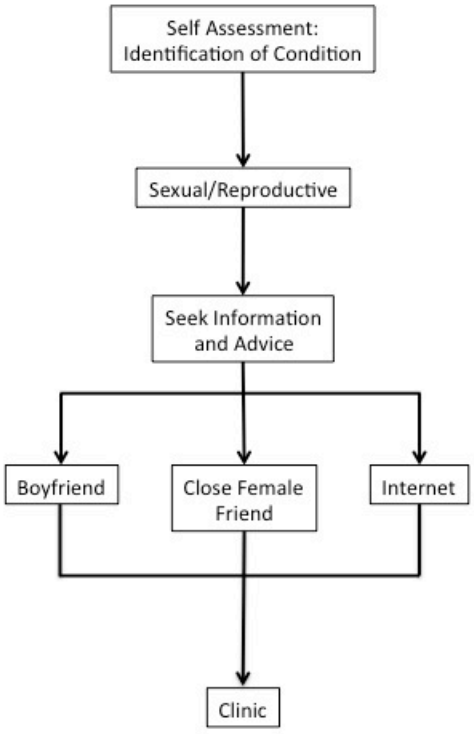
> *Now only two are circumcised, and two are uncircumcised. I went to the clinic today and made a booking. Eh, these two! Eh! You know it's like, you're not real man. You're man, but you're not man enough.*
> *~21 year old male, DJ's on the weekends, lives with both parents*

One of our male participants discussed how a pervious girlfriend used to encourage him to get tested for HIV and STIs. He never went to a clinic to get tested because he was scared. However, he was recently circumcised and made it known that he was very proud of the fact that

he had decided to have a procedure that would prevent STIs and HIV. He talked about how his male cousins encouraged him to get the operation.

> *Last weekend I was chatting with my older brother on Facebook, and he asked me like, if I went to get circumcised. And then I said yes. Then he said, 'oh, you are a man. I should go, too.'*
> *~ 22 year old male, DJ's on the weekends, lives with younger male cousin*

(A)



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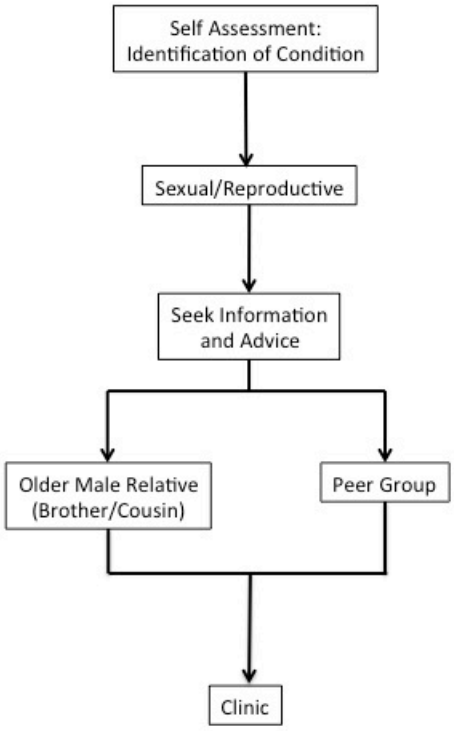

Figure 2. Help seeking pathways for sexual and reproductive health concerns and information. (A) Represents the pathway for young women. (B) Represents the pathway for young men.

CHAPTER 5: DISCUSSION

The process of seeking health information and services seemed to be indirectly affected by gender roles. Social support networks formed as a result of gender norms. Young men and women choose to consult different individuals when they had specific health questions or concerns because their social support networks differed.

5.1. Sociocultural Context

In traditional South African gender roles, men were defined as the providers and expected to demonstrate physical strength. Within the last fifty years, ideas of masculinity have also incorporated violent behaviors. In contrast, women were traditionally defined as caregivers and were expected to be submissive to men (Coovadia, et al., 2009; Jewkes, et al., 2009; Mindry, 2010). These gender norms were evident in the lives of our participants and manifested throughout generations.

For the young women in this study, their feminine roles had been defined by the social context as the caretaker as well as the provider for their families. They often have to balance their domestic and work responsibilities. A few of the young women talked about the father of their children or the father of a friend's child not financially supporting their child, which was a source of stress for the young women. This is common in South Africa, and even though there is legislation in place to prevent this, it is rarely enforced (Kaufman, et al., 2008). However, the lack of financial support forced the young women to have to work in stable jobs in order to financially provide for their dependents while still fulfilling their domestic duties. Even though women were financially independent, their domestic responsibilities did not necessarily decrease.

Our female participants formed smaller social networks that revolved around those living in the same households as result of their increased responsibilities due to the unequal burden of acting as the financial provider and caretaker. Young women talked about attempting to maintain connections with peers using technology and social media, but had limited success in maintaining close relationships. Since their social networks were small, the young women became more concerned about fitting into a socially constructed ideal that valued physical health and emotional stability. The fear of gossip was formed out of this idea that if others who were not close knew about personal problems and concerns, then the young women's emotional strength would be questioned. Their reputation was one component of their lives with which they felt they had control over.

The familial structure meant that fathers were absent from the child rearing process. This had significant implications for our male participants. There was a general lack of male role models within their social network to help define the idea of masculinity for the young men. This has also been observed in other South African studies (Coovadia, et al., 2009; C. MacPhail, 2003). Young men went to other sources, such as their peers, to construct their self-identity. Furthermore, the lack of financial and domestic obligations meant that young men had a more time to spend forming those relationships outside of the household. In general, our male informants had larger social networks than did the women and did not feel the need to use technology and social media in order to maintain them.

Other studies have also noted a shift in masculinity and femininity definitions. The meaning of masculinity and femininity has recently been challenged as a result of the changing social and economic environment in South Africa. In an area with high unemployment and high HIV prevalence, such as Soweto, traditional gender norms are being reconstructed. Limited

employment opportunities have forced women to become less financially dependent on their partners in order to provide for their families, while the spread of HIV has forced both men and women to reconsider the social value of multiple sexual partners (Hunter, 2005; Jewkes, et al., 2009; Kaufman, et al., 2008; Mindry, 2010; Pettifor, et al., 2012).

5.2 Help Seeking Behaviors

Socially acceptable help seeking behaviors are defined by the cultural context (Airhihenbuwa & Webster, 2004). Cultural context and gender roles defined help seeking behaviors all the time, but they were even important with sexual health. As a result of being more socially isolated than young men, the young women had to be more conscious about seeking help and advice regarding sexual health. Figure 3 shows how the social context influenced help seeking behaviors of young women and young men.

As the provider and caretaker of their family, the young women had different pathways to seek healthcare services than young men. The process of becoming social isolated resulted in young women having to take the initiative for their health. They were not as exposed to health information as often and had to seek out help from their social networks, the internet or the formal healthcare system. Part of this willingness of young women to question the validity of the information and use multiple information sources was due to the lack of trust. Other studies have noted that past experiences have been shown to be instrumental in adolescent help seeking behavior in other countries as well (Barker, 2007). Young women had fewer people with whom they were close to and approaching individuals with whom they had weak social ties could be intimidating especially when the health concern was potentially stigmatizing, such as an STI. Young women had to take more of an initiative to seek information regarding their health.

On the other hand, young men acquired health information more readily, especially relating to sex, through their peers. Peer groups discussed opinions about the obtained knowledge before making decisions about the validity of the information. However, their decisions to seek additional health advice were heavily influenced by their peers' opinions and behaviors. Peer-related social desirability influencing behavior in adolescent young men has been noted in other studies as well (Barker, 2007; Govender, 2011).

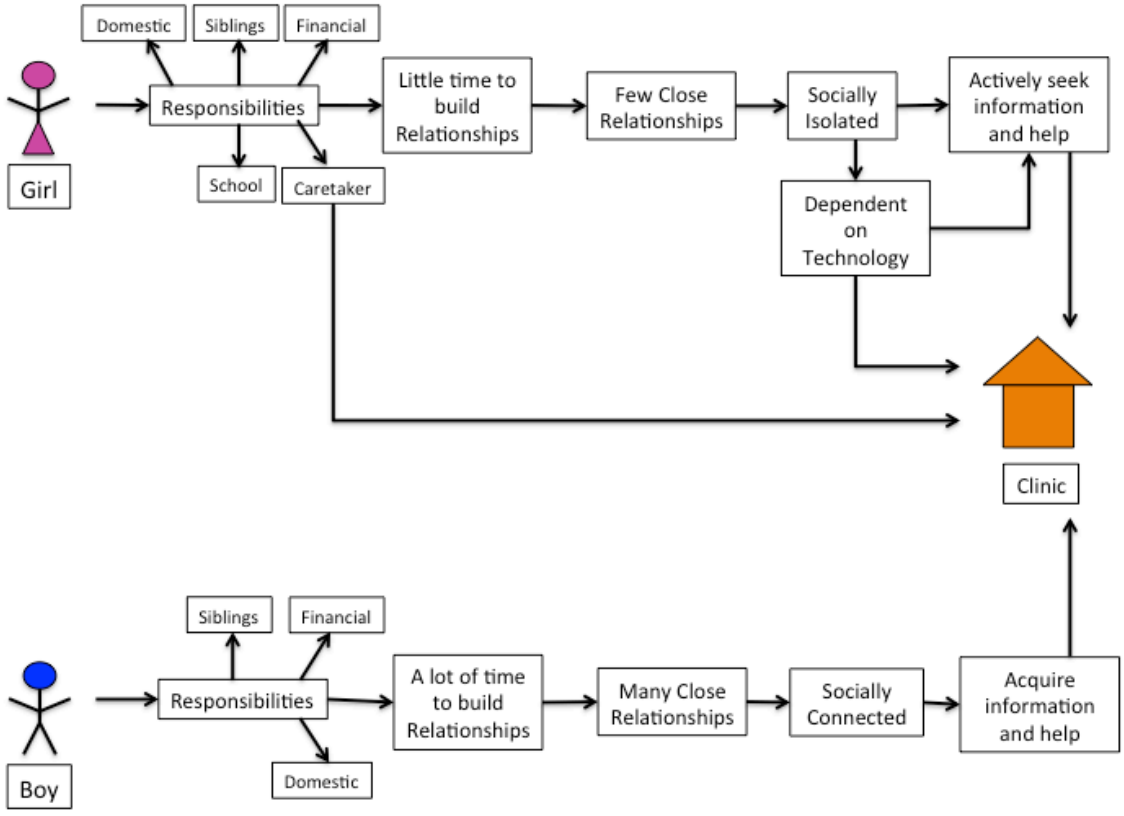

Figure 3. Conceptual Map of how the societal context leads to differentials in Help Seeking Behaviors among youth.

Other researchers have discussed the idea that men avoid attending healthcare services because is it a very female dominated space. In health clinics, the staff is primarily female nurses and nursing is considered one of the few professions where women have power over men

(Markus & Kitayama, 1991). Other scholars have reported that seeking healthcare services went against the idea of being masculine (Barker, 2007; Lynch, et al., 2010). Although this still may be true, it was not a salient discussion point for any of our male participants. Their main concerns with the clinics were centered on quality of care, long waiting periods, and nurses' attitude towards them. The young women reported the same concerns about the clinics and the descriptions of the quality of experiences were the same between the young men and young women. No concerns were expressed about the gender of the nurses or doctors. Other studies have found that the most import aspect of whether or not youth seek heath care services is the staff (Barker, 2007).

When our participants sought out formal healthcare, they typically went to a government health clinic or to a private doctor. None of our participants sought out the medical assistance of traditional healers, while noting they did not necessarily believe in the effectiveness of this method. This shift away from traditional healers has also been cited in other urban settings in Zimbabwe (Pearson & Makadzange, 2008).

Young men and women had different opinions about how to implement more effective and efficient health services. This may reflect differences in gender and societal roles and in whether healthcare advice was actively or passively sought. When asked about preferences for implementation of different services, the females had a greater distribution of preferences than the males. This is reflective of the fact that they attended clinics for a variety of reasons that were not necessarily related to their personal health. As a result, they became more familiar with the healthcare system. They also are more aware of the problems and inefficiencies with the clinics. The female distribution of preferences reflects what the individuals think to be the most

problematic aspects of the clinic, whether it is the nurses, queues, health education, or limited mobility of the patients.

5.3 Conclusion

In South Africa, both gender norms and social networks shape help and healthcare seeking behaviors. Differences in help seeking behaviors were embedded in this larger contextual framework of gender roles. Understanding pathways of help seeking behaviors has implications for how to best distribute and communicate important health information. Many studies do not examine how the context affects the process of help seeking behaviors. However, in order to influence healthy behaviors, it is important to understand these pathways of help seeking behaviors and sources of information. Cultural context and gender roles define these practices and play even more of a role when the health concerns are sexual. Health promotion campaigns and the distribution of health information need to be culturally sensitive and appropriate for the social gender structure in order to facilitate a higher sense of individual agency so that youth will seek health services for testing and treatment.

CHAPTER 6: LIMITATIONS

This study was a qualitative investigation and the results cannot be generalized. It is important to recognize the limitations of this study and consider these results in context. This study was done in an urban township outside of Johannesburg where individuals have opportunities to get an education and pursue additional employment opportunities. They also have access to the internet and recent technologies. This may not be true for other areas, especially those that are more rural areas.

Although the Bt20 cohort is roughly representative of South African demographics, we purposively sampled within a subset of the cohort. All of our participants were Zulu ethnicity, and we may have accidentally introduced some sampling bias. It is difficult to ascertain if the proportion of individuals in the formal employment sector is representative of the regional estimates.

Some interviewer bias may have been introduced as a result of the context and identity of the researchers. Since the participants are part of a twenty-year cohort study that routinely conducts surveys and health assessments, the participants may be more aware of what investigators want to hear and may respond differently. Additionally, the interviews were conducted by the PIs who were young white American female graduate students. As outsiders to the community, participants may not have felt as comfortable discussing some topics. However, the pilot interviews indicated this was the best interviewing method.

Although the context of this research and identity of the research team may have introduced some interviewer bias, the pilot interviews reduced our concerns that this possibility may have excessively biased the data. By being outsiders, the participants seemed more open to

discussing domains as compared to having an African Bt20 staff member who was also a resident in the community conduct the interview. Another qualitative study investigating adolescent intimate partner violence in South Africa also found that having someone outside of the community conduct the interview seemed to facilitate a more honest discussion among young men. This perceived honesty was rationalized as the interviewer was socially removed from the situation and so the participants were more willing to openly discuss potentially sensitive topics (Walker, 2005).

Although there are some limitations to this study, this investigation offers a more thorough understanding of the process of help seeking behaviors among youth. Many studies do not explain how the context affects the process of help seeking behaviors. More work will need to be done before the findings here can be generalized to other urban and rural contexts in South Africa.

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APPENDIX A: IN-DEPTH INTERVIEW GUIDE

Good day, and thank you for agreeing to this interview today. My name is _____, and I am part of the Birth to Twenty research team here in Soweto. As you know, we have been collecting information on health access and utilization among youth here in Soweto. Today, I would like to interview you specifically on your perception and feelings about these services. The aim of this study is to better understand how you experience health services in this area. I will be asking you questions about your life to hear about your personal experiences and opinions on the issues we discuss.

((TAKE CONSENT))

Thank you for your consent. I want to remind you that participation in this interview is completely voluntary and if you do not feel comfortable answering any questions or would like to stop at any time, please don't hesitate to let me know. Additionally, if you feel you would be more comfortable or could better express yourself in a language other than English, feel free to do so.

Is it alright if I turn on the recorder now?

((TURN ON RECORDER))

Do you have any other questions before we begin?

A. Introduction

Great! I am excited to speak with you today! I want to get to know you better, so I want to talk to you first about you and your friends and family, but would like you to bring up any ideas of topics you feel are related. I am very interested in your ideas and experiences and appreciate you meeting me.

1. I want to know what a day is like for you. So let's start with when you wake up. What do you do when you wake up?

   Probes: Then what do you do? Who do you see? Who do you stay with? What do you enjoy doing on weekends? Who do you enjoy spending time with? (*probe on whatever they talk about. Ie: school/work/shopping/activities*)

B. *Support Network*

2. Can you describe the relationship you have with your family.
   Probes: How has this changed from when you were younger? Do you go to your family for advice? What kind of advice do you ask? Can you tell me about a time when you specifically asked for their advice? Does anyone in your family come to you for advice? What things do you talk about?

3. Can you tell me about the friendships in your life.
   Probes: Can you describe the relationship you have with your friends (how long has the friendship been/how close are you)? Anyone else? (keep probing until they say no) Do you go to your friends for advice? What kind of advice do you ask? Can you tell me about a time when you specifically asked for their advice? Do your friends come to you for advice? What things do you talk about?

4. Are you romantically involved with anyone?
   Probes: Can you talk about them? Can you describe the relation you have with this person? Anyone else? (keep probing until they say no) Do you go to this person for advice? What kind of advice do you ask? Can you tell me about a time when you specifically asked for their advice?

5. Are there other groups or people that you interact with?
   Probes: Can you describe the relationship you have with the people you interact within those groups? Are there any other groups that you interact with? (continue to ask and probe until no) Do you go to these people for advice? What kind of advice do you ask? Can you tell me about a time when you specifically asked for their advice?

6. Can you draw me a picture of the people/relationships in you life?
   Probe: Who would you talk to for advice about your health? Why? Why not? Can you tell me about a time when you specifically asked for their advice about your health? Why would you go to this person but not this person?

C. Healthy living

7. Where do you think **other** people learn about their health?
   Probes: What do these people/sources say about being healthy? What do you think people can do to stay healthy? Where do **you** learn about staying healthy? Is there any other place? What do you do if you have a question about health?

8. What do you do if you wake up and you are not feeling well?

   Probes: Do you talk to someone about it? Who do you talk to first (Why)? Why not *one of other people mentioned*? Where do you go if they didn't answer your questions? What do you do if it does not get better/continues?

9. Where do you learn about sexual health (eg: HIV/STIs/condoms/pregnancy/ pregnancy prevention)?

   Probes: Is there any other place? What do you do if you have a question about your sexual health? What would you do if you were worried about your sexual health? Who would you talk to about it? Who would you talk to first (Why)? Why not *one of the other people mentioned?* Where would you go if they didn't answer your questions?

D. Experience with Health Facilities

10. What have you heard about the local clinics?

    Probes: How do **other** people describe the care they get there? What are the types of services there? What do people say about the waiting time? How do people describe the place (location, clean, space for privacy)? What do people say about the people who work there?

Thank you for your responses so far. I want to ask you a little more about **your** experience with the local clinics now.

11. Have you been to a local clinic in the last six months?

    (if no) Was there a time in the last six months you did not feel well? Have you sought treatment from another place or person (chemist, private doctor, sangoma)? Why did you choose to seek treatment from them? (**if no to both of these first two questions, go to question 13**) What were some reasons you decided not go to the clinic? Did you talk to anyone about going to the clinic? If so, who? What was their reaction? (**Go to question 13**)

    (if yes) How many times did you go (For each of those times, why did you go?) Can you talk about the last time you went? What did you go for that time? Which clinic did you go to? (*If for illness:* Did you go as soon as you started feeling unwell (why/why not)?) Why did you go to that clinic? How did you get to the clinic (Can you describe what it was like to get there)? Did you talk to anyone about going to the clinic? If so, who? What was their reaction? Did you go with anyone to the clinic (Who? Why did you go with that person?)?

12. Can you describe for me what it was like when you were at the clinic?

Probes: Can you describe for me the care you got there? How much did it cost? How long did you wait to be seen by a sister/nurse/healthcare worker? If you had a similar problem again, would you go back? Why/why not?

13. What do you think would make young people more likely to use local clinics?

E. *Youth Friendly Services*

So as I said, we're looking to improve health services for people your age. There have been some suggestions about how to do this but I wanted to get your opinion on these ideas.

14. Have you heard of something called Youth Friendly Services?

    (**if no**) Have you heard of loveLife groundBREAKERS? Can you tell me what you know about them? Have you had any interaction with a groundbreaker (if so what/describe?)? How did you feel about your experience with the groundBREAKER? **(go to question 16)**

    (**if yes or unsure**) Tell me what you know about Youth Friendly Services (YFS). What would you say are some of the similarities between YFS clinics and other clinics? What are some of the differences? How do you feel about the differences between the two types of clinics? Which clinic type would you prefer to go to? Why?

15. Have you ever used a Youth Friendly Services clinic? (**if no, go to question 16**)

    Probes: Can you describe your experience there? Can you describe the place (location, clean, space for privacy)? How did the doctors/sister/nurses treat you? How did you feel about the Youth Friendly Services while you were there? Why? Do you feel like the services were friendly towards youth? Why/why not?

16. Great! So Youth Friendly Services is a program where nurses are specifically trained to work with young people to provide services for their specific needs within the local clinics. What do you think a Youth Friendly Services clinic should be like?

    Probes: Which services do you think Youth Friendly Services clinics should provide (Health education, reproductive health, check BP, diabetes, social work/counseling, general health/illness)? Do you think there would be any advantages to having Youth Friendly Services? Would there be anything you would be concerned about? What do you think could be done to limit these concerns?

F. Alternatives/Solutions/Closing

17. Another idea is School-Based Health Clinics that are clinics that are set up on school premises. Are you in school now?

    (if no) Thinking back to when you were in school, how do you think you would have felt about having a School-Based Health Clinic at your school? Why? What do you think a School-Based clinic should be like? Which services do you think School-Based Health Clinics should provide (Health education, reproductive health, check BP, diabetes, social work/counseling, general health/illness)? Do you think there would be any advantages to having a clinic on the school premises? Would there be anything you would be concerned about? What do you think could be done to limit these concerns?

    (if yes) How would you feel about having a School-Based Health Clinic at your school now? Why? What do you think a School-Based clinic should be like? Which services do you think School-Based Health Clinics should provide (Health education, reproductive health, check BP, diabetes, general health/illness)? Do you think there would be any advantages to having a clinic on the school premises? Would there be anything you would be concerned about? What do you think could be done to limit these concerns?

18. So we've talked about improving services in the clinics, how do you think young people would feel if they could access health services outside of a clinic?

    Probes: Which services do you think young people would want to be provided outside of the clinics (eg: Health education, reproductive health, check BP, diabetes, social work/counseling, general health/illness)? Which ones would **you** want available to **you**? Where should they be provided (Why)?

19. How would you feel about Community Health Workers coming to your **home** to provide the services you need rather than at the clinic?

    Probes: What do you think a Community Health Worker should be like? Which services do you think Community Health Workers should provide (Health education, reproductive health, check BP, diabetes, social work/counseling, general health/illness)? Do you think there would be any advantages to having Community Health Workers visit your home? Would there be anything you would be concerned about? What do you think could be done to limit these concerns?

20. So from the ideas we've talked about- Youth Friendly Services, School-Based Health Clinics, and Community Health Workers- Which of these three options do you think would work best in Soweto?

    Probes: Why? Which of these three options do you think **you** would prefer to use? Why?

21. If you were the Minister of Health, what would you do to improve health services for young people in this area?

    Probes: What do you think would make young people feel more comfortable? In your opinion, what do you think would make it easier to use services? What would you do to improve young people's **knowledge** about their health?

22. What advice would you give to young people about using the local clinics?

23. Are there other factors that affect young people seeking medical care in Soweto you feel are important that we have not discussed?

24. Do you have any questions for me?

Thank you so much for your participation today!

APPENDIX B: Participant Recruitment Call Sheet

Participant Call Script

Young people's perception of a Youth Friendly Services intervention in South Africa

Hello, my name is _____ and I am part of the Birth to Twenty research team in Soweto. We're calling to firstly thank you for your recent participation in the health access survey. We would like to hear more about **your** personal perceptions and experiences with health services. We are hoping to better improve health services for young people in Soweto, and your opinion is very valuable to us.

We would ask you some questions that would not take more than 1 hour. You will be compensated for transport, and refreshments will be provided. Participation is voluntary and all information will be kept confidential. Do you have any questions?

Would you be interested in coming to Bara to participate in this study?

If you would like some time to think about it or have any questions before the interview, please contact Brittany Schriver or Kate Meagley on 079 366 3373. You can also contact the Birth to Twenty Cohort offices at The University of the Witwatersrand on 011 933 1122.

APPENDIX C: Informed Consent Sheet

Participant Information Sheet
Young people's perception of a Youth Friendly Services intervention in South Africa

Hello, my name is _____ and I am part of the Birth to Twenty research team in Soweto. As you know, we have been collecting information on health access and utilization among youth here in Soweto. Today, I would like to interview you specifically on your perception and feelings about these services. The aim of this study is to better understand how you experience health services in this area.

Why are we doing this study?
We know that a healthy lifestyle begun in adolescence may help improve the future health of adolescents and their children. Health services play a key role in this and to support the development and implementation of interventions to improve adolescent health it would be really helpful to understand how you, as a young person, experience health services in the area.

What would taking part involve?
If you agree to take part I would ask you some questions that would not take more than 1 hour. I will take notes when we talk but I would also like to record our conversation to help me remember what you said and because I might not be able to keep up with my note taking. Recordings will be digitally recorded and the files will be downloaded and kept in a password-protected file on a password-protected computer. Only members of the Birth to Twenty research team will have access to these files which will be stored securely. You can indicate whether or not you are happy for me to record our interview on the consent sheet.

Are there any risks and does it cost anything to take part?
We don't anticipate that there will be any risks involved in taking part in this study. It does not cost anything to take part in this study. We will be asking some questions that might be sensitive. If you would like additional counseling, a referral can be made for you.

Are there any benefits?
In taking part in this study you would be helping us to find out how adolescents experience health services in this area. This information could be very interesting to the Department of Health. It will also help us to improve the health of adolescents in this area. You will be given a snack and cool drink during the interview. At the end of the interview before you go home, you will be given R50 for transport.

What if I don't want to take part, or if I change my mind?
Participation in this study is voluntary. You may refuse to participate, or withdraw your consent to participate, at any time during the study without any penalty or loss of benefits.

Will my details be kept confidential?
All your details will be kept confidential except where we are required to disclose them by law. Your name will never be recorded during the interview. Only the researchers in the team will have access to your interview and results, and these will be stored securely. This study protocol has been submitted to the University of Witwatersrand, Human Research Ethics Committee (HREC), and written approval has been granted by that committee.

What will happen to the results of the study?
The results from this study will be presented to the Department of Health and may be published in academic journals. However, any publication of results will not identify participants. In some cases we might like to use quotes from out interviews but these will never identify participants by name. You can indicate whether or not you would be happy for me to use quotes on the next page. I commit to making the results of my study available to you as soon as they are available.

What if I have any questions?
If you have any questions please contact Brittany Schriver, Kate Meagley or Professor Shane Norris on 011 933 1122. You can also contact the Human Research Ethics Committee of The University of the Witwatersrand if you have any questions or concerns about the ethics or the conduct of the study.

YOU WILL HAVE A COPY OF THIS INFORMATION SHEET TO KEEP.

If you are interested in taking part in this study please read and sign the following consent form.
Thank you for your time,

Informed Consent Sheet

Before you decide whether to sign this form please make sure of the following:

• You have read this consent form, or someone has read it to you
• The study has been explained to you
• You have had all your questions answered
• You understand you can ask more questions at any time
• You understand your clinic's study records will be available to the study team but that they will be kept confidential

I _____ confirm that I have been informed about the study "Young people's perception of a Youth Friendly Services intervention in South Africa" and that I understand what participating in this study would involve. I hereby give my consent to participate in this study:

☐ Yes, I give my consent to participate in this study
☐ No, I do not give my consent to participate in this study

☐ Yes, I give my consent for quotes from my interview, that will NOT have my name attached to them, to be used in publication of the results of this study
☐ No, I do not give my consent quotes from my interview, that will NOT have my name attached to them, to be used in publication of the results of this study

☐ Yes, I give permission for the interview to be recorded
☐ No, I do not give permission for the interview to be recorded

PARTICIPANT:

Printed Name	**Signature**	**Date**

RESEARCH ASSISTANT:

Printed Name	**Signature**	**Date**

APPENDIX D: IRB EXEMPTION LETTER

5 June, 2012

RE: Determination: No IRB Review Required
58317- Title: Young people's perception of a Youth Friendly Services intervention in South Africa: A qualitative investigation
PI: Brittany Schriver

Dear Brittany Schriver,

Thank you for requesting a determination from our office about the above-referenced project. Based on our review of the materials you provided, we have determined that it does not require IRB review because it does not meet the definition(s) of research involving "human subjects" or the definition of "clinical investigation" as set forth in Emory policies and procedures and federal rules, if applicable. Specifically, in this project, you will be evaluating young adults perception of LoveLife's Youth Friendly Services initiative through conducting 45 minute interviews.

This determination could be affected by substantive changes in the study design, subject populations, or identifiability of data. If the project changes in any substantive way, please contact our office for clarification.

Thank you for consulting the IRB.

Sincerely,

Julia Duckworth
Research Protocol Analyst

This letter has been digitally signed

Emory University
1599 Clifton Road, 5th Floor - Atlanta, Georgia 30322
Tel: 404.712.0720 - Fax: 404.727.1358 - Email: irb@emory.edu - Web: http://www.irb.emory.edu
An equal opportunity, affirmative action university

APPENDIX E: COLLECTIVE CODING TREE

Collective Coding Tree
11/16/12

(1) SOCIETAL INTERACTIONS

(1.1) CORRUPTION: References to corruption including nepotism, favoritism, etc.

(1.2) SAFETY: When talking about concerns for safety as well as crime

(1.3) TECHNOLOGY: References to the use of technology (including but not limited to BBM, Google, WhatsApp, Facebook, cell phones)

(2) INTERNAL INFLUENCES

(2.1) SHAME/EMBARRASEMENT: References to shame, embarrassment, anxiety of being 'found out' or talked about by others

(2.2) FATALISM: References to a lack of control or fatalism

(2.3) AVOIDANCE: References to individuals intentionally avoiding seeking health care

(2.4) BOREDOM: References to individuals talking about boredom, lack of alternative activities when engaging in risky behavior

(3) SOCIAL NETWORKS

(3.1) SCHOOL: Either when talking about past, present, or future hopes for school or location of services/topics (DOES NOT INCLUDE SBHC)

(3.2) EMPLOYMENT: When talking about past, current, or future work. Apply when talking about not having a job or money (unemployment)

(3.3) MENTOR: Apply when talking about role models and their role/importance.

(3.4) RELIGION: Apply when talking about religion and activities related to religion

(3.5) FAMILY: Apply when talking about family

(3.6) PEERS: Apply when talking about friend group or a specific friend

(3.7) ROMANTIC RELATIONSHIPS: When talking about romantic relationships. Includes both current and past relationships. Includes boyfriends and girlfriends

(4) EXTERNAL INFLUENCES

(4.1) AGE: Includes references to someone's age as a factor in seeking advice/health services/information

(4.2) GENDER: Includes references to explicit responsibilities that are different depending on gender. When talking about going to someone because they the opposite gender. When talking about NOT going to someone because they the opposite gender.

(4.3) CHIT CHAT: References to confidentiality and gossip. Particularly when talking about fear of sensitive information becoming common knowledge.

(5) SUPPORT

(5.1) TANGIBLE: References financial assistance or providing a resource that is tangible

(5.2) EMOTIONAL: References to providing advice and emotional support

(6) HEALTHY LIVING

(6.1) STAYING HEALTHY

(6.1.1) Definition: What it means for the individual to be healthy. Also apply when definition is manifested in other parts of life

(6.1.2) Behavior: When talking about the activities necessary to stay healthy

(6.2) HEALTH EDUCATION

Includes references to informal (brochures, advertisement, billboards, signs, etc.) and formal health education programs.

(6.3) SEX/REPRO: Includes when talking about "sex" and "love life"

(6.3.1) Condoms and Prevention

(6.3.2) Circumcision

(6.3.3) STIs

(6.3.4) HIV/AIDS

(6.3.5) Pregnancy

(6.4) SUBSTANCE USE: References to alcohol, drugs, etc.

(6.5) MENTAL HEALTH/COUNSELING: Includes references to experience, services, treatment, and advice related to mental health including but not limited to depression, anxiety, stress, etc.

(6.6) GENERAL HEALTH/ILLNESS: Includes references to experience, services, treatment, and advice related to general health and illness including but not limited to sickness, injury, chronic disease, etc.

(6.7) EMPOWERMENT: When talking about getting youth involved and activities or training them to get the skills to get jobs. Also when talking about additional peer educators

(7) USE OF HEALTH SERVICES

(7.1) LOCAL CLINICS/HOSPITALS

(7.2) PRIVATE CLINICS/HOSPITALS

(7.3) OTHER SERVICES

(7.4) HOME REMEDIES

(8) PERCEPTION OF CURRENT SERVICES

(8.1) QUALITY OF SERVICE: Includes references to quality of service including quality of nurses, doctors, information given, etc.

(8.2) TIMELINESS: Includes references to timeliness, waiting times, tea times, time related to staff and individual, etc.

(8.3) FACILITIES: Includes references to the environment of the clinic- how it looks, hygiene, cleanliness, etc.

(8.4) VARIABILITY OF SERVICE: Includes references to variability of services depending on location, SES, private vs. public, etc.

(8.5) RESOURCES: Includes references to resources within the clinic including medicines, equipment, transportation, etc.

(9) SUGGESTED SERVICES

(9.1) COMMUNITY HEALTH WORKERS

(9.2) SCHOOL BASED CLINICS

(9.3) YOUTH FRIENDLY SERVICES: Includes when talking about loveLife GROUNDBREAKERS