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Harnessing Resilience: An exploration into individual and contextual factors that facilitate uptake of sexual and reproductive health services (SRHS) and HIV testing amongst South African youth

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A thesis submitted in partial fulfillment of the requirements for Doctoral Degree of Philosophy (Ph.D.), School of Public Health, University of the Western Cape (South Africa)

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Keywords: Sexual and Reproductive Health (SRH), Youth, Service Uptake, Resilience, South Africa.

Declaration of originality

I declare that the study titled, *Harnessing Resilience: An exploration into individual and contextual factors that facilitate uptake of sexual and reproductive health services (SRHS) and HIV testing amongst South African youth,* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name: ……. Sarah Spence Christie..... **Date**...9th of August 2022.....

Signed.....

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Abstract

Youth is generally defined as young people between the ages of 14- 24 years, however, in South Africa the age range is extended to 34 years. In 2020, the estimated youth population (14-35 years) in South Africa was 20.1 million, with just over 5 million being between the ages of 15-19 years. In 2009, the World Health Organization (WHO) described South Africa as experiencing a 'youth health crisis', reflective of a syndemic disease burden caused by early childbearing, poor nutrition, high HIV incidence, sexual risk behavior, substance abuse, violence, and injuries. Although there have been some improvements, the burden of disease amongst youth remains high, with tuberculosis and HIV emerging as the leading causes of death among South African youth, along with violence and traffic accidents for young men. Historically disadvantaged urban communities and rural areas are particularly subject to health disparities in terms of violence exposure, substance abuse, and mental health.

Safeguarding the health of adolescents, the period following the onset of puberty during which a young person develops from a child into an adult (spanning 10-19 years) and youth (14-35 years) is vitally important for the future of South Africa, as interventions initiated at this critical phase of development have lifetime health consequences and productivity benefits. Access to and utilization of youth-friendly health services is important to ensure the health and mental wellbeing of youth as they transition to adulthood. Sexual and Reproductive Health Services aim to provide information, education and health services to help adolescents and youth understand their sexuality and protect them from unintended pregnancy and/or sexually transmitted infections including HIV. While much research has focused on the barriers to Sexual and Reproductive Health service) utilization amongst youth, few have isolated contextual and individual factors that may facilitate uptake, including the potential role of resilience. Resilience is understood as the ability of individuals, communities, and systems to adapt in the face of adversity.

This study explored whether there was a link between resilience and healthcare-seeking behavior amongst school-based youth in a cross-sectional study design using quantitative research methods. Uptake of Sexual and Reproductive Health Services including self-reported HIV testing and contraceptive use was characterized in this key population and potential factors associated with service uptake were analyzed. Approval to use study data for purposes of this research was obtained from the University of the Western Cape's Biomedical Research Ethics Committee.

The study population consisted of school-based youth aged 15 – 24 years old at 30 secondary

schools in the Nyandeni and Umzimvubu sub-districts. In the study sample of 1,318 youth from 30 schools, routine uptake of Sexual and Reproductive Health Services was rarely reported, although most youth had recent interactions with the public health sector. Over half reported having had an HIV test, with 2.8% self-reported HIV prevalence. Youth had high exposure to violence but also demonstrated high levels of resilience across domains. Youth ratings of the quality of Sexual and Reproductive Health Services revealed that the health services are not sufficiently adapted to Adolescent and Youth Friendly Service standards. These are services that are accessible, acceptable, equitable and appropriate to meet the Sexual and Reproductive Health needs of young people aged between 10–24 years. Resilience was not associated with healthcare-seeking behavior, but those with certain Sexual and Reproductive outcomes, including a positive HIV status and history of pregnancy, had less resilience.

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Dedication

I dedicate my thesis to Zandile Jojo – Za as we called her affectionately – with her radiant smile and journey of resilience that epitomized the promise and potential of young South Africans everywhere. This work is for Za and countless other young women, to harness the resilience within and never give up.

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Heaps of thanks to my 'partner in crime', Adrian, and my gorgeous family for never giving up on me. This work is for my daughters – Senna Maxine and Daisy Summer Jones.

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Abbreviations

AYFS	Adolescent and Youth Friendly Services
AGYW	Adolescent Girls and Young Women
ART/ARVs	Anti-retroviral Therapy/Anti-Retroviral medications
AIDS	Acquired Immune Deficiency Syndrome
CYRM-28	Child and Youth Resilience Measure
DBE	Department of Basic Education
EC	Eastern Cape
ECF	Enhancing Care Foundation [implementing partner]
GBV	Gender-based Violence
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit [sponsor]
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
HF	Health Focus [implementing partner]
HSRC	Human Science Research Council
IEC	Information Education Communication
IMB	Information-Motivation-Behavioral Skills Model
IPV	Intimate Partner Violence
NAFCI	National Adolescent-Friendly Clinic Initiative
NDoH	National Department of Health
PMTCT	Prevention of Mother to Child Transmission
PReP	Pre-Exposure Prophylaxis
QA	Quality Assurance
QI	Quality Improvement
RA	Research Assistant
SDG	Sustainable Development Goal
SRHS	Sexual and Reproductive Health Services
STI	Sexually Transmitted Infection
TOP	Termination of Pregnancy
UNAIDS	Joint United Nations Programme on HIV/AIDS

UNFPA	United Nations Family Planning Association
UNDP	United Nations Development Programme
UTT	Universal Test and Treat
WHO	World Health Organization
YLWH	Youth living with HIV
YRBS	Youth Risk Behavior Survey

Glossary

Adolescence: The period following the onset of puberty during which a young person develops from a child into an adult.

Adolescents: WHO defines 'Adolescents' as individuals in the 10-19 years old age group (Dick and Ferguson, 2015).

Contraception: The deliberate prevention of conception or impregnation through various drugs, techniques, or devices; including short- and long-term methods. Short-term methods comprise hormonal Oral Contraceptive Pills and Injectable Contraceptives as well as Emergency Contraception, which needs to be taken as soon as possible after unprotected sexual intercourse. Long-term reversible contraceptive methods include the intrauterine device (IUD) and the sub-dermal hormonal implant. Long-term permanent methods include male or female sterilization. Barrier methods consist of male and female condoms (World Health Organization, 2017a).

Information-Motivation-Behavioral Skills (IMB) Model of Behavior Change: The IMB model posits that an individual who has accurate information, sufficient motivation, and appropriate behavioral skills will be better positioned to enact and maintain a health behavior, including HIV prevention. According to the IMB model developed by Fisher & Fisher (1992b), information is defined as knowledge of a prevention behavior. Motivation depends on a person's perceived vulnerability to a health risk, and is comprised of the individual's attitudes and beliefs toward that behavior, often driven by social norms. Lastly, behavioral skills include an individual's objective abilities to perform health behaviors (the ability to navigate and access health services, or protect oneself from HIV and unplanned pregnancy) and self-efficacy (the confidence in one's ability to perform such behaviors). Thus, health-seeking behavior would be enhanced as the result of an individual being 1. informed about available health services and their significance, 2. motivated to safeguard one's health, and 3. having the requisite behavioral skills (self-efficacy) to access services and support in a given setting. For more details, please refer to Chapter 2.

Resilience: Resilience is broadly understood to mean positive adaptation in the face of adversity. It highlights two key criteria that can be used to describe a young person as being resilient. The first is the experience of an identifiable context of adversity (including psychosocial or economic vulnerability, experiences of trauma, violence and/or biological risk). The second is that person's ability to adapt well to this context of risk/vulnerability. Thus, resilience relies on a complex transactional process between individuals and their social ecology. Within this transaction process, the individual navigates toward health-promoting resources, and

the social ecology reciprocates by providing support in culturally aligned ways (Ungar, 2013, van Rensburg et al., 2015).

Sexual Health and Reproductive Services: Sexual and Reproductive Health (SRH) is described as an amalgamation of "sexual health" and "reproductive health". Sexual health has been defined by the World Health Organization (2006, p. 5) as *"a state of complete physical, emotional, mental and social well-being in relation to sexuality, not merely the absence of disease, dysfunction or infirmity. A positive and respectful approach to sexuality and sexual relationships with the possibility of having safe sexual experiences which are free from discrimination, coercion and violence, and allowing for a sexual life that is safe and satisfying, with the freedom to decide if, when and how often to reproduce."* Reproductive health includes the *"rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."*(World Health Organization, 2006). Adolescent SRH services therefore aim to provide information, education and health services to adolescents to help them understand their sexuality and protect them from unintended pregnancy and/or sexually transmitted infections including HIV (see Youth Friendly Services).

Unmet need for contraception/family planning: The United Nations Organization (UN) defines the unmet need for contraception/family planning as the percentage of women of reproductive age, either married or in a union, who want to stop or delay childbearing but are not using any method of contraception (United Nations et al., 2014). This indicator is aligned with the UNDP Sustainable Development Goal (SDG) 2030 strategy that has been adopted by developing nations worldwide (World Health Organization, 2020b).

Young People: WHO (2002b) defines young people as those within the age range between 10-24 years old.

Youth: Youth is defined as the those in the 15-24 year age group (World Health Organization, 2002b). However, in South Africa, as elsewhere in the African Union, the definition of youth is extended to 34 years of age (United Nations, 2013).

Youth Friendly Services: WHO (2002a) defines youth-friendly SRH services as services that are accessible, acceptable, equitable and appropriate to meet the SRH needs of young people aged between 10–24 years. UNFPA defines youth-friendly healthcare as a package of services

that include the following: universal access to accurate sexual and reproductive health information; a range of safe and affordable contraceptive methods; sensitive counselling; quality obstetric and antenatal care for all pregnant women and girls; and the prevention and management of sexually transmitted infections, including HIV (United Nations Population Fund, 2014).

CHAPTER 1: INTRODUCTION

1.1 Chapter Overview

This chapter provides an overall background to adolescent and youth health. It focuses on the key vulnerabilities during adolescence, and benefits of safeguarding adolescent health, highlighting the importance of adolescent and youth health both globally and in the South African context. It draws on the literature in exploring the triple threat South African youth face in terms of health problems, economic vulnerability, and violence. It describes what is known about the healthcare-seeking behaviors of South African youth and draws from current evidence to describe their reported barriers to accessing health services. It additionally identifies gaps in evidence on factors at the individual, community and system levels that might facilitate youth uptake of health services and improve wellbeing. Given the adversity that South African youth face in their daily lives, resilience, characterized by a process of positive adaptation in the face of adversity (Ungar, 2013, van Rensburg et al., 2015) may be a factor for some youth to successfully navigate health services and access support.

Despite the potential role for resilience, little is known about whether it could influence healthcare-seeking behavior among youth, including the uptake of Sexual and Reproductive Health Services (SRHS) and HIV testing. Thus, based on current literature, this chapter describes the key problem that this thesis has sought to address – i.e., the burden of sexual and reproductive health issues amongst South African youth and those in the Eastern Cape in particular - and the need to identify potential factors that can facilitate uptake and demand of health services in this population. The thesis frames the barriers that youth face within the Information-Motivation-Behavioral Skills theoretical framework, to isolate specific factors that may be contributing to poor health outcomes and limited health service utilization amongst youth. This chapter highlights the rationale and significance of this research, as well as describes the overall aim of the thesis, i.e., to explore whether there is a potential role for resilience in healthcare-seeking behavior among South African youth.

1.2 Adolescent and Youth Health

In 2017, the World Health Organization renewed its focus on adolescent and youth health and has invested in a myriad of initiatives to promote access to youth-friendly services and support. Significant investment in training; capacity building of youth-led agencies; demand creation; and standardization of youth-friendly services were established in sub-Saharan Africa. The investment in youth health contributes a “triple-dividend” – for adolescents now, for their future, and for the productivity, security and health of nations in future generations (World Health Organization, 2017b).

Figure 1: The "triple dividend" of benefits for adolescent health *– World Health Organization (2017)*

- ***For adolescents now*** – promotion of positive behaviours (e.g., good sleep habits and constructive forms of risk-taking, such as sport or drama) and prevention, early detection and treatment of problems (e.g., substance use disorders, mental disorders, injuries, unplanned pregnancies, and sexually transmitted infections) can immediately benefit adolescents.
- ***For adolescents' future*** – support for establishing healthy behaviours in adolescence (e.g., diet, physical activity and, if sexually active, contraception including condom use) and reduction of harmful exposures and behaviours (e.g., poor nutrition; alcohol and tobacco use) will help set a pattern of healthy lifestyles and reduce morbidity, disability and premature mortality in adulthood.
- ***For the next generation*** – promotion of emotional well-being and healthy practices in adolescence (e.g., managing and resolving conflicts, appropriate vaccinations and good nutrition) and prevention of risk factors and burdens (e.g., interpersonal violence, substance use, early pregnancy) can help protect the health of future offspring.

Adapted from World Health Organization (2017) Section 2. "Investments in adolescent health bring a triple dividend of health benefits", p. 4

Adolescence is a transitional phase between childhood and adulthood. It is increasingly recognized as a pivotal period characterized by physical, social and psychological changes that can influence risk behavior in several areas (Alliance for Excellent Education, 2019). Examples include sexual activity, alcohol and drug use, school attendance, and healthy living. Adolescents experience several unique vulnerabilities, as summarized below (Bearinger et al., 2007):

i. *Physiological vulnerability, i.e., immature reproductive systems which make them vulnerable to STIs, cervical cancer and the hazards of early pregnancy and childbirth, all factors which impact significantly on maternal mortality;*
ii. *A tendency to engage in risky sexual behaviors;*
iii. *High susceptibility to peer pressure;*
iv. *Less negotiating power for safer sex practices, vulnerability to sexual coercion and gender-based violence, especially for females; and*
v. *Difficulty accessing quality SRH information and services, particularly in the public health sector.*

Safeguarding adolescent health and wellbeing is considered critical as much of the global burden of disease has its roots in adolescence (Sawyer et al., 2012). Targeted interventions initiated at this pivotal phase can influence health behavior, prevent acute and chronic health conditions, and support healthy lifestyle choices for individuals (Sawyer et al., 2012) as well as confer benefits to the health system and society as a whole (Sweeny et al., 2019). Despite the increasing global focus and investment in adolescent health and wellbeing, as well as a progressive policy landscape in South Africa (described later), there has been little progress in attaining universal health care for South African adolescents (Jonas et al., 2020) and far less

understanding of how to successfully engage and retain youth in health services (Lall et al., 2015). Universal health care is distinguishable from Universal Health Coverage. The former focuses on an overall primary healthcare system that provides care appropriate to people's needs. Whereas the latter focuses on financing and human resource allocations to establish systems to cover healthcare for people and groups who have insufficient financial cover (Stigler, Macinko, & Pettigrew et al, 2016).

Adolescents in particular are vulnerable to a lifecycle that predisposes them to risk behavior due to an emerging reliance on social evaluation for decision-making (i.e., sensitivity to peer pressure and what others may think) and a heightened susceptibility to engage in negative forms of risk-taking (due to perceived social norms) that can foster a sense of belonging, acceptance, admiration and respect from such behaviors (Alliance for Excellent Education, 2019, Shikukutu and Ramrathan, 2022). Furthermore, puberty, stress hormones, and brain development complicate the way that adolescents cope with life stressors, such as poverty, bias, and violence, which can compromise their cognitive function and emotional response, making them more vulnerable to such adversity (Alliance for Excellent Education, 2019). Nonetheless, they also are in a period of identity formation, personal motivation, and a future-focused mindset, which provides a critical opportunity for self-agency, learning, and reflection to seek meaning and purpose in their lives, communities and environments (Alliance for Excellent Education, 2019).

This complex landscape highlights the importance of delivering age-appropriate interventions during this key phase of development, particularly in sub-Saharan Africa where such vulnerabilities may be more acute (Romero et al., 2018b). Furthermore, adolescents and young people are less likely to seek healthcare services until they are acutely ill, and may delay prenatal care during pregnancy due to a myriad of factors including perceived stigma, traditional values toward youth sexuality, and reportedly negative attitudes of healthcare workers in primary care facilities (Davids et al., 2020, Nkosi et al., 2019, Pleaner et al., 2022). Adolescents living with HIV are particularly vulnerable to such pressures, contributing to gaps in accessing the HIV care cascade as well as risk behaviors that can lead to onward HIV transmission (Hamzah and Hamlyn, 2018).

1.3 Why Youth Health Matters – South African Youth in Context

In South Africa, the estimated youth population (15-34 years) was 20.6 million in 2019 (Statistics South Africa (SSA), 2019), making up over a third of the population (35.1%), with just over 4.5 million between the ages of 15-19 years (Statistics South Africa (SSA), 2019)). South African youth continue to experience a high burden of ill health caused by early sexual

debut, pregnancy and childbearing, high HIV incidence, substance abuse, poverty, violence, and injuries (Ashton et al., 2009, Cooper et al., 2015, Lake et al., 2019). Such findings remain persistent (Cooper et al., 2015, Lake et al., 2019, Shung-King et al., 2019). Recent literature describes an intersection between the influence of low educational attainment, limited economic opportunity, and high levels of violence that complicate universal health care for adolescents (Jonas et al., 2020). Economic opportunities for South African youth have remained limited and unemployment has increased in this age bracket. Since 2017, the unemployment rate has been 50% or higher for youth (15-34 year old) across South Africa, and more pronounced for youth with less education (Trading Economics, 2020). Further, violence is a pervasive threat to the daily life of young people, whether in interpersonal relationships, families, schools, and communities (Kaminer et al., 2013, Richter et al., 2018).

In 2011, the 3rd South African National Youth Risk Behavior Survey (YRBS) administered to school learners[1] aged 11-20 years – the most recent national survey conducted before this study -- found that 36% of South African learners reported having sex, with 12% of these reporting their sexual debut before 14 years of age. Only one third of sexually active youth in this YRBS study reported consistent condom use. More recent data from school-based youth across seven provinces in South Africa confirm that early sexual debut among young women (before age 15) remains common among the youngest cohort of respondents (12.4% among those 15-19 years vs. 6.1% of 20-24 years), signaling a temporal rebound in early sexual debut (McClinton Appollis et al., 2021). Furthermore, AGYW in both age groups who had an early sexual debut were more likely to have been coerced at first sex and less likely to have used a condom, compared with those who had a later sexual debut (McClinton Appollis et al., 2021). Such activity can lead to unplanned pregnancy and HIV infection at an early age (Hardee et al., 2014).

Overall, 18% of learners in the YRBS 2011 reported a history of being pregnant or making someone pregnant (Reddy et al., 2012). In 2016, pregnancy was reported by 11.6% of adolescent girls and young women in population-based surveys, with the highest prevalence in the Eastern Cape (Statistics South Africa (SSA), 2018). Recent surveys show an increased prevalence of pregnancy among females 14-19 years old in South Africa between 2018-2019 (Statista, 2021), which has further risen with the emergence of COVID-19 (Jonas, 2022). Furthermore, pregnancy among adolescents results in more adverse health outcomes than pregnancy in older peers, due to the greater risk of complications before and during childbirth, leading to a higher rate of maternal

[1] Learners is the term used for students in primary and secondary/ high schools in South Africa.

mortality (World Health Organization, 2020a). This, together with STIs (including HIV), threatens the health of young women (Bearinger et al., 2007, Cooper et al., 2015, Reddy et al., 2016).

South Africa is home to 7.8 million people living with HIV (UNAIDS, 2019), where approximately 18.8% of the adult population 15 years and older were living with HIV in 2017 (Simbayi et al., 2019). South African youth continue to be at-risk, with an HIV prevalence of 7.3% among those 15-24 years old in 2017 (Simbayi et al., 2019). Youth aged 15-24 years old also had the highest HIV incidence, with 88,000 new infections in 2017 and almost a third of all new infections nationwide occurring in females 15-24 years old (Simbayi et al., 2019). Young women and girls in South Africa continue to be disproportionately affected by HIV incidence compared to their male peers (UNAIDS, 2019) and are vulnerable to HIV from an earlier age (Dellar et al., 2015, Karim and Baxter, 2019). In 2022, the HIV prevalence among young women in South Africa was 9.1% - more than triple that of similarly aged young men (3.0%) (UNAIDS, 2022).

Whilst huge strides have been made to curb HIV morbidity and mortality by provision of universal ART in South Africa, youth living with HIV (YLWH) aged 15–24 years had the lowest proportion of antiretroviral treatment (ART) coverage among all age groups in 2017, at 39.9% (Simbayi et al., 2019). Youth are less likely to be tested for HIV, initiated on ART and retained in care (Gosset et al., 2019, Shisana et al., 2014, Simbayi et al., 2019). Young age was found to be a predictor of poor retention in care and for delayed ART initiation among YLWH eligible for treatment (Govindasamy et al., 2012). Despite the introduction of the Universal Test and Treat (UTT) policy in late 2016, in which all people living with HIV in South Africa were given immediate access to antiretroviral therapy regardless of CD4 count, young age was associated with greater loss-to-follow-up after immediate ART initiation as well as later presentation in the continuum of ART care (Gosset et al., 2019) and unsuppressed viral load (Joseph Davey et al., 2018). Young age was also associated with lower uptake of PMTCT (Ng'eno et al., 2020). While there is limited but emerging research on promoting adherence and retention in HIV care amongst youth (Lall et al., 2015, Shangase et al., 2021, Shenderovich et al., 2021), these data suggest an unmet need for SRHS, particularly in the context of the HIV care cascade (Enane et al., 2018, Reif et al., 2018).

1.4 Youth in the Eastern Cape

Youth in the Eastern Cape (EC) province of South Africa – this study setting – also continue to struggle with early sexual debut, unplanned pregnancy, and a disproportionate incidence of STIs and HIV, particularly amongst young women (Adeniyi et al., 2018, Reddy et

al., 2012). Complications from traditional male circumcision in the EC also pose a threat to the sexual health of young men (Wilcken et al., 2010). Overall, HIV prevalence in the Eastern Cape in 2017 was 15.3%, slightly above the national average of 14% (Simbayi et al., 2019), signaling low adoption of safer sexual behavior and limited uptake of SRHS.

The 2011 Youth Risk Behavior Survey found that the Eastern Cape reported the second highest rate of teen pregnancy in the country, with 19.3% of youth surveyed reported being pregnant or making someone pregnant (Reddy et al., 2012). In 2016, the Eastern Cape had the highest prevalence of pregnancy among AGYW at 14.2% (Statistics South Africa (SSA), 2018). In 2015[2] nearly one out of five (19.2%) antenatal attendees in the 15-24 age group were HIV positive (National Department of Health, 2017), with an overall antenatal HIV prevalence rate of 33.7% for the EC province in 2017 (Woldesenbet et al., 2020). Of concern is that the HIV prevalence of antenatal attendees in the Eastern Cape under 15 years of age was 13.6% in 2012 compared to 0% in the previous two years. Indeed, early pregnancy, a proxy for unprotected sex, is a key predictor for HIV incidence in young women (Christofides et al., 2014).

1.5 Problem Statement

Despite South Africa's significant progress in the area of HIV testing, care, and treatment services, there remain serious challenges in reaching adolescents with the health services needed to protect their health (Pettifor et al., 2013, Mmari et al., 2016). Navigating an adverse context to prioritize HIV testing and health care, in the midst of the persistent barriers that youth experience in accessing SRHS may require adequate information; sufficient motivation; and relevant skills to safeguard one's health. Further, the South African context presents specific and multi-faceted barriers to health service utilization at many levels, which may be better managed by individuals who demonstrate resilience to successfully reach and utilize health services. Conversely, those with lower levels of resilience may be less likely to access health services and support, increasing their vulnerability to poorer outcomes. If resilience is found to be associated with improved health seeking behavior, interventions that foster resilience may be important in contributing to strengthening such behavior amongst youth, to safeguard their health and protect their future.

Significant challenges to effective HIV prevention and care for adolescents and young people are well-documented. These include inadequate access to high-quality, youth-friendly SRHS, as well as persistent gender inequity and sexual violence against young women which

[2] The 2015 National Antenatal HIV and Syphilis report was the last of these reports to provide an age breakdown of HIV prevalence by province.

heighten HIV risk (MiET Africa, 2011). Various barriers have been cited for poor access to SRHS for adolescents. These include lack of knowledge about where and what services are available, sexual and reproductive health myths and misinformation, "youth-unfriendly" attitudes of healthcare workers, and stigma as adolescent sexuality is often discouraged by adults in traditionally conservative communities (Erasmus et al., 2020). Young women routinely cite limited awareness of available services, stigma associated with SRH, and negative experiences with healthcare providers as barriers to care (Jonas et al., 2018, Mokomane et al., 2017, Muller et al., 2016, Schriver et al., 2014). Structural barriers to accessing SRHS for youth include inconvenient hours and service location, transport costs, and a lack of privacy and confidentiality at facility-level. Efforts to expand services and improve SRH among Adolescent Girls and Young Women (AGYW) have been hindered by uneven implementation, fragmented programs and services, poor outreach, and limited demand (Denno et al., 2015, Mokomane et al., 2017, Pretorius et al., 2015). Resilience may assist youth to successfully navigate not only a difficult healthcare landscape, but also a context which discourages youth, and particularly young women, in discussing their sexuality and protecting their sexual health (Nkosi et al., 2019).

Against this backdrop, it is clear that young people in South Africa have an urgent need for accessible, youth-friendly SRHS. And despite the need for effective, integrated SRHS for adolescents, there is also limited evidence on specific factors that would facilitate uptake (Jonas et al., 2020, Lambert et al., 2018). Few rigorous intervention studies that promote health service utilization amongst youth have been conducted and evaluated in Sub-Saharan Africa to date, although evidence for effective interventions have begun to emerge (Scott-Sheldon et al., 2013, Napierala Mavedzenge et al., 2011, Shanaube et al., 2017, Toska et al., 2017). Community-based programs adopting comprehensive approaches to HIV prevention amongst youth have shown modest reductions in risky sexual behavior but no impact on HIV incidence (Scott-Sheldon et al., 2013, Harrison et al., 2010, Michielsen et al., 2010).

Recommendations from systematic reviews show that interventions should include broadening youth-focused approaches to address interpersonal, cultural and structural factors that contribute to HIV risk (Michielsen et al., 2010, Pettifor et al., 2013, Shangase et al., 2021). The results from these reviews further illustrate gaps in identifying enabling factors that facilitate protective health behaviors, and interventions that work best to drive demand for health services amongst the youth population (Shangase et al., 2021). Recent research that has promoted PreP notes the importance of 'gain-framing vs. loss-framing' when reaching youth with health

communications.[3] This signifies a shift toward the importance of emphasizing a future-focused and aspirational mindset to safeguard one's health – that is, what can be gained by protective health behavior - (Amico and Bekker, 2019) - rather than fear-based or loss-framed messaging. Emerging work from South Africa signals promise for this approach (Kuo et al., 2020).

In summary, despite some successes, interventions targeting South African youth have yet to yield significant reductions in HIV incidence and teenage pregnancy (Harrison et al., 2010, Pettifor et al., 2013, Reddy et al., 2012). Population-based surveys indicate a decline in the percentage of youth who can correctly identify how HIV is transmitted (Reddy et al., 2012, Shisana et al., 2014, Zuma et al., 2016). HIV testing rates amongst youth remain relatively low (Ramirez-Avila et al., 2012, Shisana et al., 2014, Simbayi et al., 2019) and the decline of HIV incidence in the population as a whole (Shisana et al., 2014) tends to mask the persistence of new HIV infections in young people (Karim et al., 2011, Baisley et al., 2018, Chimbindi et al., 2018). Youth uptake of SRH services including contraception and HIV Counseling and Testing (HCT) from the public sector is likely to be inhibited by perceived lack of privacy, stigma and negative staff attitudes (Eastern Cape Department of Health, 2014, MiET Africa, 2011, Newton-Levinson et al., 2016). Identifying culturally-aligned and social factors that will facilitate demand and enable uptake of health services is critical to protect adolescent health and safeguard their future well-being.

1.6 Study Rationale

This study was conducted to understand the utilization of Sexual and Reproductive Health services amongst school-based youth in the Eastern Cape Province in South Africa, and to explore factors that promote demand and uptake of health services, including HIV testing, by relying on the Information-Motivation-Behavioral Skills model of heath behavior change to identify both barriers and facilitators to protective health behavior. The study also explored the potential role of resilience in facilitating uptake of SRHS, given the well-documented barriers that young people face in accessing health care and support services, and the adversity present in their daily lives.

1.7 Study Significance

This study is significant because it contributes new knowledge on the utilization of Sexual and Reproductive Health services among school-based youth in South Africa's Eastern Cape Province. It explores the potential association of resilience among other factors with

[3] Information about a health behavior that emphasize the benefits of taking action is defined as a gain-framed appeal whereas those that describe the costs of failing to act is defined as a loss-framed appeal. pS205 https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1460-2466.2006.00290.x

health-seeking behaviors, in a setting that is historically disadvantaged and adverse in terms of economic and educational opportunities, high exposure to violence, teen pregnancy, and HIV. Many studies have described how resilience manifests at the individual level (Theron and Theron, 2010) in terms of buffering the effects of violence and poverty, and to a lesser extent at the organizational (Barasa et al., 2018, Huey and Palaganas, 2020) and systems level (Cooper et al., 2019). However, few have explored whether resilience may be associated with health service utilization and specific health outcomes, particularly amongst youth (Bhana et al., 2016, Katz et al., 2019, van Rensburg et al., 2015). This study seeks to contribute to this gap in knowledge.

1.8 How the Thesis is Organized

The thesis consists of eight chapters:

- ***Chapter One*** introduced the thesis by describing the importance of adolescent health, with an emphasis on access to Sexual and Reproductive Health services (SRHS) in South Africa; identified gaps in literature on facilitative factors that predict health service utilization amongst youth; provided a problem statement, as well as the rationale for and significance of the study.
- ***Chapter Two*** begins with a summary of the relevant South African policy landscape related to adolescent and youth health, and how this provided a basis for the study. This chapter also draws from literature on the Information-Motivation-Behavioral Skills (IMB) theory as the foundation for understanding health behavior change, whereby adequate information, motivation and behavioral skills must be present to enable protective health behavior, including HIV prevention and uptake of SRHS. The chapter also provides a detailed overview of the broader literature on resilience as a conceptual framework for the study. It reveals how resilience – or positive adaptation to adversity – may be an important factor for adolescents to seek health services in an environment where violence, economic disadvantage and health threats are prevalent. It also focuses on the current evidence within resilience literature from South Africa.
- ***Chapter Three*** describes the study methodology. It documents the research questions, the study aims and objectives. It describes the study setting, study population, research design, sampling, methods and instruments used to obtain data to answer the research questions for the study objectives. It also explains the methods used for data management and entry, data analysis and the study's ethics considerations.
- ***Chapter Four presents the results for Research Objective 1[4].*** This includes the descriptive

[4] The objectives are documented in Chapter 3, the chapter on the study methodology.

quantitative results of youth who participated in the study, to characterize the population and setting in which youth access care. It describes their demographic characteristics; exposure to violence; sexual activity; alcohol and drug use; and uptake of relevant health services as primary outcomes of interest, including HTC and contraception.

- ***Chapter Five presents the results for Research Objective 2[4].*** It explores the key factors that may influence the uptake of SRHS; knowledge, attitudes and practices towards SRH; and quantifies the experiences of youth who accessed health services in the two study subdistricts.
- ***Chapter Six presents the results for Research Objective 3[4], i.e., whether resilience has an association with uptake of HIV testing and SRHS among school-based youth.*** It characterizes levels of resilience in the sample, and presents analyses on whether resilience is associated with HIV testing, contraceptive use, and other SRH outcomes among youth.
- ***Chapter Seven*** provides a discussion and synthesis of the results from the three study objectives. The chapter reflects on the uptake of SRHS, youths' reported experience with health care and possible barriers including knowledge deficits about HIV prevention (information barriers); limited self-agency (motivation barriers); and insufficient uptake of contraception (skills barriers); exposure to violence, levels of resilience, and its association with health service utilization and SRH outcomes. This chapter also includes interpretation of these results and study limitations.
- ***Chapter Eight*** briefly provides the Conclusions and Recommendations from the thesis.
- ***Appendices for this study*** include the participating schools; survey instruments; the consent forms; the institutional ethics approvals and the approval letter to conduct the study from the Eastern Cape Department of Basic Education.

1.8 Summary

This chapter has provided an overall background to adolescent and youth health highlighting the key vulnerabilities and benefits of safeguarding adolescent health, while stressing the importance of focusing on adolescent and youth health globally and in the South African context. It draws on the literature to describe the status of adolescent and youth health in South Africa – and in the Eastern Cape in particular - with a focus on Sexual and Reproductive Health (SRH), as well as the HIV care cascade. It has summarized the evidence on the various barriers that youth experience in terms of accessing health services in the country. It has thus introduced whether there is a potential role for resilience in supporting South African youth to access health services, by 1. describing the adverse context which youth navigate to access care and 2. considering certain protective factors that predict safer sexual behavior – i.e., a future-

focused mindset and strong social support – which are also associated with resilience (Sayles et al., 2006, Closson et al., 2018). It has explained how youth are particularly vulnerable to gender-based dynamics, poverty and violence, and reviewed the documented factors that may hinder uptake of SRHS at multiple levels. It has highlighted the significance of this study as the first that has directly explored the potential link between resilience and protective healthcare-seeking behavior in South African youth.

CHAPTER 2: LITERATURE REVIEW

2.1 Chapter Overview

This chapter begins with a description of the evolution and current provision of youth-friendly services, the policy landscape, and related interventions targeting youth for health services in South Africa. Articles accessed from peer-reviewed journals and various electronic databases as well as policy documents comprise this review.

This chapter also describes the theoretical frameworks which guided this research. The study relied on the Information-Motivation-Behavioral Skills Model (IMB) as the theoretical foundation to assess barriers and facilitators to health service utilization. The IMB model postulates that having accurate information, sufficient motivation and adequate behavioral skills enhances youths' ability to successfully access health services and protect their health. The chapter also examines the existing literature on resilience and its association with youth health overall, with a particular emphasis on South Africa. It seeks to define resilience in context, and to describe available evidence which may shed light on the association between resilience, health determinants and social outcomes. Further, it will demonstrate the gaps in the literature which this study aims to address.

2.2 Evidence gaps in the literature

As argued in the previous chapter, health services targeting South African youth have yet to yield significant reductions in HIV incidence and teenage pregnancy (Harrison et al., 2010, Pettifor et al., 2013, Reddy et al., 2012). Population-based surveys have indicated declines in the percentage of youth who can correctly identify how HIV is transmitted (Shisana et al., 2014) and a significant proportion of youth continue to report early sexual debut, particularly young men (Zuma et al., 2016, Kharsany et al., 2018, Kharsany et al., 2019, Shung-King et al., 2019). HIV testing and treatment rates amongst South African youth remain relatively low (Ramirez-Avila et al., 2012, Shisana et al., 2014, Simbayi et al., 2019) and HIV incidence is concentrated in youth, particularly young women (Chimbindi et al., 2018, Karim and Baxter, 2019, Karim and Baxter, 2021, Risher et al., 2021). Thus, despite South Africa's significant progress across the HIV care continuum (Shung-King et al., 2019, UNAIDS, 2019), the need to engage youth in health services remains imperative to achieve an AIDS-free generation (Pettifor et al., 2013).

Gap 1. Data are limited that characterize SRHS uptake amongst youth (Mazur et al., 2018). Despite considerable research in the domain of adolescent and youth health in South Africa, data are limited in terms of actual sexual and reproductive health service uptake amongst school-based youth and how this corresponds with demand, a critical feature of the indicators for the Sustainable Development Goals of 2030 (United Nations, 2015). Sustainable Development

Goal 3 aims *"to ensure healthy lives and promote well-being for all at all ages"* with a target to *"ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programs"* by 2030 (United Nations, n.d). A key indicator for achievement of this target is the percentage of women whose need for modern contraception is satisfied, highlighting the importance to meet the contraceptive needs of young women globally, and addressing this specifically in SRHS demand generation research (Belaid et al., 2016). This thesis seeks to address this gap, by characterizing the SRHS utilization – including contraception - amongst school-based youth, particularly amongst those who need such services.

Gap 2. Barriers to SRHS uptake are well documented, but facilitators are less well understood (Hayter et al., 2019). While the barriers to HIV prevention and uptake of SRHS have been explicitly described, less is known about individual and contextual factors that may facilitate uptake of services among South African youth and predict successful and consistent interactions with the public health sector. The IMB model provides an important theoretical roadmap to understand not only the barriers that youth face in accessing services, but what strengths or facilitators may be present in youth to access care. Such protective factors are of key importance in informing policy decisions and the downstream benefits of investments in adolescent and youth-friendly services (AYFS) (Odimegwu et al., 2019). Evidence remains limited in isolating the main factors that would facilitate uptake of health services (Jonas et al., 2019, Lambert et al., 2018). Such information is necessary for program planning, policy needs, and resource allocation and to improve the quality and uptake of adolescent and youth-friendly services (AYFS). Factors that predict success in accessing SRHS could be targeted in interventions for youth to promote SRH demand and service utilization, including HIV testing.

Gap 3. The role of resilience in accessing health services remains unexplored for South African youth, despite the well-documented adverse context that youth navigate to access care (Cooper et al., 2019). Health-seeking behavior may be an adaptive process adopted by resilient youth to safeguard their health and wellbeing, and the presence of resilience among youth may be significant in facilitating their uptake of protective health services. With a significant focus on the barriers facing South African youth in accessing care, this study seeks to explore whether there is a potential role for resilience in addressing these barriers. It examines whether this adverse context acts as a potential pathway to resilience - capable of activating adaptive, culturally resonant processes (i.e., *Ubuntu* – if I'm safe, then we are all safe) and protective factors (i.e., a future-focused mindset) that are facilitative of health-seeking behavior. It thus re-centers the cultural context and social ecology as assets that may be protective of

health and well-being (Atkinson et al., 2009). The final section will define resilience as a conceptual basis for this study. By characterizing the context of adversity in everyday lives of South African youth, quantifying resilience amongst this population, and exploring the relationship between resilience and health seeking behavior, this thesis will add new knowledge framed within the resilience literature at both a theoretical and practical level.

2.3 Policy Landscape Supporting Adolescent and Youth-Friendly Services (AYFS)

The South African government has an extensive policy and legal framework aimed at improving the health of adolescents and youth through an integrated provision of services through the national Departments of Basic Education and Health. Key legal, policy and other documents that guide the provision of AYFS in South Africa and the Eastern Cape include:

- The South African Constitution (1996) (Republic of South Africa, 1996)
- Batho Pele Principles (1997) (Republic of South Africa, 1997)
- Patients' Rights Charter (1999) (South Africa National Department of Health, 1999)
- The Children´s Act (2005) (Republic of South Africa, 2005)
- National Core Standards for Health Establishments in South Africa: NDoH (2011) (Republic of South Africa, 2011)
- Integrated School Health Policy (2012) (Republic of South Africa, 2012b)
- WHO Guidelines: Making Health Services Adolescent Friendly (2012) (World Health Organization, 2012)
- Integrated Youth Development Strategy of South Africa (2012-2016) (Republic of South Africa, 2012-2016)
- Adolescent and Youth Policy Guidelines (2012) (Republic of South Africa, 2012a)
- National Contraception Clinical Guidelines and the National Contraception and Fertility (Republic of South Africa, 2012c) Planning Policy and Service Delivery Guidelines (2012)
- National Implementation Guidelines for AYFS: 2013-17 (Republic of South Africa National Department of Health, 2013)
- South African National Strategic Plan (NSP) for HIV/AIDS 2012-2016 (Republic of South Africa and South African National AIDS Council, 2012-2016)
- National Adolescents Sexual and Reproductive Health and Rights Framework Strategy (2015) (Republic of South Africa, 2015)

A National Youth Policy was adopted in 2017 (RSA NDoH 2017) (Republic of South Africa, 2017) after data collection was complete for this study, which outlines provisioning of health services and support for South African youth.

2.4 Evolution of Policy Interventions for AYFS in South Africa

Between 1999 and 2006, the non-governmental organization, LoveLife managed the National Adolescent Friendly Clinic Initiative (NAFCI), which was a component of a national HIV prevention campaign. The aim of NAFCI was to improve the quality of Youth Friendly Health Services (YFHS) at the primary health care level and to strengthen the public sector's

ability to respond appropriately to adolescent health needs. NAFCI involved training service providers, multi-media campaigns, efforts to improve facilities, and community involvement. Outreach services included youth centers and peer educators (known as groundBREAKERS). The groundBREAKERS volunteered for a period of one year to become leaders of HIV prevention within their communities. These young people, aged between 18 and 25 years, completed a series of training programs, which aimed to equip them with healthy sexuality and positive lifestyle information as well as community mobilization, presentation, facilitation, event planning and project management skills for effective outreach to other youth.

In 2006, the Department of Health took over the management of a simplified version of the NAFCI program, which was comprised of facility accreditation and health worker training. An Essential Service Package (ESP) that clinics offered for youth was developed with key stakeholders, which included:

- Information and education on sexual and reproductive health
- Information, counselling and referral for violence/abuse and mental health issues
- Contraceptive information and counselling
- Contraception method provision including hormonal oral contraception pills, injectables, condoms, and emergency contraception
- Pregnancy testing and counseling and antenatal and postnatal care
- Pre- and post-termination of pregnancy (TOP) counseling and referral
- STI information, including information on the effective prevention of STIs and HIV, diagnosis and syndromic management of STIs

In 2009, the WHO published an assessment of a NAFCI clinic initiative that was launched nationwide as a pilot study in which 11 NAFCI clinics were compared to 11 control (non-NAFCI) clinics in all provinces (Ashton et al., 2009, Dickson et al., 2007). This assessment found that NAFCI clinics were able to implement the standards regardless of size or location, were cleaner than control clinics, implemented better infection control measures, managed to maintain confidentiality and privacy, and that staff worked as a team and took responsibility for care quality.

In 2010, these initiatives were reinforced when the South African president announced the commitment of the government to reinstate health programs in public schools as a key component to strengthening primary health care delivery (The Presidency of the Republic of South Africa, 2010). The focus of the Integrated School Health Policy (ISHP), developed by the Departments of Health and Basic Education in SA (2012b), was to address immediate health problems that served as barriers to learning, and offer interventions to promote health and

wellbeing in childhood through adolescence. The school health program targeted every learner from Grade R-12 (grouped into 4 phases) and encouraged all learners in Grade 7-12 to be offered HIV Counseling and Testing (HCT), screening for STIs and provision of dual contraception by a professional nurse (Republic of South Africa, 2012b).

Furthermore, in 2012, all learners were provided with compulsory Life Orientation education, with grade-appropriate curricula delivered to Grades 4-12 (Republic of South Africa, 2019). The objective of this curriculum was to provide age-appropriate education in human sexuality, health and health education, life skills, career guidance, physical education, and human rights to address social issues affecting youth, such as poverty, substance abuse, violence, sexually transmitted infections, and sexual and reproductive health. Despite the potential of such a curriculum required in all schools (a review of such interventions in low- and middle-income countries shows promise at addressing mental health issues and strengthening life skills- see Singla et al., (2020)), putting the learning plans into practice with limited resources has had mixed results in South Africa (Mayeza and Vincent, 2019, Smith and Harrison, 2013, Van Zyl et al., 2021).

In 2017, the National Youth Policy was adopted (RSA NDoH 2017) (Republic of South Africa, 2017), which outlines provisioning of health services and support for South African youth, according to a set of standards for AYFS. The policy outlines the need for a comprehensive, inclusive set of objectives to promote overall youth health and mental well-being, as follows:

1. Use innovative, youth-oriented programs and technologies to promote the health and wellbeing of adolescents and youth
2. Provide comprehensive, integrated sexual and reproductive health services
3. Prevent, test and treat for HIV/AIDS, TB and NCDs
4. Reduce substance abuse and violence
5. Promote healthy nutrition and reduce obesity
6. Empower adolescents and youth to engage with policy and programming on youth health, and be responsible for their health and wellbeing – Leave no one behind including youth with disability

Despite the strong policy framework, assessments of youth-friendly service consistently demonstrated gaps in implementing AYFS standards across the country (Davids et al., 2020, James et al., 2018). Further, these initiatives had not yielded sustainable youth-friendly services nor significantly increased the use of SRH services amongst youth in the Eastern Cape. At the time of the study in 2016, the implementation of the NAFCI had waned without sufficient

oversight and ongoing capacity building for in-service personnel, and the ISHP had yet to be launched widely. In 2013/2014, the German International donor organization, GIZ jointly with UNFPA supported the Eastern Cape Department of Health to conduct an "*Assessment of Adolescent and Youth Friendly Services implemented in the Eastern Cape Province*", the results of which inform this thesis. The EC AYFS Report (2014), revealed that most of the clinics surveyed were not youth-friendly, that no specific AYFS model existed, and that services for youth and adults were integrated. Furthermore, there was no specific package of health services available to adolescents and youth. The assessment also found that very few healthcare providers had knowledge of the latest policies, program goals, indicators, guidelines and processes developed to support adolescent and youth health and protect their rights. Further, negative health-provider attitudes toward youth were found to be a major barrier to this target group accessing SRHS, as was a lack of privacy and confidentiality during consultations. The assessment confirmed that basic health care services were not sufficiently adapted to the needs of adolescents and young people in the Eastern Cape.

In response, GIZ funded an initiative to establish adolescent and youth friendly health care (AYFS) services in two health districts in the Eastern Cape, by:

- Improving skills, knowledge and attitudes of health staff currently providing services for youth
- Inducing change by applying a quality management approach to health service delivery using the relevant National Primary Health Care Standards
- Enhancing cooperation and coordination between the schools, NGOs targeting youth, and the public and private health care services in cooperation with local AIDS Councils
- Participation of youth

This thesis research was thus nested within a broader program evaluation that included a detailed assessment of the above initiative to strengthen health service utilization among youth in these two districts, as well to understand their barriers, facilitators, and preferences for AYFS (Christie, 2017).

2.5 Theoretical Frameworks

This study relied on two theoretical constructs to answer the research questions presented. First, the study was structured to assess the relevant information, motivation and skills barriers and facilitators that are present in youth to influence uptake of SRHS, including HIV testing. Secondly, the study hypothesized that resilience amongst youth may be a factor associated with uptake of SRHS, given the adverse context that youth navigate to access care and health services. Resilient youth may be better informed to make healthy decisions for

themselves; motivated to seek care and services; and skilled in navigating the healthcare system. Conversely, those will less resilience may be less likely to access health services, and have poorer sexual and reproductive health outcomes.

2.5.1 The Information, Motivation and Behavioral Skills (IMB) Theory of Health Behavior Change

This study applies the Information, Motivation and Behavioral Skills (IMB) theory of behavior change, to assist in identifying barriers and facilitators of health-seeking behavior. Formulated by Fisher and Fisher (1992a, 2002) and validated in numerous studies with multiple health behaviors and populations, including youth (for a systematic review, see: (Chang et al., 2014)), this theory emerged to understand and inform interventions to promote HIV prevention behavior. Interventions based on the IMB model have successfully targeted a multitude of health behaviors including condom use (Ybarra et al., 2012), adherence to HIV treatment (Amico et al., 2017), initiation and retention in HIV care (Smith et al., 2012), diabetes management (Nelson et al., 2018, Osborn and Egede, 2009), and adoption of Pre-exposure Prophylaxis (PreP) for HIV (Dubov et al., 2018, Shrestha et al., 2016) among diverse global populations, including those living in sub-Saharan Africa (Fisher et al., 2014a, Sinan et al., 2020).The IMB theory posits that in order for people to change or maintain healthy behavior, they need accurate information, sufficient motivation and the requisite behavioral skills to make a change.

Information is thus a necessary but insufficient factor in promoting behavior change on its own. Motivation is a key additional factor, serving as a function of an individual's perceived vulnerability to the negative outcome associated with a behavior as well as influenced by the support of peers and social norms. That is, individuals are likely to be motivated to change their health behavior if their peers, partners or social networks are supportive of such change, or are also modeling that change with their own health behavior. This may also include the adoption of adaptive systems that promote healthy behavior (peers, families and schools). Information interacts with motivation – i.e., the better-informed people are about the impact of certain health behaviors, the more motivated they become to make a change. Similarly, when people are motivated to make a change, they will seek out the relevant information. Finally, individuals require the appropriate skills to make a change. This could involve understanding how to get to a health facility; accessing the means for transportation to a health facility; being able to candidly discuss their needs with a healthcare provider; and successfully and consistently attending health services (e.g., for contraception). The presence of these three factors can facilitate the adoption of healthy behavior, as shown in Figure 2.

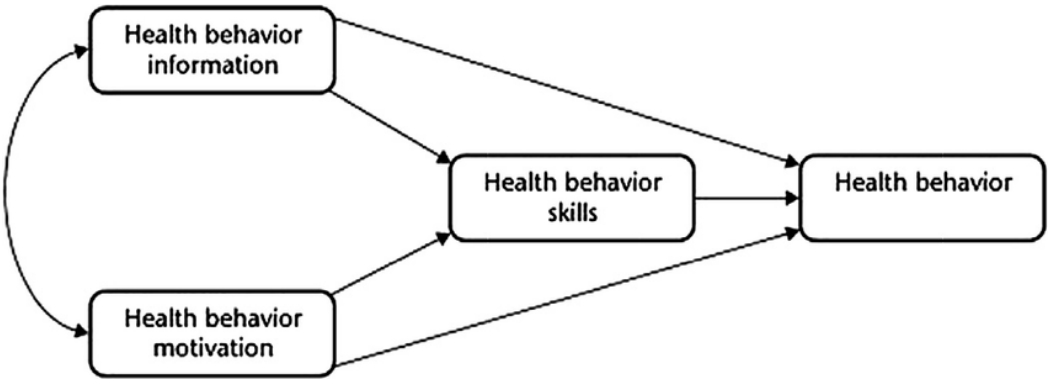


Figure 2. The Information, Motivation Behavioral Skills Model of Health Behavior Change *(Haggar et al., 2020, Fisher and Fisher, 1992a, Fisher et al., 2003, Fisher et al., 2014b)* NB: Figure appears on Fisher et al, 2014, p155.

The IMB theory is useful for understanding the potential barriers and facilitators to healthcare-seeking behavior. In this study, it was used to inform the development of this study's survey and questions that assessed youths' levels of information, motivation and behavioral skills related to HIV prevention and access to services. The first stage of IMB research inquiry is called elicitation, as can be seen in Figure 3. This stage involves understanding the specific levels of information, motivation, skills and behavior present in the target population (in this case, school-based youth) to inform future interventions. Only the first stage was used in this thesis as no interventions were developed or evaluated in this study (Fisher et al., 2003).

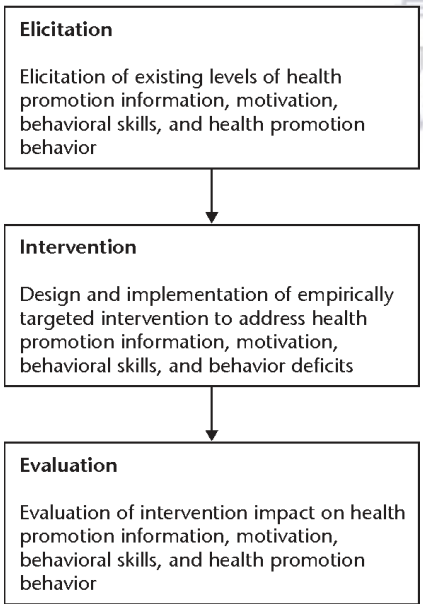


Figure 3. Stages of Research for IMB Interventions

From *W. A. Fisher and J. D. Fisher (1993). A general social psychological model for changing AIDS risk behavior. In J. Pryor and G. Reeder (Eds), The Social Psychology of HIV Infection (pp. 27-53).*

The theory of change for this study is drawn from IMB theory, with resilience acting as a potential motivating factor that may strengthen health behavior skills, and/ influence healthcare-seeking behavior directly (Fisher et al., 2003). The barriers to youth engagement in sexual and reproductive health services are well-documented in South Africa, and signal a myriad of IMB factors that may hinder uptake of protective health services including: a lack of information

about the availability of adolescent and youth-friendly health services; low self-efficacy and social support attached to accessing SRH services; and inadequate skills in navigating the opportunity costs, and perceived stigma associated with SRHS utilization.

2.5.2 Resilience

Resilience research has gone through what is considered four waves of evidence generation (Masten and Obradovic, 2006, Richardson, 2002). These include:

- Resilience Defined: The first wave of research was descriptive, defining and describing resilience.
- Resilience Processes: The second wave shifted to process questions about how resilience emerged.
- Resilience Theory: The third wave focused on applying theory to foster resilience through interventions to promote mental health and development via bolstering protective factors that had been identified in resilience research.
- Resilience in Systems: The fourth wave is focused on the integrated processes of resilience across system levels that influence individual development in a given context. It employs statistical methods that accommodate multilevel dynamics.

The research in this thesis relies on the understanding of resilience represented in the fourth wave of inquiry (Masten, 2007, Sapienza and Masten, 2011) - to explore its potential role on health-seeking behavior and describe adaptive processes at multiple levels. It quantifies resilience, and investigates whether resilience plays a role in facilitating youth uptake of SRHS in the Eastern Cape, South Africa, including demand for contraception and HIV testing. The study examines whether and if so, how adversity is experienced in school-based youth; how youth encounter sexuality, healthcare services, HIV knowledge, motivation and skills; and if they adopt adaptive processes that include safeguarding their health by accessing SRHS, including contraception.

In a recent review by van Rensburg, Rothman and Theron (2015), quantitative evidence remained scant on how to statistically describe the complex and dynamic transactions between South African youth and their contexts which potentiate adjustment to hardship and support resilience. Little is known regarding the specific pathways that resilience may have on the uptake of SRHS, and whether protective factors in individuals, families and communities can convey specific benefits in terms of healthcare-seeking behavior and HIV prevention amongst youth. Further, few studies have conducted multivariate analysis on representative samples to understand the contributions and accumulation of risk (e.g., violence) at the individual and interpersonal level that may signify whether and how resilience emerges (van Rensburg et al.,

2015) and its interplay with protective health behaviors in South Africa. In addition, in many studies, the social ecology of risk was not sufficiently described to confirm the presence of adversity, and thus the emergence of resilience. Therefore, this study seeks to not only quantify exposure to violence and resilience in a representative sample of school-based youth in the Eastern Cape, but also to understand how the presence of these two constructs may be associated with healthcare-seeking behavior, including HIV testing and the utilization of contraception.

2.5.3 Resilience in context

The study of resilience within youth has gained traction in the past two decades particularly in low- and middle-income settings that are resource-constrained. As indicated, resilience was originally conceived as an individual trait or construct. However, resilience is increasingly being defined as a process between individuals and their social environments, with local authors contending that:

> *Resilience, or positive adjustment to hardship, relies on a complex transactional process between individuals and their social ecology in which the individual navigates towards, and negotiates for, health-promoting resources, and the social ecology reciprocates by providing support in culturally aligned ways (van Rensburg et al., 2015)-p1.*

This transactional process relies on an understanding of both the context in which youth live and their social ecology i.e., families, communities and systems – and the ability of youth to negotiate and transcend the risk and adversity present in their daily lives. The transaction enables youth to articulate their needs, and for their environment (peers, teachers, healthcare providers) to reciprocate in productive and responsive ways. The ability of youth to transcend adversity is often grounded in cultural roots and a shared value system, whereby youth can derive strength and the ability to persevere in the face of adversity based on a common cultural narrative and collective pride (Theron and Theron, 2010). Such processes may be especially salient in South Africa where the apartheid regime enforced separation and persecution of people of color. Although clearly unintended by the regime, this may have led to the forging of a potential legacy of protective factors in individuals, families and communities that could be leveraged for health promotion (Theron and Donald, 2013, Theron and Pasha, 2013, Theron and Theron, 2010).

Hence, resilience as a process emerges as a potential way for South African youth, living in post-apartheid South Africa to navigate risk and derive strength from the shared history and culture that shapes their lived experiences of adversity (Theron and Theron, 2013). An Afrocentric lens of resilience moves beyond the importance of individual agency alone to overcome adversity, elevating the significance of family and community to support youth

(Theron, 2016, Theron and Pasha, 2013). Further, scholars have argued (Freeman and Logan, 2004), it is this very lens of common heritage and enduring diversity of African cultures that should frame our resilience research and service delivery efforts with black families and communities as described below:

> *This African continuity perspective is at the heart of efforts to identify a common heritage framework for black families living in Africa, North America, Europe, South America, and the Caribbean. Such a framework does not ignore important differences that existed centuries ago, or the differences that developed from the various geographical, political, social and economic conditions that confronted black families… during the African diaspora. However, a failure to acknowledge common cultural resources and problems may impede efforts to address environmental barriers, and utilize common planning and implementation strategies for helping black families and communities… "*(Freeman and Logan, 2004, p8)

Masten (2009) reflects on resilience as 'ordinary magic' and a common phenomenon in individuals – resilience is not reserved as a trait in the rare few who overcome adversity as was previously understood (Masten, 2014), nor is it reliant on extraordinary resources and services to combat adverse environments. While reducing risk and adversity in the lives of youth is paramount to ensure their wellbeing and future health, resilience arises from the interaction of basic adaptive systems that foster and protect human development (Masten, 2001). This includes forging attachments, gaining mastery and self-agency, drawing on cultural traditions and spirituality, and attaining a sense of belonging. Masten (2009) contends that resilience can be mobilized and facilitated through protective adaptive systems that are already present and powerful influencers in the lives of youth.

Such protective factors may be present in individuals, in families and in communities, with schools recognized as a potential primary source of resilience for youth (Malindi and Machenjedze, 2012, Theron and Theron, 2010). A recent review by Sapienza & Masten (2011, pp. 267-268) found, the most widely reported correlates of resilience in young people include the following, which feature supports at the individual, family, and community level:

1. Positive relationships with caring adults
2. Effective care giving and parenting
3. Intelligence and problem-solving skills
4. Self-regulation skills
5. Perceived efficacy and control
6. Achievement motivation
7. Positive friends or romantic partners
8. Faith, hope, spirituality
9. Belief that life has meaning
10. Effective teachers and schools

Assertiveness, empathy, optimism, autonomy, a sense of self-worth and goal-orientation, with

an internal locus of control are individual traits also linked to resilience (Abukari, 2018, Mampane, 2014). Resilient South African youth have been found to be better-equipped to constructively improve their environments and advance their future within stressed communities (Mosavel et al., 2015).

Some have argued that the black South African cultural experience serves as a foundation for resilience, with its emphasis on cultural values of inter-connectedness, interdependence and *Ubuntu* (Theron, 2016). However, findings in this domain are limited and only beginning to emerge (Theron and Pasha, 2013). Furthermore, there may be a more nuanced understanding of *Ubuntu* seen as a necessary adaptive process for survival, rather than a culturally-driven ethos, particularly given the diversity of African culture. In fact, van Breda (2018) argues that it is nearly impossible to disentangle the study of culture's impact on resilience processes beyond the legacy of shared circumstance, given the centuries-long persecution of African people that began with the painful history of 400+ years of colonialism on the continent, and cemented by the apartheid regime in South Africa. Similarly, van Breda (2018) maintains it could be disparaging to equate e.g., passive stoicism as an adaptive cultural process, one that individuals should aspire to adopt and endure to navigate adversity. Finally, Hailey (2008) and others caution the pitfalls and paradox of *Ubuntu* principles in contemporary South African society, particularly among urban townships plagued by violence and xenophobia (Akinola and Uzodike, 2018).

Here rather, *Ubuntu* is described as one cultural ethos that may be capable of igniting protective processes in individuals and communities, but acknowledging that in practice, this application would be nuanced and highly specific to context and communities. Whether rooted in historical injustice or cultural fortitude, *Ubuntu* remains an ethos which scholars and communities gravitate towards to encourage youth to protect themselves and help others (Masten, 2014). While *Ubuntu* is particularly salient in South Africa, it is reportedly common in other cultures in countries on the African continent as well (Hailey, 2008). It refers to an interdependence, kinship and sense of belonging that defines humanity – in which humans derive their self-worth, successes and failures not only from their individual achievements, but for how their conduct supports their families and extended communities (Mnyaka and Motlhabi, 2005).

This worldview may also serve to encourage youth to 'transform contemporary South Africa' through their educational achievements and career pursuits, and may further support resilience in youth, since youth may feel accountable to safeguard their health for a sustainable future beyond themselves (Theron, 2016). Conversely, these values may also complicate

engagement with health services, serving to both hinder and support protective behavior. For example, sometimes youth may sacrifice self-agency and individual achievement for the collective good. They may feel pressure to keep elders content by conforming to gender expectations and customary practices while forgoing individual self-protection and healthy behavior (Theron and Pasha, 2013). Further, adults and youth may have divergent perspectives on what are key enablers of resilience, particularly with adults emphasizing the importance of youth's individual qualities and family support, while youth report to derive resilience through academic achievement (Theron, 2020). That is, South African youth articulate a pathway to self-reliance through educational attainment, while adults lean into traditional values to support resilience (Theron, 2016, van Rensburg et al., 2019a)

Resilience may be fostered in contexts where children are raised in inclusive, extended families where 'every person belongs, co-exists, and contributes' (Theron and Pasha, 2013). Families and particularly, strong mothers (Theron and Ungar, 2019) that convey supportive relationships to their children in the face of poverty, violence and abuse may provide a buffer against the negative consequences of these settings (Theron and Theron, 2010, Theron, 2020, Theron, 2016). Finally, communities that value youth and encourage their active participation; share resources such as food, clothing, skills, and advice; and which mobilize against crime and violence tend to promote greater resilience amongst youth (Theron and Theron, 2010).

While not wishing to oversimplify the lived experience of South African youth post-1994 – particularly, given the damaging legacy of colonialization, apartheid, and Global North influences - this thesis seeks to understand how certain cultural norms may interact to confer resilience and adaptive processes and systems that protect adolescents and youth health, particularly in complex landscapes of HIV risk, violence, social injustice, and gender inequity. If South African youth demonstrate pathways to resilience, as some studies have reported (Theron and Donald, 2013, Abukari, 2018, Theron, 2016), these processes may be forged from cultural and social norms in meaningful and productive ways that could be leveraged to facilitate dialogue, promote health, and inform future interventions to safeguard youth (Theron, 2016). This rationale is consistent with Panter-Brick's conceptualization of resilience as a context-driven, culturally-specific process to harness resources for sustained well-being (Southwick et al., 2014) and coheres with recent research on processes of resilience that youth living in adverse circumstances elsewhere experience in meaningful and dynamic ways (Fleming and Ledogar, 2008, Kirmayer et al., 2011, Liebenberg et al., 2014, Panter-Brick, 2014). Furthermore, resilient youth may be better-equipped to seek health services and protect their health, given the well-documented barriers to SRH service utilization that youth commonly experience (Theron, 2016).

2.6 Summary

This chapter documented the youth health policy landscape in which this study was situated, as well as introduced the parent project in which this study was nested. The study also described the Information-Motivation-Behavioral Skills (IMB) Theory of Behavior Change (Fisher and Fisher, 2002) as the guiding theoretical framework used in developing measures to identify barriers and facilitators to protective health behavior, including HIV testing and contraception use. Lastly, a detailed review of the literature on resilience and its possible role in youth healthcare-seeking behavior was included, highlighting the potential significance of youth resilience in the South African context.

CHAPTER 3: AIMS, OBJECTIVES AND METHODOLOGY

3.1 Chapter Overview

Chapter 3 focuses on the research methodology, describing the research questions, aim and objectives. It provides an overview of the study population, study setting, and the sampling process. The research methods, study procedures, and tools for data collection and analysis are described for each study component, along with a closing section on study ethics.

3.2 Research Questions

The following research questions were pursued by this study:

- What is the uptake of sexual and reproductive health services (e.g., HIV testing, contraception, and STI treatment) by youth?
- What are the facilitators and barriers to accessing SRHS, for example, HIV testing?
- What are the levels of resilience within school-based youth, and is there any association between resilience and uptake of SRHS, including HIV testing?

Addressing these research questions may help to identify factors that could be harnessed in future interventions to generate improved demand for services and increase health service utilization for youth.

3.3 Aim

The overall aim of this research was to determine youth uptake of SRHS (e.g., HIV testing, contraception, and STI treatment) and understand how to optimize uptake through an exploratory analysis of IMB factors that may correlate with successful SRHS utilization, including resilience. This thesis investigates whether resilience is associated with healthcare-seeking behavior among youth. It also aims to contribute new information on whether resilience may be leveraged to ultimately safeguard adolescent health and well-being through targeted interventions, particularly in settings where youth face adversity in accessing health services.

3.4 Objectives

The objectives of this study are thus:

i. To quantify the uptake of SRH health services amongst adolescents and young people,
ii. To identify barriers and facilitators to uptake of SRH health services, and
iii. To characterize resilience in the sample, and explore whether there is an association between resilience and SRH health seeking behaviors to inform future interventions that seek to increase uptake of health services amongst youth.

3.5. Study Setting

The study was conducted in the Eastern Cape (EC) Province of South Africa in the Alfred Nzo and O.R. Tambo Health Districts, as shown in Figure 4 below. In Alfred Nzo, the Umzimvubu sub-district, and in O.R. Tambo, the Nyandeni sub-district, were selected as study sites.

Figure 4. Map of Eastern Cape province, South Africa with study setting/sites indicated – *Nyandeni sub-district in O.R. Tambo and Umzimvubu sub-district in Alfred Nzo.*

The Eastern Cape is the second largest of South Africa's nine provinces and has the third highest population (Statistics South Africa (SSA), 2016). In 2016, people under 25 years of age comprised the largest proportion of the province's population, representing 53.4% of the overall EC population, with 21.47% in the 15-24 age group (Statistics South Africa (SSA), 2016). The EC remains one of the poorest and least resourced provinces with a high youth unemployment rate (53.3%) and intense levels of poverty (Eastern Cape Socio Economic Consultative Council, 2020, South Africa Gateway, 2019).

The Alfred Nzo District covers the northeast of the province, bordering Lesotho and KwaZulu Natal. The district has a population of 878,635 (Census 2011, Cooperative Governance & Traditional Affairs and Republic of South Africa, 2020a). The main center is Kokstad. IsiXhosa is the first language in most areas. The Alfred Nzo district contains remote, mountainous areas with dramatically high levels of poverty. In this district, the proportion of those unemployed in 2018 was high (reported as 40.7% overall and 52.3% for youth), with 71.8% of the population reported to be living below the poverty line (Cooperative Governance & Traditional Affairs and Republic of South Africa, 2020a). The formal economy is small and

heavily dependent on government services, with private sector activity primarily concentrated in forestry and related industries. The Umzimvubu Local Municipality is one of four local municipalities that fall under the Alfred Nzo district, with a population of 199,620 in 2016 (Statistics South Africa (SSA), 2016). It comprises two towns, Mount Frere and Mount Ayliff, which are located along the N2 route between Mthatha and Kokstad.

The O.R. Tambo District had reported a total population of 1,514,306 in 2019 (Cooperative Governance & Traditional Affairs and Republic of South Africa, 2020b). The unemployment rate was reported as being 38.7%, and highest among youth at 54.5%. Just over two thirds (66.5%) are reportedly living below the poverty line (Cooperative Governance & Traditional Affairs and Republic of South Africa, 2020b). The O.R. Tambo District lies along the coastline and is mainly rural, with only 9.3% of the population living in urban areas. Nyandeni municipality is one of the five municipalities that make up the O.R. Tambo District. It has a population of 309,702 (Statistics South Africa (SSA), 2016) and comprises two magisterial areas, viz. Libode and Ngqeleni. The municipality's economy is largely dependent on agriculture. In 2011, it had a reported unemployment rate of 44.8% and a youth unemployment rate of 55% (National Government of South Africa, 2016).

3.6 Overall Study Design

The study for this thesis was nested within a broader parent project funded by GIZ that aimed to strengthen adolescent and youth friendly services (AYFS) in the Eastern Cape in the two participating sub-districts, Nyandeni and Umzimvubu (Enhancing Care Foundation, 2021). In the parent project, 52 clinics were randomly selected to monitor quality improvement (QI) and AYFS utilization among youth aged 10-24 years in the two subdistricts over time.

This thesis research employed a cross-sectional study design to survey a representative sample of school-based youth participants (Setia, 2016) for the quantitative assessment of SRHS uptake, and related factors including resilience. The methods for this study comprised collection of data in pursuit of all three of the study objectives. In addition to quantifying SRHS utilization amongst school-based youth, the survey allowed characterization of those who had successfully accessed SRHS, including HIV testing.

The sampling units for this study were schools to ensure a representative sample of youth, given that roughly 2/3 of youth are enrolled in school in the Eastern Cape (Hall, 2019). Out of a possible total of 389 junior and secondary schools in Nyandeni (192) and Umzimvubu (197), thirty schools were selected due to their proximity to the 52 clinics that were randomly assigned to monitor utilization of health services among youth in the parent project (Enhancing

Care Foundation, 2021). Schools that were not in the catchment area of these 52 clinics were excluded. The study was conducted in collaboration with the NGO Restless Development, which has active youth representation in the Eastern Cape and facilitates Life Orientation classes within area schools.

3.6.1 Sampling of Schools and Study Population

The study population consisted of school-based youth aged 15 – 24 years old at 30 secondary schools in the Nyandeni and Umzimvubu sub-districts. A 2-stage, stratified cluster sampling strategy consistent with the rapid WHO 30x7 sampling strategy was used. A sample of 30 schools was deemed sufficient to yield a representative sample of school-based youth in the study settings where the parent AYFS quality improvement program was taking place (World Health Organization, 2015, World Health Organization, 2008). One class from Grades 9-11 was randomly assigned to participate prior to data collection, consistent with other studies (Reddy et al., 2012), as follows:

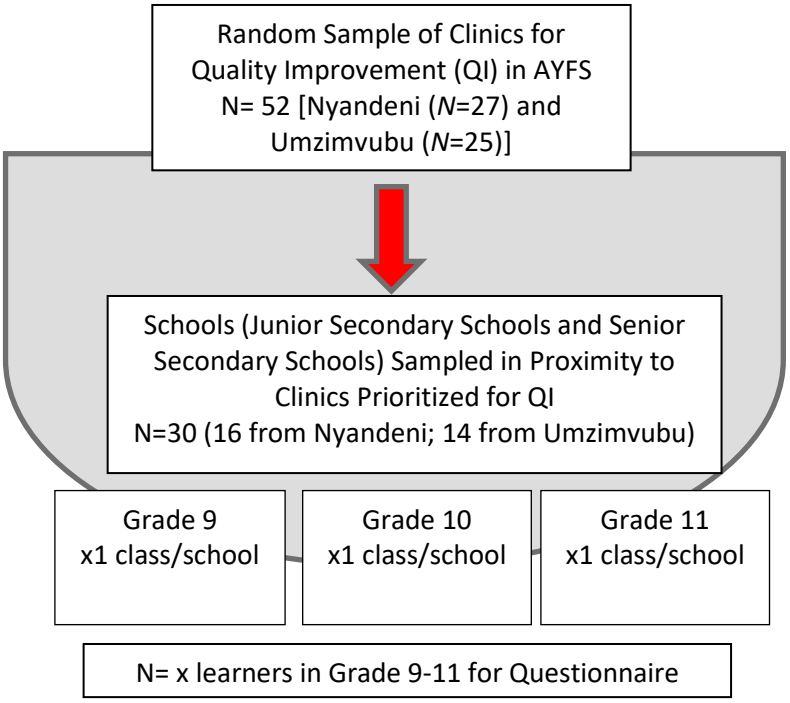


Figure 5. Sampling Diagram for Selection of Schools for Study inclusion [5]

Therefore, learners from up to three classes per participating school (one from each eligible Grades 9, 10 and 11) in 30 schools total were eligible to participate.

In order to characterize a representative sample of HIV testing uptake or prevalence of testing, I approximated a 30% coverage of 'ever tested' (consistent with what was reported in the YRBS 2011), and used a 95% confidence interval of 24-36%. Therefore, the planned

[5] Junior Secondary School typically goes up to Grade 9 only; Senior Secondary School typically begins from Grade 10-12.

prevalence of ever tested (πplan = .3) and the anticipated width of the confidence interval (.36-.24) =.12 was used to compute a standard error (SEplan =.12/ (2x1.96)) = .03. A total of 233 participants (n= [.30{1-.30)]/ ($.03^2$) =233) would be required to estimate a representative sample of HIV testing in the school-based youth population in the participating subdistricts. Presuming a 15% non-response rate, this would require approximately 268 learners in total. This calculation also took into account the design effect (D_{EFF}=2) for cluster sampling for potential variance.

The sampling strategy yielded 27 Grade 10 and Grade 11 classes (total 54) and 16 Grade 9 classes for a total of 70 classes. All learners (students) in each class selected were eligible to take part. A total of 589 and 729 participants were recruited from schools in the Nyandeni and Umzimvubu districts respectively, yielding a total sample of 1318 learners, which is adequate based on these estimates. For the full sample of participating schools, see Appendix A.

3.7 Data Collection and Research Instruments

Structured questionnaires were used to collect socio-demographic characteristics, sexual behavior, exposure to violence and bullying, health-seeking behaviors including history of pregnancy, STI treatment, and HIV testing, routine attendance to care, preference for AYFS and past clinic experience, and other potentially relevant factors (i.e., alcohol and substance use).

Validated measures from the PREPARE study[6] were adapted for this purpose (Aaro, 2014). In June 2016, the study questionnaire was piloted with 10 school-based youth who were participating in a youth workshop held by Restless Development, an NGO active throughout the Eastern Cape. Final revisions to the survey were made ahead of translation into isiXhosa, based on pilot feedback. Back translations were completed to ensure the questionnaires captured concepts as intended across languages, and the questionnaire was made available in both English and isiXhosa during survey administration.

The questionnaires were paper-based and self-administered by learners in-person at the selected schools. Participants completed them in a classroom setting with their desks separated from each other to ensure privacy. There was no budget allocated for tablet-based administration, and a group setting was deemed most efficient to achieve the sample. In addition, digital literacy amongst youth and access to internet connectivity for data storage may have been uneven given the geographic diversity of the sample (Lembani et al., 2020). Trained Research Assistants were onsite to answer any queries students may have had and to collect the

[6] The PREPARE Study was established to promote sexual and reproductive health among adolescents in southern and eastern Africa (PREPARE) by implementing multi-faceted interventions in a community-based, school-delivered platform. Spearheaded by the University of Cape Town and the Medical Research Council, the survey was designed to assess health service utilization, and a myriad of factors that may influence SRH amongst school-based youth in South Africa, Uganda and Tanzania (survey provided by Dr Catherine Mathews, PI, PREPARE Follow-up Survey, 2014).

questionnaires from participants after completion. The questionnaires were made available in English and in isiXhosa. Learners were able to choose to complete the questionnaire in the language with which they were most comfortable. (See section below on the study ethical considerations for a description of the ethics procedures implemented). The measures for each research objective are described below, and can be referred to in Appendix B.

Data Collection for Research Objective 1: *To quantify the uptake of health services amongst adolescents and young people*

The study relied on the following primary outcomes to characterize uptake of SRH services:

a) *HIV testing:* The study assessed how many youth have accessed voluntary counselling and testing services in the past year, as well as the results of the test if available; and
b) *Demand satisfied by modern contraception/unmet need:* The study measured the percentage of women aged 15-24 years old who did not wish to get pregnant and who were using modern contraception, as well as the type of method used. This is aligned with UNDP indicators for SDG 2030 (World Health Organization, 2020b, World Health Organization, n.d).
c) Secondary outcomes explored by this research were outcomes that potentially correlated to the primary outcomes of interest including sexual debut, history of pregnancy, and STI treatment.

Measures assessed the baseline utilization of SRH and HIV testing services in the public sector (dependent variables), as well as key demographic and individual factors (independent variables) that may correlate with service uptake, including resilience. These included demographics, alcohol and drug use, exposure to violence and bullying, sexual risk behavior, as well as knowledge (information), attitudes (motivation) and practices (skills) regarding HIV prevention and care-seeking behavior.

Demographics: All study participants were asked their age, sex, grade, ethnicity, employment status, residence (town/city), their household size, cell phone ownership, access to food at home and school feeding scheme, and whether they had experienced traditional Xhosa rites of passage for coming-of-age youth (this is known as *Intonjane* for females who have undergone menses (Padmanabhanunni et al., 2018), and *Ulwuluko* for males, which generally includes traditional male circumcision (Vincent, 2008)).

Sexual Behavior: All study participants were asked a series of questions about their sexual behavior, including age of when they first had sex; whether first sex was wanted; whether they were currently sexually active and/in a relationship; frequency of condom use; and

engagement in transactional sex (i.e., either having given or received material goods in exchange for sex).

Alcohol and Substance Use: All study participants were asked about the frequency of alcohol and drug use over the past six months, and a range of illicit substances were queried (tik, dagga, heroin, etc.). Binge drinking was also assessed, i.e., whether participant drank more than one drink of alcohol in a given day.

Exposure to Violence and Bullying, including Intimate Partner Violence: Study participants were asked specific questions about witnessing violence in school, at home and in communities in the past six months as well as whether they had been victimized through violence, bullying or sexual harassment. They were also asked if they had been involved in a physical fight, had taken something without permission, or had damaged property in the past six months. In addition, study participants were asked if they had experienced or perpetrated intimate partner violence, including forced sex or threatened their partner with physical violence in the past six months.

Data Collection for Objective 2: To identify barriers and facilitators to uptake of health services

The study also assessed youths' experiences with the provision of health care, based on their most recent visit to public sector health facilities. The questionnaire also assessed levels of information, motivation and behavioral skills related to SRHS uptake, to identify barriers and facilitators to care.

Attendance of Healthcare and Quality of Services: In order to determine youth's attendance of health care, and understand youths' perspective on the quality of services that they received when they last attended health services, questions were adapted from a measure that is typically administered to young clients in exit interviews to assess AYFS standards set by NDoH (National Department of Health Republic of South Africa/LoveLife, 2015). The questions related to perceived overall quality of health care, and of interactions with clinical care and support staff (e.g., being treated with respect or in contrast, being shouted at); waiting time for accessing services; access to facilities (mode of transport and associated costs); and privacy and confidentiality of consultations.

Information, Motivation and Behavioral Skills - HIV prevention and health behavior

Information Levels regarding HIV prevention: A total of 15 questions were included to assess HIV prevention knowledge, and identify gaps in information and common myths or misconceptions regarding HIV based on an adapted composite knowledge measure developed by the Human Sciences Research Council (HSRC) in 2012 for longitudinal assessments of youth knowledge (Shisana et al., 2014). The HSRC utilized a composite measure of HIV knowledge

based on responses to three questions related to HIV prevention in their population-based survey, as follows: “To prevent HIV infection, a condom must be used for every round of sex”, and “Can a healthy looking person have HIV?’ in combination with rejection of myths and misconceptions about the disease, namely, “Can AIDS be cured”, and “Can a person get HIV by sharing food with someone who is infected” as recommended by UNAIDS (2013). In addition, the South African National HIV Survey, 2012 also asked the question “Can HIV be transmitted from a mother to her unborn baby?” which was added to this measure.

In terms of knowledge about HIV transmission and prevention, if a participant answered the first set of questions correctly they scored 1, whereas if they answered any of the questions incorrectly they scored 0 (UNAIDS, 2013). Similarly, if a participant correctly rejected the two myths and misconceptions about the disease, they scored 1, whereas if they answered any questions incorrectly, they scored 0 (UNAIDS, 2013). This study adopted a similar methodology in order to compare results for HIV knowledge with national benchmarks. Study participants would need to get all five questions correct to achieve a perfect composite knowledge score.

Motivation regarding HIV prevention and health service utilization: Questions from the PREPARE study were adapted to understand learners’ perceived vulnerability to pregnancy, STIs and HIV and the perceived severity of these health outcomes. Further, attitudes towards health behavior including condom use, abstinence, having inter-generational sexual partners, and HIV testing were assessed as well as normative support for such behaviors.

Behavioral Skills and Self-Efficacy: Additional questions from the PREPARE study as well as new questions to assess youth’s ability to negotiate condom use; access HIV testing; discuss sensitive topics with healthcare providers; and avoid pregnancy were also included. Several questions also assessed youth’s ‘intentions or planned action with regard to clinic attendance, condom use, testing for HIV and STIs, and abstinence.

Data Collection for Objective 3: To characterize resilience in the sample, and explore whether there is an association between resilience and health seeking behaviors.

Resilience factors were assessed utilizing the 28-question Child and Youth Resilience Measure (CYRM-28), from the Resilience Research Centre (2016), which has been validated in several countries, including South Africa (Ungar and Liebenberg, 2011, Govender et al., 2017, van Rensburg et al., 2019b). The measure was self-administered, whereby participants rated themselves according to a 3-point Likert scale on how often they affirmed the statement with the following responses: 2- No, 3- Sometimes and 4- Yes. Questions assessed social and familial [parental] support; alignment with cultural values; community pride; the presence of role models; self-reliance; life-future orientation; and the feeling of safety, particularly within

families, schools and communities. The higher scores delineated greater resilience and were categorized in clustered domains of resilience at the individual level (11 questions); the parent-caregiver level (7 questions); and at the contextual level (10 questions) as shown in Appendix B. The highest possible total for an individual resilience score would therefore have been 112; and the lowest possible score would have been 56.

Based on user guidelines for the CYRM-28 from the Resilience Research Center (2016), seven context-specific questions were added to the resilience assessment, to characterize resilience in context but were not included in overall score. These additional questions were developed based on interactions with youth which revealed a dominating theme of youth not being taken seriously, and women being less valued in society (MiET Africa, 2011). These questions intended to quantify perceived self-efficacy and agency in being able to protect oneself from STIs, HIV and pregnancy, as well characterize the presence of supportive adult mentors and respected peers in communities, which are associated with resilient environments (Rhodes and Lowe, 2008, Theron, 2020). One question also assessed individuals' capacity for hope, an important precursor to self-agency (Theron, 2020). These question were not included in the scoring of the CYRM-28 but were added to this survey to assess potential, context-specific factors related to resilience based on prior assessments of youth and AYFS in the Eastern Cape (Eastern Cape Department of Health, 2014) as well as capture how youth interacted with their social ecologies (i.e., peers, households, and communities) to access support and resources.

In addition, ten further questions (that were not scored as part of CYRM-28) were included to assess youth aspirations, including a future-focused mindset and internal locus of control amongst learners, which have been shown to be present in resilient youth (Mampane, 2014, Mampane, 2012, Theron, 2020). Academic achievement and career aspirations were also assessed as they have been found to be associated with resilience amongst South African youth (Hendricks et al., 2015, Theron, 2020).

3.7.1 Data Reliability and Validity

Surveys were self- administered, but completed in sections whereby a trained Facilitator reviewed each section's instructions before proceeding for clarity and questions. Similar methodology for administering school-based surveys has been conducted for the Youth Risk Behavior Survey (Reddy et al., 2012) and PREPARE studies (Namisi et al., 2015). Once the questionnaires were completed, they were reviewed in real-time, when possible, with the participant to confirm any missing responses or conflicting responses prior to submission. After the data were verified with the participant, the paper-based surveys were also reviewed for missing responses and errors in completion as part of data quality assurance (QA). Learners

were accompanied by a Research Assistant for the duration of the questionnaire administration, were encouraged to respond to all questions that they were comfortable answering, and could ask clarifying questions as needed. The questionnaire was structured without skipping patterns to ensure data accuracy and completeness.

All data were captured by a Data Manager in Excel, with outliers checked against paper-based forms for accuracy, and random data checks for accurate capturing before converting into SPSS. Data with missing values on the primary outcomes and resilience measure were excluded to ensure analysis for multiple regression. Normality of distribution was also assessed for resilience scores, to ensure appropriate statistical tests. All data in Excel was converted into SPSS v26 for analysis. Data files were stored on password-protected hard drives, with access limited to the Research Team (i.e., Data Capturers) and Study Lead (myself).

All questions used to measure uptake of sexual and reproductive services, quality of SRHS, and resilience were adapted from validated measures, with questions and scales with a similar population (youth) from the same context – i.e., South Africa (Aaro et al., 2014, Mathews et al., 2016, van Rensburg et al., 2019a), strengthening confidence in the reliability and validity of the measure. All questions were piloted and adapted accordingly ahead of use with youth, to ensure readability and understanding. For example, there were several questions added to the resilience assessment to contextualize responses and quantify potential context-specific mechanisms of resilience in youth. The psychometric properties (Cronbach's alpha) of the PREPARE measure have been reported previously (see Mathews et al., 2016 and Appendix B) but an independent Cronbach's alpha was run on the CYRM-28 resilience measure for this sample, and confirmed the value for the survey was $\alpha = .866$.

3.7.2 Data Entry and Analysis

Data were entered into SPSS and analyzed in IBM SPSS v26. Descriptive statistics were computed for primary (HIV testing and contraceptive use) and secondary outcomes (i.e., age of sexual debut, history of pregnancy, and prevalence of treatment for STI). The sample was dichotomized to compare those who sought SRH services (e.g., HIV testing) vs. those who did not, to understand what factors may contribute to uptake of SRHS in this population. Chi-square and independent t-tests were conducted to assess differences between youth utilizing SRHS and those who do not. In the multivariable regression analysis, any bivariate associations significant at the $p \leq .05$ level were included. Several factors that may facilitate or hinder uptake of SRHS were explored including demographics, sexual activity, levels of information, motivation and behavioral skills to seek health services, perceived discrimination, exposure to bullying and violence, and levels of resilience. Univariate and multivariate analyses were conducted to

determine associations between the various independent variables with the key primary outcomes of interest – i.e., HIV testing and health service utilization, as well as secondary outcomes – i.e., sexual debut, history of pregnancy and STI treatment.

In order to investigate the association between resilience and health-seeking behaviors (Research Objective 3), an analysis on available data was conducted to; 1. Quantify the level of resilience within the study sample and 2. Explore whether there were any associations between resilience, health-seeking behaviors (primary outcomes) and sexual and reproductive health (secondary outcomes). Resilience questions were scored and summed in IBM SPSS v26. Mean and median of the total resilience scores for CYRM-28, as well as by domain were calculated. Skewness and kurtosis of the distribution of scores was also assessed for normality with negative skew of -1.518 with a standard error of .08, and kurtosis of 4.691 with a standard error of .016. Descriptive statistics were further used to quantify the seven additional context-specific resilience questions, and ten future aspiration questions. Primary and secondary outcomes were dummy coded, and mean scores on resilience were statistically compared using ANOVA for significant variance at $p < .05$ level.

3.7.3 Data Management

All questionnaires were paper-based, and administered in person in a group setting in a classroom. Surveys were entered by a Data Manager into an Excel spreadsheet, which was converted into an SPSS file for analysis. Outliers were double-checked for accuracy against the paper-based data, with any corrections noted in the database. Once the questionnaires were entered, they were filed in a locked file cabinet with access only permitted to the Research Team.

3.8 Ethics considerations

All study participation was voluntary. Potential participants were provided with information sheets (in a language of their choice) that informed them that study participation was entirely voluntary. They were informed that they were free to choose to participate or not participate and even if they agreed to participate, they would be free to withdraw at any stage or elect not to answer any individual question. They were assured that participation or non-participation would not in any way negatively impact on their schooling, care or any other activities or services they required. In addition, the aim of the research, what their involvement in the study would entail, and the potential risks and benefits of participation, were explained to them. They were also assured that all information collected from them in the questionnaires they completed would be kept confidential and anonymous by unique number identifiers being used on their questionnaires rather than their names.

Consistent with South African law, youth participants under 18 years of age are minors and require parental/ caregiver consent in addition to their own consent for participation in research. If participants under 18 years of age assented to study participation, similar information sheets were also provided to their parents/caregiver and their consent was also sought. Parents/caregivers were also assured that they were free to not grant permission for their children's study participation and to withdraw their children from the study at any stage, without fear of negative consequences. Youth less than 18 years old were enrolled into the study only if both their assent and parental/caregiver consent were obtained. Youth who were 18-24 years of age provided their own independent informed consent, for participation. (Please see appendices for relevant Information Sheets and Consent Materials.)

It was accepted that the study procedures included the discussion of some sensitive topics, which may have caused unanticipated discomfort or distress for some study participants. The study was implemented by a trained, multi-lingual social worker that had years of experience working in counseling youth on SRH matters, including young survivors of sexual violence. She was onsite during all data collection procedures and therefore available to offer assistance and support or to counsel referred clients who exhibited any distress as part of their participation. In addition, Research Assistants were trained to identify the signs and symptoms of possible distress – e.g., crying. Procedures were established to refer participants for onsite counseling available at the participating schools in the event of them experiencing or exhibiting distress during study participation. No such referrals were made during this study as no distress was observed or reported.

All key personnel were certified in Good Clinical Practice (GCP) and adhered to the standards of ethical research provided by the Helsinki Declaration (October 2013). As the Research Lead on this study (and applying PhD candidate), I was also certified in GCP.

All efforts were taken to protect the confidentiality of participants' responses. The study Research Assistants were bound by signed Confidentiality Agreements. The participants' questionnaires were kept separate from consent and assent forms. All data resulting from this project, including the data from the questionnaires, were kept in a locked file cabinet with access limited only to the necessary research staff. All data were being stored for two years after study completion, and will then be destroyed as per GCP guidelines.

Ethics approval to conduct the parent study was obtained from the research ethics office at PharmaEthics (Registered by the South Africa National Health Research Ethics Council Registration number: REC-220508-008 and FDA OHRP: FWA No: 00012241; IRB no: 0001483) in June 2016. Permission to conduct the research was also obtained from the Eastern

Cape Department of Education (DoE) in September 2016. Approval to analyze data from the parent project, and to explore the association of resilience and other factors with healthcare-seeking behavior among study participants, was granted by the University of Western Cape Biomedical Research Ethics Committee in May 2017 (Ethics Reference Number: BM17/10/19). All letters of ethics approval for this study are included in the Appendices.

3.9 Summary

This chapter provided a summary of the overall study design, sampling strategy, data collection instruments and procedures, data management and entry, the data analysis plan for each study objective, and the study's ethical considerations. The study relies on measures that have been validated for reliability and validity with similar populations in South Africa (Mathews et al., 2016, Mũkoma et al., 2009, van Rensburg et al., 2019b), and that were piloted in the local context ahead of the study launch. Questionnaires were translated and back-translated for accuracy; and self-administered by learners in Grades 9-11 schools in the participating sub-districts in their language of choice (i.e., English or isiXhosa). The study received approval by local authorities and was granted ethics approval by the relevant Institutional Review Boards and Research Ethics Approval Committees.

CHAPTER 4: RESULTS FROM OBJECTIVE 1

TO CHARACTERIZE UPTAKE OF HEALTH SERVICES

4.1 Chapter Overview

This chapter presents results from the first objective of the study. The chapter presents social and demographic information of youth participants', exposure to violence, presence of alcohol and substance use, sexual activity, as well as uptake of HIV testing and related SRH services. It also highlights any regional and sex-based differences among participants.

4.2 Results

4.2.1 Demographic characteristics

A total of 1318 learners from Grades 9-11 from 30 schools participated in the study. This included 589 and 729 participants from the Nyandeni and Umzimvubu sub-districts, respectively. No learners selected refused to take part in the study, and any learners whose parents/caregivers refused to provide consent would have been excluded from data collection a priori. As can be seen in Figure 6, the largest proportion of participants (N=1318) was in Grade 11 (n=561, 42.6%), followed by Grade 10 (n=472, 35.8%) and Grade 9 (n=280, 21.2%).

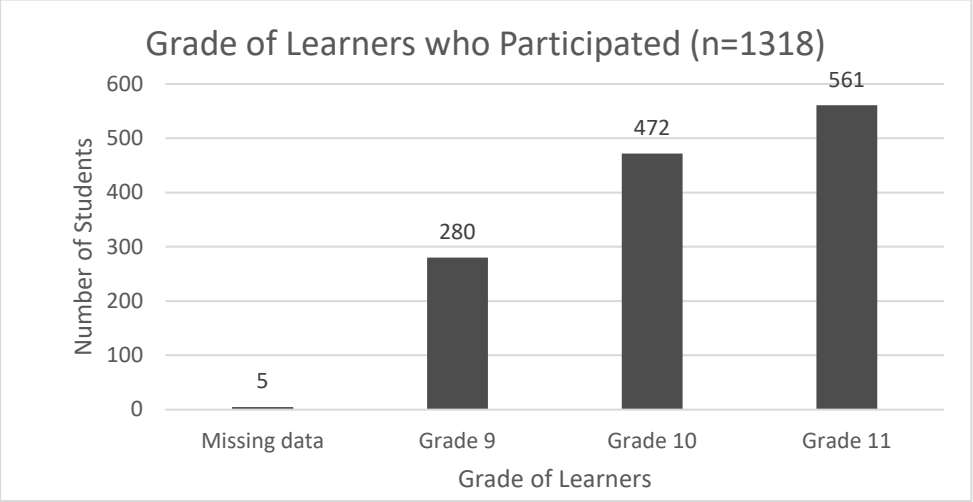


Figure 6: Participants by Grade

As shown in Figure 7, the mean age of participants was 17.81 years [median 18; range 14-25].

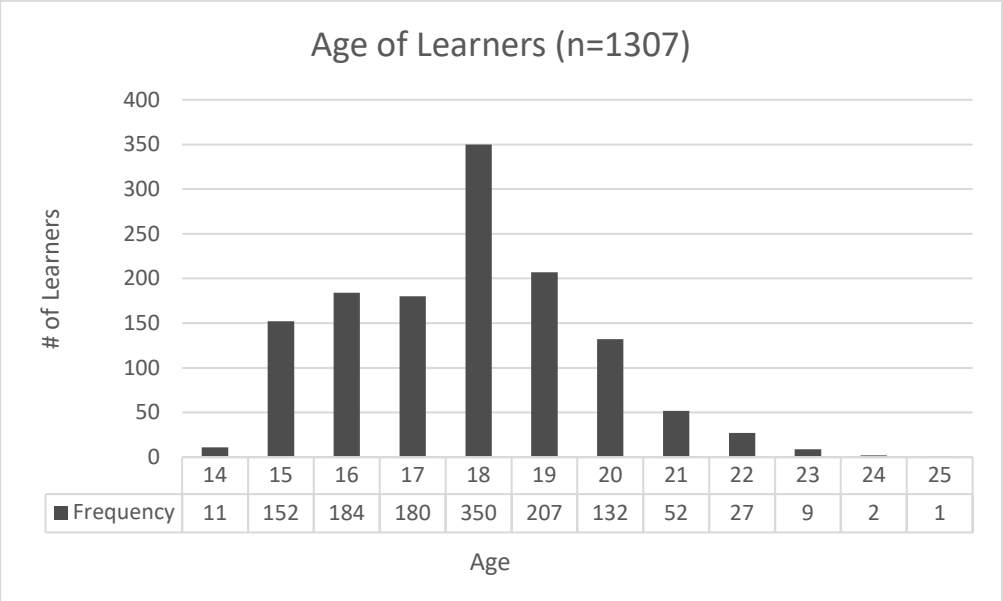


Figure 7. Age of Survey Participants

As shown in Table 1a, the sample was predominantly female [62.5%], rural [85.5%] and reported isiXhosa as their home language [97.4%]. The average household size was 7 members (median 6, range 0-32).

Table 1a: Demographic Characteristics of Participants Overall

Characteristics	Total	
		%
Subdistrict		
Nyandeni (n, %)	589	44.7%
Umzimvubu (n, %)	729	55.3%
Sex		
Female (n, %)	820	62.5%
Male (n, %)	491	37.4%
Other (n, %)	2	.2%
Age (M, range)	17.81	14-25 years old
Household size (M, range)	7.02	0-32 members
Household Location		
Rural	1093	85.5%
Town	185	14.5%
Home Language		
isiXhosa	1256	97.4%
Other (i.e., English, isiZulu, Sotho)	33	2.6%

Some of the key demographic characteristics of the sample of participants were compared by sub-district to understand if there were any significant differences between those

from Nyandeni and Umzimvubu (see Table 1b). There were no significant differences by sex or grade. However, Nyandeni learners were significantly older than Umzimvubu learners on average (18.33 years of age vs 17.38 years of age, respectively). As shown in Table 1b, just over half of the participants (52.7%) had failed a grade previously. Learners from Nyandeni were also significantly more likely to report having ever failed a grade. Further, about 42% of all learners reported having been through traditional coming of age rituals (male circumcision for boys, menses initiation for girls). Most participants had access to a cell phone, with 55.5% having their own smart phone. Only 11.1% had no access to a cell phone at all. About 42% (n=547) received a daily free meal through the government school-feeding scheme (data not shown).

Table 1b: Demographic Characteristics of participants, by sub-District

Characteristics	Sub-district						
	Nyandeni		**Umzimvubu**			**Total**	
	n	%	n	%	P value	N	%
Age (years)							
14-19	432	77.0%	652	88.8%		1084	82.9%
20-24	135	23.0%	88	12.2%	*.000	223	17.1%
Sex							
Female	357	60.8%	463	63.8%	0.785	820	62.5%
Male	229	39.0%	262	36.1%		491	37.4%
Grade							
Grade 9	81	13.8%	199	27.4%		280	21.3%
Grade 10	231	39.3%	241	33.2%		472	35.9%
Grade 11	276	46.9%	285	39.3%	0.585	561	42.7%
Ever failed a grade							
Yes	341	60.0%	382	46.9%		678	52.7%
No	227	40.0%	729	53.1%	0.002*	609	47.3%
Access to a cell phone							
No, I do not have access to any cellphone	68	12.1%	73	10.3%		141	11.1%
Yes, I have my own cellphone	132	23.4%	158	22.4%		290	22.9%
Yes, I have my own Smartphone	308	54.7%	396	56.1%		704	55.5%
Yes, I use my parents/ friend's cellphone	55	9.8%	79	11.2%		134	10.6%
Experienced coming of age initiation ritual (*Ulwuluko* for males or *Intonjane* for females)							
Yes	212	39.0%	292	44.4%		594	42.0%
No	331	61.0%	366	55.6%	0.083	697	58.0%

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

4.2.2 Alcohol and Drug Use

As shown in Figure 8, self-reported alcohol and tobacco use were relatively low amongst this sample, with 75.3% (n=989) reporting never having drunk alcohol and 86.9% (n=1078) never having smoked in the past six months. Similarly, the use of illicit drugs was rarely reported, with dagga being the most prevalently used substance by 6.4% of participants (n=84).

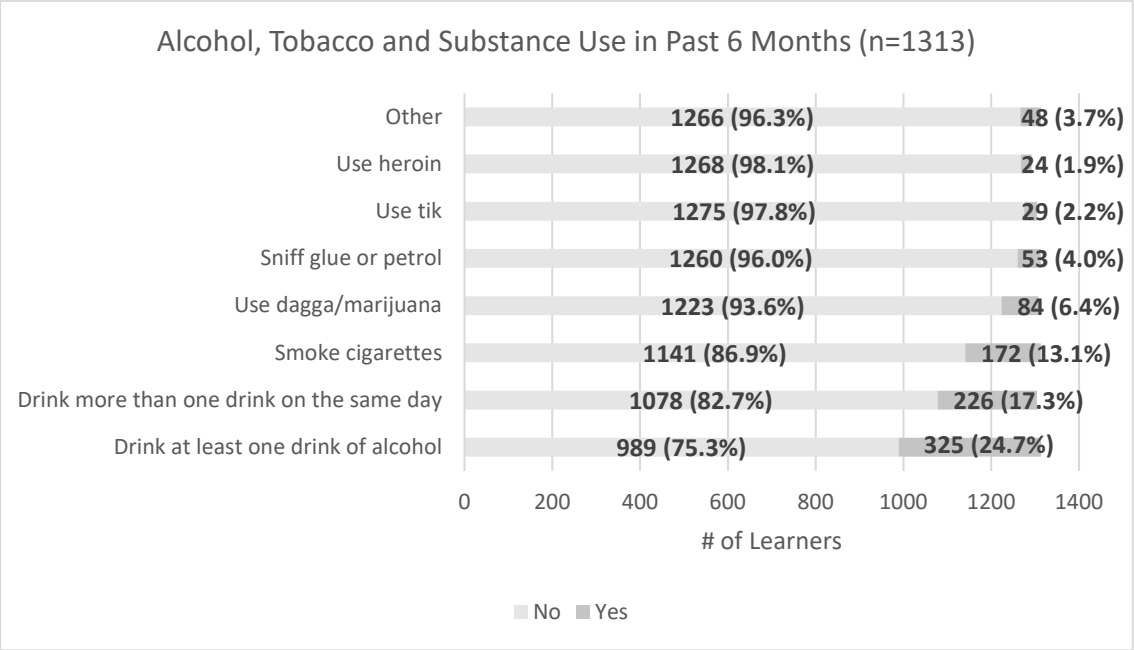


Figure 8: Learners' use of alcohol, drugs and tobacco in the past six months

Among those who reported alcohol use (n=325), frequency of drinking was reportedly low. Most participants who reported having used alcohol (n=259, 79.7%) reported only having done so once or twice in the preceding six-month period with only 5% (n=65) reporting monthly use or more. However, among those who did report alcohol use, 226 (69.5%) reported drinking more than one drink on the same day, at least once in the past six months.

As can be seen in Table 2a and 2b, gender differences were evident, with females significantly more likely to report *'Never'* using alcohol ($p<0.001$); smoking cigarettes ($p<0.001$); the use of dagga ($p<0.001$); or any other illicit substances ($p<0.003$) than male participants. There were no statistically significant gender differences when it came to sniffing glue/petrol.

Table 2a: Alcohol use by sex in past six months

Variable	Female/ n (%)	Male/ n (%)	Total/ n (%)	P-Value
DRINK AT LEAST ONE DRINK OF ALCOHOL				
Never	650 (79.6)	335(68.1)	985(75.3)	<0.001*
Once or twice	148 (18.1)	111(22.5)	259(19.8)	
Every month but not every week	13 (1.6)	30(6.1)	43(3.3)	
Every week/everyday	6 (0.7)	16(3.3)	22(1.7)	
TOTAL	**817(100)**	**492(100)**	**1309(100)**	
DRINK MORE THAN ONE DRINK ON THE SAME DAY				
Never	709(87.2)	365(75.1)	1074(82.7)	<0.001*
Once or twice	89(10.9)	85(17.5)	174(13.4)	
Every month but not every week	12(1.5)	26(5.4)	38(2.9)	
Every week/everyday	3(0.4)	10(2.1)	13(1.0)	
TOTAL	**813(100.00)**	**486(100.00)**	**1299(100.00)**	

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

Table 2b: Tobacco and substance use by sex in past six months

Variable	Female/ n (%)	Male/ n (%)	Total/ n (%)	P-Value
SMOKE CIGARETTES				
Never	750(91.7)	387(79.0%)	1137(86.9)	<0.001*
Once or twice	60(7.3)	57(11.6)	117(8.9)	
Every month but not every week	6(0.7)	7(1.4)	13(1.0)	
Every week/everyday	2(0.2)	39(8.0)	41(3.1)	
TOTAL	**818(100.00)**	**490(100.00)**	**1308(100.00)**	
USE DAGGA/MARIJUANA				
Never	787(96.9)	432(88.2)	1219(93.6)	<0.001*
Once or twice	20(2.5)	31(6.3)	51(3.9)	
Every month but not every week	2(0.3)	8(1.6)	10(0.8)	
Every week/everyday	3(0.0)	19(3.9)	22(1.7)	
TOTAL	**812(100.00)**	**490(100.00)**	**1302(100.00)**	
SNIFF GLUE OR PETROL				
Never	785(96.2)	470(95.5)	1255(96.0)	0.473
Once or twice	28(3.4)	18(3.7)	46(3.5)	
Every month but not every week	2(0.3)	1(0.2)	3(0.2)	
Every week/everyday	1(0.1)	3(0.6)	4(0.3)	
TOTAL	**816(100.00)**	**492(100.00)**	**1308(100.00)**	
USE TIK				
Never	801(98.8)	469(96.1)	1270(97.8)	0.026*
Once or twice	8(1.0)	12(2.5)	20(1.5)	
Every month but not every week	1(0.1)	4(0.8)	5(0.4)	
Every week/everyday	1(0.1)	3(0.6)	4(0.3)	
TOTAL	**811(100.00)**	**488(100.00)**	**1299(100.00)**	
USE HEROIN				
Never	795(99.1)	468(96.5)	1263(98.1)	0.013*
Once or twice	6(0.8)	12(2.5)	18(1.4)	
Every month but not every week	1(0.1)	2(0.4)	3(0.2)	
Every week/everyday	0(0.00)	3(0.6)	3(0.2)	
TOTAL	**802(100.00)**	**485(100.00)**	**1287(100.00)**	
USE ANY OTHER ILLEGAL DRUGS (not specified)				
Never	797(97.4)	464(94.5)	1261(96.3)	0.003*
Once or twice	20(2.4)	16(3.3)	36(2.8)	
Every month but not every week	1(0.1)	6(1.2)	7(0.5)	
Every week/everyday	0(0.0)	5(1.0)	5(0.4)	
TOTAL	**818(100.00)**	**491(100.00)**	**1309(100.00)**	

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

4.2.3 Exposure to Violence and Bullying, including Intimate Partner Violence (IPV)

As a measure of adversity, learners were asked a series of questions about their history of exposure to (and perpetration of) violence/crime in the past six months. As shown in Figure 9, community violence was relatively high, with a quarter (24.8%, n=326) reporting being threatened by someone in the community, and nearly one out of five learners (19.1%, n=249)

witnessing someone being stabbed, shot or killed in their communities. Over a third (35.2%, n=461) had been in a physical fight in the past six months, and 38.4% (n=502) had witnessed someone being hit at home.

Many reported either witnessing or themselves being hit by teachers was reported within the student population, with 44.3% witnessing and 58.8% reporting having experienced physical punishment from teachers at least once in the past six months (n=577 and 772, respectively). Furthermore, approximately 45% (n=593) of learners reported being insulted or humiliated at school at least once in the past six months, with about 9% overall experiencing such bullying monthly or more often (7.5% of girls and 12% of boys). Nearly one out of ten learners (9.4% overall; 7.7% of female learners, 12.4% of male learners) reported that they felt a teacher had 'flirted' or made sexual advances towards them in the preceding six months. This is depicted in Figure 9.

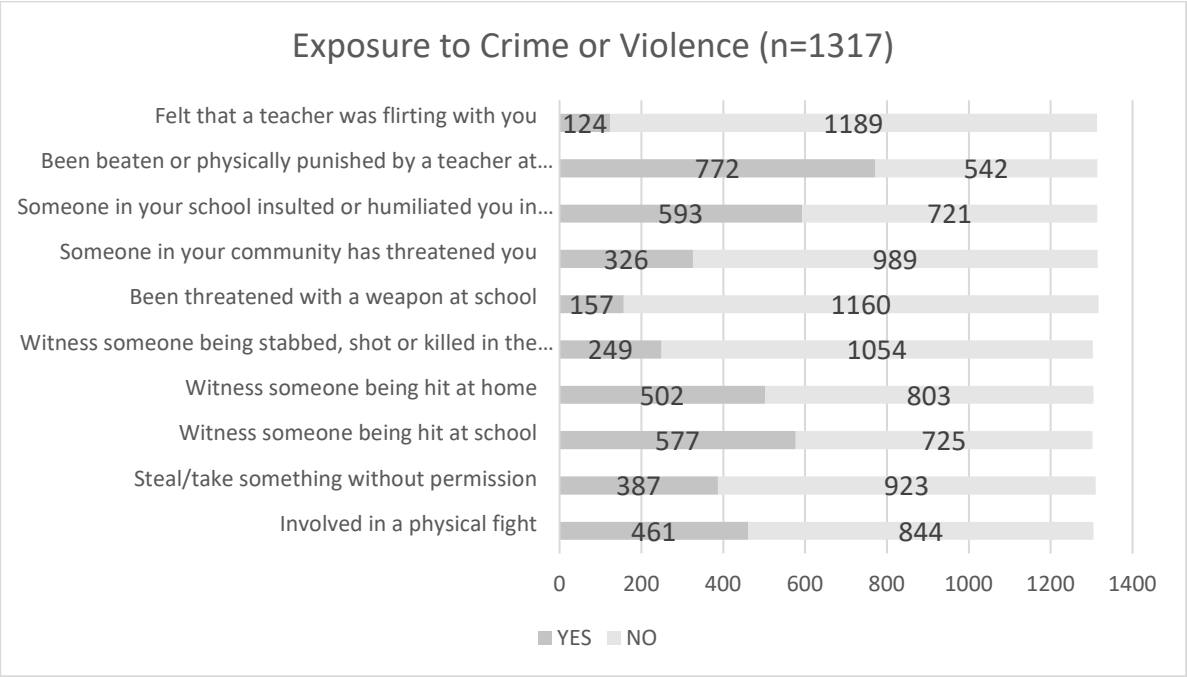


Figure 9: Learners' exposure to crime or violence

Learners were also asked whether they had experienced forced sex or violence from their sexual partners, or perpetrated such acts. Reports of overall intimate partner violence (IPV) are noted in in the following Table 3a:

Table 3a: Learners' reports of Intimate Partner Violence (IPV)

In past six months, has your partner…	Yes n (%)	No n(%)	N/A - I do not have a boyfriend/ girlfriend
Insulted/humiliated you or made you feel bad about yourself	438 (33.7%)	719 (55.4%)	141 (10.9%)
Threatened to hurt you	300 (23.2%)	848 (65.6%)	145 (11.8%)
Pushed, kicked, choked or burnt you	117 (9.0%)	1032 (79.5%)	149 (11.5%)
Forced you to have sex with them	95 (7.3%)	1048 (80.9%)	152 (11.7%)
Been forced by you to have sex with you (IPV perpetration)	80 (6.2%)	1064 (82.4%)	148 (11.5%)
Been threatened with injury by you (IPV perpetration)	51 (4.3%)	974 (82.9%)	150 (12.8%)

Table 3b shows reported intimate partner violence by sex, which reflects that there were significant gender differences in partner threats of violence, physical violence, and forced sex. Similar proportions of males and females reported being insulted or humiliated by their partner, with 37.5% and 38.5% respectively. Furthermore, there were no significant gender differences in perpetration of IPV (forced partner to have sex with them).

Table 3b: Intimate Partner Violence, by sex

		Never	Once or more than once	Total	p-value	
		n (%)	n (%)			
Partner insulted/humiliated you or made you feel bad about yourself						
	Male	227(62.5)	166(37.5)	443	0.734	
	Female	435(61.5)	272(38.5)	707		
Partner threatened to hurt you						
	Male	344(77.7)	99(22.3)	443	0.018*	
	Female	498(71.4)	200(28.6)	698		
Partner pushed, kicked, choked or burnt you						
	Male	412(93.2)	30(6.8)	442	0.002*	
	Female	613(87.6)	87(12.4)	700		
Been forced by partner to have sex with them						
	Male	394(89.8)	45(10.4)	439	<0.001*	
	Female	665(95.3)	33(4.7)	698		
Have threatened a partner with injury (IPV Perpetration)						
	Male	365(83.3)	73(16.7)	438	0.217	
	Female	603(86.0)	98(14.0)	701		
Forced partner to have sex with them (IPV perpetration)						
	Male	408(92.9)	31(7.1)	439	0.272	
	Female	635(91.1)	62(8.9)	697		

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

4.2.4 Sexual Activity

As shown in Table 4, approximately two thirds of participants (66.6%, n= 873) reported that they had ever had sex. A significantly greater proportion of male participants (80.8%) reported having ever had sex than female participants (58%), p=.000. The mean age of sexual debut for all learners who reported having had sex was 15 years of age (n=878; range 3-22 years of age; SD=2.78). Males who reported having had sex (n=402) had a significantly lower mean age of sexual debut at 13.7 years (SD=3.086, median 14, range 5-22) compared to females (n=475) at 16.1 years (SD= 1.824, median 16, range 3-20) (p=.000).

Most participants reported that they had wanted their first sexual experience, as shown in Table 4. However, a combined total of 28% (n=238) of those who reported sexual debut reported that their first sex experience was either something they did not want or were forced to do. A significantly higher proportion of female learners indicated that first sex was something they did not want or were forced to do, compared to male learners.

The mean number of lifetime sexual partners for those who had had sex was about 3 sexual partners (range 1-19) although a further 25% reported that they '*could not remember the exact number*' and 16% stated that they preferred not to answer this question. Thus, the average is derived from roughly half of the overall sample who reported sexual debut (n=407).

Nearly 70% (n=899) reported to be in an intimate relationship. Amongst those who reported being in an intimate relationship, 59.3% (n=534) reported being currently sexually active (see Table 4). Nearly half (47.4%) reported having had sex in the past month or more recently (See Table 4). Univariate analysis revealed that males were twice as likely to be sexually active than females (OR = 2.07, 95% CI= 1.64 – 2.61).

Transactional sex was rarely reported by participants with 11% of those who had sexual debut (n=96) reporting that they'd ever had sex in order to gain something material, and a further 7.6% (n=66) reported having given something to someone in exchange for sex.

Among those who reported having had sex in the past (n=845), just over a third (36.4%) reported consistent condom use ['always using'] and nearly one out of four reporting never having used condoms (24.2%). A detailed breakdown of consistency of condom use among participants is also presented in Table 4.

Table 4: Learners' reports of age of Sexual Debut, Sexual Activity and Condom Use by Sex

Variable	Female=820 n (%)	Male = 491 n (%)	Total N =1,311 n (%)	P-Value
Sexual Debut				
Yes	476 (58%)	397 (80.8%)	873 (66.6%)	0.000*
No	344 (42%)	94 (21.2%)	438 (33.3%)	
TOTAL	**820 (100%)**	**491 (100%)**	**1311 (100%)**	
Age at Sexual Debut				
< 15 years old	62 (13.0%)	216 (54.4%)	278 (31.8%)	
15-19 years old	405 (85.9%)	179 (55.1%)	584 (66.9%)	
> 19 years old	9 (1.9%)	2 (0.5%)	11(1.3%)	<0.001*
TOTAL	**476 (100%)**	**397 (100%)**	**873 (100%)**	
The first time I had sex, it was:				
Something I wanted	263 (57.2%)	351 (89.5%)	614 (72.1%)	<0.001*
Something I did not want	157 (34.1%)	30 (7.7%)	187 (21.9%)	
Something I was forced to do against my will	40 (8.7%)	11 (2.8%)	51 (6.0%)	
TOTAL	**460 (100.00)**	**392 (100.00)**	**852 (100%)**	
Are you currently in an intimate relationship?				
Yes	565 (70.3%)	334 (69.3%)	899(69.9%)	NS
No	239 (29.7%)	138 (30.7%)	387 (30.1%)	
TOTAL	**804 (100%)**	**482 (100%)**	**1286 (100%)**	
Are you currently sexually active? (had sex in the last six months)				
Yes	279 (34.7%)	253 (52.6%)	532 (41.4%)	<0.001*
No	526 (65.3%)	228 (47.4%)	754 (58.6%)	
TOTAL	**805(100.00)**	**481 (100.00)**	**1286 (100.00)**	
When was the last time you had sex?				
In the past week	87 (18.9%)	138 (35.8%)	225 (26.6%)	
In the past month	95 (20.7%)	81 (21.0%)	176 (20.8%)	
1-2 months ago	48 (10.4%)	31 (8.1%)	79 (9.4%)	
3-4 months ago	51 (11.1%)	32 (8.3%)	83 (9.8%)	
5-6 months ago	55 (12.0%)	23 (6.0%)	78 (9.2%)	
More than six months ago	124 (27.0%)	80 (20.8%)	204 (24.1%)	
TOTAL	**460 (100%)**	**385 (100%)**	**845 (100%)**	
In the past six months, how often did you and your partner use condoms when having sex?				
Always	163 (32.3%)	154 (38.8%)	317 (35.2%)	0.026*
Most of the time/Often	81 (16.1%)	61 (15.4%)	142 (15.8%)	
Sometimes/Half the time	81 (16.1%)	44 (11.1%)	125 (13.9%)	
Rarely	22 (4.4%)	27 (6.8%)	49 (5.4%)	
Never	157 (31.2%)	111 (28.8%)	268 (29.7%)	
TOTAL	**504 (100%)**	**397 (100%)**	**901 (100%)**	

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

4.2.5 Pregnancy

As shown in Table 5, approximately one in five youth who provided responses (n=257, 19.5% of 1,311 learners) reported having ever been pregnant or being responsible for a girl/young woman becoming pregnant with sex breakdown as follows: 191 girls (or 23.3% of females) and 66 boys (13.4% of males).

Participants from Nyandeni were more likely to report a history of pregnancy than those from Umzimvubu (35.1% of females and 20.3% of males in Nyandeni reported such a history, compared to 19.6% of females and 12.6% of males in Umzimvubu, respectively) p=.000 for females; p=.017 for males.

As can be seen in Table 5, the majority of those with a history of pregnancy reported a live birth as a result of their pregnancy - 79.4% out of a total of 204; with 79.6% (n=152) for girls and 78.8% (n= 52) for boys; 3.5% (n=9) reported having had a miscarriage, and 5.6% (n=14) reported having had termination of pregnancy (through either abortion or emergency contraception).

Table 5: Pregnancy outcomes of those who reported history of pregnancy

Youth who reported pregnancy	Females (n=191) n (%)	Males (n=66) n (%)	TOTAL (n= 257) n (%)
Livebirths	152 (79.6)	52 (78.8)	204 (79.4)
Miscarriage	6 (3.1)	3 (4.5)	9 (3.5)
Abortion	4 (2.1)	6 (9.1)	11 (4.4)
Emergency Contraception	1 (0.5)	2 (3.0)	3 (1.2)
Missing Response/Other	28 (14.7)	3 (4.5)	31 (10.5)
TOTAL	**191**	**66**	**257 (100)**

4.2.6 Uptake of Sexual and Reproductive Health Services

The primary outcomes for this study were uptake of HIV testing, contraception services, and demand satisfied/need met by modern contraception among young women. Individuals were also asked their self-reported HIV status and whether they had been treated for sexually transmitted infections (STIs). Results were stratified by region and sex for comparative analysis.

HIV Testing

Out of 1,306 learners, 56.5% (n=738) indicated they had had an HIV test. As shown in Table 6, univariate logistic regression showed there was an association between HIV testing and older age (≥ 19 years); being in a relationship or sexually active; history of STI treatment or pregnancy (amongst females); and use of contraception. Male learners were significantly less likely to have had an HIV test compared to female learners (OR=.698, CI .36-1.35) and no

statistically significant sub-district differences were observed for uptake of HIV testing (see Table 6).

Table 6: Variables that correspond with HIV testing uptake among participants

Variable	Odds Ratio	95% Confidence Interval
Age		
14-18		
19-24	1.26	(0.36-1.35)
Sex		
Male	0.698	(0.55-0.87)
Female		
In a relationship		
Yes	1.98	(1.56-2.52)
No		
Sexually active		
Yes	2.08	(1.65-2.62)
No		
History of pregnancy		
Yes	7.37	(4.58-11.86)
No		
Use Contraception		
Yes	2.11	(1.69-2.65)
No		
STI Treatment		
Yes	2.03	(1.38-2.98)
No		

A multivariate regression was conducted to understand the contributions of variance to predict HIV testing from age, sex, current sexual activity and pregnancy. Only pregnancy amongst females (not males reporting partner pregnancy) was a significant predictor in the overall model. Together, these variables statistically significantly predicted HIV testing, F (4, 1290) = 30.324, $p < .0005$, $R^2 = .086$. All four variables added statistically significantly to the prediction, $p < .05$.

Given that pregnancy amongst females was a distinct predictor, the sample was dichotomized by sex to compare and differentiate multivariable factors of HIV testing for female and male learners. HIV testing among female learners was associated with age, current relationship, history of pregnancy, and contraception use, F (4, 774) =27.675, p=.000, $R^2 = .148$ with all four variables adding statistically significant variance to the prediction. For male learners, HIV testing was associated with current relationship, history of partner pregnancy, history of STI treatment, and no condom use (p=.006).

Reasons for Not Testing

Out of a total of 568 learners who did not test for HIV, 352 learners (62%) cited the reasons for not testing as 1. they feared or were not prepared for the result (n=125, 35.3%), 2. felt they were negative/not at-risk/already knew their status (n=51, 15.3%) or 3. there was no need to test based on not having been sexually active (n=58, 16.5%), used condoms (n=34, 9.7%) or were faithful to their partner (n=1, <.01%)], which together comprised the majority of responses (n=269, 76.4%). Others simply had no desire to test or had never thought about it (n=38, 10.7%).

However, a small proportion (n=40 or 11.4%) reported access issues, i.e., they could not access the clinic (n=16), had no time (n=19) or financial means to test (n=3), or were not allowed to take part (n=2). Four individuals feared blood draws (n=4, 1.1%) and one was misinformed and reported they could not be HIV+ with blood type O positive.

HIV Status

Participants were asked to self-report the results of their HIV test, or decline to answer. It is of note that 2.4% (n=18 out 738) of the sample who had had an HIV test reportedly did not receive their results, and a further 9.6% did not provide a response for their HIV status (n=71). Thus, a total of 649 (87.9% of the 738 who reported having tested for HIV) provided a definitive response for the result of their HIV test. Of these, 30 (4.6%) reported they were HIV-positive, and 619 (95.4%) reported they were HIV-negative.

Importantly, an additional 7 participants reported that their HIV status was positive but did not report ever having an HIV test. These learners may have been infected perinatally as they may have been told of their HIV status but did not recall an HIV test. The self-reported prevalence of HIV among the overall sample was thus 2.8% (n = 37 out of 1318 learners surveyed).

The demographic characteristics of these 37 participants is in Table 7, who were predominantly female (70.3%; OR 1.45, CI: .71-2.96), 18 years of age or younger (56.8%) but risk increased with age (OR 1.29, CI: 1.03 – 1.45), and sexually experienced (83.8%; OR 2.25; CI: .873-5.78). NB: Six participants living with HIV did not report sexual debut.

Table 7: Demographic Characteristics of participants who reported an HIV positive status

Characteristics	Total (n=37)	
	n	%
Sex		
Female (n, %)	26	70.3%
Male (n, %)	11	29.7%
Subdistrict		
Nyandeni (n, %)	22	59.5%
Umzimvubu (n, %)	15	40.5%
Age (M, *SD* range)	18.49; *1.71*	14-23 years old
Sexual Debut	31	83.8%
History of Pregnancy (females, males)	13 (12, 1)	35.1%
History of STI Treatment	10	27.0%

STI Treatment/Syndromic Management

Approximately 10.7% of learners (n=141) reported having been treated for an STI. Treatment was predominantly sought at a clinic (82.3%), followed by GP/Private Doctor (14.2%), Traditional Healer (12.1%) and Other (1.4%). No differences by sex were observed.

Contraceptive use

Nearly half of the sample (623 out of 1,285 learners who responded, or 48.4% overall) reported some type of contraception use, even though not all were currently sexually active. Among the sexually active sample (n=524), 70% (n=368) reported they were currently using contraception, with the remaining 30% (n=156) reporting that they were not currently using contraception. Sex and district differences are described below in Table 8a and 8b.

Learners were asked what type of contraception they were currently using to avoid pregnancy. This included the use of oral hormonal contraception pills (the Pill), intrauterine device (IUD), the sub-dermal hormonal implant (Implanon), barrier methods, i.e., female and male condoms, as well as hormonal injectable contraceptives (Injectables). The different types of contraception reportedly used are depicted in Figure 10 below.

Multiple responses were possible, as some female learners may have been using more than one method (i.e., dual method contraception – for example, a hormonal contraceptive as well as a condom). The majority of participants reported using male condoms followed by Injectables (for girls/young women). A small number of males from each sub-district reported use of a female

contraceptive method (i.e., IUD). This response may indicate that they were referring to the method used by their sexual partners. However, it is also possible that this response was in error. A small minority (4.8%) also reported that they used the 'withdrawal' method as a means of contraception (not shown).

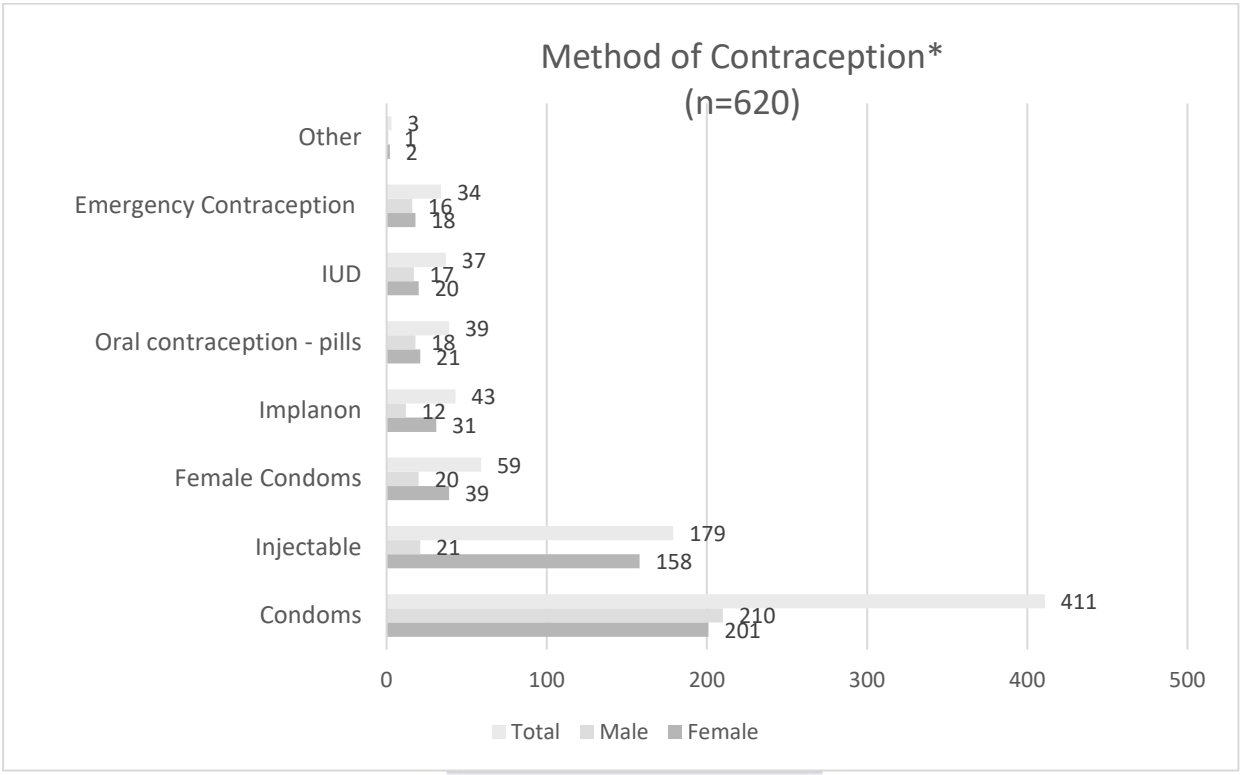


Figure 10: Method of Contraception reportedly used by the learners

*Individuals could mark more than one response.

Intentions for pregnancy and use of contraception: (Unmet need for Contraception)

Overall, 760 female learners out of a total of 820 (92.7%) reported they did not wish to become pregnant in the next six months. Of these female learners who did not wish to become pregnant, 332 (43.6%) were currently using contraception. When restricting the analysis to those who reported being currently in a relationship (n=522), 311 (59.6%) were using contraception to prevent pregnancy. This translates into less than half of demand satisfied by contraception overall for young women, and roughly 60% demand satisfied for those in relationships.

Table 8a indicates reported uptake of sexual and reproductive health services (specifically HIV testing, STI management and contraception) by sex, and notes whether any gender differences were observed. No differences were observed by sex for those treated for an STI, but female learners were significant more likely to report having had an HIV test and male learners were more likely to report current use of contraception (i.e., condoms). Overall, there were no statistically significant differences in self-reported HIV status by sex.

Table 8a: Uptake of SRHS by Sex

Variable	Female=815 n (%)	Male = 486 n (%)	Total N =1,301 n (%)	P-Value
Have you ever had an HIV test?				
Yes	490 (60.1%)	247 (50.8%)	737 (56.6%)	0.001*
No	325 (39.9%)	239 (49.2%)	564 (43.4%)	
TOTAL	**815 (100%)**	**486 (100%)**	**1301 (100%)**	
What were the results of your HIV test?				
Positive	26 (3.2%)	11 (2.2%)	37 (2.8%)	
Negative/Did not receive results/NA	794 (96.8%)	487 (97.8%)	1,281 (97.2%)	0.305
TOTAL	**820 (100%)**	**498 (100%)**	**1318 (100%)**	
Have you ever been treated for an STI?				
Yes	81 (10.0%)	60 (12.3%)	141 (10.0%)	0.203
No	727 (90.0%)	428 (87.7%)	1155 (90.0%)	
TOTAL	**808 (100%)**	**488 (100%)**	**1296 (100%)**	
Are you currently using contraception?				
Yes	369 (46%)	251 (52.5%)	620 (48.4%)	0.023*
No	434 (54%)	227 (47.5%)	661 (51.6%)	
TOTAL	**803 (100%)**	**478 (100%)**	**1281 (100%)**	

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

History of STI treatment and use of contraception was significantly reported more amongst learners from Nyandeni than Umzimvubu, as shown in Table 8. There were no statistically significant differences for uptake of HIV testing across the sub-districts.

Table 8b: Uptake of Sexual and Reproductive Health Services, by sub-district

Variable	Nyandeni n (%)	Umzimvubu n (%)	Total N =1,306 n (%)	P-Value
Have you ever had an HIV test?				
Yes	334 (56.9%)	404 (56.2%)	738 (56.6%)	0.141
No	253 (43.1%)	315 (43.8%)	568 (43.4%)	
TOTAL	**587 (100%)**	**719 (100%)**	**1306 (100%)**	
Have you ever been treated for an STI?				
Yes	80 (13.8%)	61 (8.5%)	141 (10.8%)	0.009*
No	501 (86.2%)	659 (91.5%)	1160 (89.2%)	
TOTAL	**581 (100%)**	**720 (100%)**	**1301 (100%)**	
Are you currently using contraception?				
Yes	326 (56.7%)	297 (41.8%)	623 (48.5%)	0.000*
No	249 (43.3%)	413 (58.1%)	662 (51.5%)	
TOTAL	**575 (100%)**	**710 (100%)**	**1285 (100%)**	

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

4.9 Summary

Chapter 4 presented the descriptive results from the cross-sectional survey held with youth and characterized the uptake of sexual and reproductive health services amongst youth, including the primary outcomes (independent variables) associated with this study: HIV testing and contraception uptake, as well as secondary outcomes including sexual debut, history of pregnancy, HIV status, and STI treatment. It also quantified the adverse context that youth face, and highlighted levels of exposure to violence and crime in communities, schools and intimate relationships. It characterized the sample based on various characteristics (demographics, household size, participation in coming-of-age rituals, and alcohol and drug use) and assessed various demographic factors that may be associated with uptake of SRH (e.g., HIV testing, contraception and STI treatment), including age, sex, and sub-district.

CHAPTER 5: RESULTS FROM OBJECTIVE 2

BARRIERS AND FACILITATORS TO SRHS UPTAKE

5.1 Chapter Overview

In Chapter 5, I will describe the experiences of youth seeking health services in facilities and seek to understand barriers and facilitators to health service utilization, including information, motivation and behavioral skills related to SRHS uptake.

5.2 Results

Learners were asked a series of questions about the quality of health services they received based on health standards for AYFS as adopted by the NDoH at the time of study (National Department of Health Republic of South Africa/LoveLife, 2015). This was to understand their experiences in care, and characterize their contacts with the healthcare system.

5.2.1 Access to Care

Clinic Attendance

A sizeable proportion of youth (n=577, 44.6%) reported that they had attended a health facility/clinic in the past month or more recently, with an additional 25.9% reporting that they had done so within the past six months (n=341). However, a substantial proportion reported not having attended a health facility for a year or more (n=376, 28.5%). Most of the youth surveyed (n=1,057, 80.9%) reported that the main reason they attended a health service/clinic was when they felt ill. Routine attendance for the collection of medications or contraception was relatively rare, with only 13.4% (n=177) reporting collecting medications monthly or every three months.

Opportunity Costs to Access Care

The majority of youth (n=779, 58.5%) reported that they needed to take off school or not perform chores in order to attend health facilities. Most reported (n=823, 62.4%) walking as their primary mode of transportation to attend the clinic, followed by public transport (e.g., bus/taxi n=391, 29.7%). For those who needed to pay for transportation, the average cost was R15 ZAR or approximately the equivalent of $1 USD at the current exchange rate (range R1 ZAR-R300 ZAR). Over a third (n=483, 36.6%) reported that it took them more than one hour to get to the clinic.

5.2.2 Quality and Experience of Healthcare Services

On a 5-point Likert scale, the quality of health services was rated 3.29 on average overall, and was similar in both sub-districts. The mean scores for satisfaction with privacy and

confidentiality, and for helpfulness of staff were 3.07 and 3.24, respectively. These mean scores were in the response range of "Needs Improvement." No statistically significant differences between sub-districts on these quality-of-service ratings were observed in the independent t-tests conducted, as shown in Table 9.

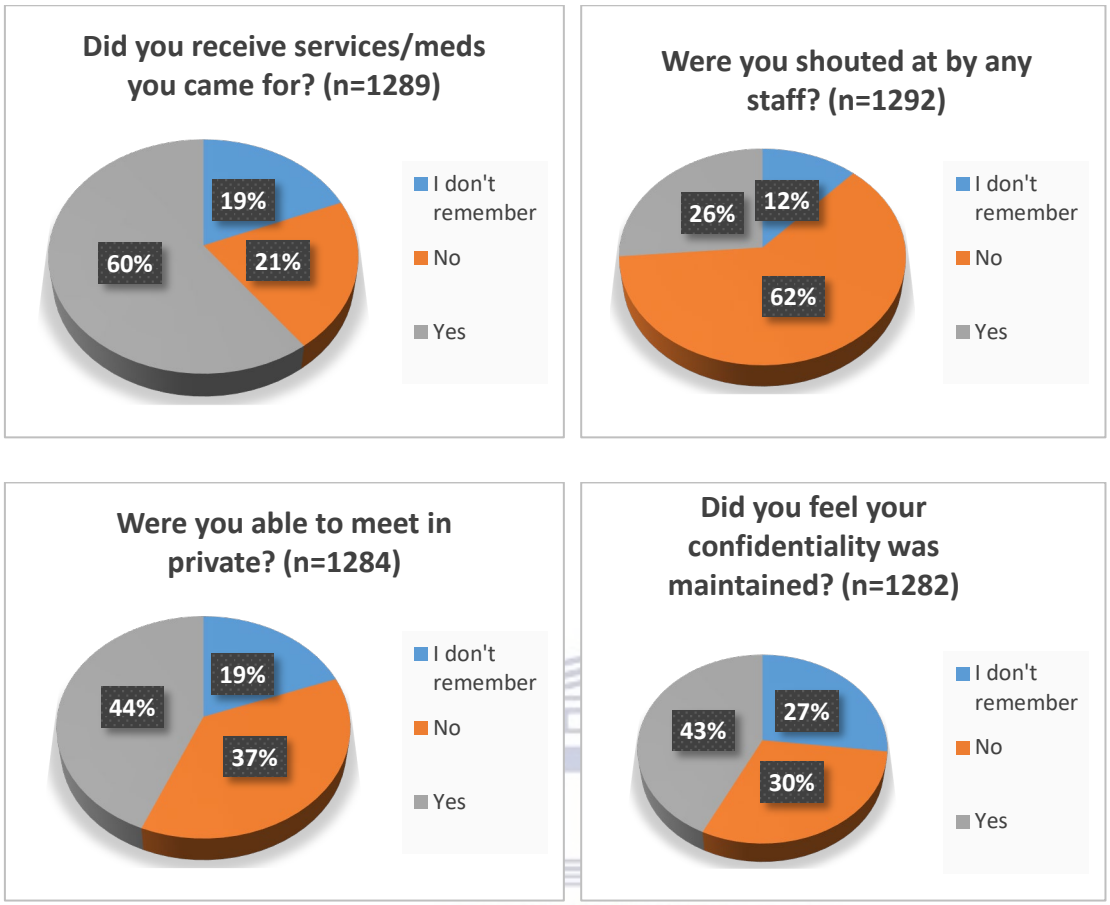
Table 9: Quality of Service Ratings with Health Services by Sub-District

Quality of the clinic services		**Nyandeni (n=583) n (%)**	**Umzimvubu (n=706) n (%)**	**Total n**	**% of total**	**Cumulative % of total**
1	Very bad	76(13%)	101(14.3%)	177	13.7%	13.7%
2	Bad	60(10.3%)	83(11.8%)	143	11.1%	24.8%
3	Needs improvement	180(30.9%)	177(25.1%)	357	27.7%	52.5%
4	Good	161(27.6%)	189(26.8%)	350	27.2%	79.7%
5	Very good	106(18.2%)	156(22.1%)	262	20.3%	100.0%
Mean Scores		**M=3.28**	**M=3.30**	**M=3.29**	**p=.385, NS**	
Satisfied with the privacy and confidentiality of the consult		Nyandeni (n=574)	Umzimvubu (n=697)	Total (n=1271)	% of total	Cumulative % of total
1	Not at all satisfied	131(22.8%)	176(25.3%)	307	24.2%	24.2%
2	Somewhat satisfied	54(9.4%)	76(10.9%)	130	10.2%	34.4%
3	Needs improvement	117(20.4%)	119(17.1%)	236	18.6%	53.0%
4	Satisfied	163(28.4%)	203(29.1%)	366	28.8%	81.7%
5	Very satisfied	109(19.0%)	123(17.6%)	232	18.3%	100.0%
Mean Scores		**M=3.11**	**M=3.03**	**M=3.07**	**p=.307, NS**	
Helpfulness of the clinic staff		Nyandeni (n=580)	Umzimvubu (n=702)	Total (n=1282)	% of total	Cumulative % of total
1	Not at all helpful	91(15.7%)	121(17.2%)	212	16.5%	16.5%
2	Somewhat helpful	106(18.3%)	102(14.5%)	208	16.2%	32.8%
3	Needs improvement	89(15.3%)	110(15.7%)	199	15.5%	48.2%
4	Helpful	180(31.0%)	201(28.6%)	381	29.7%	78.0%
5	Very helpful	114(19.7%)	168(23.9%)	282	22.0%	100.00%
Mean Scores		**M=3.21**	**M=3.27**	**M=3.24**	**p=.385, NS**	

Consistent with these ratings, Figure 11 shows that a significant proportion of participants reported unfavorable experiences during their most recent visit to health facilities. A total of 340 learners (26%) reported being shouted at; 385 (30%) felt their confidentiality was not maintained; and a further 561 (37%) were not able to meet their healthcare provider in private.

Over one in five (21% or n=777) did not receive all the services and medications they came for. This reflects that a considerable proportion of youth were either not able to have a private consultation or receive all the services they required.

Figure 11: Overall Experience at Most Recent Visit to Health Facilities



Wait Times

As shown in Table 10, the vast majority of participants who recalled their wait time at the health facility (n=1060) reported having waited for two hours or less for services (n=744, 70.1% of participants.) The majority overall (n=601, 55.7%) felt that these wait times were unacceptable.

Table 10: Learners' report on waiting time for health services

How long did you wait for services at the clinic?			
Wait Time Responses	**n**	**%**	**Cumulative %**
Less than one hour	421	39.7%	39.7%
One to two hours	323	30.5%	70.1%
Three to four hours	155	14.6%	84.7%
More than four hours	161	15.2%	100.0%
Total	**1060**	**100.0**	

Sub-district differences were analyzed to describe youth experiences of care by sub-district (see Table 11). There were no statistically significant differences between sub-districts for participant reports of being shouted at by staff or in their ability to get all medications/services that they had come for. Umzimvubu participants were less likely to report waiting for more than 1 hour than Nyandeni learners, and they were also less likely to report that they found their waiting time unacceptable. However, Umzimvubu learners were less likely to report that they were treated with respect compared to those in Nyandeni, and less likely to report that confidentiality was maintained. This reflects that when accessing services, the Umzimvubu participants perceived better wait times, but encountered more disrespect and breaches in patient confidentiality than the Nyandeni participants.

Table 11: Sub-districts analysis of Past Visit Experience to Clinic and Wait Times

		Nyandeni	Umzimvubu	Total	p-value
		n (%)	n (%)		
How long did you wait for services at the clinic?					
	<1 hour	180(33.9)	241(42.7)	421 (39.7)	0.037*
	>1 hour	351(66.1)	324(57.3)	639 (60.3)	
Was this wait time acceptable to you?					
	Yes	202(40.6)	276(47.4)	478 (44.3)	0.026*
	No	295(59.4)	306(52.6)	601 (55.7)	
Did you receive all the services/medication you went for?					
	Yes	385(76.5)	392(72.1)	777 (74.2)	0.098
	No	118(23.5)	152(27.9)	270 (25.8)	
Were you treated with respect?					
	Yes	407(76.2)	429(70.7)	836 (73.3)	0.035*
	No	127(23.8)	178(29.3)	305 (26.7)	
Were you shouted at by any of the staff?					
	Yes	154(28.6)	186(31.0)	340 (29.9)	0.371
	No	385(71.4)	414(69.0)	799 (70.1)	
Were you able to meet with the health care worker in private?					
	Yes	274(55.5)	287(52.9)	561 (54.1)	0.339
	No	220(44.5)	256(47.1)	476 (45.9)	
Did you feel that your confidentiality was maintained?					
	Yes	288(63.2)	260(54.1)	548 (58.5)	0.005*
	No	168(36.8)	221(45.9)	389 (41.5)	

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

5.3 IMB Barriers and Facilitators to Care

5.3.1 Information: Knowledge of HIV

Learners completed a series of questions to understand their levels of HIV knowledge. Figure 12 shows the overall participant knowledge scores, based on UNAIDS benchmarks. A total of 678 learners (51.4%) answered both knowledge questions correctly and therefore scored 1 for knowledge. However, in contrast, only 83 (6.3%.) learners answered all three key misconception questions correctly, scoring a 1 for myth rejection. Thus, only 59 (4.5%) out of the 1318 learners overall achieved a perfect composite knowledge score.

Figure 12: HIV Knowledge Scores based on UNAIDS/HSRC Benchmarks

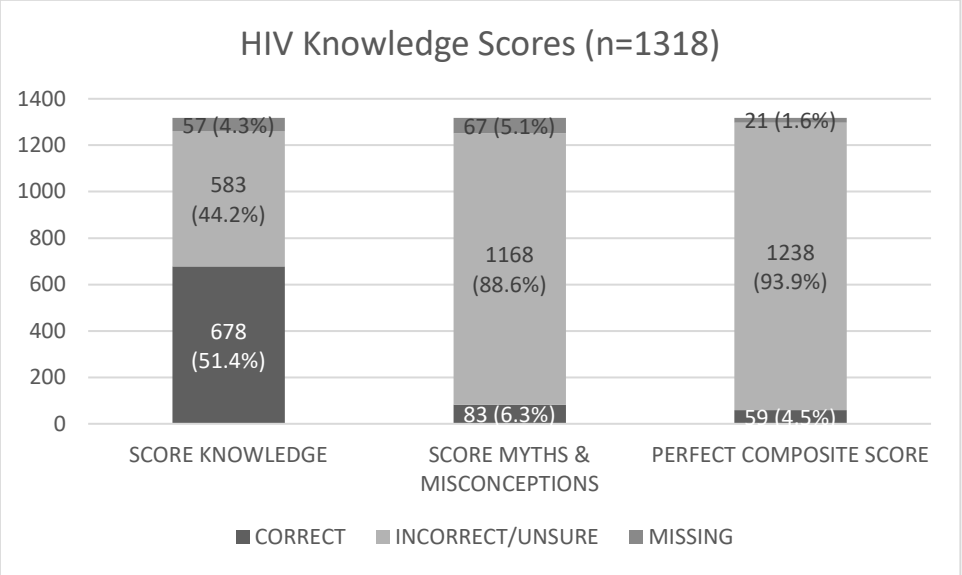


Table 12 below shows the participants' responses to a series of basic questions about HIV transmission. It should be noted that the composite knowledge score was weighted downwards by over 75% of the sample (n=985) having endorsed (responded as TRUE or NOT SURE) to the myth/misconception that HIV could be transmitted by sharing a toothbrush or cooking utensils.

Table 12: Knowledge Levels regarding HIV [responses below 50% correct highlighted]

Question	**% of learners (N=1318) who gave the correct answer per question** % (n)
HSRC Benchmark Knowledge Questions (UNAIDS 2013)	
Knowledge 1. Condoms can prevent against HIV and other STIs	76.8% (1014)
Knowledge 2. You can tell someone has HIV by looking at that person	63.3% (835)
Myth/Misconception 1. HIV can be cured	40.9% (540)
Myth/Misconception 2. HIV can be passed by sharing a toothbrush or cooking utensils	22.3% (295)
Myth/Misconception 3. HIV+ mothers can pass HIV on to their infants through breastfeeding	61.4% (810)

Supplementary Knowledge Questions (PREPARE Study)	
If you have anal sex with a person who is HIV positive, you can become infected with HIV	31.8% (420)
Abstaining from sex is the only way to avoid getting HIV	33.2% (438)
When a girl uses contraceptive pills or the injection for family planning, this protects her against STIs	36.1% (477)
Young men who are circumcised cannot get HIV	49.7% (656)
HIV can be caused by being bewitched	52.8% (667)
If you have sex only once with a person who is HIV positive, you can become infected with HIV	62.2% (821)
A person with HIV can live a full and healthy life	64.5% (851)
Women can transmit HIV to men	67.9% (896)
HIV can be passed by sharing a toilet with someone who has HIV	71.4% (943)
If you kiss a person who is HIV positive, you can become infected with HIV	79.6% (1051)

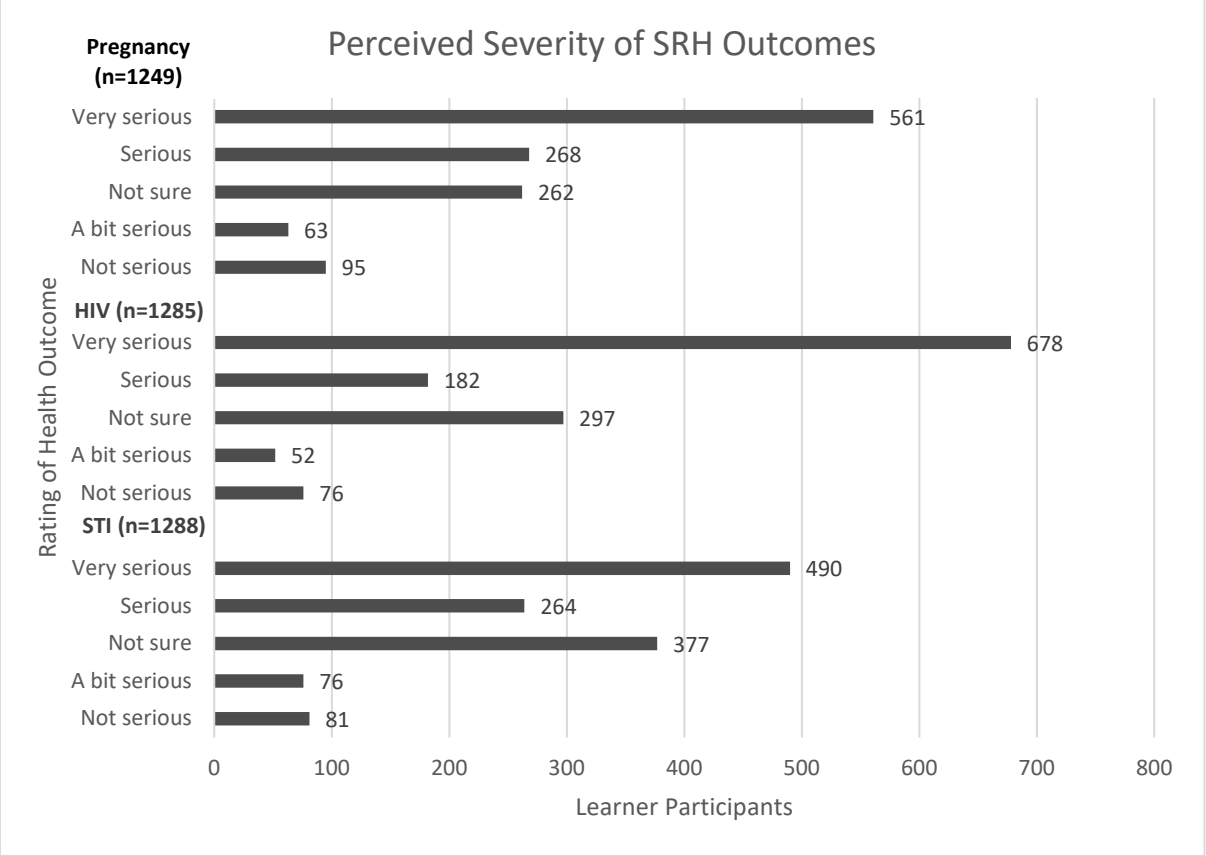
Key knowledge gaps as shown above in highlighted sections included the possible transmission of HIV via anal sex; that oral/injectable contraception can protect against STIs; and that young men who are circumcised cannot become infected with HIV. Learners in Nyandeni achieved higher mean Knowledge scores than those in Umzimvubu (data not shown). However, there were no significant Knowledge score differences based on age or sex in the two sub-districts.

5.3.2 Motivation for HIV Prevention and to Access SRHS

The study assessed the motivation levels for youth to protect their health and access services, by focusing on whether they felt vulnerable to negative health outcomes associated with sexual risk behavior (i.e., pregnancy, HIV diagnosis and STIs) and the perceived seriousness of those outcomes.

Out of 1285 learners, 72.9% (n=961) felt they were at high risk of getting HIV and a further 65.5% (n=843) felt they were at high risk of getting an STI, if they did not use condoms. Figure 13 demonstrates the perceived severity of such health outcomes amongst participants.

Figure 13: Perceived Severity of Health Outcomes by Participants



Thus, learners perceived a high risk of contracting HIV or STIs without the use of condoms, and the vast majority considered these outcomes serious or very serious. However, there was less certainty about the seriousness of STIs vs. HIV and pregnancy as noted in Figure 13.

5.3.3 Behavioral Skills and Perceived Self-Efficacy to Access SRHS

Further, social norms around attending clinics and HIV testing were assessed, to understand if there was social support for healthcare seeking behavior amongst youth, including HIV testing. Results are shown in Table 13 with responses to Behavioral Skills and Self-Efficacy, as well as behavioral intentions.

As shown in Table 13, there was considerable stigma with learners worrying about what other may think and fear of discrimination when visiting the health facility. There was normative support for HIV testing, and strong intent among learners to test annually, with 60.4% endorsing this. There was a fair amount of hesitancy to speak candidly to healthcare workers, with over half (56.4%) afraid or not sure whether they could tell the truth at clinic, for fear of judgement. Nonetheless, the majority endorsed plans to attend clinic when needed for contraception (53.3%), HIV testing (60.4%), and STI symptoms (72.2%), as warranted.

Table 13: Motivation, Behavioral Skills, and Self-Efficacy among participants

	Strongly Agree/ Agree n (%)	Not Sure n (%)	Strongly Disagree/ Disagree n (%)	Total n (%)
Motivation Factors: Social Support for Clinic Attendance/HIV testing				
I worry about what others may think of me if I went to the clinic for services	509 (40.0)	278 (21.8)	486 (38.2)	1273 (100%)
I feel discriminated against when I attend my local clinic	345 (27.1)	360 (28.3)	568 (44.6)	1273 (100%)
Most people I know have had an HIV test	544 (42.5)	529 (41.3)	208 (16.2)	1281 (100%)
Most people who care about me think that I should have an HIV test	803 (62.3)	255 (19.8)	231 (17.9)	1289 (100%)
Behavioral Skills: Perceived self-efficacy in accessing services				
I would feel comfortable taking to a nurse/healthcare worker about sex	816 (64.1)	216 (17.0)	241 (18.9)	1273 (100%)
I am afraid to tell the truth when I visit the clinic, for fear of judgement	498 (39.2)	219 (17.2)	555 (43.6)	1272 (100%)
Intention and Action Plan: Health-seeking behavior				
I plan to go to the clinic to collect my contraception/family planning if required	678 (53.3)	433 (34.0)	162 (12.7)	1273 (100%)
I will get an HIV test every year	773 (60.4)	355 (27.8)	151 (11.8)	1279 (100%)
I will talk freely to the nurses and healthcare workers who care for me at the clinic for my sexual and reproductive health needs	741 (57.8%)	418 (32.6)	123 (9.6%)	1282 (100%)
I will attend the clinic if I have any symptoms of an STI	929 (72.2%)	268 (20.8%)	90 (7.0)	1287 (100%)

5.4 Summary

This chapter quantified how often youth participants accessed health services, and characterized the experiences of youth as recalled from their most recent clinic visit. Youth were asked to rate their last visit based on AYFS standard measures for quality of services, including confidentiality and privacy of consultations. Most youth had contact with a primary health care facility within the past year. The chapter also described the opportunity costs that youth encounter to access care (transportation, time, and financial resources) which may serve as barriers to SRHS uptake. The chapter also highlighted key IMB barriers and facilitators that may hinder or facilitate demand for, and access to, SRHS.

CHAPTER 6: RESULTS FROM OBJECTIVE 3

RESILIENCE & HEALTH BEHAVIOR

6.1 Chapter Overview

In this chapter, levels of resilience as measured by the Child and Youth Resilience Measure-28 (CYRM-28) (Liebenberg et al., 2012, Ungar and Liebenberg, 2011) are quantified to characterize resilience levels in this population. Chapter 6 focuses on the results from this scale, by age, sex and other demographics. This chapter will also explore any association with resilience and the primary and secondary outcomes of this research, i.e., uptake of sexual health and reproductive services (HIV testing and contraception), as well as sexual debut, history of pregnancy, STI treatment, and HIV status.

6.2 Results [Descriptive]: Only individuals who answered all 28 questions on the CYRM-28 scale could be scored. This resulted in a sample of 931 participants (70.9% of the surveyed population) which was predominantly female (62.3%) and consistent with the overall sample demographics. Based on scoring, a low score would be 56, a medium score 84, and a high score 112. The median resilience score was 101 (shown as red line in Figure 14) with mean score of 99.55 with a range of 56 – 112 (SD, 8.18)).

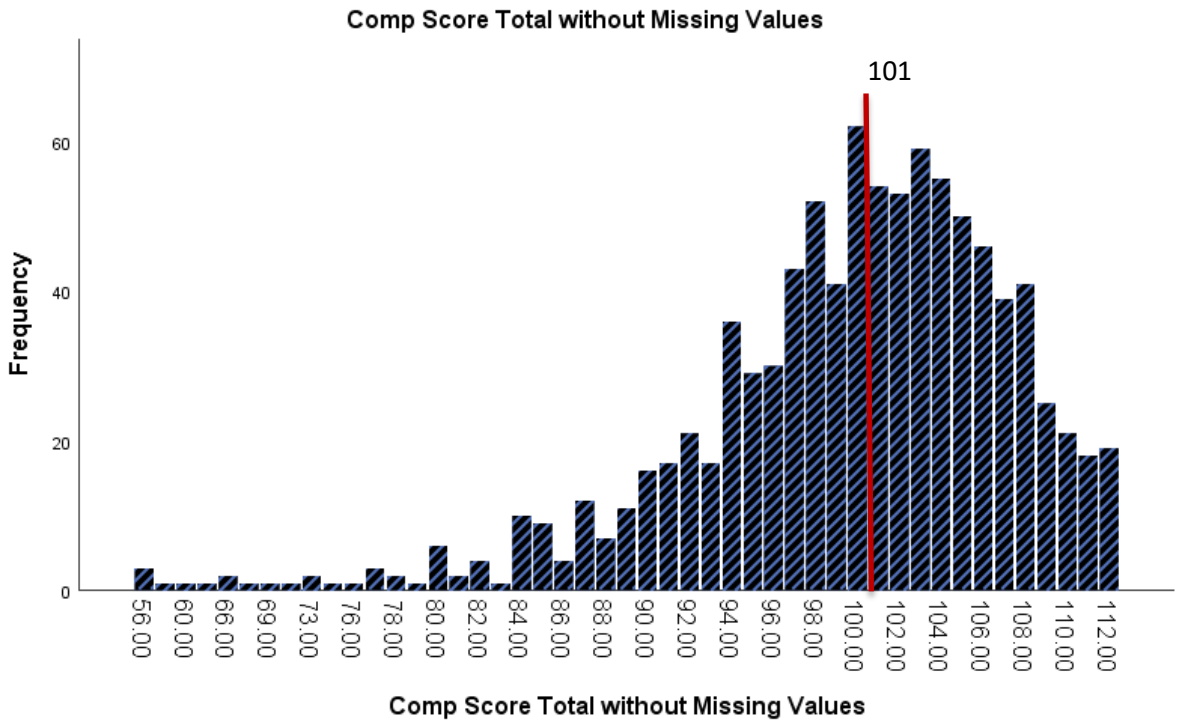


Figure 14: Composite Resilience Scores among learners surveyed (n=931)

Resilience scores were skewed high for all school-based youth participants, with age, district, and sex not conveying any significant differences in mean resilience scores. Females

and males had mean scores (M= 99.37, SD=8.33, range 56-112, median 101) and (M= 99.83, SD=7.92 range 66-112, median 101) respectively which were not significantly different (*p*=.460). Similarly, those from Nyandeni had similar mean scores (M=100.08, SD=7.47, median 101) than those from Umzimvubu (M=99.12, SD=8.69, median 101), p=.076. Age had no significant correlation with resilience scores, based on bivariate correlation analysis *r* (908) =.011, p=.749**.** Those who reported having been through traditional Xhosa rites of passage for coming of age had higher mean resilience scores (M=100.19, median 101) than those who had not (M=99.03, median 100), which was significant (p=.042).

The CYRM-28 is categorized into three domains which assess resilience at three levels: i.e., the individual level, the parent-caregiver level, and the contextual level, assessing educational, spiritual and cultural supports. The minimum and maximum scores for each construct were 22-44 (11 questions), 14-28 (7 questions) and 20-40 (10 questions), respectively. As shown in Table 14, scores across these domains were as follows:

Table 14: Scores to Resilience Measures by Domain

Domain	**Mean Score, *SD***	**Median**	**Range**
Individual Resilience	38.9, *3.53*	39.00	22-44
Parent-Caregiver Supports	24.9, *2.65*	25.00	14-28
Context: Educational, Spiritual, Cultural	35.7, *3.12*	36.00	20-40
All	**99.55, *8.18***	**101**	**56-112**

As shown in Table 15, there follows a descriptive analysis of responses on the additional seven resilience questions, assessing further contextual factors that support resilience.

Table 15: Responses to Resilience Measures on Social Support and Self-Agency

Questions	**Yes n (%)**	**Sometimes n (%)**	**No n (%)**	**Total n (%)**
1. I have people who are older than me whom I admire/ look up to	606 (65.4%)	235 (25.4%)	85 (9.2%)	926 (100.0%)
2. I have people my own age whom I admire/look up to	500 (54.2%)	300 (32.5%)	123 (13.3%)	923 (100.0%)
3. Young people are valued in my community	444 (48.5%)	373 (40.7%)	99 (10.8%)	916 (100.0%)
4. People in my culture respect women	587 (63.2%)	285 (30.7%)	57 (6.1%)	929 100.0%
5. I am confident that I can protect myself and/ my partner from falling pregnant.	645 (69.7%)	181 (19.6%)	99 (10.7%)	925 (100.0%)
6. I feel getting HIV is unavoidable and there is not much I can do to prevent it	215 (23.4%)	261 (28.4%)	444 (48.3%)	920 (100.0%)
7. When bad things happen, I blame myself	277 (29.8%)	495 (53.2%)	158 (17.0%)	930 (100.0%)

Youth widely affirmed the presence of supportive role models, with the majority acknowledging the presence of older people they admired as well as peers, at 65.4% and 54.2% respectively. Contextually, less than half agreed that youth were valued in their communities (48.5%), although nearly 2/3 (63.2%) felt that their culture respected women. Most youth endorsed confidence in their ability to protect themselves or their partners from pregnancy, with nearly 70% agreeing to this statement. However, the majority of youth felt that getting HIV was unavoidable (only 48.3% or 444 thought it was not) and most youth blamed themselves when bad things happen, with 17% (n=158) not endorsing this statement.

Finally, descriptive statistics were analyzed to understand the aspirations and future-focused mindset of youth, as a factor contributing to resilience. Youth were highly future-focused, with reported aspirations to finish high school (92.4%, n= 854) and 87.5% (n=804) planned to proceed to tertiary education (varsity/Technikon). Youth expressed more ambivalence about ability to return to school if they (or their partners) faced pregnancy (76.5% agreed they would complete high school, n=708), and whether there were opportunities after high school (80.7% agreed there were, n=748), see Table 16.

Table 16: Responses to Resilience Measures on Future Aspirations

	Agree n (%)	Not sure n (%)	Disagree n (%)	Total n (%)
I plan to finish high school	854 (92.4%)	54 (5.8%)	16 (1.7%)	924 (100%)
I know what I want to be when I grow up	818 (88.3%)	84 (9.1%)	24 (2.6%)	926 (100%)
I have plans to attend varsity/Technikon after high school	804 (87.5%)	98 (10.7%)	17 (1.5%)	919 (100%)
If my partner or I fell pregnant, I would still finish high school	708 (76.5%)	164 (17.7%)	53 (5.7%)	925 (100%)
I have goals in life	870 (93.9%)	42 (4.5%)	15 (1.6%)	927 (100%)
I plan to succeed in life	857 (93.2%)	47 (5.1%)	16 (1.7%)	920 (100%)
I would like to have a family of my own someday	798 (86.5%)	101 (10.9%)	24 (2.6%)	923 (100%)
I can picture what my future will be like 10 years from now	796 (85.8%)	111 (12.0%)	21 (2.3%)	928 (100%)
There are opportunities for me after high school	748 (80.7%)	154 (16.6%)	25 (2.7%)	927 (100%)
I have dreams for my future	874 (94.0%)	38 (4.1%)	18 (1.9%)	930 (100%)

6.3 Results [Correlation with Primary and Secondary Outcomes]

In this section, the association of resilience with protective health behavior was assessed. The analysis relies on the responses to CYRM-28, as well as dichotomized dependent variables that are implicated in protective health behavior, including:

- Sexual debut - whether or not respondent has had sex,
- HIV testing – whether respondent has tested for HIV and his/her self-reported HIV status (no HIV tests were performed in the study)
- Contraceptive Use – whether respondent is currently using contraception
- History of Pregnancy - whether respondent has become pregnant (females) or made someone pregnant (males)
- STI treatment – whether respondent has been treated for an STI

Independent sample t-tests were conducted to compare means of resilience scores for dichotomized outcomes of interest, with two-tailed significant outcomes at $p < .05$ (Table 17). Non-parametric tests were conducted to compare median scores for the outcomes of interest in an independent-samples median test given the skewed distribution of resilience scores Significant results and any divergent findings based on median comparisons are highlighted in text below.

Table 17: Comparison of Resilience Scores, based on Primary and Secondary Outcomes

Variable	Resilience (Mean, *SD*)	Resilience (Median)	Total n (%)	P-Value
Sexual Debut				
Yes	99.55, *8.05*	101	610 (65.5%)	0.983
No	99.54, *8.35*	101	321 (34.7%)	
Have you ever had an HIV test?				
Yes	99.56, *8.31*	101	525 (56.8%)	0.859
No	99.46, *8.03*	101	399 (43.2%)	
HIV status (n, %)				
Positive	94.8, *10.55*	98	28 (3.0%)	0.002*
Negative/Unknown	99.7, *8.06*	101	903 (97.0%)	
Have you ever been treated for an STI?				
Yes	98.1, *9.53*	100	91 (9.8%)	.084
No	99.7, *8.00*	101	840 (90.2%)	
Are you currently using contraception?				
Yes	99.90, *8.01*	101	439 (48.3%)	.260
No	99.29, *8.33*	101	469 (51.7%)	
History of Pregnancy				
Yes	97.74, *10.05*	100	177 (19.0%)	.001*
No	99.97, *7.62*	101	754 (81.0%)	

Note: significant associations are denoted with an asterisk (*) using a p value of <0.05.

Sexual Debut: For all participants with complete resilience scores (n=931), a total of 321 (34.47%) reportedly had not had sex and 610 (65.5%) did. There was no significant difference in the resilience scores between the two groups, t (2) =-.021, p = 0.983. These results suggest that resilience scores do not differ among those with sexual debut, and nonparametric tests comparing median scores above confirmed this result (p=.958).

HIV Testing and Serostatus: Furthermore, mean resilience scores were compared for those who tested for HIV (n=525 out of 924, or 56.8%) to those who did not test for HIV (n=399 or 43.2%), finding no statistically significant difference; t (2) =-.178, p = 0.859. Nonparametric tests comparing medians confirmed this result (p=.820).

Those who reported a positive HIV status (n=28 or 3%) had statistically lower mean resilience scores than those with unknown or negative HIV status, with M=94.82, SD=10.55 among those living with HIV compared to those who were not living with HIV M=99.70, SD=8.055; t (2) =3.122, p=.002. This result held in nonparametric tests of median scores, (p=.025).

Contraception Uptake: Mean resilience scores for those who were using contraception (n=469) were compared to those who were not using contraception (n=439). An independent samples t-test confirmed that differences were not statistically significant; t (2) =-1.128, p = 0.260. When restricting the sample to those currently sexually active (n=379), these results were sustained with no significant difference between mean resilience scores (p=0.664). Nonparametric tests comparing medians of those who used contraception vs. those who did not confirm this result (p=.653).

History of Pregnancy: There were 178 participants (138 females, 40 males) who reported a history of pregnancy or making someone pregnant which represented 19.01% of the total sample for whom resilience scores were available (n=931). An independent samples t-test confirmed that differences in mean resilience scores were statistically significant, with mean scores significantly lower among those who reported a history of pregnancy compared to those who did not (M=97.74, SD=10.05 vs to M=99.97, SD=7.618; t (2) =3.290, p = 0.001). However, nonparametric comparisons of above median scores did not confirm this result (sig=.112)

STI Treatment: Those who were treated for an STI (n=91) also had lower mean scores for resilience than those who were not treated for an STI, which trended toward significance (p=.084). When medians were compared, this was confirmed as non-significant (p=.458).

6.4 Summary

This chapter assessed the levels of resilience in participants and explored the potential role of resilience in SRHS uptake among learners. Resilience levels in youth were skewed high on average, and there were strong future aspirations as expressed by youth. There were no significant associations with resilience and healthcare-seeking behavior. There were significant associations between resilience levels and SRH outcomes, including significantly lower resilience levels among those reporting an HIV positive test result, and history of pregnancy.

CHAPTER 7: DISCUSSION AND LIMITATIONS

7.1 Chapter Overview

This thesis set out to characterize the uptake of sexual and reproductive services (SRHS), and experiences of care in a representative sample of learners from two sub-districts in the Eastern Cape, to inform future interventions that aim to strengthen protective health behavior in youth and support demand for health services. The policy landscape and evolution of AYFS in South Africa within a Child's Rights framework is advantageous to targeted health provision for adolescents and youth. The thesis sought to characterize uptake of SRHS among youth, and assessed potential barriers and facilitators to SRHS utilization amongst youth. Much of the peer-reviewed literature has focused on barriers to care, with less attention to facilitators. Furthermore, much of the literature has focused on the deficits among youth in accessing care, rather on than assets or strengths they might have to facilitate uptake (Agdal et al., 2019, Cassetti et al., 2020, Mosavel et al., 2018). Barriers and facilitators were framed within the IMB Model of Health Behavior Change, theorizing that individuals with adequate information (knowledge), motivation (peer support and perceived vulnerability), and behavioral skills (ability to access care and services) would be able to access SRHS and protect their health. Finally, resilience was considered as an unexplored asset in youth that may be protective and potentiate their journey to healthcare.

Specifically, with acknowledgement of the complex and adverse landscape which youth navigate to access care, and recognizing the persistent threat of violence, economic hardship, and HIV in the daily lives of young people, it was hypothesized that resilience may play a role in facilitating protective health behavior. Experiences of violence at the inter-personal, school, and community level were assessed as a potential benchmark of adversity amongst school-based youth living in the Eastern Cape (Mathews and Benvenuti, 2014). Levels of resilience amongst this study sample could also shed light on whether resilience could be leveraged to safeguard youth health, and activate mechanisms and adaptive processes that ensure successful SRHS utilization, including individual, caregiver and contextual supports. Resilience theory predicts that resilient youth interact with their peers, caregivers and social ecologies, including their homes, schools, and communities to adapt positively in stressful environments (Theron, 2012). Thus, the exploration of resilience also considered the contextual and enabling factors that youth may encounter in their environment, and how they articulate support from these resources (Rothmann et al., 2018). Further exploration on learners' perceived vulnerability to HIV, declared self-agency, and capacity for hope were assessed to understand whether learners felt

they could influence their environment, and protect their health. This chapter summarizes the study findings, its limitations, and implications for intervention development.

7.2 Discussion

This study provided a detailed exploration into the lives of school-based youth in two subdistricts in the Eastern Cape. Learners in this study commonly reported sexual activity with a mean age of sexual debut of approximately 15 years old in line with estimates of sexual debut in the latest Youth Risk Behavior Surveys conducted in the Eastern Cape (Reddy et al., 2012, Zuma et al., 2016). Roughly a third reported not yet being sexually active, which may demonstrate a delay in sexual debut, particularly among AGYW. It is notable that males had a significantly younger age for sexual debut than females consistent with other studies (Richter et al., 2014, Zuma et al., 2010), and a substantial and alarming proportion of male learners indicated sexual debut at 10 years of age or younger, which merits further investigation (~13.2% of available responses). As other researchers have noted, sexual experiences of young men can be characterized by coercion (Stern and Cooper, 2014) and there is a dearth of information about sexual abuse perpetrated against boys, with all sexual activity considered non-consensual at this age (Richter et al., 2014, Richter et al., 2015).

It is also unclear with whom these first sexual experiences are occurring since female peers in this study endorsed a much higher age for sexual debut. Intergenerational or age-disparate partnerships were not directly characterized in this study, but norms regarding these partnerships were assessed which may provide clues. While more young men endorsed preference for older partners than young women, the existence of age-disparate relationships among young men and older women has been found to be rare in other studies elsewhere in South Africa (Harling et al., 2014). However, early sexual debut (< 16 years of age) has been implicated as a predictor of multiple partnerships, heightened HIV risk, and negative education outcomes in the region (Bengesai et al., 2018, Richter et al., 2014, Richter et al., 2015, Zuma et al., 2010, Zuma et al., 2016).

Teen pregnancy was encountered by nearly one out of five learners (19%), which was also consistent with reports in the Eastern Cape region which queried respondents if they ever had been pregnant, for young women -- or made someone pregnant, for young men (Reddy et al., 2012). Intentions to fall pregnant are low amongst this group, and past pregnancy among young women is roughly aligned with prevalence rates seen in 2016 in the Eastern Cape, where approximately 17.9% of 15-19 year olds had begun childbearing (National Department of Health (NDoH) et al., 2019).

Despite the need for contraception, uptake is relatively low with nearly half of women who report the potential need for contraception not utilizing it. This highlights a gap for AYFS and comprehensive SRHS. Condoms and injectables (for women) remain the most common contraceptive devices in use, which were reported by 70% of the sexually active sample. Consistency of contraceptive use remains uneven however, particularly with the use of condoms. Only 60% of young women in relationships who did not wish to become pregnant were accessing contraception consistently, highlighting a significant unmet need for contraceptive provision, and below current population estimates (UNAIDS, 2022).

Self-reported HIV testing uptake was higher than what was reported by province in 2011 (Reddy et al., 2012) - over half the sample reported that they had been tested for HIV (or 56.5%) which was more common in females and for those in relationships. This was also above the national average reported in 2016 by HSRC for this age group, which was 50.4%, and consistent with recent estimates of HIV testing among young people (National Department of Health (NDoH) et al., 2019). These are encouraging signs that HIV test and treat guidelines are being taken up by youth in the Eastern Cape. This analysis demonstrates that those with more contact to the primary care system through access to contraception, STI treatment and pregnancy may be more likely to be offered an HIV test. It is also encouraging to see that those in relationships and who are sexually active were more likely to test. About 3% of the entire sample self-reported they were living with HIV.

Furthermore, females were significantly more likely than males to report sexual debut as forced or something they did not want, which is also consistent with past research in both quantitative and qualitative descriptions (Richter et al., 2015, Stern and Cooper, 2014). Roughly a third of males and females reported some level of intimate partner violence in their relationships, but there were no statistically significant differences in learners perpetrating sexual violence or threats against their partners for sex. While females were nearly twice as likely to have encountered physical violence by their partner, or report having been threatened with physical violence, they were statistically *less likely* than males to have been forced by their partner to have sex. This finding may seem counter-intuitive based on gendered norms in the region, but consistent with other research in KwaZulu-Natal which has demonstrated that young men have higher or equal reports of forced sex than young women (De Vries et al., 2014).

In addition to intimate partner violence, youth witnessed or experienced violence at multiple levels with concerning prevalence – in their homes, schools and communities – consistent with past research (Leoschut, 2008, Kaminer et al., 2013, Richter et al., 2018). Youth reported witnessing physical violence at school (44.3%), homes (38.5%) and in their

communities with 19.1% of youth reporting witnessing someone being shot, stabbed or killed in the last six months. Alarmingly, over half (58.5%) reported having been hit or physically punished in the last six months by their teachers, and a further 9.4% reportedly felt their teachers made sexual advances toward them. Over a third (35.3%) had been in a physical fight, and 45.1% reported bullying from peers at least once in the past six months. Such levels of violence are not uncommon in the school setting, but their confluence demonstrates that few learners were free of witnessing or experiencing some level of violence in the prior six-month period. Only 191 (14.5%) learners reported no exposure to violence, demonstrating the adverse context in which participants learn and live. This is comparable to poly-violence exposure estimates in Gauteng, Western Cape, and KwaZulu-Natal which are far more urban than these two subdistricts (Choe et al., 2012, Otwombe et al., 2015, Richter et al., 2018, Sanders-Phillips and Kliewer, 2020).

Exposure to violence was endemic for learners surveyed, and puts them at risk for school delay [defined as enrolment below the age-appropriate grade] (Romero et al., 2021) and other risk behaviors (Sanders-Phillips and Kliewer, 2020). As noted above, youth experienced physical abuse from their teachers, or witnessed physical violence from their teachers with alarming frequency. With schools implicated as a mainstay in resilient environments (Theron and Theron, 2010), with supportive teachers and caring adults a key predictor of educational attainment for South African learners (Choe et al., 2012, Dass-Brailsford, 2005, Liebenberg et al., 2012, Romero et al., 2018a), this requires urgent attention to ensure learners are safe in schools and equipped to meet their full potential. In 2019, South Africa passed legal protections effectively ending corporal punishment in schools, and this study was conducted in 2016, which may shed light on the high levels of physical punishment witnessed and experienced by learners in this study (Global Initiative to End all Corporal Punishment of Children, 2020).

Much work has been conducted in the Eastern Cape to explore the relationship between different levels of exposure to violence, and correlation with educational (schooling) delays, aspirations, and sexual risk behavior. Other researchers have profiled youth in terms of levels of accumulated violence exposure (Romero et al., 2018b, Romero et al., 2021, Sui et al., 2020) having a cumulative impact on risk behavior among youth (Sanders-Phillips and Kliewer, 2020). Although not the explicit focus of inquiry for this thesis, further exploration of stratifying this sample is merited to assess the relative contributions of various types of violence to risk behavior, health service utilization, and resilience. Despite significant reports of violence at multiple levels, the majority of youth in this study endorsed feeling safe in their homes (86.3%), yet to a lesser extent in their schools (63.7%) and clinics (62.8%) suggesting that this backdrop

did not necessarily equate to perceived heightened vulnerability to crime or violence. As suggested in past work, this collective exposure to violence in the daily lives of young people may have normalized this experience, rather than conveying a sense of insecurity (Pelser, 2008).

Qualitative evidence amongst youth in South Africa also suggests that endemic violence in communities may limit access to health services who may be afraid to walk to services or collect medications, such as ARVs or contraception, on a routine basis (Cooper et al., 2015). In this sample, nearly two thirds (62.4%) walked to clinic for services, and it took them over an hour to make the journey. Further, the study confirmed that youth not only encounter an adverse environment to safeguard their sexual and reproductive health with high levels of violence, self-blame for adversity, and ambivalence on self-agency on whether one could protect oneself against HIV, but also a need to navigate health services that are reportedly unfriendly and at times hostile toward youth. Feedback from youth regarding health service utilization reflected a public health service that requires attention, with average ratings across quality measures in the range of 3 out of 5, reflecting a need for improvement. Despite several opportunities for youth to be provided sexual and reproductive health services (69.7% had contact with the health system in the prior six months), experiences with the health system would seem to reinforce hesitancy in accessing services, with significant proportions of youth reporting gaps in privacy and confidentiality assurances, as well as being shouted at or feeling discriminated against by clinic staff.

Routine access to care for contraception or medication collection was rare, with the vast majority only attending clinic when they felt ill. Youth reported unacceptable waiting times, and opportunity costs for attending clinic including having to take time off from work and school, and transportation costs for a return fare to the clinic. Such costs may be prohibitive, and delay young people from seeking care. Furthermore, a small but significant proportion of those who had not received an HIV test reported such obstacles, including having no time or financial means to attend clinic to receive an HIV test. Such findings corroborate other studies in the Eastern Cape and South Africa which indicate significant gaps in the quality of care and demand for AYFS offered to youth (MiET Africa, 2011, Mokomane et al., 2017).

Information, Motivation and Behavioral Skills: Furthermore, youth lacked appropriate information about protective health behavior, particularly with regard to HIV prevention. The IMB Model postulates that youth must have accurate information; sufficient motivation and behavioral skills to change their behavior. The knowledge levels of youth were low, consistent with other studies (Bryan et al., 2006, De Wet et al., 2019, Reddy et al., 2012). Key gaps in

knowledge existed about the possible transmission of HIV via anal sex; the misconception that HIV can be passed by sharing a toothbrush or cooking utensils; that contraception can protect against STIs; and that young men who are circumcised cannot get HIV. This highlights a need for further education amongst youth. As a baseline, youth had significant gaps in knowledge and highlighted a need for appropriate and specific Information and Education Communication (IEC) materials. Despite a strong policy landscape for sexuality education with the compulsory introduction of Life Orientation skills in all schools, comprehensive knowledge about HIV and its modes of transmission were lacking.

Since youth described high vulnerability to HIV, but limited perceived self-efficacy to face this threat, it would be advantageous to build interventions that address the proximal barriers to accessing care and services, situated within a future-focused aspirational mindset. As documented in other explorations, South African youth often endorse dreams for their future, despite circumstances of poverty and limited opportunity (Swartz et al., 2012). Intentions to test for HIV annually, access contraception, and seek treatment for STIs in the future were high among youth, although there was much more proximal ambivalence in being able to speak candidly with health professionals during health consultations, highlighting a potential 'say-do' gap. That is, while youth endorsed statements that reflected sufficient motivation to protect their health and safeguard their future, youth lacked self-efficacy in speaking to healthcare providers, were concerned about what others might say when they attended health facilities, and shared little confidence in their ability to protect themselves from HIV, an outcome many perceived as inevitable. This is not a new finding – many researchers have illuminated the discrepancy between youth awareness, intentions and protective health behavior (Bryan et al., 2006, James et al., 2005, James et al., 2004, Romero et al., 2018b) -- but aligns with past research that identifies self-efficacy as a potential mediating factor in protective health behavior (Eggers et al., 2014) and revisits the potential of a future-focused mindset to safeguard youth health (Bryan et al., 2006, Hendriksen et al., 2007, De Lannoy and Swartz, 2015).

Resilience: Despite high levels of self-reported exposure to violence and first-hand accounts of unfriendly health services, youth demonstrated high levels of resilience at the individual, caregiver and contextual levels, with scores heavily skewed in the positive direction. This was remarkable, and seems to validate the support provided by the family and cultural context, as elicited in the CYRM-28. Youth had high levels of individual resilience and also took pride in their culture, and collective communities. Youth endorsed the presence of role models in their social networks – both older mentors and admired peers – and most agreed that women were respected in their culture. However, over half of youth felt that they were not

valued in their communities, and more than half felt that getting HIV was unavoidable, potentially diminishing their capacity for self-agency to protect themselves against HIV and seek health services as needed. There was a fair amount of self-blame amongst youth when bad things happen, which merits further exploration.

Youth conveyed future aspirations in career and academics, and strong intent to complete high school (nine out of ten planned to finish) and many saw opportunities for themselves on a 10-year horizon. The violence and lack of employment in their communities did not dissuade youth from a future-focused mindset, and dreams for their future. This finding aligns with work conducted by Herrero Romero et al. (2019) in the Eastern Cape who found that academic aspirations persisted in the context of high violence, and did not dampen academic motivation – yet accumulated exposure to violence could diminish their capacity to reach those goals.

There were no statistically significant differences in resilience among youth by age, sex, and district. Interestingly, youth who had experienced traditional rites of passage for coming of age (Intonjane for girls, Ulwaluko for boys) reported statistically higher levels of resilience. Such traditional practices may confer social cohesion and provide a 'teachable moment' to impart cultural pride and accurate health information (Kheswa and van Eeden, 2018, Malisha et al., 2008, Peltzer and Kanta, 2009) yet significant health risks remain for such practices, particularly traditional male circumcision (Peltzer et al., 2008, Wilcken et al., 2010).

Mean resilience scores for those who accessed health services including HIV testing and contraception did not significantly differ from those who did not access such services. For youth with a history of pregnancy, STI treatment or living with HIV, mean resilience scores were lower than those without such a history, and this difference was significant among those with a history of pregnancy and who reported a positive HIV serostatus. Those who reported living with HIV had significantly lower resilience scores on average than those who tested HIV negative or reported an unknown status, which potentially signifies the lack of social support and cultural stigma attached to the diagnosis, conveying less individual resilience. This is consistent with other studies of resilience of adolescents living with HIV (ALWH) in the region (Kaunda-Khangamwa et al., 2020).

Similarly, youth who had been pregnant or made someone pregnant had lower mean scores of resilience, than those who had not, which may be indicative of a lower individual resilience, caregiver support, or cultural stigma which discourages teen pregnancy. An HIV diagnosis or unplanned pregnancy may be a shock to youth, straining resources and limiting sources of social support. Unfortunately, these are also outcomes of inadequate access to sexual reproductive health services, and it is difficult to interpret the relationship between these

constructs (i.e., are less resilient youth more prone to adverse sexual health and reproductive health outcomes including HIV and pregnancy, or do such conditions make youth less resilient in this context). Emerging data from Soweto (Kidman et al., 2018) demonstrates that exposure to violence increases the sexual risk of adolescents perinatally infected with HIV, and can contribute to onward transmission. Resilience in this context could thus be protective.

Overall, the study demonstrated that youth continue to navigate an adverse context in terms of exposure to violence, sexual risk, and reportedly unfriendly health services. However, there were significant assets apparent in youth that could be explored as intervention targets including their high levels of resilience, expressed regard for family and community belonging, future career and educational aspirations, and motivation to protect themselves from the perceived consequences of HIV and unplanned pregnancy.

7.4 Implications for Intervention

This study relied on an individual, cross-sectional assessment to describe the experience of school-based youth in healthcare-seeking behavior, in order to identify possible barriers and enablers for youth to seek care. Youth reported an adverse context in which to negotiate resources, with potential exposure to violence, sexual risk and unfriendly health services. Nonetheless, there were significant opportunities for intervention, and strengths noted among adolescent and youth participants in this study, which could be leveraged in future interventions. These are categorized by the theoretical underpinnings which support this study, in relevant domains.

Information Levels. Youth had notable knowledge gaps on key HIV transmission behaviors, which could be remedied in school-based Life Orientation classes, or in clinic-based, youth-appropriate Information Education and Communication materials. Specific gaps could be readily addressed, particularly to resolve common misunderstandings and misconceptions about anal sex, transmission of HIV by sharing cooking utensils, circumcision and oral contraception. Further, cell phone access among youth was pervasive, which may provide an easy, confidential way for youth to access credible information, and connect with services.

Motivation Levels and Resilience. Most youth perceived severe consequences for the outcomes of sexual risk behavior, and also endorsed intentions to protect oneself from unplanned pregnancy and HIV. Although HIV was often considered unavoidable, youth demonstrated perceived normative support for contraception and HIV testing as well. Therefore, interventions that support youth intention to protect themselves, by providing the means and safe spaces to discuss their needs, could protect youth from the consequences they perceive. While

not all youth were affected by this risk perception, recent health promotion research has honed in on the importance of gain-frames versus risk- or loss-frames to bolster health communications with youth and support demand for protective health services, including post-exposure prophylaxis and ART initiation (Amico and Bekker, 2019). Such targets may be yet unexplored in youth and have significant potential given their future-focused mindset (Amico and Bekker, 2019, Brault et al., 2021a, Lambert et al., 2018, Rothman et al., 2006, Rothman and Salovey, 1997). Youth were generally resilient and future-focused, but they did not perceive a link with safeguarding their health now to securing the healthy future they envisaged for themselves. Recent work in eSwatini that developed an aspirational brand that situated health and wellness within the arc of young women being able to safeguard their future has shown promise and such interventions may be appropriate in this setting (Brault et al., 2021a, Brault et al., 2021b).

In addition to the potential for gain frame and future-focused, holistic programming, youth also endorsed the presence of strong family connection, cultural pride, and respect for peers and elders alike. This supportive community could be strengthened to pivot resources to protect youth, and ensure their safe journey into adulthood. Families, and particularly supportive mothers, are critical mainstays for youth that could be leveraged here for support. For example, experiencing coming of age rituals further strengthened resilience in this sample, indicating the potential for these experiences to become teachable moments to impart relevant information and self-efficacy in protective, healthcare seeking behavior. Often, such rituals involve a touchpoint with the health facility to clear youth for participation in the ritual, which may provide youth with opportunities for credible information, care and support from healthcare workers. Embedding sexuality education and health services into such rituals would require extensive community consultation and stakeholder engagement, including active youth participation.

Behavioral Skills and Self-Efficacy: Youth demonstrated limited skills in navigating health services, speaking candidly with healthcare providers, and articulating their healthcare needs. A Childs Rights framework would emphasize that youth deserve to be heard, and AYFS training is needed for healthcare workers and clinic staff to remove an immediate barrier to care that youth perceive, i.e., stigma toward youth sexuality. The GirlChamp brand noted above reframed healthcare workers as Coaches, which was a more neutral identity than how nurses regard young patients as extended family, and enabled healthcare workers to better serve youth from that perspective (Brault et al., 2021).

Youth also faced significant opportunity costs for accessing healthcare services, including transportation costs and distance to facilities, which could be addressed partially with

cash transfers and incentives for service provision. Such interventions have shown promise, and are likely cost-efficient mechanisms if they lead to preventing pregnancy, STIs, and HIV which have enduring costs on the healthcare system (Cluver et al., 2018).

Further system-level recommendations to align services with the current AYFS standards are as follows:

- Prioritize the AYFS Program in all public health facilities, including primary health care clinics, community health centers and hospitals (Branson and Byker, 2018)
- Include youth representation on clinic committees and amongst HCW staff, to ensure their voices are heard and needs catered for
- Ensure that the feedback loop between young clients and the facility is maintained, in confidence, so that the suggestions of youth can be addressed – i.e., via Youth Committees, Suggestion Boxes, community dialogues and Indabas
- Assure confidentiality and privacy of consultations as much as possible, acknowledging space constraints
- Assure that medications and services are available to youth when and where they need them, to avoid repeat trips to the clinic and acknowledging the opportunity costs youth experience
- Capacitate all staff, form clinical service providers to non-clinical support staff to be youth-friendly, and address potential burnout issues that may be contributing to hostile service for youth
- Develop engaging IEC material through multi-media platforms that may speak to youth health issues, and noted knowledge gaps
- Engage parents, community health workers, and schools (through School Governing Bodies) in AYFS achievement, support and maintenance

7.3 Limitations

The survey results were based on self-reported data, which are subject to social desirability and recall bias and likely represent an under-reporting of risk behavior, including sex, alcohol and drug use, and criminal activity. Thus, data should be interpreted with caution, given the strong stigma attached to youth sexuality in Southern Africa, and the school-based setting which may have hindered candid responses amongst learners. Nonetheless, they are important lower bound estimates for these behaviors and indicate a substantial need for appropriate and acceptable AYFS in the participating sub-districts, even with this caveat.

Furthermore, the results are based on accounts from youth in two specific sub districts in the Eastern Cape, which are not necessarily generalizable. Yet, with the robust sample representative of school-based youth, these results paint a vivid picture of the experience of school-based youth with SRHS in the participating health districts.

Further analysis is needed to understand the relative contribution of the levels of information, motivation and behavioral skills on the outcomes of interest – i.e., HIV testing and contraception use. An IMB model test similar to Ybarra et al. (2012) and Shrestha et al (2016) to assess the correlations with these constructs and the behavior of interest is warranted, but currently beyond the scope of this research. Future analyses will focus on this inquiry for publication, if the sample size permits. This study was not powered for a model fit test.

The resilience levels were not a normal distribution, and highly skewed in the positive direction, which could have also meant the measure was not sensitive to detect different levels of resilience in the sample. Alternatively, the pervasive levels of violence that were reported could have activated strong adaptive responses en masse, contributing to high resilience scores. Such a distribution made it difficult to deconstruct or disentangle the effects of resilience on the primary outcomes of interest – i.e., HIV testing.

Given the cross-sectional, observational nature of this study which was held exclusively with in-school youth, and the lack of sufficient qualitative methods, this study did not achieve a contextualized picture of resilience that could shed a more nuanced light on the statistical associations that emerged. Panter-Brick (2014), Southwick et al., (2014) and others have cautioned of a generic lens of resilience, and future avenues of research should explore what youth envisage for their future success, the resources they require, and build measure (quantitative) and ethnographic inquiry (qualitative) around these constructs. Finally, promising new research has shown relationships between improvements in information, motivation and behavioral skills correlated with resilience and individual health and wellness outcomes, which remains to be explored in this data set (Yao et al., 2020).

Finally, this study was conducted without consideration of cyber-bullying or violence that can occur in the digital space, and this type of violence is not captured, despite its documented negative impact on learners' mental health and well-being in South Africa (Khuzwayo et al., 2018). The study also did not quantify depression, anxiety or post-traumatic stress disorder among learners as a function of their overall wellbeing (Harrison et al., 2021).

7.4 Summary

Exposure to violence in schools, homes and communities was common, particularly witnessing or experiencing physical punishment from teachers, which was particularly alarming. Bullying amongst peers was also concerning with ~9% suffering insults monthly or more often. Alcohol, tobacco and substance use were not commonly reported, although this could have been due to the social desirability of responses. Knowledge levels regarding HIV were very low, with prevalent misconceptions about HIV transmission that need to be remedied.

Routine use of clinic services was rare, and youth experience with clinic services endorsed the need for improvements in privacy, confidentiality and staff engagement with youth. Experiences of youth in the clinics were somewhat concerning, with relatively high reports of being shouted at, failures to maintain privacy and confidentiality, and not being given the services or medications they came for. Wait times generally were under two hours, but a sizable proportion found them unacceptable. In this predominantly rural sample, 62.4% of participants reported walking to the clinic for services with over one third taking an hour or more to get there.

As noted, high levels of resilience, however, did not equate to higher levels of uptake of health services, as those who had tested for HIV or accessed contraception were no more resilient than those who had not. While individual resilience scores did not differ for those who sought HIV testing or contraception compared to those who did not, those who reported an HIV positive diagnosis or history of pregnancy did have lower resilience scores that were statistically significant. Those who sought STI treatment also were marginally less resilient than those who had not, which approached significance.

Importantly, while resilience may not correlate with health service utilization and uptake, it may be implicated in the outcomes from the absence of such protective behaviors. That is, those who had experienced an HIV positive diagnosis, STI treatment, or pregnancy were less resilient than those who had not. Such outcomes which are the direct consequences of failure to engage in protective health behavior (i.e., contraception uptake and condom use) may predict lower levels of resilience or conversely, failure to engage in protective behavior may be preceded by relatively lower levels of resilience, leading to negative SRH outcomes. The direction of this association merits further investigation, which could be achieved in a longitudinal study of resilience levels amongst youth.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS

8.1 Conclusions

This thesis provides a detailed understanding of the uptake of sexual and reproductive health services among learners, as well as describes various factors that may influence youth health and well-being including exposure to violence; alcohol and substance use; clinic experiences with health service utilization; HIV prevention knowledge (information), attitudes (motivation) and practices (behavioral skills); as well as levels of resilience. It has highlighted concerning levels of exposure to violence within schools and communities, as well as within intimate partnerships. It has demonstrated gaps in HIV knowledge that should be addressed in comprehensive interventions, as well as low uptake of contraception and inconsistent condom use among sexually active adolescents and youth. It has shone a light on the disconnect that youth experience with the future aspirations they see for themselves, and the sexual behavior that may put them at risk for unintended pregnancy and STIs, including HIV. It has proven that youth participants in this study had overall remarkable resilience, and endorsed strong individual, caregiver and community support, that should be leveraged in future interventions. It emphasizes that HIV remains a threat to youth, particularly adolescent girls and young women (Birdthistle et al., 2019). Finally, there are considerable recommendations for AYFS, given the firsthand accounts of learners and their interactions with the health sector, particularly for differentiated service delivery that puts youth at the center (Reif et al., 2018) and requires fresh thinking on how to reach and engage youth from the ground up (Cluver et al., 2018, Lake et al., 2019).

8.2 Study Implications and Future Research

This study has implications to strengthen youth healthcare-seeking behavior at multiple levels, based on the socio-ecological model which predicts an enabling environment is essential for youth to access SRH resources and navigate their daily lives. When considering resources at the individual level, youth require support in accessing HIV testing and contraception. As noted above, youth need accessible information, and services that acknowledge the assets that they have, particularly their high levels of resilience and future aspirations. Such assets can be leveraged as strong motivators for continued school achievement, safeguarding their health and protecting their future plans. Strengths-based interventions which draw on community support, family ties and cultural pride to promote sexual health and well-being may be uncharted. Providing resources and incentives for youth may provide short-term incentives to keep youth safe and engaged in care.

At the family and caregiver level, the vast majority of youth perceived high levels of support from parents and caregivers. These ties can be leveraged to provide support of youth sexuality, candid discussions about HIV risk, and support for healthcare-seeking behavior, to ensure that youth can absorb the opportunity costs associated with seeking health services, such as taking a day off school or transport fees. The involvement of families and caregivers has demonstrated protective outcomes for teen pregnancy and academic achievement, which may further facilitate healthcare-seeking behavior (Bosire et al., 2021).

At the school level, there remains much work to ensure a safe and enabling environment for learners to receive credible information, and feel safety in schools from teachers and peers alike. Violence reduction interventions, anti-bullying interventions, and rewards for academic achievement and dedication could ensure youth have resilience-supporting mechanisms in schools. Despite the high marks that learners gave for educational aspirations, the day-to-day experience of youth in schools painted a highly adverse context that requires systemic intervention to support youth, particularly to safeguard their physical and mental wellbeing.

Finally, there are significant system level changes, particularly in health facilities, that could be leveraged to support youth more sustainably, which take advantage of the current resources that are available to youth within communities. This does not necessarily require additional resources, but a youth-friendly mindset among healthcare workers and staff. Youth also derived significant pride from their culture, traditions, and celebrations, which may provide unique opportunities to embed age-appropriate interventions for youth within culturally-recognized rituals and celebrations. Culture and context was a significant source of resilience.

Future avenues of research would be to design and evaluate assets-based, multi-level interventions that speak to the enabling factors that allow youth to convert their aspirations and dreams into tangible goals, by focusing on sexual health and wellness as part of a successful transition into adulthood. Rather than focusing solely on the barriers to care, interventions that leverage the individual, family, and community-level supports which were pervasively recognized by youth, could turn the tide to support youth in sustainable and meaningful ways. Further, if resilience is the transactional process that youth derive support from their environment, then grit – or the passion and perseverance for long-term goals – may be a quality that can be further cultivated to enable youth to thrive, and realize their aspirations. Supporting youth in the more proximal skills of speaking to healthcare providers, negotiating condom use, coping with challenging schools and healthcare systems, and accessing support and services from traditional sources but in non-traditional ways, may be of benefit.

APPENDICES

A. List of participating schools

B. Survey Instruments

- **a. School-Based Survey Instrument (in English)**
- **b. School-Based Survey Instrument (in isiXhosa)**
- **c. List of Primary and Secondary Outcome Variables, with theorized dependent variables**

C. Ethical approval letters

- **a. University of Western Cape Approval**
- **b. Biomedical Research Ethics Committee Approval (PharmaEthics)**
- **c. Ministry of Health and Department of Basic Education Approval**

D. Participant Information Sheets

E. Permission Forms

- **a. Youth Assent Form**
- **b. Consent Form-Adult Caregiver of Minor Study Participant (<18 years of age)**
- **c. Consent Form – School Survey (18+ years of age)**

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APPENDIX A. List of Participating Schools

Appendix A. List of Participating Schools

Learner participant numbers sampled by sub-district and school [in alphabetical order][1]

Name of sSchool	Sub-district		Total number of learner participants
	Nyandeni	Umzimvubu	
Bhekizulu SSS	31	0	31
CHB SSS	18	0	18
Hlamandane SSS	0	19	19
Huku SSS	0	73	73
Jojo SSS	0	68	68
Mafini JSS	19	0	19
Mnceba SSS	0	52	52
Mount Frere High School	0	52	52
Mt. Ayliff Comprehensive SSS	0	47	47
Ngqeleni JSS	30	0	30
Ngqeleni SSS	60	0	60
Nongeke SSS	0	27	27
Ntabankulu SSS	0	51	51
Ntafufu SSS	51	0	51
Ntlaza JSS	11	0	11
Osborne SSS	0	47	47
Pangalele SSS	56	0	56
Phondolwendlovu SSS	54	0	54
Port St. John SSS	31	0	31
Rhode SSS	0	75	75
Sandi SSS	49	0	49
Sewushe SSS	19	0	19
Sithukuthezi SSS	0	43	43
St Patrick's SSS	34	0	34
Toli SSS	52	0	52
Tshayingca SSS	0	48	48
Upper Corana SSS	53	0	53
Zanokhanyo JSS	21	0	21
Zwelakhe SSS	0	60	60
Zwelitsha SSS	0	67	67
Total	**589**	**729**	**1318**

[1] Junior Secondary Schools (JSS) typically go up to Grade 9 only; Senior Secondary Schools (SSS) often begin from Grade 10-12.

APPENDIX B.

a. School-Based Survey Instrument (in English)
b. School-Based Survey Instrument (in isiXhosa)
c. List of Primary and Secondary Outcome Variables, with theorized dependent variables.

BASELINE YOUTH SURVEY: AYFS Implementation Project

All about you: The next set of questions asks all about you, where you come from, and how you describe yourself. Please remember all your answers are confidential.

1. How old are you? _____ years old

2. What is your gender?
   - ❑ Male
   - ❑ Female
   - ❑ Other

3. Are you still in school?
   - ☐ Yes
   - ☐ No If No, please indicate which grade that you completed: _____

4. What grade are you currently in?
   - ❑ Standard 9
   - ❑ Standard 10
   - ❑ Standard 11
   - ❑ Standard 12

5. Have you ever failed a grade?
   - ❑ Yes
   - ❑ No

6. How would you best describe yourself?
   - ☐ Black--Zulu
   - ☐ Black--Xhosa
   - ☐ Black--Sotho
   - ☐ Black – Other:_____
   - ☐ Indian
   - ☐ Coloured
   - ☐ White
   - ☐ Other
   - ☐ Prefer not to Answer

7. What is your home language? _____

8. Where do you live?
   - ❑ Town
   - ❑ Rural Area

9. How many people stay in your household/home? _____

10. Are you currently employed (including self-employment)?
    - ❑ Yes
    - ❑ No

11. Do you have access to a cell phone?
    - ❑ Yes, I have my own SmartPhone *(a phone that takes pictures and can connect to internet - eg. iPhone, Samsung)*
    - ❑ Yes, I have my own cell phone *(a phone that does not take pictures but receives SMS/texts - eg. Nokia)*
    - ❑ Yes, I use my parents or friend's cell phone
    - ❑ No, I do not have access to any cell phone.

12. Sometimes kids don't have enough food in their home. *(Please fill in a number for each response.)*
    a) How many days **in the past 7 days** did you not have enough food in your home? _____
    b) **In the past 7 days**, how many days did you go to bed hungry? _____
    c) **In the past 7 days**, how many days did you go to school without breakfast? _____
    d) **In the past 7 days**, how many days did you get a meal from the school feeding scheme? _____

13. **In the past six months, how often**

a) Did you drink at least one drink of alcohol?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
b) Did you drink more than one drink of alcohol on the same day?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
c) Did you use dagga or marijuana?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
d) Did you sniff glue or petrol?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
e) Did you use tik?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
f) Did you use heroin?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
g) Did you smoke cigarettes?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
h) Did you use any other illegal drugs (e.g., Wonga)?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
i) Were you involved in a physical fight (at home, at school or in your community)?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
j) Did you steal something or take something from someone without permission?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
k) Did you cause serious damage to property on purpose?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
l) Did you witness someone getting beaten or hit at school?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
m) Did you witness someone getting beaten or hit at home?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day
n) Did you witness someone getting stabbed, shot or killed in your community?				
◯ Never	◯ Once or twice	◯ Every month, but not every week	◯ Every week	◯ Every Day

o)	How often has someone **at school** threatened you with a weapon (i.e., penga, knife or gun)?
◯ Never ◯Once or twice	◯Every month, but not every week ◯Every week ◯Every Day
p)	How often has someone **in your community** threatened you with a weapon (i.e., penga, knife or gun)?
◯ Never ◯Once or twice	◯Every month, but not every week ◯Every week ◯Every Day
q)	How often has someone **at school** insulted or humiliated you in front of other people?
◯ Never ◯Once or twice	◯Every month, but not every week ◯Every week ◯Every Day
r)	How often have you been beaten or physically punished **by a teacher at school**?
◯ Never ◯Once or twice	◯Every month, but not every week ◯Every week ◯Every Day
s)	How often have you felt that **a teacher** was flirting with you or making sexual advances?
◯ Never ◯Once or twice	◯Every month, but not every week ◯Every week ◯Every Day

All about your health: The next set of questions asks about your health in general, your sexual practices and what you are doing to keep you and your partners healthy. Some of the questions may make you uncomfortable. All responses are confidential. Please be honest so we can understand what matters to you in terms of your health!

1. How old were you when you had sex for the first time?

   - ❑ _____years old

   - ❑ Not Applicable. I have not had sex.

2. The first time you had sex, it was:
   - ❑ Something I wanted.
   - ❑ Something I did not want.
   - ❑ Something I was forced to do against my will.
   - ❑ Not Applicable: I have never had sex.

3. How many people have you had sex with in your life? *(If you have not had sex, please write-in '0'.)*_____
   - ❑ Cannot remember the exact number
   - ❑ Prefer not to answer.

4. Are you currently in a relationship?
   - ❑ Yes
   - ❑ No

5. Are you currently sexually active (had sex in the last six months)?
   - ❑ Yes
   - ❑ No

6. When was the last time you had sex?
   - ❑ In the past week
   - ❑ In the past month
   - ❑ 1-2 months ago
   - ❑ 3-4 months ago
   - ❑ 5-6 months ago
   - ❑ More than six months ago
   - ❑ Not Applicable. I have not had sex.

7. In the past six months, how often did you and your partner use a condom when having sex?
   - ❑ Never
   - ❑ Rarely
   - ❑ Sometimes/half the time
   - ❑ Often
   - ❑ Most of the Time
   - ❑ Always
   - ❑ N/A - I did not have sex in the past six months.

8. Have you ever had sex with someone in order to RECEIVE money or material gifts, like cell phones, airtime, clothing, etc.?
   - ❑ Yes
   - ❑ No
   - ❑ Not Applicable. I have not had sex.

9. Have you ever GIVEN someone money or material gifts, like airtime, to have sex with you?
   - ❑ Yes
   - ❑ No
   - ❑ Not Applicable. I have not had sex.

10. Within your close circle of friends, has anyone become pregnant (unplanned) within the last year?
   - ❑ Yes
   - ❑ No

11. For girls, have you ever fallen pregnant?
   - ❑ Yes
   - ❑ No – If NO, SKIP to Question 13

   For boys, have you ever made someone pregnant?
   - ❑ Yes
   - ❑ No – If NO, SKIP to Question 13.

12. If yes, do you have any children?
   - ❑ Yes — If yes, how many children do you have? _____
   - ❑ No — If no, please explain what happened:
     - o Miscarriage
     - o Termination of Pregnancy/Abortion
     - o Emergency Contraception "morning after pill"
     - o Other: _____

13. Have you been through Intonjane (for girls) or Ulwuluko (for boys) ?
   - ❑ Yes
   - ❑ No

14. Have you ever been treated for an STI (sexually transmitted infection)?
   - ❑ Yes
   - ❑ No

15. If yes, where did you go to seek treatment? *(Tick all that apply).*
   a. From the clinic ◯Yes ◯No
   b. From a traditional healer ◯Yes ◯No
   c. From a GP/private doctor ◯Yes ◯No
   d. Other:_____

16. Do you wish to fall pregnant (or have your partner fall pregnant) in the next six months?
   - ❑ Yes
   - ❑ No

17. Are you currently using any contraception? (i.e., condoms, family planning, injectable, etc.)?
   - ❑ Yes
   - ❑ No

18. If yes, please specify method/s that you are using to avoid pregnancy (Tick Yes or No for all that apply):
   - ❑ IUD ◯Yes ◯No
   - ❑ Implanon ◯Yes ◯No
   - ❑ Injectable - Depo/Nuristerate ◯Yes ◯No
   - ❑ Oral contraception – i.e., the pill ◯Yes ◯No
   - ❑ Emergency contraception – 'morning after pill' ◯Yes ◯No
   - ❑ Condoms ◯Yes ◯No

- ❑ Female Condoms ◯Yes ◯No
- ❑ Withdrawal method (withdrawing before ejaculation) ◯Yes ◯No
- ❑ Other: _____

19. How often do you go to clinic to get contraception?
    - ❑ Monthly
    - ❑ Every three months
    - ❑ Every six months
    - ❑ Annually
    - ❑ Never
    - ❑ Other:_____

20. Where do you usually get condoms*? (Tick all that apply).*
    - ❑ Clinic ◯Yes ◯No
    - ❑ School ◯Yes ◯No
    - ❑ Tuck shop/spaza ◯Yes ◯No
    - ❑ Till at grocery store/super market/pharmacy ◯Yes ◯No
    - ❑ My boyfriend/girlfriend usually brings them. ◯Yes ◯No
    - ❑ Other:_____
    - ❑ N/A – I do not use condoms.

21. Do you usually get condoms for free, or do you buy them?
    - ❑ Free condoms
    - ❑ Buy condoms
    - ❑ Both
    - ❑ N/A – I do not use condoms.

22. Where would you prefer to get condoms?
    - ❑ Clinic ◯Yes ◯No
    - ❑ School ◯Yes ◯No
    - ❑ Tuck shop/spaza ◯Yes ◯No
    - ❑ Till at grocery store/super market/pharmacy ◯Yes ◯No
    - ❑ Other:_____

23. Have you ever had an HIV test?
    - ❑ Yes
    - ❑ No

24. If yes, when did you have your last HIV test?
    - ❑ In the past month
    - ❑ Between 1-3 months ago
    - ❑ Between 4-6 months ago
    - ❑ Between 7-12 months ago
    - ❑ More than one year ago
    - ❑ N/A – I have not had an HIV test.

25. If yes, where did you get your HIV test done?
    - ❑ Home
    - ❑ Clinic
    - ❑ School
    - ❑ Campaign/Mobile Health Unit
    - ❑ Other_____
    - ❑ N/A – I have not had an HIV test.

26. If yes, what was your HIV status?
    - ❑ HIV+
    - ❑ HIV-negative
    - ❑ Did not receive results
    - ❑ Prefer not to answer
    - ❑ N/A – I have not had an HIV test.

27. If No, what was your reasons for NOT having an HIV test? _____

Sometimes when we are in relationships, things get hectic. Please let us know if any of these issues have happened to you in the past six months.

28. In the past 6 months, how often has a **boyfriend or a girlfriend** insulted you, or humiliated you or made you feel bad about yourself?
    ◯Once ◯More than once ◯Never ◯N/A: I have not had a boyfriend/ girlfriend in past 6 months.

29. In the past 6 months, how often has a **boyfriend or a girlfriend** threatened to hurt you?
    ◯Once ◯More than once ◯Never ◯N/A: I have not had a boyfriend/ girlfriend in past 6 months.

30. In the past 6 months, how often has a **boyfriend or a girlfriend** hit, pushed, kicked, choked or burned you?
    ◯Once ◯More than once ◯Never ◯N/A: I have not had a boyfriend/ girlfriend in past 6 months.

31. In the past 6 months, how often has a **boyfriend or a girlfriend** forced you to have sex with him/her?
    ◯Once ◯More than once ◯Never ◯N/A: I have not had a boyfriend/ girlfriend in past 6 months.

32. In the past 6 months, how often have you forced your **boyfriend or girlfriend** to have sex with you?
    ◯Once ◯More than once ◯Never ◯N/A: I have not had a boyfriend/ girlfriend in past 6 months.

33. In the past 6 months, how often have you threatened to hurt **your boyfriend or girlfriend**?
    ◯Once ◯More than once ◯Never ◯N/A: I have not had a boyfriend/ girlfriend in past 6 months.

All about your community: This section asks about the health services available to you in your community. This may include services you receive from the clinic, youth centre, and school.

34. How often do you attend the clinic in your community?
    - ❑ As needed – when I'm feeling ill.
    - ❑ Every month to collect contraception or medication
    - ❑ Every three months to collect contraception or medication
    - ❑ Every six months to a year for visits for routine check-up, etc.

35. When was the last time you went to clinic?
    - ❑ Last week
    - ❑ In the past month
    - ❑ In the past three months
    - ❑ In the past six months
    - ❑ In the past year
    - ❑ More than a year ago

36. **FOR GIRLS ONLY.** Have you ever received family planning services from your local clinic?
- ❑ Yes
- ❑ No

37. Have you ever received Implanon – the contraceptive device that is implanted under your skin?
- ❑ Yes
- ❑ No

38. Have you ever requested that the Implanon be removed, before it was due to be removed?
- ❑ Yes
- ❑ No

If yes, what was the reason for the removal?_____

39. The last time you went to clinic, what was the main reason(s) for your visit? *(Please tick any that apply).*
- ❑ Contraception
  - ○ Oral contraception – the pill, pills
  - ○ Condoms
  - ○ Injectable - Depo
  - ○ IUD
  - ○ Hormonal Implant - Implanon
- ❑ Emergency contraception (IUD or pill)
- ❑ Ill Health (Cold, cough, flu)
- ❑ HIV counselling and testing (HCT/VCT)
- ❑ ART initiation or pill collection
- ❑ Post exposure prophylaxis (PEP)
- ❑ STI screening and treatment
- ❑ Pregnancy testing
- ❑ Antenatal care
- ❑ Medical male circumcision/referral for circumcision
- ❑ Other (specify)_____

40. The last time you went to clinic, did you receive all the services and medications you came for?
- ❑ Yes
- ❑ No
- ❑ I don't remember.

41. The last time you went to clinic, were you treated with respect?
- ❑ Yes
- ❑ No
- ❑ I don't remember.

42. The last time you went to clinic, were you able to meet with the health care worker in private?
- ❑ Yes
- ❑ No
- ❑ I don't remember.

43. The last time you went to clinic, were you shouted at by any of the staff - i.e., nurses, counsellors, clerks?
- ❑ Yes
- ❑ No
- ❑ I don’t remember.

44. The last time you went to clinic, did you feel that your confidentiality was maintained (i.e., that the reason for your visit and what you said was kept private, and only between you and the health care worker)?
    - ❑ Yes
    - ❑ No
    - ❑ I don't remember.

45. How long did you wait for services at the clinic?
    - ❑ Less than 1 hour
    - ❑ 1-2 hours
    - ❑ 3-4 hours
    - ❑ More than 4 hours
    - ❑ I don't remember

46. Was this wait time acceptable to you?
    - ❑ Yes
    - ❑ No
    - ❑ I don't remember

47. Overall, how would you rate the quality of services you receive at the clinic, with 1 being very bad and 5 being very good? *(Please tick one.)*
    - ☐ 1. Very Bad
    - ☐ 2. Bad
    - ☐ 3.Needs Improvement
    - ☐ 4. Good
    - ☐ 5. Very Good

48. Overall, how satisfied are you with the measures taken to keep your consultation private and confidential, with 1 being Not at all Satisfied and 5 being Very Satisfied? *(Please tick one.)*
    - ☐ 1. Not at all Satisfied
    - ☐ 2. Somewhat Satisfied
    - ☐ 3. Needs Improvement
    - ☐ 4. Satisfied
    - ☐ 5. Very Satisfied

49. Overall, how helpful would you say the clinical care staff were who took care of you at the clinic, with 1 being Not at all Helpful and 5 being Very Helpful? *(Please tick one.)*
    - ☐ 1. Not at all Helpful
    - ☐ 2. Somewhat Helpful, but did not meet all my needs
    - ☐ 3. Needs Improvement
    - ☐ 4. Helpful
    - ☐ 5. Very Helpful

50. How long does it take you to get to the clinic?
    - ☐ 0-30 minutes
    - ☐ 31-60 minutes
    - ☐ > 1 hour

51. Do you have to take time off from work / school / household chores to come to clinic?
    - ❑ Yes
    - ❑ No

52. Typically, how do you get to the clinic?
    - ❑ Walk
    - ❑ Public Transport - take a taxi/bus
    - ❑ By car – Get a lift from a friend/drove myself

53. How much do you pay to get to the clinic (one way)?
    - ☐ _____ Rand
    - ☐ Nothing

54. In general then, how easy is it for you to get services at the clinic?
    - ❑ Easy
    - ❑ Somewhat difficult
    - ❑ Very Difficult

55. Are there nurses or health workers available that you can visit at school?
    - ❑ Yes
    - ❑ No

56. Are any health services offered at school?
    - ❑ Yes
    - ❑ No

57. If yes, please list all services that have been available at your school in the past six months *(Tick all that you are aware of):*
    - ❑ Deworming ◯Yes ◯No
    - ❑ Eye and Hearing Tests ◯Yes ◯No
    - ❑ HIV testing ◯Yes ◯No
    - ❑ Contraception ◯Yes ◯No
    - ❑ STI screening ◯Yes ◯No
    - ❑ Nutrition services ◯Yes ◯No
    - ❑ Pregnancy testing ◯Yes ◯No
    - ❑ Condoms ◯Yes ◯No
    - ❑ Female condoms ◯Yes ◯No
    - ❑ Health Education ◯Yes ◯No
    - ❑ Life Skills Orientation ◯Yes ◯No
    - ❑ Other:_____

FOR BOYS: In the past six months, have you accessed any of the following services AT THE CLINIC?

Service	**Yes or No**	**If YES, how often did you access the service in the past 6 months?**
FOR BOYS: Contraception		
☐ Condoms	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Female Condoms.	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Male Medical Circumcision (MMC) or referral for initiation	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
HIV counselling and testing (HCT/VCT)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
ART initiation or pill collection	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
STI screening and treatment	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
General health Concerns – flu, injury, feeling ill	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Chronic Conditions	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Tuberculosis screening/treatment	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Diabetes screening or care	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ High blood pressure screening	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Mental Health (i.e., depression, anxiety, etc.)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Dental services	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Other:_____	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*

FOR GIRLS: In the past six months, have you accessed any of the following services AT THE CLINIC?

Service	Yes or No	If YES, how often did you access the service in the past 6 months?
FOR GIRLS: Contraception		
☐ Oral contraception – the pill.	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Injectable - Depo	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ IUD insertion	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Hormonal Implant – Implanon INSERTION	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Hormonal Implant – Implanon REMOVAL	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Condoms – male condoms.	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Female Condoms.	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Emergency contraception (IUD or pill)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Post exposure prophylaxis (PEP)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
HIV counselling and testing (HCT/VCT)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
ART initiation or pill collection	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Service related to Termination of Pregnancy (TOP)/Abortion	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
STI screening and treatment	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Pregnancy testing	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Antenatal care	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ <20 weeks (Before 20 weeks)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ > 20 weeks (After 20 weeks)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
PMTCT (prevention of maternal-child transmission)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
General health Concerns – flu, injury, feeling ill	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
Chronic Conditions	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Tuberculosis screening/treatment	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Diabetes screening or care	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Hypertension screening	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Mental Health (i.e., depression, anxiety, etc.)	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*
☐ Dental services	◯Yes ◯No	◯Once or twice ◯3-5 times ◯6 times or more*

* Monthly – accessing services monthly or more.

58. If you have a reproductive health/sex-related problem, question or issue, where do you USUALLY go for help or advice? (Tick all that apply)

☐ Seek no help or advice – keep it to myself.	◯Yes ◯No
☐ Parents	◯Yes ◯No
☐ Other Family Members – i.e., siblings, aunt, uncle	◯Yes ◯No
☐ Teachers	◯Yes ◯No
☐ Friends	◯Yes ◯No
☐ Local Clinic	◯Yes ◯No
☐ Social Worker or Counsellor	◯Yes ◯No
☐ Peer Educator	◯Yes ◯No
☐ Traditional Healer	◯Yes ◯No
☐ Church Pastor	◯Yes ◯No
☐ Community Leader	◯Yes ◯No
☐ Other: Specify_____	◯Yes ◯No

59. Besides where you USUALLY go for help or advice, what other support or assistance would help you with your sexual health?

_____
_____
_____
_____

60. Where would you prefer to receive this assistance and support? (Tick YES for all that apply; if not, tick NO).

☐ At home	◯Yes ◯No
☐ At school	◯Yes ◯No
☐ At clinic	◯Yes ◯No
☐ At mobile unit	◯Yes ◯No
☐ At youth centre/community centre	◯Yes ◯No
☐ At church	◯Yes ◯No
☐ Other: _____	

61. Where would you <u>most</u> prefer to receive information about HIV, sex and reproductive health? (Tick all that apply).

☐ On my phone	◯Yes ◯No
☐ On the internet	◯Yes ◯No
☐ On TV	◯Yes ◯No
☐ On the radio	◯Yes ◯No
☐ At home	◯Yes ◯No
☐ At school	◯Yes ◯No
☐ At clinic	◯Yes ◯No
☐ At youth centre/community centre for youth only	◯Yes ◯No
☐ At church	◯Yes ◯No
☐ Other: _____	

What people think: The next section asks about what you and others you care about think about sex, relationships, condoms and HIV. There are no right or wrong answers. Please select the response that suits you. The tool below will help you with the questions that ask whether you Agree or Disagree with the statement.

1. Strongly Agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree

	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
1. Most of my **friends** think that I should use a condom when I have sex.					
2. My **parents/caregivers** think that I should use a condom when I have sex.					
3. Most of my **community** thinks that I should use a condom when I have sex.					
4. My **boyfriend/girlfriend** thinks that I should use a condom when I have sex.					
5. Most of my friends think I should wait until I'm older to have sex.					
6. My parent/caregivers think I should wait until I'm older to have sex.					
7. Most of my friends think that getting pregnant at my age is no big deal.					
8. My parents/caregivers think that girls my age should not fall pregnant.					
9. Most people I know have had an HIV test.					
10. Most people who care about me think that I should have an HIV test.					
11. My friends think that it is ok for girls to have sex with an older guy or 'sugar daddy', if you are getting something in return (i.e. airtime, money, clothes, groceries).					
12. Most of the people I prefer to have sex with are at least five years older than me.					
13. Most of the people I care about would think I would be 'easy' or 'asking for sex' if I carried condoms.					
14. I worry about what others may think of me if I went to the clinic for services.					
15. Most of my friends think that is ok to pressurize a person to have sex, even if they say they do not want it.					
16. Using condoms shows that you have respect for yourself and your partner.					

	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
17. When a person insists on using condoms, it shows that he or she has been with many partners.					
18. Most of my friends think that it is ok to have more than one sex partner at a time (i.e., a *side dish*).					
19. I would feel comfortable talking to a social worker or counsellor about sex.					
20. I would feel comfortable talking to a teacher about sex.					
21. I would feel comfortable talking to my parents about sex.					
22. I would feel comfortable talking to a nurse or health care worker about sex.					
23. I would feel comfortable talking to my friends about sex.					
24. I feel discriminated against when I attend my local clinic.					
25. The staff at the local clinic do not keep my information confidential.					
26. I am afraid to tell the truth when I visit the clinic for fear of judgement.					
27. I am satisfied with the services I receive at the clinic.					
28. I feel safe at the clinic.					
29. I feel safe at school.					
30. Condoms are difficult to use if you've been drinking.					
31. I would feel comfortable insisting on condom use even if it is the first time I am having sex with that person.					
32. I would feel comfortable insisting on condom use, even if my partner is much older than me.					
33. I feel safe at home.					
34. I am confident that I know how to use a condom correctly.					
35. I would feel embarrassed to buy condoms for myself.					

All about HIV: Knowledge is power. Please rate whether the following statements are true or false.

	True	False	Not Sure
1. If you have sex only once with a person who is HIV positive, you can become infected with HIV.			
2. If you kiss a person who is HIV positive, you can become infected with HIV.			
3. If you have anal sex with a person who is HIV positive, you can become infected with HIV. *NB: This means sex during which the penis enters the anus (bum).*			
4. A person with HIV can live a full and healthy life.			
5. HIV can be cured.			
6. You can tell someone has HIV by looking at that person.			
7. When a girl uses contraceptive pills or the injection for family planning, this protects her against sexually transmitted infections (STI).			
8. HIV can be caused by being bewitched.			
9. Condoms can prevent against HIV and other sexually transmitted infections (STIs).			
10. Abstaining from sex is the only way to avoid getting HIV.			
11. HIV can be passed by sharing a toothbrush or cooking utensils.			
12. HIV can be passed by sharing a toilet with someone who has HIV.			
13. HIV+ mothers can pass HIV on to their infants through breastfeeding.			
14. Women can transmit HIV to men.			
15. Young men who are circumcised cannot get HIV.			

16. If I do not use a condom when having sex, my risk of getting a sexually transmitted infection (STI) will be:
◯Very Low ◯Low ◯Not Sure ◯High ◯Very High

17. If I do not use a condom when having sex, my risk of HIV infection will be:
◯Very Low ◯Low ◯Not Sure ◯High ◯Very High

18. If I got an STI, I would find this:
◯Not Serious ◯A bit serious ◯Not Sure ◯Serious ◯Very Serious

19. If I have HIV, I would find this:
◯Not Serious ◯A bit serious ◯Not Sure ◯Serious ◯Very Serious

20. If I fell pregnant (for girls) or got somebody pregnant (for boys), I would find this
◯Not Serious ◯A bit serious ◯Not Sure ◯Serious ◯Very Serious

All about stress and coping: As we grow up, we face many challenges. The next questions ask about how you handle stress and cope with life's obstacles and who you have available for support.

1. I have people I want to be like	◯No ◯Sometimes ◯Yes
2. I share/cooperate with people around me	◯No ◯Sometimes ◯Yes
3. Getting an education is important to me	◯No ◯Sometimes ◯Yes
4. I know how to act in different situations (such as school, home and church)	◯No ◯Sometimes ◯Yes
5. My parent(s)/caregiver(s) watch me closely, they know where I am and what I am doing most of the time	◯No ◯Sometimes ◯Yes
6. I feel that my parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do)	◯No ◯Sometimes ◯Yes
7. There is enough to eat at home when I am hungry	◯No ◯Sometimes ◯Yes
8. I try to finish activities that I start	◯No ◯Sometimes ◯Yes
9. Spiritual beliefs are a source of strength for me (for example, believing in a God or ancestors)	◯No ◯Sometimes ◯Yes
10. I am proud of my ethnic background (for example, I know where my family comes from or know about my family's history)	◯No ◯Sometimes ◯Yes
11. People think I am fun to be with.	◯No ◯Sometimes ◯Yes
12. I talk to my family about how I feel (for example when I am hurt or sad)	◯No ◯Sometimes ◯Yes
13. When things don't go my way, I can fix it without hurting myself or other people (for example hitting others or saying nasty things)	◯No ◯Sometimes ◯Yes
14. I feel supported by my friends	◯No ◯Sometimes ◯Yes
15. I know where to go to get help when I need it.	◯No ◯Sometimes ◯Yes
16. I feel I belong at my school	◯No ◯Sometimes ◯Yes
17. My family cares about me when times are hard (for example if I am sick or have done something wrong)	◯No ◯Sometimes ◯Yes
18. My friends care about me when times are hard	◯No ◯Sometimes ◯Yes
19. I am treated fairly	◯No ◯Sometimes ◯Yes
20. I have chances to show others that I am growing up and can do things by myself	◯No ◯Sometimes ◯Yes
21. I know what I am good at	◯No ◯Sometimes ◯Yes
22. I participate in religious activities (such as church, mosque)	◯No ◯Sometimes ◯Yes
23. I think it is important to help out in my community	◯No ◯Sometimes ◯Yes
24. I feel safe when I am with my family	◯No ◯Sometimes ◯Yes
25. I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)	◯No ◯Sometimes ◯Yes
26. I like the way my family celebrates things (like holidays or special occasions)	◯No ◯Sometimes ◯Yes
27. I like the way my community celebrates things (like holidays, festivals)	◯No ◯Sometimes ◯Yes
28. I am proud to be a citizen of South Africa.	◯No ◯Sometimes ◯Yes
29. Young people are valued in my community.	◯No ◯Sometimes ◯Yes
30. I feel getting HIV is unavoidable, and there is not much I can do to prevent it.	◯No ◯Sometimes ◯Yes
31. I am confident that I can protect myself and/ my partner from falling pregnant.	◯No ◯Sometimes ◯Yes
32. I have people my own age whom I admire/look up to.	◯No ◯Sometimes ◯Yes
33. I have people who are older than me whom I admire/look up to.	◯No ◯Sometimes ◯Yes
34. People in my culture respect women.	◯No ◯Sometimes ◯Yes
35. When bad things happen, I blame myself.	◯No ◯Sometimes ◯Yes

All about the future: This last section asks about your plans for the future, your intentions and your life goals. Even if you are not sexually active right now, please PRETEND as if you were.

	Agree	Not Sure	Disagree
1. I plan to use condoms every time I have sex in the next six months.			
2. If I have sex in the next six months, I will talk to my partner about using condoms.			
3. If I have sex in the next six months, I will refuse to have sex if a condom is not available.			
4. If I am drinking, I plan to use condoms every time I have sex in the next six months.			
5. If I am with an older partner, I plan to use condoms every time I have sex.			
6. When I have a sexual partner, I plan to be faithful and have sex with only that person.			
7. I plan to abstain from sex in the next six months.			
8. I plan to go to the clinic to collect my contraception/family planning if required.			
9. I will get an HIV test every year.			
10. I will talk freely to the nurses and healthcare workers who care for me at clinic for my sexual and reproductive health needs.			
11. I will attend the clinic if I have any symptoms of a Sexually Transmitted Infection (STI).			
12. I will not pressurize my boyfriend or girlfriend to have sex without a condom in the next six months.			
13. I will bring condoms with me when I plan to have sex.			
14. I will not threaten to abuse or hit my partner.			
15. I plan to finish high school.			
16. I know what I want to be when I grow up.			
17. I have plans to attend varsity/technikon after high school.			
18. If my partner or I fell pregnant, I would still finish high school.			
19. I have goals in life.			
20. I plan to succeed in life.			
21. I would like to have a family of my own someday.			
22. I can picture what my future will be like 10 years from now.			
23. There are opportunities for me after high school.			
24. I have dreams for my future.			

Tell us what you think! Please share with us your suggestions to improve health services and support for youth. Any feedback, final thoughts or comments in this section is appreciated:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking this survey! You are a star! If you have any questions or concerns, please see your Research Assistant or Survey Facilitator.

Isaveyi yengcaciso yokwandlalela ukuqalisa uPhononongo (Baseline Survey) kuLutsha naBantwana abafikisayo abaneminyaka yobudala eyi-15 nangaphezulu

Intshayelelo

Molo! Isikolo sakho sithatha inxaxheba kwiphulo lokuphucula iinkonzo zezempilo ezijolise kulutsha eMpuma Koloni. Le saveyi iqhutywa yimibutho engekho phantsi kukarhulumente (NGO) ebizwa i-Health Focus and the Enhancing Care Foundation, isebenzisana ne-Eastern Cape Department of Health. Sifuna ukukumema ukuba uthathe inxaxheba kule saveyi yokuqonda ngeembono zakho namava eenkonzo zezempilo owazifumanayo njengomntu omtsha, kwanokuqonda ngokuba zeziphi na iimfuno zakho nezinto ozithandayo ngokumalunga neenkonzo zezempilo ezimalunga nezesini nokufumana abantwana.

Le saveyi iya kuthatha malunga neyure enye (1) ukugqitywa. Unokwala ukuthatha inxaxheba nangaliphi na ixesha, okanye wale ukuphendula nayiphi na imibuzo ekwenza uzive ungonwabanga. Ukukhetha ukungathathi nxaxheba okanye ukwala ukuphendula nawuphi na umbuzo akuyi kukuchaphazela nangayiphi na indlela.

Kucelwa unyaniseke ngeempendulo zakho. Sifuna ukuphucula iinkonzo zezempilo ngokungaphezulu, kodwa akukho nto sinokuyenza ngaphandle kolutsha! Siya kufuna! Inkcazo yakho ngokuqhubekayo ibalulekile ekwenzeni le projekthi ibe yimpumelelo. Iimpendulo zakho akuyi kwabelwana ngazo naye nabani na esikolweni okanye ekhaya yaye igama lakho liya kuhlala liyimfihlo ngokuyingqongqo. Igama lakho aliyi kuvela kwisaveyi. Ukuba uyavuma ukuthatha inxaxeba, kucelwa usayine isivumelwano (assent) kwifom eyahlukileyo. Abazali bakho okanye abanonopheli bakho sele bevumile ukuba uthathe inxaxheba.

Imiyalelo: Wakuba uqalile kwisaveyi, kucelwa uthikishe okanye ubiyele zonke iimpendulo ozinikiweyo. Kwimpendulo ozibhalayo, kucelwa ubhale ngokucacileyo naNGOONOBUMBA ABAKHULU.

Qaphela Mququzeleli: Uyacelwa uzalise ifom ngokwahlukeneyo kwimibuzo kwangaphambi kokuba uyingenise le saveyi. Zalisa imibuzo 1 a-f emva kokuvuma komthathi-nxaxheba ukubuzwa imibuzo yodliwano-ndlebe naphambi kokuba udliwano-ndlebe luqale. Zalisa imibuzo 2-3 emva kokuphela kwesaveyi.

1.	a) I-ID yomthathi-nxaxheba kuPhononongo (AMANANI AMA-5)	____ ____ - ___ ___ ___
	b) Isithilana (Nyandeni/ Umzimvubu)	
	c) Isixeko/Idolophu/**I**lali	
	d) Igama lesikolo	
	e) Umhla wesaveyi	
	f) Igama loMququzeleli	
2.	Zithini iziphumo zesaveyi?	☐ Igqityiwe ☐ Igqitywe ngokungaphelelanga ☐ Ayigqitywanga Nika isizathu sokungagitywa kwayo/ sokugqitywa kwayo ngokungaphelelanga: _____
3.	IINGONGOMA EZIBHALIWEYO:	

ISAVEYI YENGCACISO YOKWANDLALELA UKUQALISA UPHONONONGO KULUTSHA: Iprojekthi yokuQalisa kwe-AYFS

Konke ngawe: Iseti yemibuzo elandelayo ikubuza ngawe, apho uvela khona, nokuba ungazichaza njani na wena siqu. Uyacelwa ukhumbule ukuba zonke iimpendulo zakho ziyimfihlo.

1. Uneminyaka emingaphi ubudala? _____ iminyaka ubudala

2. Sesiphi isini sakho?
   - ❑ Indoda
   - ❑ Ibhinqa
   - ❑ Okunye

3. Ingaba usesesikolweni?
   - ☐ Ewe
   - ☐ Hayi Ukuba nguHayi, uyacelwa uxele leliphi ibanga oligqibileyo: _____

4. Ukweliphi ibakala (grade) ngoku?
   - ❑ Ibanga 9
   - ❑ Ibanga 10
   - ❑ Ibanga 11
   - ❑ Ibanga 12

5. Wakha wangaliphumeleli ibakala?
   - ❑ Ewe
   - ❑ Hayi

6. Ungazichaza njani wena ngeyona ndlela igqibeleleyo?
   - ☐ Umntu omnyama--umZulu
   - ☐ Umntu omnyama --UmXhosa
   - ☐ Umntu omnyama-- umSuthu
   - ☐ Umntu omyama- Olunye uhlanga:_____
   - ☐ Indiya
   - ☐ UngoweBala
   - ☐ OMhlophe
   - ☐ Okunye
   - ☐ Ndikhetha ukungaphenduli

7. Loluphi ulwimi lwakho lwasekhaya? _____

8. Uhlala phi?
   - ❑ Idolophu
   - ❑ Indawo esemaphandleni

9. Ingaba bangaphi abantu abahlala endlwini/ekhayeni lakho? _____

10. Ingaba uqeshiwe ngoku (kubandakanywa nokuziqesha ngokwakho)?
    - ❑ Ewe
    - ❑ Hayi

11. Ingaba unayo iselula?
    - ❑ Ewe, ndineselula yam eyi-SmartPhone *(ifowuni enakho ukuthatha imifanekiso nenako ukukhonektha ku-intanethi umz. iPhone, Samsung)*
    - ❑ Ewe, ndinayo iselula yam *(ifowuni engathathi mifanekiso kodwa enako ukufumana iSMS/iitheksti - umz.Nokia)*
    - ❑ Ewe, ndisebenzisa iselula yabazali bam okanye eyomhlobo wam
    - ❑ Hayi , andikwazi ukufumana nayiphi na iselula.

12. Ngamanye amaxesha abantwana abanako ukutya okwaneleyo ekhayeni labo. *(Uyacelwa uzalise kwinani kwimpendulo nganye.)*

a) Zingaphi iintsuku **kwezi ntsuku ziyi-7 zidlulileyo** ongakhange ube nako ngazo ukutya okwaneleyo ekhayeni lakho? _____

b) **Kwezi ntsuku zisi-7 zidlulileyo**, zingaphi iintsuku okhe waya kulala ngazo ulambile? _____

c) **Kwezi ntsuku zisi-7 zidlulileyo**, zingaphi iintsuku okhe waya ngazo esikolweni ungasityanga isidlo sakusasa? _____

d) **Kwezi nsuku zisi-7 zidlulileyo,** zingaphi iintsuku okhe wafumana ngazo ukutya kwiskim sokutyisa abafundi sesikolo? _____

13. **Kwezi nyanga zintandathu zidlulileyo, ngamaxa amangaphi**

a)	Ukhe wasela isiselo esinxilisayo kwakanye ubuncinane?		
◯ Zange	◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki	◯ Qho ngeveki
◯ Yonke imihla			
b)	Ingaba usela ngaphezu kwesinye isiselo esinxilisayo kwangolo suku lunye?		
◯ Zange	◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki	◯ Qho ngeveki
◯ Yonke imihla			
c)	Ukhe wasebenzisa intsangu okanye imarijuana?		
◯ Zange	◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki	◯ Qho ngeveki
◯ Yonke imihla			
d)	Ukhe wafunxa iglue okanye ipetroli?		
◯ Zange	◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki	◯ Qho ngeveki
◯ Yonke imihla			
e)	Ingaba wayisebenzisa i-tik?		
◯ Zange	◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki	◯ Qho ngeveki
◯ Yonke imihla			
f)	Ingaba wayisebenzisa i-heroin?		
◯ Zange	◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki	◯ Qho ngeveki
◯ Yonke imihla			
g)	Wakha wayitshaya isigarethi?		
◯ Zange	◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki	◯ Qho ngeveki
◯ Yonke imihla			

h)	Ukhe wasebenzisa ezinye iziyobisi ezingekho mthethweni (umz., i-Wonga)?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
i)	Ingaba wakha wabandakanyeka kumlo (ekhaya, esikolweni okanye kwindawo ohlala kuyo)?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
j)	Wakha waba into ethile okanye wathatha into komnye umntu ngaphandle kwemvume?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
k)	Ingaba wakha wabangela umonakalo kwiprophathi ngenjongo?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
l)	Ingaba wakha wabona umntu ebethwa esikolweni?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
m)	Ingaba wakha wabona umntu ebethwa ekhaya?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
n)	Ingaba ukhe wabona umntu othile ehlatywa, edutyulwa okanye ebulewe kwindawo ohlala kuyo?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
o)	Ngamaxa amangaphi umntu othile **esikolweni** ekhe wakoyikisa ngesixhobo (oko kukuthi iphanga, imela okanye umpu)?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
p)	Ngamaxa amangaphi umntu othile **endaweni ohlala kuyo** ekhe wakoyikisa ngesixhobo (oko kukuthi iphanga, imela okanye umpu)?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
q)	Ngamaxa amangaphi umntu othile **esikolweni** eye wakuthuka okanye waphoxisa ngawe phambi kwabanye abantu?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
r)	Ngamaxa amangaphi okhe wabethwa ngawo emzimbeni okanye wohlwaywa **ngutitshala esikolweni?**
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	
s)	Ngamaxa amangaphi okhe weva ngathi **utitshala** wayekuncokolisa okanye ekuphatha-phatha kumalungu ezesondo?
◯ Zange ◯ Kanye okanye kabini	◯ Qho ngenyanga, kodwa akwenzeki qho ngeveki ◯ Qho ngeveki
◯ Yonke imihla	

Konke ngempilo yakho: Le seti ilandelayo yemibuzo ikubuza ngempilo yakho ngokubanzi, izenzo zakho zezesondo naloo nto uyenzayo ukuzigcina wena neqabane lakho ninempilo. Unokuyifumana eminye imibuzo ingakuphathi kakuhle. Zonke iimpendulo ziyimfihlo. Uyacelwa unyaniseke ukwenzela ukuba siqonde ukuba yeyiphi na imiba ebalulekileyo kwimpilo yakho.

1. Ubuneminyaka emingaphi xa wawusabelana ngesondo okokuqala ngqa?

   - ❑ _____iminyaka ubudala
   - ❑ Ayifanelekanga. Azange ndabelana ngesondo.

2. Ithuba lokuqala ngqa usabelana ngesondo, kwaku:
   - ❑ Yinto endandiyifuna.
   - ❑ Yinto endandingayifuni.
   - ❑ Yinto endanyanzelwa ukuba ndiyenze ndingafuni.
   - ❑ Ayifanelekanga: Azange ndabelana ngesondo.

3. Bangaphi abantu owakha wabelana nabo ngesondo ebomini wakho? *(Ukuba zange wabelana ngesondo, uyacelwa ubhale ku-'0'.)*_____
   - ❑ Andilikhumbuli elona nani kanye
   - ❑ Ndikhetha ukungaphenduli.

4. Ingaba ngoku uyathandana?
   - ❑ Ewe
   - ❑ Hayi

5. Ingaba ngoku uyabelana ngesondo (ukhe wabelana ngesondo kwiinyanga ezintandathu ezidlulileyo)?
   - ❑ Ewe
   - ❑ Hayi

6. Leliphi ixesha lokugqibela lokwabelana ngesondo?
   - ❑ Kwiveki edlulileyo
   - ❑ Kwinyanga edlulileyo
   - ❑ Kwiinyanga eziyi-1-2 ezidlulileyo
   - ❑ Kwiinyanga eziyi-3-4 ezidlulileyo
   - ❑ Kwiinyanga eziyi-5-6 ezidlulileyo
   - ❑ Ngaphezu kweenyanga ezintandathu ezidlulileyo
   - ❑ Ayifanelekanga. Azange ndabelana ngesondo.

7. Kwezi zinyanga zintandathu zidlulileyo, ngamaxa amangaphi wena neqabane lakho nikhe nasebenzisa ikhondom xa nanisabelana ngesondo?
   - ❑ Zange
   - ❑ Kunqabile
   - ❑ Ngamanye amaxesha /ihafu yexesha
   - ❑ Amaxesha amaninzi
   - ❑ Ubuninzi bexesha
   - ❑ Lonke ixesha
   - ❑ N/A – Azange ndabelane ngesondo kwezi nyanga zintandathu zidlulileyo.

8. Wakha wabelana ngesondo nomnye umntu ukwenzela ukuba uFUMANE imali okanye izinto ezithile, ezifana neselula, i-airtime, iimpahla, njalo-njalo?
   - ❑ Ewe
   - ❑ Hayi
   - ❑ Ayifanelekanga. Azange ndabelana ngesondo.

9. Ingaba wakha WANIKA omnye umntu izipho ezifana ne-airtime, ukuze abelane nawe ngesondo?
   - ❑ Ewe
   - ❑ Hayi
   - ❑ Ayifanelekanga. Azange ndabelana ngesondo.

10. Kwisangqa sabahlobo abasondeleyo kuwe, ingaba kukho omnye kubo okhe wakhulelwa (ebengenanjongo yoko) apha kulo nyaka uphelileyo?
    - ❑ Ewe
    - ❑ Hayi

11. Kumantombazana, wakha wakhulelwa?
    - ❑ Ewe
    - ❑ Ukuba nguHAYI, TSIBA uye kuMbuzo 13

    Kumakhwenkwe, ingaba kukho mntu wakha wamenza wakhulelwa?
    - ❑ Ewe
    - ❑ Ukuba nguHAYI, TSIBA uye kuMbuzo 13.

12. Ukuba ngu-ewe, ingaba unabo abantwana?
    - ❑ Ewe — Ukuba ngu-ewe, bangaphi abantwana onabo? _____
    - ❑ Hayi — Ukuba nguhayi, uyacelwa ukuba ucacise kwenzeka ntoni:
      - Ukuphuma kwesisu
      - Ukusikhupha isisu/Ukuqhomfa
      - Indlela yongxamiseko yokucwangcisa nokuthintela ukukhulelwa "Ipilisi yentsasa elandela ukwabelana ngesondo"
      - Okunye: _____

13. Ingaba wakha wenzelwa Intonjane (kumantombazana) okanye Ulwaluko (kumakhwenkwe)?
    - ❑ Ewe
    - ❑ Hayi

14. Ingaba wakha wanyangelwa izigulo ezosulela ngokwabelana ngesondo [STI (sexually transmitted infection)]?
    - ❑ Ewe
    - ❑ Hayi

15. Ukuba ngu-ewe, waya phi ukufumana unyango? *(Thikisha konke okufanelekileyo).*
    a. Eklinikhi ◯Ewe ◯Hayi
    b. Kwigqirha/kwixhwele ◯Ewe ◯Hayi
    c. Kugqirha onyanga zonke izifo/kugqirha wabucala ◯Ewe ◯Hayi
    d. Okunye:_____

16. Ingaba uyanqwenela ukukhulelwa (okanye wenze likhulelwe iqabane lakho) kwezi nyanga zintandathu zilandelayo?
    - ❑ Ewe
    - ❑ Hayi

17. Ingaba ngoku usebenzisa izinto zocwangciso okanye zokuthintela ukufumana abantwana? (o.k.t., iikhondom, ukucwangcisa, iinaliti ezihlatywayo, njalo-njalo.)?
    - ❑ Ewe
    - ❑ Hayi

18. Ukuba ngu-ewe uyacelwa ucacise indlela (iindlela) ozisebenzisayo ukuthintela ukukhulelwa (thikisha u-Ewe okanye uHayi kuzo zonke ezifanelekileyo):
    - ❑ I-IUD ◯Ewe ◯Hayi
    - ❑ Implanon ◯Ewe ◯Hayi
    - ❑ I- Depo/Nuristerate ehlwatywayo ◯Ewe ◯Hayi
    - ❑ Ichiza locwangciso elityiwayo- o.k.t., ipilisi ◯Ewe ◯Hayi
    - ❑ Ipilisi yakusasa yocwangciso longxamiseko - 'emva kokubelana ngesondo ngezolo' ◯Ewe ◯Hayi
    - ❑ Iikhondom ◯Ewe ◯Hayi
    - ❑ Iikhondom zabasetyhini ◯Ewe ◯Hayi
    - ❑ Indlela yokukhupha ilungu lobudoda (ukulikhupha phambi kokuchama [ejaculation]) ◯Ewe ◯Hayi
    - ❑ Okunye: _____

19. Uya amaxesha amangaphi eklinikhi ukuya kufumana iipilisi/ amachiza/izinto zocwangciso zokuthintela ukufumana abantwana?
    - ❑ Qho ngenyanga
    - ❑ Qho kwiinyanga ezintantu
    - ❑ Qho kwiinyanga ezintandathu
    - ❑ Qho ngonyaka
    - ❑ Zange
    - ❑ Okunye:_____

20. Uqhele ukuzifumana phi iikhondom*? (thikisha konke okufanelekileyo).*
    - ❑ Eklinikhi ◯Ewe ◯Hayi
    - ❑ Esikolweni ◯Ewe ◯Hayi
    - ❑ Etakhishophu/espaza ◯Ewe ◯Hayi
    - ❑ Kwithili kwivenkile yokwenza igrosari/esuphamakethi/ekhemesti ◯Ewe ◯Hayi
    - ❑ Iqabane lam eliyindoda /eliyintombi liqhele ukuza nazo. ◯Ewe ◯Hayi
    - ❑ Okunye:_____
    - ❑ Akufanelekanga – Andisebenzisi zikhondom.

21. Uqhele ukufumana iikhondom mahala okanye uyazithenga?
    - ❑ Iikhondom ezimahala
    - ❑ Ukuthenga iikhondom
    - ❑ Zozibini
    - ❑ Akufanelekanga – Andisebenzisi zikhondom.

22. Ukhetha ukuzifumana phi iikhondom?
    - ❑ Eklinikhi ◯Ewe ◯Hayi
    - ❑ Esikolweni ◯Ewe ◯Hayi
    - ❑ Etakhishophu/espaza ◯Ewe ◯Hayi
    - ❑ Kwithili kwivenkile yokwenza igrosari/esuphamakethi/ekhemesti ◯Ewe ◯Hayi
    - ❑ Okunye:_____

23. Ingaba wakhe walwenza uvavanyo lwe-HIV?
    - ❑ Ewe
    - ❑ Hayi

24. Ukuba ngu-ewe, kwakunini ukwenza kwakho uvavanyo lwe-HIV lokugqibela?
    - ❑ Kwinyanga edlulileyo
    - ❑ Phakathi kweenyanga eziyi-1-3 ezidlulileyo
    - ❑ Phakathi kweenyanga eziyi-4-6 ezidlulileyo
    - ❑ Phakathi kweenyanga eziyi-7-12 ezidlulileyo
    - ❑ Ngaphezu konyaka omnye odlulileyo
    - ❑ Akufanelekanga – Azange ndenze uvavanyo lwe-HIV.

25. Ukuba ngu-ewe, ingaba wenziwa phi uvavanyo lwe-HIV?
    - ❑ Ekhaya
    - ❑ Ekliniki
    - ❑ Esikolweni
    - ❑ Iphulo/Iyunithi yeNkonzo eziHambahambayo (mobile)
    - ❑ Okunye_____
    - ❑ Akufanelekanga – Azange ndenze uvavanyo lwe-HIV.

26. Ukuba ngu-ewe, ingaba yayisithini imeko yakho nge-HIV?
    - ❑ Ndandine-HIV (HIV+)
    - ❑ Ndandingenayo i-HIV
    - ❑ Andizifumananga iziphumo
    - ❑ Ndikhetha ukungaphenduli
    - ❑ Akufanelekanga – Azange ndenze uvavanyo lwe-HIV.

27. Ukuba ngu-Hayi, sasisithini isizathu sakho SOKUNGENZI uvavanyo lwe-HIV?
    _____

Ngamanye amaxesha xa uthandana, izinto ziba nzima. Uyacelwa ukuba usazise ukuba eminye imiba kule ikhe yenzeka kuwe kwezi nyanga zintandathu zidlulileyo.

28. Kwezi nyanga ziyi-6 zidlulileyo ngamaxa amangaphi iqabane lakho eliyindoda okanye eliyintombazana lithe lakuthuka, okanye lakuphoxa okanye lakwenza wacinga ukuba ungumntu ombi?
    ◯Kanye ◯Ngaphezu kwakanye ◯Zange ◯Akwenzekanga: Azange ndaba nendoda/nentombazana endithandana nayo kwezi nyanga ziyi-6 zidlulileyo.

29. Kwezi nyanga ziyi-6 zidlulileyo, ngamaxa amangaphi **indoda okanye intombazana othandana nayo** eyakoyikisa ngokukwenzakalisa?
    ◯Kanye ◯Ngaphezu kwakanye ◯Zange ◯Akwenzekanga: Azange ndaba nendoda/nentombazana endithandana nayo kwezi nyanga ziyi-6 zidlulileyo.

30. Kwezi nyanga ziyi-6 zidlulileyo, ngamaxa amangaphi **indoda okanye intombazana othandana nayo** ikhe yakubetha, yakutyhala, yakukhaba, yakukrwitsha okanye yakutshisa?
    ◯Kanye ◯Ngaphezu kwakanye ◯Zange ◯Akwenzekanga: Azange ndaba nendoda/nentombazana endithandana nayo kwezi nyanga ziyi-6 zidlulileyo.

31. Kwezi nyanga ziyi-6 zidlulileyo, ngamaxa amangaphi **indoda okanye intombazana othandana nayo** ikunyanzele ukuba wabelane naye ngesondo?
    ◯Kanye ◯Ngaphezu kwakanye ◯Zange ◯Akwenzekanga: Azange ndaba nendoda/nentombazana endithandana nayo kwezi nyanga ziyi-6 zidlulileyo.

32. Kwezi nyanga ziyi-6 zidlulileyo, ngamaxa amangaphi **indoda okanye intombazana othandana nayo** ikunyanzele ukuba wabelane naye ngesondo?
    ◯Kanye ◯Ngaphezu kwakanye ◯Zange ◯Akwenzekanga: Azange ndaba nendoda/nentombazana endithandana nayo kwezi nyanga ziyi-6 zidlulileyo.

33. Kwezi nyanga ziyi-6 zidlulileyo, ngamaxa amangaphi owoyikisa ngawo ukwenzakalisa **indoda okanye intombazana othandana nayo**?

◯Kanye ◯Ngaphezu kwakanye ◯Zange ◯Akwenzekanga: Azange ndaba nendoda/nentombazana endithandana nayo kwezi nyanga ziyi-6 zidlulileyo.

Konke ngendawo ohlala kuyo: Eli candelo libuza malunga neenkonzo zezempilo ezifumanekayo kuwe kwindawo ohlala kuyo. Oku kunokubandakanya iinkonzo ozifumana eklinikhi, kwiziko lolutsha nasesikolweni.

34. Ngamaxa amangaphi oya ngawo eklinikhi kwindawo ohlala kuyo?
    - ❑ Xa kuyimfuneko - xa ndiziva ndigula.
    - ❑ Qho ngenyanga ukuya kuthatha iipilisi zokucwangcisa nokuthintela ukukhulelwa okanye amayeza
    - ❑ Qho ngenyanga ezintathu ukuya kuthatha iipilisi zokucwangcisa nokuthintela ukukhulelwa okanye amayeza
    - ❑ Qho kwiinyanga ezintandathu ukuya kunyaka ukuya kumathuba otyelelo okutshekishwa kwesiqhelo, njalo-njalo.

35. Lalinini ixesha lokugqibela wawuye eklinikhi?
    - ❑ Kwiveki edlulileyo
    - ❑ Kwinyanga edlulileyo
    - ❑ Kwinyanga ezintathu ezidlulileyo
    - ❑ Kwinyanga ezintandathu ezidlulileyo
    - ❑ Kunyaka odlulileyo
    - ❑ Ngaphezu konyaka owadlulayo

36. **KUBHEKISWA KUMANTOMBAZANA KUPHELA.** Ingaba wakha wafumana iinkonzo zokucwangcisa nokuthintela ukukhulelwa kwiklinikhi yengingqi yakho?
- ❑ Ewe
- ❑ Hayi

37. Wakha wafumana i-Implanon – isixhobo zokucwangcisa nokuthintela ukukhulelwa esifakwa phantsi kolusu lwakho?
- ❑ Ewe
- ❑ Hayi

38. Wakha wacela ukuba i-Implanon ikhutshwe, phambi kokuba kufike ixesha lokukhutshwa kwayo?
- ❑ Ewe
- ❑ Hayi

Ukuba ngu-ewe, sasiyintoni isizathu sokuba ikhutshwe?_____

39. Ixesha lokugqibela uye eklinikhi , yayisesiphi isizathu (izizathu) esiphambili sokuya kwakho eklinikhi? *(Nceda uthikishe nakuphi na okufanelekileyo).*
    - ❑ Ukucwangcisa nokuthintela ukukhulelwa
        - ○ Amachiza atyiwayo – ipilisi, iipilisi
        - ○ Iikhondom
        - ○ Aziinaliti ezihlatywayo -i-Depo
        - ○ I-IUD
        - ○ I-Hormonal Implant - Implanon
    - ❑ Indlela yongxamiseko yokucwangcisa nokuthintela ukukhulelwa (I-IUD okanye ipilisi)
    - ❑ Ukungaphili (umkhuhlane, ukukhohlela, iflu)
    - ❑ Ukunikwa iingcebiso nokuvavanyelwa i-HIV (HCT/VCT)
    - ❑ Ukuqalisa amayeza azii-ART okanye ukuthatha iipilisi
    - ❑ Ukukhusela kwisifo kwasemva kokuvezeka [Post exposure prophylaxis (PEP)]
    - ❑ Ukuhlolelwa izigulo ezosulela ngokwabelana ngezesondo (STI) nonyango
    - ❑ Uvavanyo lokukhulelwa
    - ❑ Ukunonotshelwa kwabakhulelweyo
    - ❑ Ukoluka esibhedlele kwamadoda /ukuthunyelwa kwawo ukuya kolukela esibhedlele
    - ❑ Enye (cacisa)_____

40. Ixesha lokugqibela owaya ngalo eklinikhi, ingaba wafumana zonke iinkonzo nonyango owawuzizele?
    - ❑ Ewe
    - ❑ Hayi
    - ❑ Andikhumbuli.

41. Ixesha lokugqibela owaya ngalo eklinikhi, waphathwa ngentlonipho?
    - ❑ Ewe
    - ❑ Hayi
    - ❑ Andikhumbuli.

42. Ixesha lokugqibela owaya ngalo eklinikhi, wabanako ukuhlangana nonompilo bucala?
    - ❑ Ewe
    - ❑ Hayi
    - ❑ Andikhumbuli.

43. Ixesha lokugqibela owaya ngalo eklinikhi, wangxoliswa ngabanye abasebenzi - o.k.t., amanesi, abacebisi, oomabhalana?
    - ❑ Ewe
    - ❑ Hayi
    - ❑ Andikhumbuli.

44. Ixesha lokugqibela owaya ngalo eklinikhi, ingaba wacinga ukuba yimfihlo kweenkcukacha zakho kugcinwe kunjalo (o.k.t., isizathu sokuya kwakho eklinikhi naso sagcinwa siyimfihlo, yaye oko kuphakathi kwakho nonompilo wakho kuphela)?
    - ❑ Ewe
    - ❑ Hayi
    - ❑ Andikhumbuli.

45. Walinda ixesha elingakanani ukufumana iinkonzo eklinikhi?
    - ❑ Ngaphansi kweyure e-1
    - ❑ Iiyure ezi-1-2
    - ❑ Iiyure ezi-3-4
    - ❑ Ngaphezu kweeyure ezi-4
    - ❑ Andikhumbuli
46. Ingaba eli xesha lokulinda lalamkelekile kuwe?
    - ❑ Ewe
    - ❑ Hayi
    - ❑ Andikhumbuli

47. Ngokwento yonke, ungawubeka kweliphi iqondo umgangatho weenkonzo ozifumana eklinikhi, apho u-1 athetha embi kakhulu aze u-5 athethe ezilunge kakhulu? *(Nceda uthikishe enye.)*
    - ☐ 1. Imbi kakhulu
    - ☐ 2. Imbi
    - ☐ 3. Ufuna ukuphuculwa
    - ☐ 4. Ulungile
    - ☐ 5. Ulunge kakhulu

48. Ngokwento yonke, waneliseke kangakanani ngamanyathelo athathwayo ukubonana nabezonyango bucala nangokuyimfihlo apho u-1 athetha Andanelisekanga kwaphela aze u-5 abe ngu-Ndaneliseke kakhulu? *(Nceda uthikishe enye.)*
    - ☐ 1. Andanelisekanga Kwaphela Tu
    - ☐ 2. Ndanelisekile Noko
    - ☐ 3. Ufuna ukuphuculwa
    - ☐ 4. Ndanelisekile
    - ☐ 5. Ndaneliseke kakhulu

49. Ngokwento yonke, baluncedo kangakanani abasebenzi bononophelo lwezonyango abakunonophelayo eklinikhi, apho u-1 engu-Abaloncedo Kwaphela aze u-5 abe ngu-BaluNcedo kaKhulu? *(Nceda uthikishe enye.)*
    - ☐ 1. Abaloncedo kwaphela
    - ☐ 2. Bebeluncedo noko, kodwa abazange bazifezekise zonke iimfuno zam
    - ☐ 3. Lufuna ukuphuculwa uncedo
    - ☐ 4. Iluncedo
    - ☐ 5. Baluncedo kakhulu

50. Ingaba kukuthatha ixesha elingakanani ukuya/ukufika eklinikhi?
    - ☐ Imizuzu eyi-0-30
    - ☐ Imizuzu eyi-31-60
    - ☐ > kweyure e-1

51. Ingaba kufuneka uthathe ixesha ungabikho emsebenzini /esikolweni /ungayenzi imisebenzi yasekhaya ukuze uze eklinikhi?
    - ❑ Ewe
    - ❑ Hayi

52. Ngokwesiqhelo, uya njani eklinikhi?
    - ❑ Uhamba ngeenyawo
    - ❑ Ngezithuthi zikawonke-wonke - uthatha iteksi/ibhasi
    - ❑ Ngemoto – Ukukhweliswa ngumhlobo wakho /uyaziqhubela

53. Ubhatala malini ukuya eklinikhi (ukuya kuphela)?
    - ☐ _____iiRandi
    - ☐ Akukho nto

54. Ngokuqhelekileyo, kulula kangakanani kuwe ukufumana iinkonzo eklinikhi?
    - ❑ Kulula
    - ❑ Kunzima noko
    - ❑ Kube Nzima Kakhulu

55. Ingaba akho amanesi okanye oonompilo abafumanekayo onako ukubatyelela esikolweni?
    - ❑ Ewe
    - ❑ Hayi

56. Ingaba zikhona iinkonzo zezempilo ezibonelelwa esikolweni?
    - ❑ Ewe
    - ❑ Hayi

57. Ukuba ngu-ewe, nceda udwelise zonke iinkonzo ebezifumaneka esikolweni sakho kwezi nyanga zintandathu zidlulileyo (*Thikisha zonke ozaziyo*):

❑ Ukukhutshwa kweentshulube	◯Ewe ◯Hayi
❑ Uvavanyo lwamehlo kunye nokuva	◯Ewe ◯Hayi
❑ Uvavanyo lwe-HIV	◯Ewe ◯Hayi
❑ Ucwangciso-ntsapho	◯Ewe ◯Hayi
❑ Ukuhlolelwa izigulo ezosulela ngokwabelana ngezesondo (STI)	◯Ewe ◯Hayi
❑ Iinkonzo zokondliwa	◯Ewe ◯Hayi
❑ Uvavanyo lokukhulelwa	◯Ewe ◯Hayi
❑ Iikhondom	◯Ewe ◯Hayi
❑ Iikhondom zabasetyhini	◯Ewe ◯Hayi
❑ Imfundo yezempilo	◯Ewe ◯Hayi
❑ Izakhono zokuphila ubomi	◯Ewe ◯Hayi
❑ Okunye:_____	

KUBHEKISWA KUMAKHWENKWE: Kwiinyanga ezintandathu ezidlulileyo, ingaba wakha wafumana ezi nkonzo zilandelayo EKLINIKHI?

Inkonzo	**Ewe okanye Hayi**	**Ukuba ngu-EWE, ngamaxa amangaphi ofumana ngawo inkonzo kwezi nyanga ziyi-6 zidlulileyo?**
KUBHEKISWA KUMAKHWENKWE: Ukucwangcisa nokuthintela ukukhulelwa	→	
❑ Iikhondom	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
❑ Iikhondom zabafazi.	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukolukela eSibhedlele kwamaKhwenkwe [Male Medical Circumcision (MMC)] okanye ukuthunyelwa khona ukuya koluka	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukunikwa iingcebiso nokuvavanyelwa i-HIV (HCT/VCT)	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukuqalisa amayeza azii-ART okanye ukuthatha iipilisi	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukuhlolelwa izigulo ezosulela ngokwabelana ngezesondo (STI) nonyango	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Iinkxalabo ngezempilo eziqhelekileyo - iflu, umenzakalo, ukuziva ugula	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Izigulo zinganyangekiyo	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
❑ Ukuhlolelwa i-TB/unyango	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
❑ Ukuhlolelwa isifo seswekile okanye unonophelo	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
❑ Ukuhlolwa kweqondo loxinzelelo lwegazi eliphezulu	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*

☐ Impilo ngokwasengqondweni (o.k.k.t, ukudakumba, udandatheko, njalo-njalo)	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Iinkozo eziphathelene namazinyo	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Okunye:_____ _____	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*

KUBHEKISWA KUMANTOMBAZANA KUPHELA: Kwiinyanga ezintandathu ezidlulileyo, ingaba wakha wafumana ezi nkonzo zilandelayo EKLINIKHI?

Inkonzo	**Ewe okanye Hayi**	**Ukuba ngu-EWE, ngamaxa amangaphi ofumana ngawo inkonzo kwezi nyanga ziyi-6 zidlulileyo?**
KUBHEKISWA KUMANTOMBAZANA: Ukucwangcisa nokuthintela ukukhulelwa		
☐ Amachiza okucwangcisa nokuthintela ukukhulelwa aselwayo – ipilisi.	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Aziinaliti ezihlatywayo -i-Depo	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Ukufakwa i-IUD	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Ukufakwa kulusu intongana yechiza lokucwangcisa nokuthintela ukukhulelwa (hormonal implant) - UKUFAKWA i-Implanon	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Ukufakwa kulusu intongana yechiza lokucwangcisa nokuthintela ukukhulelwa – UKUKHUTSHWA kwe-Implanon	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Iikhondom - iikhondom zamadoda.	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Iikhondom zabafazi.	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Indlela yongxamiseko yokucwangcisa nokuthintela ukukhulelwa (I-IUD okanye ipilisi)	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukukhusela kwisifo kwasemva kokuvezeka [Post exposure prophylaxis (PEP)]	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukunikwa iingcebiso nokuvavanyelwa i-HIV (HCT/VCT)	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukuqalisa amayeza azii-ART okanye ukuthatha iipilisi	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Inkonzo enxulumene noKukhutshwa kweSisu (TOP)/Ukuqhomfa	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukuhlolelwa izigulo ezosulela ngokwabelana ngezesondo (STI) nonyango	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Uvavanyo lokukhulelwa	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Ukunonotshelwa kwabakhulelweyo	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ <iiveki ezingama-20 (phambi kweeveki ezingama-20)	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*

☐ <iiveki ezingama-20 (emva kweeveki ezingama-20)	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
I-PMTCT [ukuthintelwa kokusulelwa komntwana zizigulo zikamama (prevention of maternal-child transmission)]	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Iinkxalabo ngezempilo eziqhelekileyo - iflu, umenzakalo, ukuziva ugula	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
Izigulo ezinganyangekiyo	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Ukuhlolelwa i-TB/unyango	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Ukuhlolelwa isifo seswekile okanye unonophelo	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Ukuhlolelwa uxinzelelo lwegazi oluphezulu	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Impilo ngokwasengqondweni (o.k.k.t, ukudakumba, udandatheko, njalo-njalo)	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*
☐ Iinkozo eziphathelene namazinyo	◯Ewe ◯Hayi	◯Kanye okanye kabini ◯Amaxesha ama-3-5 ◯ Amaxesha ama-6 okanye ngaphezulu*

* Qho ngenyanga – ukufumana iinkonzo qho ngenyanga okanye ngaphezulu.

58. Ukuba unengxaki emalunga nezempilo yokubanako ukufumana abantwana /emalunga nokwabelana ngesondo, imibuzo okanye imiba ethile, UQHELE ukuya phi ukufumana uncedo okanye iingcebiso? (Thikisha konke okufanelekileyo)

☐ Andikhe ndifune uncedo okanye iingcebiso – ndiyigcina kum ngaphakathi.	◯Ewe ◯Hayi
☐ Abazali	◯Ewe ◯Hayi
☐ Amanye amalungu osapho – o.k.t., abantakwenu, u-anti, umalume	◯Ewe ◯Hayi
☐ Ootitshala	◯Ewe ◯Hayi
☐ Abahlobo	◯Ewe ◯Hayi
☐ Iklinikhi yasekuhlaleni	◯Ewe ◯Hayi
☐ UNontlalontle okanye uMcebisi	◯Ewe ◯Hayi
☐ Umfundisi onguntangandini	◯Ewe ◯Hayi
☐ Igqirha lesiNtu	◯Ewe ◯Hayi
☐ Umfundisi weCawa	◯Ewe ◯Hayi
☐ Iinkokheli zasekuhlaleni	◯Ewe ◯Hayi
☐ Okunye: Cacisa_____	◯Ewe ◯Hayi

59. Ngaphandle kwalapho UQHELE ukufumana khona uncedo okanye iingcebiso, yintoni enye eyinkxaso okanye uncedo olufumana malunga nempilo yakho yezesondo?

_____
_____
_____
_____

60. Ubungakhetha ukulufumana phi olu ncedo nenkxaso? (Thikisha u-EWE kuzo zonke ezifanelekileyo; ukuba akunjalo, thikisha u-HAYI).

☐ Ekhaya	◯Ewe ◯Hayi
☐ Esikolweni	◯Ewe ◯Hayi
☐ Eklinikhi	◯Ewe ◯Hayi
☐ Iyunithi eHambahambayo (mobile)	◯Ewe ◯Hayi
☐ Kwiziko lolutsha /kwiziko loluntu ekuhlaleni	◯Ewe ◯Hayi
☐ Ecaweni	◯Ewe ◯Hayi
☐ Okunye: _____	

61. Ungakhetha ukuyifumana phi ubukhulu becala ingcaciso nge-HIV, ezesondo nangempilo engokufumana abantwana? (Thikisha konke okufanelekileyo).

☐ Kwifowuni yam	◯Ewe ◯Hayi
☐ Kwi-Intanethi	◯Ewe ◯Hayi
☐ Kwithivi (TV)	◯Ewe ◯Hayi
☐ KwiRediyo	◯Ewe ◯Hayi
☐ Ekhaya	◯Ewe ◯Hayi
☐ Esikolweni	◯Ewe ◯Hayi
☐ Eklinikhi	◯Ewe ◯Hayi
☐ Kwiziko lolutsha /kwiziko loluntu ekuhlaleni lolutsha kuphela	◯Ewe ◯Hayi
☐ Ecaweni	◯Ewe ◯Hayi
☐ Okunye: _____	

Into ecingwa ngabantu: Icandelo elilandelayo libuza ukuba wena nabanye abantu onenkathalo ngabo nicinga ntoni na ngokwabelana ngesondo, ngezobudlelwane bokuthandana, iikhondom ne-HIV. Akukho zimpendulo zilungileyo nezingalunganga. Uyacelwa ukhethe impendulo ezikulungeleyo. Esi sixhobo singezantsi siya kukunceda ngemibuzo ebuza ukuba uYavumelana na okanye Akuvumelani nenkcazo leyo.

1. Ndivumelana Ngamandla **2. Ndiyavumelana** **3. Andiqinisekanga** **4. Andivumi** **5. Andivumelani ngamandla**

	Ndivumelana ngamandla	Ndiya-vumelana	Andiqinise kanga	Andivumelani	Andivumelani ngamandla
1. **Abahlobo** bam abananinzi bacinga ukuba ndimele ukusebenzisa ikhondom xa ndisabelana ngesondo.					
2. **Abazali /abanonopheli bam** bacinga ukuba ndimele ukusebenzisa ikhondom xa ndisabelana ngesondo.					
3. **Abantu abaninzi kwindawo endihlala kuyo** bacinga ukuba ndimele ukusebenzisa ikhondom xa ndisabelana ngesondo.					
4. **Iqabane lam eliyindoda /eliyintombi** licinga ukuba ndimele ukusebenzisa ikhondom xa ndisabelana ngesondo.					
5. Abahlobo bam abaninzi bacinga ukuba mandilinde de ndibe mdala ukuze ndabelane ngesondo.					
6. Abazali/abanonopheli bam bacinga ukuba mandilinde de ndibe mdala ukuze ndabelane ngesondo.					
7. Abahlobo bam abaninzi bacinga ukuba ukukhulelwa ndikobu budala ndikubo asiyonto ixhomisa amehlo.					
8. Abazali /abanonopheli bam bacinga ukuba amantombazana akobu budala bam abafanele ukuba bakhulelwe.					
9. Abantu abaninzi endibaziyo bakhe balwenza uvavanyo lwe-HIV.					
10. Abantu abaninzi abakhathalayo ngam bacinga ukuba ndimele ukwenza uvavanyo lwe-HIV.					

	Ndivumelana ngamandla	Ndiyavumelana	Andiqinisekanga	Andivumelani	Andivumelani ngamandla
11. Abahlobo bam bacinga ukuba kulungile ukuba amantombazana abelane ngesondo nendoda endala okanye 'u-sugar daddy', ukuba ufumana okuthile kuye ngenxa yoko (o.k.t., i-airtime, imali, iimpahla, igrosari).					
12. Abantu abaninzi endikhetha ukwabelana ngesondo nabo baneminyaka yobudala ubuncinane engaphezulu ngemihlanu kunam.					
13. Abantu abaninzi endinenkathalo ngabo bangacinga ukuba 'kungalula ukuvuma' okanye 'ukucela ukwabelana ngesondo' ukuba ndiphethe iikhondom.					
14. Ndiyakhathazeka ngokuba abanye bacinga ntoni na ngam ukuba ndiye eklinikhi ukuya kufumana iinkonzo ezithile.					
15. Abahlobo bam abaninzi bacinga ukuba kulungile ukumnyanzela umntu ukuba abelane ngesondo nokuba bathi abakufuni oko.					
16. Ukusebenzisa iikhondom kubonisa ukuba uyazihlonipha wena siqu neqabane lakho.					
17. Xa umntu enyanzelisa ukusebenzisa iikhondom, oko kubonisa ukuba ubekade enamaqabane amaninzi.					
18. Abahlobo bam abaninzi bacinga ukuba kulungile ukuba namaqabane amaninzi owabelana nawo ngesondo (o.k.t., *umakhwapheni*).					
19. Ndingaziva ndonwabile ukuthetha nonontlalontle okanye umcebisi malunga nezesondo.					
20. Ndingaziva ndonwabile ukuthetha notitshala wam ngezesondo.					
21. Ndingaziva ndonwabile ukuthetha nabazali bam ngezesondo.					
22. Ndingaziva ndonwabile ukuthetha nonesi okanye nonompilo ngezesondo.					
23. Ndingaziva ndonwabile ukuthetha nabahlobo bam ngezesondo.					
24. Ndiziva ndicalulwe ngokobuhlanga xa ndiye eklinikhi esengingqini yam.					
25. Abasebenzi kwiklinikhi yengingqi yam abazigcini iinkcukacha ezingam ziyimfihlo.					

	Ndivumelana ngamandla	Ndiyavumelana	Andiqinisekanga	Andivumelani	Andivumelani ngamandla
26. Ndiyoyika ukuthetha inyani xa ndityelele eklinikhi kuba ndisoyika ukuba babe neembono ezithile ngam.					
27. Ndonelisekile ziinkonzo endizifumanayo eklinikhi.					
28. Ndiziva ndikhuselekile eklinikhi.					
29. Ndiziva ndikhuselekile esikolweni.					
30. Iikhondom kunzima ukuzisebenzisa ukuba ubusela utywala.					
31. Ndingaziva ndikonwabele ukunyanzelisa ukusetyenziswa kwekhondom nokuba ngaba kokokuqala ngqa ndisabelana ngesondo nalo mntu.					
32. Ndingaziva ndikonwabele ukunyanzeliswa kokusetyenziswa kwekhondom, nokuba ngaba iqabane lam lidala ngokungaphezulu kum.					
33. Ndiziva ndikhuselekile ekhaya.					
34. Ndiqinisekile ukuba ndiyakwazi ukusebenzisa ikhondom ngokuchanekileyo.					
35. Ndingaziva ndiphoxekile kukuthenga iikhondom ngokwam.					

Konke nge-HIV: Ulwazi lungamandla. Kucelwa uhlele ngokubaluleka ezi nkcazo zilandelayo njengeziyinyani okanye ubuxoki.

	Yinyani	Bubuxoki	Akuqinisekanga
1. Ukuba wakhe wabelana ngezesondo kwakanye nomntu one-HIV, ungosuleleka nawe ubene-HIV.			
2. Ukuba uphuza umntu one-HIV, ungosuleleka nawe ubene-HIV.			
3. Ukuba wabelana ngezesondo ngomva ezimpundwini nomntu one-HIV ungosuleleka nawe ubene-HIV. *Makuqatshelwe: Oku kuthetha ukuba ukwabelana ngesondo apho ilungu lobudoda lingena ngemva ezimpundwini.*			
4. Umntu one-HIV angaphila ubomi obunempilo ngokupheleleyo.			
5. Inako ukunyangeka i-HIV.			
6. Unokumazi umntu one-HIV ngokumjonga nje.			
7. Xa intombazana isebenzisa iipilisi zocwangciso nokuthintela ukukhulelwa okanye inaliti yokucwangcisa, oku kuyayikhusela ngakwizifo ezosulela ngesondo (STI).			
8. I-HIV inokubangelwa kukuthakathwa.			
9. Iikhondom zithintela i-HIV nezinye izifo ezosulela ngokwabelana ngesondo (STIs)			
10. Ukungabelani ngesondo kuphela kwendlela yokuthintela ukufumana i-HIV.			
11. I-HIV inokugqithiswa ngokubolekisana ngebrashi yamazinyo okanye izinto zokupheka.			
12. I-HIV inokugqithiswa ngokwabelana ngethoyilethi kunye nomntu one-HIV.			
13. Oomama abane-HIV bangayigqithisela i-HIV kwiintsana zabo ngobisi lwebele.			
14. Oomama banako ukuyigqithisela i-HIV kumadoda.			
15. Abafana abolukileyo abanako ukosuleleka yi-HIV.			

16. Ukuba andisebenzisi khondom xa ndisabelana ngesondo, ingozi yam yokosuleleka zizifo zokwabelana ngesondo (STI) iya kuba:
◯ Isezantsi kakhulu ◯Isezantsi ◯Andiqinisekanga ◯Iphezulu ◯Iphezulu kakhulu

17. Ukuba andisebenzisi khondom xa ndisabelana ngesondo, ingozi yam yokosuleleka yi-HIV iya kuba:
◯ Isezantsi kakhulu ◯Isezantsi ◯Andiqinisekanga ◯Iphezulu ◯Iphezulu kakhulu

18. Ukuba ndosuleleka sisifo sokwabelanga ngesondo (STI), ndingakufumana oku:
◯ Isezantsi kakhulu ◯Isezantsi ◯Andiqinisekanga ◯Iphezulu ◯Iphezulu kakhulu

19. Ukuba ndine-HIV, ndingakufumana oko:
◯ Isezantsi kakhulu ◯Isezantsi ◯Andiqinisekanga ◯Iphezulu ◯Iphezulu kakhulu

20. Ukuba ndiye ndakhulelwa (kubhekiswa kumantombazana) okanye wenza omnye umntu akhulelwe (kubhekiswa kumakhwenkwe), ndingakufumana oko:
◯ Isezantsi kakhulu ◯Isezantsi ◯Andiqinisekanga ◯Iphezulu ◯Iphezulu kakhulu

Konke okumalunga noxinzelelo (stress) kwanokumelana nalo:
Njengokuba sikhula, sijongana nemiceli-mngeni (challenges) emininzi. Imibuzo elandelayo ibuza ngokuba umelana njani na noxinzelelo kwakunye nemiceli-mngeni yobomi nokuba ngubani na okuxhasayo okhoyo.

1. Ndinabo abantu endifuna ukufana nabo	◯Hayi ◯Ngamanye amaxesha ◯Ewe
2. Ndiyabelana /ndiyasebenzisana nabantu abandingqongileyo	◯Hayi ◯Ngamanye amaxesha ◯Ewe
3. Ukufumana imfundo kubalulekile kum	◯Hayi ◯Ngamanye amaxesha ◯Ewe
4. Ndiyazi ukuba ndiziphathe njani na kwiimeko ezahlukileyo (ezifana nasesikolweni, ekhaya nasecaweni)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
5. Abazali bam /abanonopheli bam bayandigada kakhulu, bayazi ukuba ndiphi na nokuba ndenzani na amaxesha amaninzi	◯Hayi ◯Ngamanye amaxesha ◯Ewe
6. Ndicinga ukuba abazali/abanonopheli bam bazi lukhulu ngam (umzekelo ngoobani abahlobo bam, yintoni endithanda ukuyenza)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
7. Kukho ukutya okwaneleyo ekhaya xa ndilambile	◯Hayi ◯Ngamanye amaxesha ◯Ewe
8. Ndiyazama ukugqiba imisebenzi ebendiyiqalile	◯Hayi ◯Ngamanye amaxesha ◯Ewe
9. Iinkolo zingoovimba bamandla kum (umzekelo ukukholwa kuThixo okanye kwizinyanya)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
10. Ndiyazidla ngenkcubeko eyimvelaphi yam (umzekelo, ndiyazi ukuba usapho lwam luvela phi na okanye ndiyazi ngembali yosapho lwam)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
11. Abantu bacinga ukuba kumnandi ukuba nam.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
12. Ndiyathetha nosapho lwam malunga nokuba ndiziva njani na (umzekelo xa ndinentliziyo ebuhlungu okanye ndidakumbile)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
13. Xa izinto zingahambi ngendlela endiyifunayo, ndinako ukuzilungisa ndingazivisanga kabuhlungu mna okanye abanye abantu (umzekelo, ukubetha abanye okanye ukuthetha izinto ezimbi ngabo)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
14. Ndiziva ndifumana inkxaso yabahlobo bam	◯Hayi ◯Ngamanye amaxesha ◯Ewe
15. Ndiyazi ukuba ndiye phi na ukufumana uncedo xa ndilufuna.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
16. Ndiziva ndingowasesikolweni sam	◯Hayi ◯Ngamanye amaxesha ◯Ewe
17. Usapho lwam luyakhathala ngam xa amaxesha enzima (umzekelo, ukuba ndiyagula okanye ndenze into embi)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
18. Abahlobo bam bayakhathala ngam xa amaxesha enzima	◯Hayi ◯Ngamanye amaxesha ◯Ewe
19. Ndiphethwe kakuhle	◯Hayi ◯Ngamanye amaxesha ◯Ewe
20. Ndinamathuba okubonisa ukuba ndiyakhula yaye ndingazenzela izinto ngokwam	◯Hayi ◯Ngamanye amaxesha ◯Ewe
21. Ndiyazi into endinako ukuyenza ncam	◯Hayi ◯Ngamanye amaxesha ◯Ewe
22. Ndithatha inxaxheba kwimisebenzi yezenkolo (efana necawa, necawa yamaSilamsi)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
23. Ndicinga ukuba kubalulekile ukunceda kwindawo endihlala kuyo	◯Hayi ◯Ngamanye amaxesha ◯Ewe

24. Ndiziva ndikhuselekile xa ndinosapho lwam	◯Hayi ◯Ngamanye amaxesha ◯Ewe
25. Ndinamathuba amahle okufunda izinto naya kuba luncedo xa ndimdala (afana nokupheka, ukusebenza, nokuncedisa abanye)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
26. Ndiyayithanda indlela usapho lwam oluzibhiyozela ngalo iziganeko ezithile (ezifana neeholide namatheko akhethekileyo)	◯Hayi ◯Ngamanye amaxesha ◯Ewe
27. Ndiyayithanda indlela abantu bendawo endihlala kuyo abazibhiyozela ngayo iziganeko (ezifana neeholide neminyhadala [festivals])	◯Hayi ◯Ngamanye amaxesha ◯Ewe
28. Ndiyazingca ngokuba ngummi waseMzantsi Afrika.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
29. Abantu abatsha baxatyisiwe kwindawo endihlala kuyo.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
30. Ndicinga ukuba ukufumana i-HIV akunakuthintelwa, yaye akukho nto ndinokuyenza ukuyithintela.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
31. Ndiqinisekile ukuba ndinako ukuzikhusela mna neqabane lam ukuze ndingabinakukhulelwa.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
32. Ndinabantu abakubudala bam endibancomayo/endijonge kubo.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
33. Ndinabantu abadala kunam endibancomayo/endijonge kubo.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
34. Abantu benkcubeko (culture) yam bayabahlonipha oomama.	◯Hayi ◯Ngamanye amaxesha ◯Ewe
36. Xa kusenzeka izinto ezimbi, ndiziva ndinobutyala.	◯Hayi ◯Ngamanye amaxesha ◯Ewe

Konke ngengomso: Eli candelo lokugqibela likubuza ngezicwangciso zakho zexesha elizayo, iinjongo zakho ebomini. Nokuba ngaba akwabelani ngesondo ngoku, kucelwa WENZE NGATHI uyakwenza oko.

	Ndiya-vumelana	Andiqinise-kanga	Andivume-lani
1. Ndinezicwangciso zokusebenzisa iikhondom qho xa ndisabelana ngesondo kwezi nyanga zintandathu zizayo.			
2. Ukuba ndabelana ngesondo kwezi nyanga zintandathu zizayo, ndiya kuthetha neqabane lam ngokusebenzisa iikhondom.			
3. Ukuba ndabelana ngesondo kwezi nyanga zintandathu zizayo, ndiya kwala ukwabelana ngesondo ukuba ikhondom ayifumaneki.			
4. Ukuba ndisela utywala, ndineplani yokusebenzisa iikhondom qho xa ndisabelana ngesondo kwezi nyanga zintandathu zizayo.			
5. Ukuba ndineqabane elidala kunam, ndineplani yokusebenzisa iikhondom qho ndisabelana ngesondo.			
6. Xa ndineqabane endabelana nalo ngesondo, ndineplani yokunyaniseka yaye ndabelane ngesondo nomntu omnye kuphela.			
7. Ndineplani yokungabelani ngesondo kwezi nyanga zintandathu zizayo.			
8. Ndineplani yokuya eklinikhi ukuya kuthatha iipilisi zokucwangcisa/zokuthintela ukukhulelwa ukuba kuyimfuneko.			
9. Ndiya kwenza uvavanyo lwe-HIV qho ngonyaka.			

	Ndiya-vumelana	**Andiqinis e-kanga**	**Andivume-lani**
10. Ndiya kuthetha ngokukhululekileyo kumanesi nakoonompilo abandinonopheleyo eklinikhi kwiimfuno zam zempilo zokwabelana ngezesondo nokufumana abantwana.			
11. Ndiza kuya eklinikhi ukuba kukho naziphi na iimpawu zeZifo ezoSulela ngoKwabelana ngeSondo (STI).			
12. Andiyi kulifaka phantsi koxinzelelo iqabane lam eliyindoda okanye eliyintombazana ukuba labelane nam ngesondo ngaphandle kwekhondom kwezi nyanga zintandathu zizayo.			
13. Ndiya kuza neekhondom xa ndineplani yokwabelana ngesondo.			
14. Andiyi koyikisa ngokulingcungcuthekisa okanye ngokulibetha iqabane lam.			
15. Ndiplana ukugqiba ukufunda kwisikolo esiphakamileyo.			
16. Ndiyazi ukuba yintoni na endiya kuba yiyo xa ndimdala.			
17. Ndinezicwangciso zokuya eyunivesithi /ethekhnikhon emva kokugqiba ukufunda kwisikolo esiphakamileyo.			
18. Ukuba iqabane lam okanye mna ndiye ndakhulelwa, ndisafuna ukugqiba ukufunda kwisikolo esiphakamileyo.			
19. Ndinenjongo ebomini bam.			
20. Ndiplana ukuphumelela ebomini.			
21. Ndingathanda ukuba nosapho olulolwam ngenye imini.			
22. Ndinomfanekiso wekamva lam ukuba liya kuba njani na kwiminyaka eli-10 ukususela ngoku.			
23. Ndinamathuba amahle emva kokuba ndigqibe ukufunda kwisikolo esiphakamileyo.			
24. Ndinamaphupha ekamva lam.			

Sixelele ukuba ucinga ntoni! Uyacelwa ukuba wabelane ngeengcebiso zakho ukuphucula iinkonzo zezempilo nezenkxaso zolutsha. Nayiphi na inkcazo ngokuqhubekayo, iingcinga zokugqibela okanye izimvo kweli candelo ziya kuthakazelelwa:

Translation Certificate

This is to certify that the translation of the document entitled:

Baseline Survey for Youth and Adolescents Aged 15 and older

AYFS Youth Survey – V1.5 22 August 2016

From English into Xhosa has been completed to the best of the ability of our translator and is true to the meaning and wording of the original English text. The translation was carried out by the following translator:

English to Xhosa by Thembela Sineke

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Appendix B. List of Primary and Secondary Outcome variables, as well as theorized dependent variables and their psychometric properties

Variable	Number of items	Items	Scoring	Alpha
Primary Outcomes – Sexual and Reproductive Health Service (SRHS) Utilization				
HIV testing		Have you ever had an HIV test? □ Yes □ No If yes, when did you have your last HIV test?		NA
Unmet contraception need		Do you wish to fall pregnant (or have your partner fall pregnant) in the next six months? □Yes □No Are you currently using any contraception? (i.e., condoms, family planning, injectable, etc.)? □Yes □No		NA
Secondary Outcomes – Sexual and Reproductive Health Indicators				
History of pregnancy		For girls, have you ever fallen pregnant? For boys, have you ever made someone pregnant?		NA
History of STI treatment		Have you ever been treated for an STI (sexually transmitted infection)?		NA
Sexual debut		How old were you when you had sex for the first time? □_____years old □ Not Applicable. I have not had sex.	Early sexual debut < 15 years of age	NA
HIV Status		If yes, what was your HIV status? □ HIV+ □ HIV-negative □ Did not receive results □ Prefer not to answer □ N/A – I have not had an HIV test.		NA

Variable	Number of items	Items	Scoring	Alpha
Quality of Care Received				
Quality of Interactions with Service Providers	5 items	- The last time you went to clinic, did you receive all the services and medications you came for? - The last time you went to clinic, were you treated with respect? - The last time you went to clinic, were you able to meet with the health care worker in private? - The last time you went to clinic, were you shouted at by any of the staff - i.e., nurses, counsellors, clerks? - The last time you went to clinic, did you feel that your confidentiality was maintained (i.e., that the reason for your visit and what you said was kept private, and only between you and the health care worker)?		
Waiting Times	2 items	- How long did you wait for services at the clinic? □Less than 1 hour □1-2 hours □3-4 hours □More than 4 hours □I don't remember - Was this wait time acceptable to you?		
Overall Satisfaction with Services	3 items	- Overall, how would you rate the quality of services you receive at the clinic, with 1 being very bad and 5 being very good? (Please tick one.) - Overall, how satisfied are you with the measures taken to keep your consultation private and confidential, with 1 being Not at all Satisfied and 5 being Very Satisfied? (Please tick one.) - Overall, how helpful would you say the clinical care staff were who took care of you at the clinic, with 1 being Not at all Helpful and 5 being Very Helpful? (Please tick one.)		

Variable	Number of items	Items	Scoring	Alpha
Sexual behavior				
Unwilling first sex (defined by b, c, or d)		The first time you had sex, it was: □ Something I wanted. □ Something I did not want. □ Something I was forced to do against my will. □ Not Applicable: I have never had sex.		NA
Gave money or gifts for sex		Have you ever GIVEN someone money or material gifts, like airtime, to have sex with you?	a	NA
Received money or gifts for sex		Have you ever had sex with someone in order to RECEIVE money or material gifts, like cell phones, airtime, clothing, etc.?	a	NA
Number of sex partners		How many people have you had sex with, in your life?		NA
Condom use frequency		In the past six months, how often did you and your partner use a condom when having sex?	j	NA
Exposure to Violence – at home, school and community				
Crime/violence victimization including bullying	9	Were you involved in a physical fight (at home, at school or in your community)? Did you witness someone getting beaten or hit at school? Did you witness someone getting beaten or hit at home? Did you witness someone getting stabbed, shot or killed in your community? How often has someone at school threatened you with a weapon (i.e., penga, knife or gun)? How often has someone in your community threatened you with a weapon (i.e., penga, knife or gun)? How often has someone at school insulted or humiliated you in front of other people? How often have you been beaten or physically punished by a teacher at school? How often have you felt that a teacher was flirting with you or making sexual advances?		
Crime/violence perpetration	2	Did you steal something or take something from someone without permission?		

Variable	Number of items	Items	Scoring	Alpha
		Did you cause serious damage to property on purpose?		
Exposure to intimate partner violence (IPV)				
IPV victimization (defined by at least once on a, b, c or d)	4	In the past 6 months how often has a boyfriend or girlfriend: - Insulted you or humiliated you or made you feel bad about yourself? - Threatened to hurt you? - Hit, pushed, kicked, choked or burned you? - Forced you to have sex with him/her?	k	NA
IPV perpetration (defined by at least once on a, b, c or d)	4	In the past 6 months, how often have you: - Insulted or humiliated a girlfriend or boyfriend or made them feel bad? -Threatened to hurt a boyfriend or girlfriend? - Hit, pushed, kicked, choked or burned a boyfriend or girlfriend? - Forced a boyfriend or girlfriend to have sex with you?	k	NA
Theorized variables for Sexual Behavior and Health Service Utilization – Information (Knowledge), Motivation (Attitudes and Risk) and Behavioral Skills (Self-Efficacy)				
Information: condom use	3	Condoms can prevent against HIV and other STIs When a girl uses contraceptive pills or the injection for family planning, this protects her against STIs Abstaining from sex is the only way to avoid getting HIV	a	NA
Information: HIV/AIDS	5 scored items plus 7	– If you have sex only once with a person who is HIV positive, you can become infected with HIV – If you kiss a person who is HIV positive, you can become infected with HIV – If you have anal sex with a person who is HIV positive, you can become infected with HIV – A person with HIV can live a full and healthy life – HIV can be cured – You can tell someone has HIV by looking at that person – HIV can be caused by being bewitched – HIV can be passed by sharing a toothbrush or cooking utensils – HIV can be passed by sharing a toilet with someone who has HIV – HIV+ mothers can pass HIV on to their infants through breastfeeding – Women can transmit HIV to men – Young men who are circumcised cannot get HIV	a	NA

Variable	Number of items	Items	Scoring	Alpha
Motivation: Risk susceptibility	2	If I do not use a condom when having sex, my risk of getting a STI will be.. If I do not use a condom when having sex, my risk of HIV infection will be...	b	0.73
Motivation: Risk severity	3	If I got an STI, I would find this: If I have HIV, I would find this: If I fell pregnant (for girls) or got somebody pregnant (for boys), I would find this	c	0.82
Motivation - Attitude: pros condom use	1	Using condoms shows that you have respect for yourself and your partner.	d	0.63
Motivation - Attitude: cons condom use	**4**	Most of the people I care about would think I would be 'easy' or 'asking for sex' if I carried condoms. When a person insists on using condoms, it shows that he or she has been with many partners.	d	0.78
Motivation: Social norm condom use	**4**	Most of my friends think that I should use a condom when I have sex. My parents/caregivers think that I should use a condom when I have sex. Most of my community thinks that I should use a condom when I have sex. My boyfriend/girlfriend thinks that I should use a condom when I have sex.	d	0.86
Motivation: Social norm delaying sex	2	Most of my friends think I should wait until I'm older to have sex. My parent/caregivers think I should wait until I'm older to have sex.	d	0.76
Motivation: Social norm becoming pregnant	2	Most of my friends think that getting pregnant at my age is no big deal. My parents/caregivers think that girls my age should not fall pregnant.		
Motivation: Social norm/individual preference regarding older partners	**2**	My friends think that it is ok for girls to have sex with an older guy or 'sugar daddy', if you are getting something in return (i.e. airtime, money, clothes, groceries). Most of the people I prefer to have sex with are at least five years older than me.		
Motivation: Social norm –	**2**	I worry about what others may think of me if I went to the clinic for services.		

Variable	Number of items	Items	Scoring	Alpha
Clinic attendance		I feel discriminated against when I attend my local clinic.		
Motivation: Social norm – HIV testing	**2**	Most people I know have had an HIV test. Most people who care about me think that I should have an HIV test.		
Skills: Self-efficacy condom use[e]	5	I would feel comfortable insisting on condom use even if it is the first time I am having sex with that person. I would feel comfortable insisting on condom use, even if my partner is much older than me. I am confident that I know how to use a condom correctly. I would feel embarrassed to buy condoms for myself. Condoms are difficult to use when I've been drinking.	e	0.73
Skills: Self-efficacy attending clinics	4	I am afraid to tell the truth when I visit the clinic for fear of judgement. I would feel comfortable talking to a nurse or health care worker about sex. The staff at the local clinic do not keep my information confidential. I am satisfied with the services I receive at the clinic.	e	0.79
Intentions and Action Plan: to abstain from sex	1	I plan to abstain from sex in the next six months	d	NA
Intentions and Action Plan: condom use[d]	4	I plan to use condoms every time I have sex in the next six months. If I have sex in the next six months, I will talk to my partner about using condoms. If I have sex in the next six months, I will refuse to have sex if a condom is not available. If I am drinking, I plan to use condoms every time I have sex in the next six months. If I am with an older partner, I plan to use condoms	d	NA

Variable	Number of items	Items	Scoring	Alpha
		every time I have sex.		
Intentions and Action Plan: to go to clinic for SRHS	1	I plan to go to the clinic to collect my contraception/family planning if required. I will get an HIV test every year. I will talk freely to the nurses and healthcare workers who care for me at clinic for my sexual and reproductive health needs. I will attend the clinic if I have any symptoms of a Sexually Transmitted Infection (STI).	d	NA

[a]Percentage of correct answers (see thesis for scoring)
[b]Scale from 'very low' (1) to 'very high' (5)
[c]Scale from 'not serious' (1) to 'very serious' (5)
[d]Scale from 'strongly disagree' (1) to 'strongly agree' (5)
[e]Scale from 'very difficult' (1) to 'very easy' (5)
[f]Scale from 'never' (0), 'once' (1) to 'more than once' (2)
[g]Scale from 'never' (1), 'sometimes' (2) to 'often' (3)
[h]'No' (0) and 'yes'(1)
[j]Scale from 'never' (1) to 'always' (6) Never (1) Rarely (2) Sometimes/half the time (3) Often (4) Most of the Time (5) Always (6) or N/A - I did not have sex in the past six months.
[k]Never (0), Once or more than once (1)

Variable	Number of items	Items	Scoring	Alpha
Child Youth Resilience Measure (CYRM-28)				
Individual Resilience	11	*Individual: Personal Skills (5 items)* - I share/cooperate with people around me - I try to finish activities that I start - People think I am fun to be with. - When things don't go my way, I can fix it without hurting myself or other people (for example hitting others or saying nasty things) - I know what I am good at *Individual: Peer Support (2 items)* - I feel supported by my friends - My friends care about me when times are hard		.866

Variable	Number of items	Items	Scoring	Alpha
Child Youth Resilience Measure (CYRM-28)				
		Individual: Social Skills (4 items) - I know how to act in different situations (such as school, home and church) - I know where to go to get help when I need it. - I have chances to show others that I am growing up and can do things by myself - I have chances to learn things that will be useful when I am older (like cooking, working, and helping others)		
Relationship with Caregiver	7	*Caregiver: Physical Caregiving (2 items)* - My parent(s)/caregiver(s) watch me closely, they know where I am and what I am doing most of the time -There is enough to eat at home when I am hungry *Caregiver: Psychological Caregiving (5 items)* - I feel that my parent(s)/caregiver(s) know a lot about me (for example, who my friends are, what I like to do) - I talk to my family about how I feel (for example when I am hurt or sad) -My family cares about me when times are hard (for example if I am sick or have done something wrong) - I feel safe when I am with my family - I like the way my family celebrates things (like holidays or special occasions)		
Context	10 items	*Context: Spiritual (3 items)* - Spiritual beliefs are a source of strength for me (for example, believing in a God or ancestors) - I participate in religious activities (such as church, mosque) - I think it is important to help out in my community *Context: Education (2 items)* - Getting an education is important to me - I feel I belong at my school		

Variable	Number of items	Items	Scoring	Alpha
Child Youth Resilience Measure (CYRM-28)				
		Context: Cultural (5 items) - I have people I want to be like - I am proud of my ethnic background (for example, I know where my family comes from or know about my family's history) - I am treated fairly - I like the way my community celebrates things (like holidays, festivals) - I am proud to be a citizen of South Africa.		

Resilience – Additional Contextual Questions				
Perceived self-worth, presence of role models, self-agency	7 items	- Young people are valued in my community. - I feel getting HIV is unavoidable, and there is not much I can do to prevent it. - I am confident that I can protect myself and/ my partner from falling pregnant. - I have people my own age whom I admire/look up to. - I have people who are older than me whom I admire/look up to. - People in my culture respect women. - When bad things happen, I blame myself.		
Future-focused mindset/ aspirations	10 items	- I plan to finish high school. - I know what I want to be when I grow up. - I have plans to attend varsity/technikon after high school. - If my partner or I fell pregnant, I would still finish high school. - I have goals in life. - I plan to succeed in life. - I would like to have a family of my own someday.		

		- I can picture what my future will be like 10 years from now. - There are opportunities for me after high school. - I have dreams for my future.		

APPENDIX C.

a. University of Western Cape Approval
b. Biomedical Research Ethics Committee Approval (PharmaEthics)
c. Ministry of Health and Department of Basic Education Approvals

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

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29 May 2018

Ms S Christie
School of Public Health
Faculty of Community and Health

Ethics Reference Number: BM17/10/19

Project Title: Harnessing resilience: An exploration into individual and contextual factors that facilitate uptake of sexual and reproductive health services (SRHS) and HIV testing amongst South African youth.

Approval Period: 24 May 2018 – 24 May 2019

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

P.O. Box 786
IRENE
0062
Republic of South Africa

PHARMA-ETHICS

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e-mail: colette@pharma-ethics.co.za

20 June 2016

FAXED

Dr S Pillay
Enhancing Care Founrdation
PO Box 50495
Musgrave
4062
Fax: 086 725 1896

Dear Dr Pillay,

PROTOCOL: AYFS-2016
STRENGHTENING ADOLESCENT AND YOUTH FRIENDLY SERVICES (AFYS) IN THE EASTERN CAPE

ETHICS REFERENCE NO: 160413726

RE : ETHICS COMMITTEE APPROVAL

Your letter dated 24 May 2016 refers.

Attached find the Ethics Committee Approval Letter for the above-mentioned study. The ORIGINAL SIGNED Ethics Committee Approval Form, with a list of documents reviewed and investigators approved, will follow shortly.

PLEASE NOTE: We do not have a hard copy of the Eastern Cape Department of Health approval for this research. Please submit.

We also recommend that you register this study on the SANCTR website even though it is not a clinical trial as the DOH registration number may be requested for purposes of publishing.

Attached find a list of members who attended the meeting.

The above has been noted for the Ethics Committee information and records.

KINDLY FORWARD TO THE RELEVANT INVESTIGATORS / CRA / SPONSOR / STUDY CO-ORDINATORS - WHERE APPLICABLE

Regards,

MRS MARZELLE HASKINS
For and on behalf of Pharma-Ethics

P.O. Box 786
IRENE
0062
Republic of South Africa

PHARMA-ETHICS

Pharma-Ethics (Pty) Ltd
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e-mail: colette@pharma-ethics.co.za

20 June 2016

FAXED

Dr S Pillay

Enhancing Care Founrdation
PO Box 50495
Musgrave
4062

ORIGINAL

Fax: 0867251896

Dear Dr Pillay,

PROTOCOL: AYFS-2016
STRENGHTENING ADOLESCENT AND YOUTH FRIENDLY SERVICES (AFYS) IN THE EASTERN CAPE

ETHICS REFERENCE NO: 160413726

RE : ETHICS COMMITTEE APPROVAL

The above-mentioned Protocol was reviewed by the Pharma-Ethics Independent Research Ethics Committee Members on 20 April 2016, and CONDITIONAL APPROVAL was given for the Investigators to participate. This letter certifies that all conditions were met to the satisfaction of the commitee and constitutes the FINAL Ethics approval. Please refer to the attached schedule for a list of documents reviewed and investigators approved.

The Study has been accepted as complying to the Ethics Standards for Clinical Research with a new drug in participants, based on FDA, ICH GCP and the Declaration of Helsinki guidelines. The Ethics Committee (IRB) granting this APPROVAL is in compliance with the Guidelines for Good Practice in the Conduct of Clinical Trials in Human Participants in South Africa (2006), ICH Harmonised Tripartite Guidelines E6: Note: for the Guidance in Good Clinical Practice (CPMP/ICH/135/95) and FDA Code of Federal Regulation Part 50, 56 and 312.

This approval is valid for a period of ONE YEAR. The Ethics Committee is to be supplied with a STATUS REPORT on the progress of the study at least ONCE A YEAR after which the study will be reviewed for annual re-approval. The FINAL REPORT on the outcome of the Study must be submitted upon study completion. If any SERIOUS ADVERSE EVENTS are reported, the Committee should be advised, as well as the relevant Regulatory Affairs Bodies.

Please refer to Pharma-Ethics Standard Operating Procedures for more information regarding applications, amendments, annual re-approval, SAE reporting etc.

The above has been noted for the Ethics Committee information and records.

KINDLY FORWARD TO THE RELEVANT INVESTIGATORS / CRA / SPONSOR / STUDY CO-ORDINATORS - WHERE APPLICABLE

Regards,

MRS MARZELLE HASKINS
For and on behalf of Pharma-Ethics

ETHICS COMMITTEE APPROVAL FORM

Ethics Reference No.	**160413726**	**Date of Meeting**	20 April 2016
Principal Investigators:	Dr S Pillay	**Investigators:**	Dr M Muzigaba Sub
Protocol Title:	STRENGHTENING ADOLESCENT AND YOUTH FRIENDLY SERVICES (AFYS) IN THE EASTERN CAPE		

DOCUMENTS REVIEWED				**Tick As Appropriate**	**Yes**	**No**
Protocol Name	AYFS-2016					
Protocol / Amendment No. (and/or)	Version 1.1 - APPROVED	**Date:**	24 May 2016		☑	☐
	Version 1.0 - WITHDRAWN	**Date:**	08 April 2016		☑	☐
Investigator's Brochure						
Subject Information/Consent Form	Information Sheet - Youth Survey for Young Persons, Version 1.1 dated 30 May 2016	Version 1.1 - APPROVED			☑	☐
	Adolesent Assent Form - Focus Group, Version 1.1 dated 27 May 2016	Version 1.1 - APPROVED			☑	☐
	Adolescent Assent Form - Youth Survey, Version1.1 dated 27 May 2016	Version 1.1 - APPROVED			☑	☐
	Information Sheet for Use by Parents/Legal Guardians (Focus Groups), Version 1.1 dated 27 May 2016	Version 1.1 - APPROVED			☑	☐
	Information Sheet for Use by Parents/Legal Guardians- Youth Survey, Version 1.1 dated 27 May 2016	Version 1.1 - APPROVED			☑	☐
	Information Sheet - Youth Survey 18 years and above, Version 1.0 dated5 April 2016	Version 1.0 - WITHDRAWN			☑	☐
	Information Sheet - Focus Group 18-24, Version 1.0 dated 8 April 2016	Version 1.0 - APPROVED			☑	☐
	Adolescent Assent Form - Focus Group, Version 1.0 dated 5 April 2016	Version 1.0 - WITHDRAWN			☑	☐
	Adolescent Assent Form - Youth Survery, Version 1.0 dated 8 April 2016	Version 1.0 - WITHDRAWN			☑	☐
	Information Sheet for Use by Parents/Legal Guardians- Focus Groups, Version 1.0 dated 5 April 2016	Version 1.0 - WITHDRAWN			☑	☐
	Information Sheet for Use by Parent/Legal Guardians - Youth Survey for Children, Version 1.0 dated 5 April 2016	Version 1.0 - WITHDRAWN			☑	☐
Advertisements					☐	☑
Questionaires	Focus Group Discussion Guide for Out-of-School Youth (18 - 24years)	N/A			☑	☐
	Focus Group Discussion Guide for Adolescents (12 - 17 years)	N/A			☑	☐
	Survey for Youth Study Participants	N/A			☑	☐
Relevent Trial Hospital/(s)					☐	☑
Insurance						
Research Unit	Enhancing Care Foundation				☑	☐
Synopsis of Study/Trial Summary	STRENGHTENING AFYS IN EASTERN CAPE				☑	☐
Other / Document Submitted	Declaration by PI				☑	☐
	GCP Certificates				☑	☐
	Pharma-Ethics Application Form and Covering Letter dated 7 April 2016				☑	☐
	Project Summary				☑	☐

ORIGINAL

ETHICS COMMITTEE APPROVAL FORM

DETAILS OF COMMITTEE	
Name	Pharma-Ethics Independant Research Ethics Committee
Address	123 Amcor Road, LYTTELTON MANOR, 0157

DETAILS OF MEETING	Yes	No
Is the Investigator a member of the committee ?	☐	☑
If "Yes" did he/she vote ?	☐	☑
Is the Committee organised and operated according to applicable laws and regulations together with ?	☑	☐
Local GCP requirements ?	☑	☐
ICH GCP requirements ?	☑	☐
FDA GCP requirements ?	☑	☐
Progress reports required on a Yearly basis ?	☑	☐

DECISION ON APPROVAL : is approval given to conduct the trial ?	Tick As Appropriate
Yes - with no conditions	☐
Yes - with conditions	☑
Specify conditions : - Eastern Cape DOH Approval	
No	☐
Specify reasons	

SIGNATURES		
I confirm that the details on this form are correct:		Date
Name: **Dr C.S.J. Duvenage** **Chairperson of Committee**	**Signature:**	**20 June 2016**

PROTOCOL NUMBER **AYFS-2016** ETHICS REF.: **160413726**

ORIGINAL

ORIGINAL

PHARMA-ETHICS

PO Box 786, Irene, 0062, Gauteng, Republic of South Africa • 123 Amkor Road, Lyttelton Manor Ext 3, Centurion, 0157
Tel: +27 (12) 664 8690/0219 • Fax: +27 (12) 664 7860 • E-mail: enquiries@pharma-ethics.co.za • Website: www.pharma-ethics.co.za

MEMBERS PRESENT AT MEETING HELD ON WEDNESDAY, 20 APRIL 2016:

Protocol No: AYES-2016 Ref No: 16043720

New Application: ☑ Major Amendment: ☐ Re-Approval: ☐

MEMBER:	GENDER:	SIGNATURE:	VOTING:
Dr C.S.J. Duvenage – *Chairperson* MBChB, FCP	F	Duvenage	YES/NO/NA*
Dr E. Hammann – *Deputy Chair* MBChB, DOH, MPharmMed	F		YES/NO/NA*
Dr J.A. Erasmus MBChB, MMedPaed, FCP(SA)(Paed)	M		YES/NO/NA*
Prof P.J. Becker MSc, PhD	M		YES/NO/NA*
Prof H.S. Schoeman BSc, MSc, DSc	M	ABSENT	YES/NO/NA*
Mr L. Scheepers BPharm	M		YES/NO/NA*
Dr N.E. Khomo BSc (Pharm), MBChB, MMed (Community), DTM&H, DHSM, DPH	F	ABSENT	YES/NO/NA*
Ms E. Beukes BPharm, BSc	F		YES/NO/NA*
Mr S. Masombuka BA (Lay Member)	M		YES/NO/NA*
Mrs M. Haskins BLC, LLB	F	PROXY	YES/NO/NA*
Mrs C. Grant BA (Law), LLB	F		YES/NO/NA*
Mr T. Molebatsi BA, BA(Hons), MPH, PGDip (Health Research Ethics)	M	ABSENT	YES/NO/NA*
Mrs L. van der Westhuizen BA(Psych),B.Ed(Hons)Educational Psychology, MA(Psychology)	F		YES/NO/NA*
Ms D Masombuka Lay Member / Community Representative	F	ABSENT	YES/NO/NA*

*Not Reviewed

P.O. Box 786
IRENE
0062
Republic of South Africa

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e-mail: colette@pharma-ethics.co.za

06 June 2017

FAXED

Dr S Pillay

Enhancing Care Founrdation
PO Box 50495
Musgrave
4062

Fax: 0867251896

Dear Dr Pillay,

PROTOCOL: AYFS-2016
STRENGHTENING ADOLESCENT AND YOUTH FRIENDLY SERVICES (AFYS) IN THE EASTERN CAPE

ETHICS REFERENCE NO: 160413726

RE : ANNUAL RE-APPROVAL

We acknowledge receipt of your letter dated 04 May 2017 with the following documentation pertaining to the above-captioned trial.

- Protocol Synopsis

- Status Report per Site

The above-mentioned documents were reviewed by Pharma-Ethics Research Ethics Committee members on 17 May 2017. By reviewing these documents, the committee granted approval for the study to continue for an additional year, or until completion, after which a FINAL REPORT must be submitted.

PLEASE NOTE: For future submissions the status reports must be completed in the relevant section of the e-submission platform. Failure to do so will result in your application not being reviewed.

Attached find a list of members who attended the meeting.

The above has been noted for the Ethics Committee information and records.

KINDLY FORWARD TO THE RELEVANT INVESTIGATORS / CRA / SPONSOR / STUDY CO-ORDINATORS - WHERE APPLICABLE

Regards,

MRS MARZELLE HASKINS
For and on behalf of Pharma-Ethics

PHARMA-ETHICS

PO Box 786, Irene, 0062, Gauteng, Republic of South Africa • 123 Amkor Road, Lyttelton Manor Ext 3, Centurion, 0157
Tel: +27 12 664 8690/0219 • Fax: +27 12 664 7860 • E-mail: enquiries@pharma-ethics.co.za • Website: www.pharma-ethics.co.za

MEMBERS PRESENT AT MEETING HELD ON WEDNESDAY, 17 May 2017:

Protocol No: AYES-2016 **Ref No:** 160413726

New Application: ☐ **Major Amendment:** ☐ **Re-Approval:** ☑

MEMBER:	GENDER:	SIGNATURE:	VOTING:
Dr C.S.J. Duvenage – *Chairperson* MBChB, FCP	F		YES/NO/NA*
Dr E. Hammann – *Deputy Chair* MBChB, DOH, MPharmMed	F		YES/NO/NA*
Dr J.A. Erasmus MBChB, MMedPaed, FCP(SA)(Paed)	M		YES/NO/NA*
Prof P.J. Becker MSc, PhD	M		YES/NO/NA*
Prof H.S. Schoeman BSc, MSc, DSc	M	ABSENT	YES/NO/NA*
Mr L. Scheepers BPharm	M		YES/NO/NA*
Dr N.E. Khomo BSc (Pharm), MBChB, MMed (Community), DTM&H, DHSM, DPH	F		YES/NO/NA*
Ms E. Beukes BPharm, BSc	F		YES/NO/NA*
Mr S. Masombuka BA (Lay Member)	M	ABSENT	YES/NO/NA*
Mrs M. Haskins BLC, LLB	F		YES/NO/NA*
Mrs C. Grant BA (Law), LLB	F	PROXY	YES/NO/NA*
Mr T. Molebatsi RA, BA(Hons), MPH, PGDip (Health Research Ethics)	M	ABSENT	YES/NO/NA*
Mrs L. van der Westhulzen BA(Psych),B.Ed(Hons)Educational Psychology, MA(Psychology)	F		YES/NO/NA*
Ms D Masombuka Lay Member / Community Representative	F		YES/NO/NA*

*Not Reviewed

Province of the
EASTERN CAPE
EDUCATION

STRATEGIC PLANNING POLICY RESEARCH AND SECRETARIAT SERVICES
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Private Bag X0032 • Bhisho • 5605 • REPUBLIC OF SOUTH AFRICA
Tel: +27 (0)40 608 4773/4035/4537 • Fax: +27 (0)40 608 4574 • Website: www.ecdoe.gov.za

Enquiries: NY Kanjana Email: nykanjana@live.co.za Date: 14 September 2016

Dr. Sandy Pillay

Enhancing Care Foundation

16 Charles Strachan Road

Westridge

Durban

4091

Dear Dr. Pillay

PERMISSION TO UNDERTAKE AN INDEPENDENT STUDY: STRENGTHENING ADOLESCENT AND YOUTH-FRIENDLY SERVICES (AYFS) IN THE EASTERN CAPE

1. Thank you for your application to conduct research.

2. Your application to conduct the above mentioned research involving 2700 learners from 30 selected Secondary Schools of the Eastern Cape Department of Education (ECDoE) is hereby approved based on the following conditions:

    a. there will be no financial implications for the Department;

    b. institutions and respondents must not be identifiable in any way from the results of the investigation;

    c. you present a copy of the written approval letter of the Eastern Cape Department of Education (ECDoE) to the Cluster and District Directors before any research is undertaken at any institutions within that particular district;

    d. you will make all the arrangements concerning your research;

    e. the research may not be conducted during official contact time, as educators' programmes should not be interrupted;

f. should you wish to extend the period of research after approval has been granted, an application to do this must be directed to Chief Director: Strategic Management Monitoring and Evaluation;

g. the research may not be conducted during the fourth school term, except in cases where a special well motivated request is received;

h. your research will be limited to those schools or institutions for which approval has been granted, should changes be effected written permission must be obtained from the Chief Director: Strategic Management Monitoring and Evaluation;

i. you present the Department with a copy of your final paper/report/dissertation/thesis free of charge in hard copy and electronic format. This must be accompanied by a separate synopsis (maximum 2 – 3 typed pages) of the most important findings and recommendations if it does not already contain a synopsis.

j. you present the findings to the Research Committee and/or Senior Management of the Department when and/or where necessary.

k. you are requested to provide the above to the Chief Director: Strategic Management Monitoring and Evaluation upon completion of your research.

l. you comply with all the requirements as completed in the Terms and Conditions to conduct Research in the ECDoE document duly completed by you.

m. you comply with your ethical undertaking (commitment form).

n. you get consent from the parents of the learners involved.

o. you submit on a six monthly basis, from the date of permission of the research, concise reports to the Chief Director: Strategic Management Monitoring and Evaluation.

3. The Department reserves a right to withdraw the permission should there not be compliance to the approval letter and contract signed in the Terms and Conditions to conduct Research in the ECDoE.

4. The Department will publish the completed Research on its website.

5. The Department wishes you well in your undertaking. You can contact the Director, Ms. NY Kanjana on the numbers indicated in the letterhead or email nykanjana@live.co.za should you need any assistance.

NY KANJANA
DIRECTOR: STRATEGIC PLANNING POLICY RESEARCH & SECRETARIAT SERVICES

FOR SUPERINTENDENT-GENERAL: EDUCATION

Province of the
EASTERN CAPE
HEALTH

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Private Bag X0038 • Bhisho • 5605 • REPUBLIC OF SOUTH AFRICA
Tel.: +27 (0)40 608 1553 • 040 608 1556 • Fax: +27 (0)40 609 8110

TO	PROVINCIAL DISTRICT MANAGERS (ALFED NZO & O.R TAMBO) MCWH PROGRAM MANAGERS - SUB-DISTRICT (NYANDENI & MZIMVUBU SUB-DISTRICT)
FROM	DEPUTY DIRECTOR: HEALTH PROGRAMS
SUBJECT	COOPERATION FOR AYFS BASELINE STUDY AND PROJECT IMPLEMENTATION
DATE	19 NOVEMBER 2015

Dear Colleagues

Cooperation for AYFS Baseline Study and Project Implementation

The Health Focus/ECF consortium, on behalf of GIZ, are supporting our department in strengthening Adolescent and Youth friendly services (AYFS) in the Eastern Cape, with a focus on Nyandeni Sub-District in OR Tambo and Umzimvubu in Alfred Nzo. The project will run until November 2017 and has the full support and approval of the ECDoH.

In order to measure if the project is successful, a baseline study will be conducted over the next few months. The baseline study will firstly involve assessing the youth-friendliness of all PHC facilities within Umzimvubu and Nyandeni, and then will survey youth to learn about their experiences of AYFS.

Once the baseline study is complete and the data analyzed, the results will be shared with everyone.

The study will be coordinated by Ntombenhle Ngcobo (Short Term Expert for Health Focus/ECF). She will be working together with Sawethu Mfenyana (National Long Term Expert for Umzimvubu), and Banzi Mkundlu (National Long Term Expert for Nyandeni). There will also be 10 Research Assistants per sub district who will be tasked with data collection at 102 facilities.

This project is very important and we kindly request that you ensure that Health Focus/ECF and all their staff receive excellent cooperation in completing this baseline study, and in implementing the AYFS project.

Your support in this regard will be highly appreciated.

Kind Regards

GABA

Mrs. Gaba – SMSB

19/11/2015

Date

APPENDIX D.
Participant Information Sheets

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872
E-mail: soph-comm@uwc.ac.za

ADOLESCENT ASSENT FORM
(Youth Survey)

Part I: Information Sheet

1. Introduction

You have been invited to take part in a survey study so we can understand the challenges you face in terms of accessing health services and support. We also want to know about you and your experiences with sex, relationships and health services. We want to hear your opinions about the health services you've received and your suggestions for improvement. The information you tell us with help us to provide better health services for young people. This form is going to explain all that is expected of you, should you agree to take part.

You can choose whether or not you want to participate. We have discussed this research with your parents (or guardian) and they know that we are also asking you for your agreement. If you are going to participate in the research, your parent (or guardian) have to agree as well. If you do not wish to take part in the research, you do not have to, even if your parents have agreed that you can. Your parents will not see the responses to the survey and all the information you share with us is confidential.

You may discuss anything in this form with your parents, friends or anyone else with whom you feel comfortable talking. You can decide whether or not to participate after you have talked it through. You do not have to decide immediately.

There may be some words that you don't understand, or things that you want explained in more detail. Please feel free to ask the Facilitator any questions or concerns.

2. Purpose: Why are you doing this research?

This is a research study being conducted by NGOs (i.e., non-governmental organizations) called Health Focus and the Enhancing Care Foundation who, in partnership with the Eastern Cape Department of Health (DoH), plan to help clinics set up services for youth in the two sub-districts of Nyandeni and Umzimvubu.

The aim of the research is to find better ways of providing health care services and support to young people in the Eastern Cape. We do this by understanding what are the needs, practices, opinions and preferences of adolescents and young people. Your responses to the survey will help us improve health services for youth in the Eastern Cape.

3. Choice of participants: Why are you asking me?

Your school has been selected as one of the schools where we will involve young people in a survey study to understand their use and preferences for health services provided by the Eastern Cape Department of Health. Learners from Grade 9-11 are being asked to take part in this survey study.

4. Participation is voluntary: Do I have to do this?

It is up to you whether you'd like to take part in the survey or not. You don't have to take part in this survey if you don't want to. There will be no consequences of any kind if you say no. And even if you say "yes" now, you can change your mind later, and that will also be okay.

5. Study Procedures: What is involved in this study?

For this study, you will be asked to complete a survey. The survey will take about one hour to complete The survey has questions that deal with a range of topics, including information about you, your sexual relationships, your knowledge and opinions about HIV and pregnancy, and your experiences with the health service. Some of the questions may be sensitive and make you uncomfortable. You do not have to answer any questions that make you uncomfortable or stressed. Your responses will remain confidential and will not be shared with your parents, teachers, or anyone outside the study team.

6. Risks: Is this bad or dangerous for me?

The only risk involved in this survey study is the discomfort you may feel answering personal questions about sex, drugs and alcohol use. You do not have to answer any questions that make you uncomfortable or stressed. You can also stop taking the survey at any time. If you are feeling upset or distressed, please let the Facilitator know so she can get you the support you need.

7. Benefits: Will anything good happen to me?

There are no direct benefits or advantages from taking part in the survey but your answers will help us to provide better health services for youth in your community.

8. Reimbursements: Do I get anything for being in the research?

You will not be paid to take part in this research and it will not cost you anything to participate.

9. Confidentiality: Is everybody going to know my business? Who can see my information?

The responses to the survey will never be seen by anyone outside the study team. Your parents, teachers or friends will not see your responses. Your name also will not be on the survey. We will only use a code number to identify you. Once you complete the survey, it will be stored in a safe location. This form will not be included with your survey.

10. Can I choose not to be in the research? Can I change my mind? What are my rights?

You do not have to be in this research. No one will be angry or disappointed with you if you say "no". It's your choice. Even if you say "yes" now, and then change your mind later, it will still be okay. You have the right to withdraw from the study at any time without any consequence.

11. Who to contact: Who can I talk to about this or ask questions?

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872
E-mail: soph-comm@uwc.ac.za

For this study, please contact Ntombenhle Ngcobo who is the Study Facilitator with any questions or concerns at 082-374-5542. She will be able to address any of your concerns or questions in a language you understand. Sarah Christie is the Study Lead and can be reached at 079-627-6953.

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Iphepha lolwazi lokusentyenziswa ngabazali/abagcini abasemthethweni

(Uvavanyo Lolutsha Lwabantwana abakubudala beminyaka eli-17 nangaphantsi)

UMphandi oyiNtloko: Gqr. Sandy Pillay, Inkokheli yeProjekthi

Isihloko Sophononongo: Ukuphunyezwa kweeNkonzo ezamkelekileyo Zabantwana abafikisayo kunye noLutsha ([Adolescent and Youth Friendly Services] AYFS) eMpuma Koloni

Umxhasi: GIZ

Intshayelelo:

Umntwana wakho okanye umntwana ongaphantsi konakekelo lwakho umenyiwe ukuba athathe inxaxheba kuphononongo lophando. Nceda uthathe ithuba lokufunda olu lwazi kunikezelwa ngalo apha, olwakuthi luchaze iinkcukacha zolu phononongo. Nceda ukhululeke ukubuza abasebenzi bophononongo nayiphi na imibuzo malunga naliphi na ibakala lolu phononongo ongaliqondi. Kubalulekile ukuba ube waneliseke ngokupheleleyo nokuba uyayiqonda ngokucacileyo ukuba liqulethe ntoni na olu phononongo kwanokuba umntwana wakho angabandanyeka njani na phambi kokuba uvume.

Ukuthatha komntwana wakho inxaxheba **kungokuzithandela ngokupheleleyo** kwaye ukhululekile ukwala ukuthatha inxaxheba. Ukuba akuvumi, oku akuyi kuchaphazela umntwana wakho ngendlela engalunganga nangayiphi na indlela. Ukuba uyavuma ukuvumela umntwana wakho ukuba athathe inxaxheba, ukhululekile kananjalo ukuba umrhoxise kuphononongo nangaliphi na ithuba.

Olu phononongo luvunyelwe yi-PharmaEthics Research Committee kwaye luza kwenziwa ngokunxulumene nemithetho-siseko yokuziphatha ye-International 2013 Declaration of Helsinki kwaye lubambelele kwiMigaqo Yokuziqhelanisa koNyango Olufanelekileyo oluthi lukhokele lonke uphando kunye nabantu abangabathathi-nxaxheba.

Kutheni umntwana wakho emenyiwe ukuba athathe inxaxheba?

Umntwana wakho umenyiwe kuba ungumntwana ofikisayo okanye ungumntu omtsha (okubudala beminyaka eli-15 okanye nangaphezulu) kwezinye zezikolo ezithatha inxaxheba e-Nyandeni nakwizithili zase Umzimvubu. Abafundi abakwi Banga 9-11 bayamenywa ukuba bathathe inxaxheba.

Lumalunga nantoni olu phononongo lophando?

Olu luphononongo lophando olwenziwa zii-NGOs (ukt., imibutho engekho phantsi kukarhulumente) ezibizwa ngokuba yi-Health Focus kunye ne-Enhancing Care

Foundation ezithi ngokumanyana kwazo neSebe lezeMpilo (Department of Health [DoH]) laseMpuma Koloni, zicebe ukunceda iindawo ukuze ziseke iinkonzo zolutsha ezamkelekileyo kwizithili ezimbini ezincinane zaseNyandeni nase-Umzimvubu.

Injongo yolu phononongo kukuqonda ngokusetyenziswa kweenkonzo zempilo ezinikezelwa kulutsha liSebe lezeMpilo laseMpuma Koloni. Singathanda ukuhlola iinkonzo ezamkelekileyo kubantwana abafikisayo kunye nolutsha (AYFS), ngokukodwa iinkonzo zempilo zokwabelana ngesondo kunye nokuzala kunye namalungelo abantu abatsha. Ezi zingaquka iinkonzo ezinjengo cwangciso-ntsapho, ukuthintelwa kunye nokunyangwa kosuleleko olugqithiseleka ngokwabelana ngesondo (STIs), Intsholongwane kaGawulayo (HIV) kunye noGawulayo (AIDS) kunye nesifo sephepha (TB), ukwaluka, unakekelo lwaphambi kokuzala kunye nonakekelo lwasemva kokuzala; ukukhusela kwisifo kwasemva kokuvezeka (post-exposure prophylaxis) kunye nokunqandwa kokukhulelwa okungxamisekileyo. Singathanda ukuqonda ngokuziqhelanisa kwangoku kolutsha, kuquka ukuziphatha kwalo ngokwabelana ngesondo kunye nokusetyenziswa kweziyobisi kunye notywala, ngoko ke singalungelelanisa iimfuno zabo kwaye sive ngemiceli-mngeni abajongene nayo xa befikelela kwiinkonzo zempilo. Izinto ezifunyenweyo zokukuhlola zizakusetyenziselwa ukuphucula ukuphunyezwa kwe-AYFS e-Mpuma Koloni.

Kuya kwenziwa ntoni ngolwazi oluqokelweyo?

Ulwazi esiza kuluqokelela kubantwana abafikisayo kunye nolutsha luza kugcinwa luyimfihlo. Ulwazi olunxulumene neemfuno zempilo zabo zokwabelana ngesondo kwangoku kunye nokuzala, ukwazi kwabo kunye nofikeleleko kwiiNkonzo ezamkelekileyo Zabantwana abafikisayo kunye noLutsha (AYFS) kunye nokunconywa kwekhwalithi ye-AYFS abazifumeneyo ziza kubaluleka ekuphunyezweni kweenkonzo zempilo ezamkelekileyo neziphendulayo kwiimfuno zabantu abatsha. Ulwazi luza kuhlahlelwa ngendlela yesishwankathelo, ukolatha iimfuno zempilo zokwabelana ngesondo kunye nokuzala kwabantu abatsha kunye nokunceda ngokuphucula iiNkonzo ezamkelekileyo Zabantwana abafikisayo kunye noLutsha (AYFS) eMpuma Koloni.

Uya kubandakanyeka njani umntwana wam?

Umntwana wakho uzakucelwa ukuba athathe inxaxheba kuvavanyo apho azakudibana khona nabanye abantwana abafikisayo kunye nolutsha ekuphenduleni uluhlu lwemibuzo olukuvavanyo. Uvavanyo luza kugqitywa ngumntwana wakho ekunye noMququzeleli oqeqeshiweyo ukuze aphendule imibuzo, anikezele ngengcaciso kwaye acacise ngezinto ezixhalabisayo.

Uvavanyo luza kuqulatha imibuzo malunga nofikeleleko lomntwana wakho kwiinkonzo zempilo zokwabelana ngesondo kunye nezokuzala kunye nokwazi kwakhe, iingcinga, izimvo kunye nokuziphatha okunxulumene nempilo yokwabelana ngesondo kunye neyokuzala. Eminye yemibuzo izakuba buthathaka, kodwa umntwana wakho akekho ngaphantsi kwaso nasiphina isibophelelo sokuphendula nayiphi na imibuzo angakhululekanga ngayo ukuba ayiphendule. Angalandula ukuba athathe inxaxheba nangaliphi na ixesha, ngaphandle kwaso nasiphi na isohlwayo. Uvavanyo luza kuthatha malunga neyure ukuligqiba.

Umququzeleli uza kugcina lonke ulwazi oluqokelelweyo luyimfihlo ngexesha lovavanyo kwaye umntwana wakho akazukolathwa ngegama lakhe kuvavanyo; oku kuthetha ukuba iinkcukacha zakhe zokuba ngubani obebandakanyeka kuphononongo kunye neempendulo zakhe kuvavanyo akuzukwabelwana ngazo kunye nesikolo, nekliniki okanye nekhaya. Bonke

abantwana abathatha inxaxheba kuvavanyo baza kunikwa inombolo yekhowudi eyodwa, kwaye zonke iimpendulo zabo ziza kudityaniswa nalo nombolo. Ngalendlela, sinako ukugcina lonke ulwazi oluqokelelweyo luyimfihlo kwaye lungenagama. Le fomu iza kugcinwa ngokwahlukeneyo kuvavanyo kananjalo.

Ulwazi lomntwana wam buqu luza kukhuselwa njani?

Zonke iimpendulo kwimibuzo ekuvavanyo ziyimfihlo. Asizukubuza igama lomntwana wakho kolu vavanyo. Le fomu iza kugcinwa ngokwahlukeneyo kwidatha (iinkcukacha eziqokelelweyo) yophononongo, ngoko ke alukho ulwazi oluza kudityaniswa nawe okanye nomntwana wakho.

Aba bantu balandelayo bangafikelela kwiingxelo zethu kananjalo ukuqinisekisa ukuba amaxwebhu ovavanyo agcinwe ngokukhuselekileyo:

- Abaqapheli bophononongo, abaphulaphuli kunye nekuvunyelwene nabo abangasebenzela Umxhasi okanye nababandakanyekayo/abameli abagunyazisiweyo, abakhangela ukuba uvavanyo lwenziwe ngokuchanekileyo kwanokuba ulwazi oluqokelelweyo ngawe luchanekile;
- Iikomiti Zokuziphatha Zophando (Research Ethics Committees) ezithe zavumela olu vavanyo kwaye ziqinisekisa ukuba amalungelo kunye nempilo yakho zikhuselekile;
- Abasemagunyeni bolawulo besizwe kunye nehlabathi ababandakanyekayo ekugcineni uphando lukhuselekile kubathathi-nxaxheba.

Ulwazi esiluqokelelayo luza kujongwa kuphela ngendlela yesishwankathelo. Lonke ulwazi lwabuqu oluqokelelweyo ngexesha lokuthatha inxaxheba kwakho luza kubonwa kuphela ngamalungu abasebenzi ophando. Ukuba iziphumo zovavanyo zipapashiwe, ukolathwa kwakho kunye nokomntwana wakho kuza kuhlala kuyimfihlo.

Kuza kufuneka ndenze ntoni?

Ukuba uyamvumela umntwana wakho ukuba athathe inxaxheba ekuhlolweni, siza kukucela ukuba utyikitye lefomu ebonisa imvumelwano yakho (imvume).

Ingaba umntwana wakho uya kuzuza ngokuthatha inxaxheba kolu phando?

Umntwana wakho akayi kufumana nzuzo ngokuthe ngqo ngokuthatha inxaxheba kolu vavanyo. Kanti, angafumana inzuzo engekho ngqo ekwazini ukuba uthathe inxaxheba kuvavanyo olubalulekile olunganceda ekuphuculeni iinkonzo ezinikezelwa kulutsha kwiikliniki zikawonke wonke.

Ingaba kunaziphi na iingozi ezibandanyekayo kumntwana wakho ngokuthatha inxaxheba kolu phando?

Ukuthatha inxaxheba kolu phando akuzukubeka umntwana wakho nakobuphi na ubungozi bokwenzakala ngokwasemzimbeni. Kanti, kukho ubungozi obuthile obunokwenzeka obuyanyaniswa nolu phononongo. Umntwana wakho angaziva engakhululekanga ekuphenduleni imibuzo ekuvavanyo. Nceda ukhumbule ukuba umntwana wakho akanyanzelekanga ukuba aphendule nayiphi na imibuzo emenza ukuba angakhululeki. Ukuba umntwana wakho uva naluphi na uxinzelelo okanye ukungakhululeki ngokuthatha inxaxheba kolu phononongo, kufuneka ukuba azise uMququzeleli oza kubhekiselela umntwana wakho kumntu ofanelekileyo ngoncedo kunye nenkxaso. Umntwana wakho angayeka ukuthatha inxaxheba kuvavanyo nangaliphi na ixesha ngaphandle kwesohlwayo.

Nangona yonke imizamo iza kuthathwa ukuze kukhuselwe ukolathwa kwakho kunye nemfihlo yeempendulo zomntwana wakho kuvavanyo, kukho ubungozi bokuba idatha ingalahleka okanye kwabelwane ngayo neqela lesithathu. Abancedisi boPhando kunye nabaQuquzeleli baqeqeshwe ngokufanelekileyo ukuze kuncitshiswe obu bungozi, kwaye batyikitye izivumelwano zemfihlo ukukhusela lonke ulwazi oluqokelelweyo olusuka kule projekti. Nakuphina ukwaphulwa kwemfihlo kuza kuthathwa njenge tyala elibi, kwaye kuza kukhokelela kwintshukumo yesohlwayo.

Ukulibaziseka kungaba lixesha eliza kuthathwa ekuthatheni inxaxheba kuvavanyo, malunga neyure enye.

Ukuba akuvumi ukuba umntwana wakho athathe inxaxheba, loluphi ukhetho umntwana wakho analo?

Ukuba ugqiba ukuba umntwana wakho angathathi inxaxheba kolu phononongo, azikho izohlwayo.

Ingaba wena okanye umntwana wakho uza kubhatalwa ngokuthatha inxaxheba kolu phononongo kwaye ingaba zikhona naziphi na iindleko ezibandakanyekayo?

Ayikho intlawulo yokubandakanyeka komntwana wakho kolu phononongo kwaye wena kunye nomntwana wakho anizukubhatala nayiphi na into yokuba umntwana wakho athathe inxaxheba kuvavanyo.

Ngaba ikho enye into ekufanele uyazi okanye uyenze?

Thatha ixesha elide kangangoko ufuna ngaphambi kokwenza isigqibo. Siza kukonwabela ukuphendula nayiphi na imibuzo onayo malunga nolu phononongo. Ukuba unayo nayiphi na imibuzo okanye iinkxalabo, nceda ukhululeke ukuthetha neqela lophononongo apha ngezantsi.

- **UVAVANYO LOLUTSHA LWENKOKHELO YEPROJEKTHI:** Sarah Christie, 079-627-6953
- **UMQUQUZELELI WOVAVANYO:** Ntombenhle Ngcobo, 082-374-5542
- **UMPHANDI OYINTLOKO:** Gq. Sandy Pillay, 082-601-3872

IDILESI: Enhancing Care Foundation, 16 Charles Strachan Road, Westridge, Durban

Ukuba unayo nayiphi na imibuzo enxulumene namalungelo omntwana wakho njengo mthathi-nxaxheba wophononongo, ungaqhagamshelana ne-PharmaEthics eyiBhodi yokuHlola Ukuziphatha enoxanduva lokuhlola kunye nokuphucula olu phononongo kunye nazo zonke iinkqubo zayo eziyimfuneko. Iinkcukacha zabo zoqhagamishelwano ziyalandela apha ngezansi:

Pharma-Ethics Research Ethics Committee

PO Box 786

Irene, 0062

Umnxeba: (0) 12 664 8690

Ifeksi: (0)12 664 7860

i-imeyili:marzele@pharma-ethics.co.za

Ukuba akufumani iimpendulo ezikwenalisayo, usenakho ukuqhagamshelana ne-National Health Research Ethics Council ngolu hlobo lulandelayo:

National Health Research Ethics Council

Umnxeba: (012) 395 8113

Ifeksi: (012) 3958467

I-imeyili: nhrec@health.gov.za

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Tel: +27 21-959 2809, Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

Information Sheet for Use by Parents/Legal Guardians
(Youth Survey for Children aged 17 years and below)

Principal Investigator: Dr. Sandy Pillay, Project Lead

Study Title: Implementation of Adolescent and Youth Friendly Services (AYFS) in the Eastern Cape

Sponsor: GIZ

Introduction:

Your child or *a child under your care* is being invited to take part in a research study. Please take some time to read the information presented here, which will explain the details of this study. Please feel free to ask the study staff questions about any part of this study that you do not understand. It is important that you are fully satisfied and that you clearly understand what this study entails and how your child could be involved before you consent.

Your child's participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you or your child negatively in any way whatsoever. If you agree to let your child take part, you are also free to withdraw him/her from the study at any point.

This study has been approved by the PharmaEthics Research Committee and will be conducted according to the ethical principles of the International 2013 Declaration of Helsinki and adhere to the Guidelines for Good Clinical Practice which guides all research with human participants.

Why has your child been invited to participate?

Your child has been invited because she/he is an adolescent or young person (15 years of age or older) in one of the participating schools in the Nyandeni and Umzimvubu districts. Learners in Grades 9-11 are invited to participate.

What is this research study all about?

This is a research study being conducted by NGOs (i.e., non-governmental organizations) called Health Focus and the Enhancing Care Foundation who, in partnership with the Eastern Cape Department of Health (DoH), plan to assist facilities to set up youth-friendly services in the two sub-districts of Nyandeni and Umzimvubu.

The aim of the study is to understand the use of health services that are provided for youth by the Department of Health in the Eastern Cape. We would like to assess adolescent and youth friendly services (AYFS), specifically the sexual and reproductive health services and rights of young people. This may include services such as family planning, prevention and treatment of sexually transmitted infections (STIs), HIV & AIDS and TB, circumcision, antenatal care and post-natal care; post-exposure prophylaxis and emergency contraception. We would also like to

understand the current practices of youth, including their sexual behavior and drug and alcohol use, so we can tailor health services to their needs as well as hear about the challenges they face when accessing health services. The findings of this assessment will be used to improve implementation of AYFS in the Eastern Cape.

What will be done with the information collected?

The information that we will be collect from adolescents and youth will be kept confidential. Information regarding their current sexual and reproductive health needs, their knowledge and access of AYFS and their appraisal of the quality of AYFS they received will be important to implement health services that are acceptable and responsive to the needs of young people. Information will be analyzed in summary form, to identify the sexual and reproductive health needs of young people and assist with improving AYFS in the Eastern Cape.

How will my child be involved?

Your child will be asked to take part in survey where she/he will join other adolescents and youth in answering a series of questions on a survey. The survey will be completed by your child with a trained Facilitator to answer questions, provide clarification and address concerns.

The survey will contain questions about your child's access to sexual and reproductive health services and his or her knowledge, attitudes, opinions and behavior with regard to sexual and reproductive health. Some of the questions will be sensitive, but your child is under no obligation to answer any question he or she is uncomfortable answering. She or he may refuse to participate at any time, without any consequence. The survey will take approximately one hour to complete.

The Facilitator will keep all information that is collected during the survey confidential and your child will not be identified by his/her name on the survey; this means that the details of who was involved in the survey and the responses to the survey will not be shared with the school, the clinic or at home. All children taking part in the survey will be given a unique code number, and all their answers will be linked to that number. In this way, we are able to keep all information collected confidential and anonymous. This form will also be kept separate from the survey.

How will my child's personal information be protected?

All of the responses to the questions in the survey are confidential. We will not ask for your child's name on these surveys. This form will also be kept separate from the data of the study, so no information can be linked to you or your child.

The following people may also access our records to ensure study documents are stored safely:

- Study monitors, auditors and contractors who may work for the Sponsor or its affiliates/authorized representatives, who check that the study is being performed correctly and that the information collected about you is accurate;
- Research Ethics Committees that approved this study and ensures that your rights and well-being are safeguarded;
- National and international regulatory authorities involved in keeping research safe for participants.

The information we collect will only be looked at in a summary form. All personal information gathered during your participation will only be seen by members of the research staff. If the results of the study are published, your identity and that of your child will remain confidential.

What will I need to do?

If you agree for your child to take part in the assessment, we will ask you to sign this form showing your agreement (consent).

Will your child benefit from taking part in this research?

Your child will not benefit directly from taking part in this survey. However, she/he may find an indirect benefit in knowing she/he has taken part in an important survey that could help improve services provided for youth in public clinics.

Are there any risks involved in your child taking part in this research?

Taking part in this research will not put your child in any risk of physical or biological harm. However, there are some possible risks associated with this study. Your child may feel uncomfortable answering questions in the survey. Please remember that your child does not have to answer any questions that make him or her uncomfortable. If your child experiences any distress or discomfort by taking part in this study, he or she should inform the Facilitator who will refer your child to an appropriate person for help and support. Your child may stop taking part in the survey at any time without consequence

Although all efforts will be taken to protect your identity and the confidentiality of your child's responses on the survey, there is a risk that data may be lost or shared with a third party. The Research Assistants and Facilitators have been thoroughly trained to minimize this risk, and have signed confidentiality agreements to protect all information collected from this project. Any breaches in confidentiality will be considered a serious offense, and will result in disciplinary action.

An inconvenience may be the time it will take to participate in the survey, approximately 1 hour.

If you do not agree to allow your child to take part, what choices does your child have?

If you decide that your child should not take part in this study, there are no consequences.

Will you or your child be paid to take part in this study and are there any costs involved?

There is no payment for your child's involvement in this study and you and your child will not pay anything for your child to participate in the survey.

Is there anything else that you should know or do?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have any questions or concerns, please feel free to speak to the study team below.

- **YOUTH SURVEY PROJECT LEAD:** Sarah Christie, 079-627-6953
- **SURVEY FACILITATOR:** Ntombenhle Ngcobo, 082-374-5542
- **PRINCIPAL INVESTIGATOR:** Dr. Sandy Pillay, 082-601-3872

ADDRESS: Enhancing Care Foundation, 16 Charles Strachan Road, Westridge, Durban

If you have any questions related to your child's rights as a study participant, you may also contact PharmaEthics which is the Ethics Review Board that is responsible for reviewing and approving this study and all its required procedures. Their contact details follow below:

Pharma-Ethics Research Ethics Committee

PO Box 786

Irene, 0062

Tel: (0) 12 664 8690

Fax: (0)12 664 7860

e-mail: marzelle@pharma-ethics.co.za

If you do not receive answers that are to your satisfaction, you can also contact the National Health Research Ethics Council as follows:

National Health Research Ethics Council

Tel: (012) 395 8113

Fax: (012) 3958467

E-mail: nhrec@health.gov.za

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E-mail: soph-comm@uwc.ac.za

IFOMU YESIVUMELWANO

Isibhengezo somzali/umgcini osemthethweni

Uza kufumana isikhutshelo solu lwazi kunye nefomu yesivumelwano yeengxelo zakho

Ngokutyikitya ngezantsi, Mna (*igama lomzali/ umgcini osemthethweni*) ……..…… ndiyavuma ukuvumela umntwana wam (igama lomntwana) …… onobudala obu ……. beminyaka, ukuba athathe inxaxheba kuphononongo lophando olusisihloko esithi: *Ukuphunyezwa kweeNkonzo ezamkelekileyo Zabantwana abafikisayo kunye noLutsha (AYFS) eMpuma Koloni*

Ndiyavuma ukuba:

- Ndiyifundile okanye ndiyifundelwe le ngcaciso nefomu yesivumelwano yaye ibhalwe ngolwimi endilwazi ncam nendiluthandayo.
- Ukuba umntwana wam ungaphezulu kweminyaka eli-14 kwaye akekho ngaphezulu kweminyaka eli-17, yena kufuneka avume ukuthatha inxaxheba kuphononongo kwaye IMVUME yakhe kunyanzelekile ukuba ishicelelwe kule fomu.
- Ndiye ndanalo ithuba lokubuza imibuzo kwaye yonke imibuzo yam iphendulwe ngokufanelekileyo.
- Ndiyayiqonda into yokuba ukuthatha inxaxheba kolu phononongo **kungokuzithandela** kwaye andinyanzeliswanga ukuba ndivumele umntwana wam ukuba athathe inxaxheba.
- Ndingakhetha ukurhoxisa umntwana wam kuphononongo nangaliphi na ixesha kwaye umntwana wam angangahlawuliswa okanye atshutshiswe nangayiphi na indlela.

Ityikitywe e (*indawo*) .....…….. nge (*umhla*)……..……

.....	.....
Igama lomzali/umgcini osemthethweni	**Isignitsha yomzali/umgcini osemthethweni**
.....	.....
Igama lengqina	**Isignitsha yengqina**
.....	.....
Igama lomntu ozuza imvume	**Isignitsha yomntu ozuza imvume**

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E-mail: soph-comm@uwc.ac.za

Information Sheet
(Youth Survey for Young Persons aged 18 years and above)

Principal Investigator: Dr. Sandy Pillay, Project Lead

Study Title: Implementation of Adolescent and Youth Friendly Services (AYFS) in the Eastern Cape

Sponsor: GIZ

Introduction:

You are invited to take part in a research study because you are a young person (18 years of age or older) in one of the participating schools in the Nyandeni and Umzimvubu districts. Learners in Grades 9-11 are invited to participate.

Please take some time to read the information presented here, which will explain the details of this study. Please ask the study staff any questions about any part of this study that you do not understand. It is important that you are fully satisfied and clearly understand how you will be involved before you agree to take part.

Your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. If you agree to take part, you are also free to withdraw from the study at any point.

This study has been approved by the PharmaEthics Research Committee and will be conducted according to the ethical principles of the International 2013 Declaration of Helsinki and adhere to the Guidelines for Good Clinical Practice which guides all research with human participants.

What is this research study all about?

This is a research study being conducted by NGOs (i.e., non-governmental organizations) called Health Focus and the Enhancing Care Foundation who, in partnership with the Eastern Cape Department of Health (DoH), plan to assist facilities to implement and improve youth-friendly services in the two sub-districts of Nyandeni and Umzimvubu.

The aim of the study is to understand the use of health services that are provided for youth by the Department of Health in the Eastern Cape. We would like to discuss adolescent and youth friendly services (AYFS), specifically the sexual and reproductive health services provided for young people. This may include family planning, prevention and treatment of sexually transmitted infections (STIs), HIV & AIDS and TB, circumcision; antenatal care; post-exposure prophylaxis and emergency contraception. We would like to understand the current practices of young people, including their sexual behavior and drug and alcohol use, so we can tailor health

services to their needs as well as hear about the challenges young people face when accessing health services. The findings of this assessment will be used to improve AYFS in the Eastern Cape.

What will I be asked to do?
You will be asked to take part in a survey where you will answer a series of questions on a number of topics. The survey includes questions about your access to sexual and reproductive health services and your knowledge, attitudes, opinions and practices with regard to sexual and reproductive health. Some of the questions will be sensitive, but you are under no obligation to answer any question that makes you uncomfortable. You can also decline to participate at any time, without any consequence. The survey will take approximately one hour to complete.

A trained Facilitator will be available to answer questions, provide clarity and address concerns. The Facilitator will keep all information that is collected during the survey confidential and you will not be identified by your name on the survey; this means that the details of who is involved in the survey and the responses to the survey will not be shared with the school, the clinic or at home. All young people taking part in the survey will be given a unique code number, and all answers will be linked to that number. In this way, we are able to keep all the information collected confidential and anonymous. This consent form will also be kept separate from the survey.

What will be done with the information collected?
The information that we will collect from you will be kept completely confidential. Information regarding your current sexual and reproductive health needs, your knowledge and access of AYFS and your feedback on the quality of the health services you've received will be important to develop health services that meet the needs of young people. Information will be analyzed in summary form, to identify the sexual and reproductive health needs of young people and assist with improving AYFS in the Eastern Cape.

How will my personal information be protected?
All of the responses to the questions in the survey are confidential. We will not ask for your name or any other identifying details on these surveys. This form will also be kept separate from the data of the study, so no information can be linked to you.

The following people may also access our records to ensure study documents are stored safely:

- Study monitors, auditors and contractors who may work for the Sponsor or its affiliates/authorized representatives, who check that the study is being performed correctly and that the information collected about you is accurate;
- Research Ethics Committees that approved this study and ensures that your rights and well-being are safeguarded;
- National and international regulatory authorities involved in keeping research safe for participants.

The information we collect will only be looked at in a summary form. Any personal information gathered during your participation will only be seen by members of the research staff. If the results of the study are published, your identity will remain confidential. No one will see your responses beyond the study team.

Are there any risks involved in taking part in this research?

Taking part in this research will not put you in any risk of physical or biological harm. However, there are some possible risks associated with this study. You may feel uncomfortable answering questions in the survey. Please remember that you do not have to answer any questions that make you uncomfortable. If you experience any distress or discomfort by taking part in this study, you can inform the Facilitator who will refer you to an appropriate person for help and support. You may stop taking part in the survey at any time without consequence.

Although all efforts will be taken to protect your identity and the confidentiality of your responses on the survey, there is a risk that data may be lost or shared with a third party. The Research Assistants and Facilitators have been thoroughly trained to minimize this risk, and have signed confidentiality agreements to protect all information collected from this project. Any breaches in confidentiality will be considered a serious offense, and will result in disciplinary action.

An inconvenience may be the time it will take to participate in the survey, approximately 1 hour.

Is there any benefit from taking part in this research?

You will not benefit directly from taking part in this survey. However, you may find an indirect benefit in knowing that you are taking part in an important study that could help improve the health services provided for youth in your community.

Will I be paid to take part in this study and are there any costs involved?

There is no payment for your involvement in this study and you will not pay anything to participate in the survey.

Is there anything else that I should know or do?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem or concern, please contact:

- **TEAM LEADER:** Sue MacDonald, 043-721-1448 or 079-872-3139
- **YOUTH SURVEY PROJECT LEAD:** Sarah Christie, 079-627-6953
- **SURVEY FACILITATOR:** Ntombenhle Ngcobo, 082-374-5542
- **PRINCIPAL INVESTIGATOR:** Dr. Sandy Pillay, 031-261-1093

ADDRESS: Enhancing Care Foundation, 16 Charles Strachan Road, Westridge, Durban

If you have any questions related to your rights as a study participant, you may also contact PharmaEthics which is the Ethics Review Board that is responsible for reviewing and approving this study and all its required procedures. Their contact details follow below:

Pharma-Ethics Research Ethics Committee
PO Box 786
Irene, 0062
Tel: (0) 12 664 8690/ Fax: (0)12 664 7860
e-mail: marzelle@pharma-ethics.co.za

If you do not receive answers that are to your satisfaction, you can also contact the National Health Research Ethics Council as follows:

National Health Research Ethics Council
Tel: (012) 395 8113 / Fax: (012) 3958467
E-mail: nhrec@health.gov.za

APPENDIX E. Permission Forms

a. Youth Assent Form

b. Consent Form-Adult Caregiver of Minor Study Participant (<18 years of age)

c. Consent Form – School Survey (18+ years of age)

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Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

CONSENT FORM

Declaration by parent/legal guardian

You will receive a copy of this information and consent form for your own records

By signing below, I *(name of parent/legal guardian)* ……..…….. agree to allow my child (name of child) …….. who is ……. years old, to take part in a research study entitled: *Implementation of Adolescent and Youth Friendly Services (AYFS) in the Eastern Cape*

I declare that:

- I have read or had read to me this information and consent form and that it is written in a language with which I am fluent and comfortable.
- If my child is older than 14 years and not older than 17 years, he/she must agree to take part in the study and his/her ASSENT must be recorded on this form.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to let my child take part.
- I may choose to withdraw my child from the study at any time and my child will not be penalised or prejudiced in any way.

Signed at (*place*) .....……..…….. on (*date*) ……..……

.....	.....
Name of parent/legal guardian	**Signature of parent/legal guardian**
.....	.....
Name of witness	**Signature of witness**
.....	.....
Name of Person Obtaining Consent	**Signature of person obtaining consent**

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Part 2. Statement of Assent

Thank you for reading the information above. If you still want to take part in the research, please circle "Yes" in answer to the questions below and sign and date the Assent Form.

If you answer "No" to any of the questions, or you do not want to take part in the research, please DO NOT SIGN your name.

- Have you read or had someone read to you the Information Sheet? YES / NO
- Has somebody explained the study to you? YES / NO
- Do you understand what the research study is about? YES / NO
- Have you asked all the questions you want? YES / NO
- Were all your questions answered in a way you understand? YES / NO
- Do you want to take part in the research study? YES / NO

_____
Name of minor participant

_____ _____
Signature of minor participant Date

I attest that the minor participant named above had enough time to consider the information, had an opportunity to ask questions and voluntarily agreed to be in this study.

_____
Printed Name of Person Explaining Consent

_____ _____
Signature of Person Explaining Consent Date

_____ _____
Signature of Investigator/Project Lead Date

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E-mail: soph-comm@uwc.ac.za

I hereby verify that assent was obtained from the above minor participant. The participant has been informed about the risks and the benefits of the research, has been given the opportunity to ask questions and have them answered to the satisfaction of the participant and gave assent, without coercion or undue influence.

_____
Printed Name of Witness

_____ _____
Signature of Witness Date

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CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY

Study Title: Strengthening Adolescent and Youth Friendly Services (AYFS) in the Eastern Cape

I have read this form and confirm that I will take part in the project described above. The project has been described to me in language that I understand, including any possible risks, benefits and inconveniences. My questions about the project have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will.

I understand that all information collected will be kept confidential and that my identity will not be disclosed to anyone outside of the study team. I understand that I may withdraw from participation at any time without fear of negative consequences.

My signature also indicates that I have received a copy of this consent form.

_____	_____	_____
Participant Signature	Print Name:	Date:
_____	_____	_____
Signature of Person Obtaining Consent	Print Name:	Date:
_____	_____	_____
Signature of Project Lead/ Principal Investigator	Print Name:	Date:

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CONSENT FORM

Declaration by parent/legal guardian

You will receive a copy of this information and consent form for your own records

By signing below, I *(name of parent/legal guardian)* ……..…… agree to allow my child (name of child) …….. who is ……. years old, to take part in a research study entitled: *Strengthening Adolescent and Youth Friendly Services (AYFS) in the Eastern Cape*

I declare that:

- I have read or had read to me this information and consent form and that it is written in a language with which I am fluent and comfortable.
- If my child is older than 11 years and not older than 17 years, he/she must agree to take part in the study and his/her ASSENT must be recorded on this form.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to let my child take part.
- I may choose to withdraw my child from the study at any time and my child will not be penalised or prejudiced in any way.

Signed at (*place*) .....……. on (*date*) ……..……

.....	.....
Name of parent/legal guardian	**Signature of parent/legal guardian**
.....	.....
Name of witness	**Signature of witness**
.....	.....
Name of person obtaining consent	**Signature of person obtaining consent**

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IFOMU YESIVUMELWANO

Isibhengezo somzali/umgcini osemthethweni

Uza kufumana isikhutshelo solu lwazi kunye nefomu yesivumelwano yeengxelo zakho

Ngokutyikitya ngezantsi, Mna (*igama lomzali/ umgcini osemthethweni*) ……..…… ndiyavuma ukuvumela umntwana wam (igama lomntwana) …… onobudala obu ……. beminyaka, ukuba athathe inxaxheba kuphononongo lophando olusisihloko esithi: *Ukuqiniswa kweeNkonzo ezamkelekileyo Zabantwana abafikisayo kunye noLutsha (AYFS) eMpuma Koloni*

Ndiyavuma ukuba:

- Ndiyifundile okanye ndiyifundelwe le ngcaciso nefomu yesivumelwano yaye ibhalwe ngolwimi endilwazi ncam nendiluthandayo.
- Ukuba umntwana wam ungaphezulu kweminyaka eli-11 kwaye akekho ngaphezulu kweminyaka eli-17, yena kufuneka avume ukuthatha inxaxheba kuphononongo kwaye IMVUME yakhe kunyanzelekile ukuba ishicelelwe kule fomu.
- Ndiye ndanalo ithuba lokubuza imibuzo kwaye yonke imibuzo yam iphendulwe ngokufanelekileyo.
- Ndiyayiqonda into yokuba ukuthatha inxaxheba kolu phononongo **kungokuzithandela** kwaye andinyanzeliswanga ukuba ndivumele umntwana wam ukuba athathe inxaxheba.
- Ndingakhetha ukurhoxisa umntwana wam kuphononongo nangaliphi na ixesha kwaye umntwana wam angangahlawuliswa okanye atshutshiswe nangayiphi na indlela.

Ityikitywe e (*indawo*) .....…..…….. nge (*umhla*) ……..……

.....	.....
Igama lomzali/umgcini osemthethweni	**Isignitsha yomzali/umgcini osemthethweni**
.....	.....
Igama lengqina	**Isignitsha yengqina**

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Part 2. Statement of Assent

Thank you for reading the information above. If you still want to take part in the research, please circle "Yes" in answer to the questions below and sign and date the Assent Form.

If you answer "No" to any of the questions, or you do not want to take part in the research, please DO NOT SIGN your name.

- Have you read or had someone read to you the Information Sheet? YES / NO
- Has somebody explained the study to you? YES / NO
- Do you understand what the research study is about? YES / NO
- Have you asked all the questions you want? YES / NO
- Were all your questions answered in a way you understand? YES / NO
- Will you keep private and confidential all that you hear during this discussion, and not share it with anyone else? YES / NO
- Do you want to take part in the research study? YES / NO

_____
Name of minor participant

_____ _____
Signature of minor participant Date

I attest that the minor participant named above had enough time to consider the information, had an opportunity to ask questions and voluntarily agreed to be in this study.

_____
Printed Name of Person Obtaining Consent

_____ _____
Signature of Person Obtaining Consent Date

_____
Printed Name of Investigator/Project Lead

_____ _____
Signature of Investigator/Project Lead Date

I hereby verify that assent was obtained from the above minor participant. The participant has been informed about the risks and the benefits of the research, has been given the opportunity to ask questions and have them answered to the satisfaction of the participant and gave assent, without coercion or undue influence.

_____
Printed Name of Witness

_____ _____
Signature of Witness Date