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Adversity, psychological distress and sexual risk taking amongst 15 – 26 year olds in the Eastern Cape, South Africa

MZIKAZI NDUNA

Academic dissertation completed by published work

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DOCTOR OF PHILOSOPHY

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UNIVERSITY OF THE WITWATERSRAND

March 2012

DECLARATION

I declare that this study represents my own original work and has not been submitted in any form for any degree or diploma to any university.

Where use has been made of the work of others I have duly acknowledged and properly referenced that in the text.

Name: Mzikazi Nduna

Signature:  Date: March 2, 2012

DEDICATION

This thesis is dedicated, in loving memory, to the following persons: Lindiwe Thengwane, Mthokozisi Madiya, Yolanda Tshona, Zimasa Hloma and Nomathamsanqa Baduza.

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ABSTRACT

Title: Adversity, psychological distress and sexual risk taking amongst 15 – 26 year olds in the Eastern Cape, South Africa

Background: the subject of the mental health of young people in Sub-Saharan Africa has received very little research attention. Despite the fact that many in this region face ubiquitous material deprivation, childhood adversity, violence, AIDS and orphanhood which could result in distress, there is very little scientific understanding of the precursors of psychological distress. Understanding and intervening in young people is important as psychological distress is believed to precede one of the most common health problems facing young people, that is, risky sexual behaviours. This thesis aims to document and describe the prevalence of depressive symptoms in a sample of young people, develop an explanatory model for factors associated with depressive symptoms and distress, and explore links with risky sexual behaviours.

Method: This thesis is based on two studies that were both conducted in the Eastern Cape Province of South Africa. Study 1 was an analysis of cross-sectional and longitudinal data collected amongst young people aged 15 to 26 who were enrolled in a cluster randomised controlled trial evaluating an HIV prevention intervention. The study sample was drawn from volunteers who normally resided in villages and townships in and around the area within 1.5 hours drive radius of Mthatha. Volunteers were mostly recruited through schools. In each of the seventy study sites, approximately twenty males

and twenty females were included resulting in the enrolment of 2,801 volunteer participants.

Quantitative data were collected by a fieldworker-administered questionnaire in 2003/4 and 2004/5, and analysed separately for men and women, using STATA IC 11.0. A cross-sectional analysis of 2003/4 data was undertaken to investigate factors associated with depressive symptoms. Presence of depressive symptoms was established through a self report measure - the Centre for Epidemiological Studies on Depression Scale. Participants who scored above a cut-off point of 16 were considered to have depressive symptoms. Results for factors associated with the presence of depressive symptoms are presented in Paper I. The association between baseline depressive symptoms and sexual risk taking at baseline (2003/4) and twelve months later (2004/5) was explored. Here, participants with depressive symptoms were treated as an exposed group and were compared to those who scored below 16 on the symptom checklist within the same cohort. These results are presented in Paper II.

In Study 2, phenomenological experiences of distress were explored. In-depth face-to-face, one-on-one interviews with forty young people were conducted in isiXhosa between 2007 and 2008. Participants for Study 2 were recruited in Butterworth from the townships. The sampling approach was a non-random, non-probability approach, with participants who self-selected and volunteered on the basis of their interest in the research topic. The sample came from a town that was included in Study 1 and generally shared similar socio economic conditions, cultural experiences, and history as the other

community sites that participated in Study 1. Criteria for inclusion into the study included having no known clinical diagnosis of a mental health problem. Participants were aged 16 to 26 years.

Each interview took about forty five minutes to an hour. Data were analysed using the constant comparison approach and following recommendations for qualitative phenomenological studies. Findings from this study are presented in two papers. Paper III of this thesis presents a conceptual model based on discussions of perceived sources of distress by participants. Paper IV discusses the role of undisclosed paternal identity in causing distress.

Findings: In Study 1, the prevalence of self-reported depressive symptoms was 21% among women and 14% among men. Child abuse and neglect (aOR 1.34 95% CI 1.116, 1.55), substance use (aOR 1.98 95% CI 1.17, 3.35), perceptions of less cohesion in the community (aOR 1.2395% CI 1.07, 1.40), intimate partner violence victimisation (aOR 2.2195% CI 1.16, 3.00) and sexual violence before the age of eighteen (aOR1.45 95% CI 1.02, 2.02) were associated with depressive symptoms in women. For men, factors associated with depressive symptoms were child abuse and neglect (aOR 1.61 95% CI 1.38, 1.88), having lost a mother (aOR 2.24 95% CI 1.25, 4.00), alcohol abuse (aOR 1.63 CI 1.13, 2.35), having been forced by a woman to have sex (aOR 2.36 95% CI 1.47, 3.80) and conflict in the current sexual relationship (aOR 1.07 95% CI 1.01, 1.12).

Findings on the associations between depressive symptoms and risky sexual behaviours show that women with depressive symptoms at baseline were more likely to have dated a man five years or older than them in their lifetime (aOR 1.37 95% CI 1.03-1.83), had transactional sex (aOR 2.60 95% CI 1.37-4.92) and experienced intimate partner violence (IPV) at baseline (aOR 2.56 95% CI 1.89-3.46). Women with depressive symptoms were more likely to have experienced IPV a year later (aOR 1.67 95% CI 1.18-2.36) after adjusting for baseline IPV experiences. At baseline, in men, an association between depressive symptoms and perpetration of intimate partner violence (aOR 1.50 95% CI 0.98-2.28) and rape was evident (aOR 1.81 95% CI 1.14-2.87). Men who had depressive symptoms were also less likely to report correct condom use at last sex, at both baseline and twelve months later (aOR 0.50 95% CI 0.32-0.78 and aOR 0.60 95% CI 0.40-0.89).

Study 2 showed that family-based adversity, most notably perceptions of mother's distress, conflict over financial resources, undisclosed paternal identity and parental substance abuse caused distress in young people. A culture of silence in families on issues considered pertinent by participants, such as paternal identity appeared to intensify distress. From this study, sexual relationship problems, including intimate partner violence, an unacknowledged pregnancy, and violent transactional sexual relationship themes dominated women's narratives of distress. In their narratives, men described violence and sexual risk taking as expressions of anger directed towards women. They described using substances and sexual philandering as ways to express distress, and as coping mechanisms, although they in turn became sources of distress.

Discussion, conclusions and recommendations: This research reports a high prevalence of depressive symptoms among young people in South Africa and supports international patterns of a higher prevalence in women than men. Findings presented in this thesis have important implications as they show that structural factors that cause different forms of disempowerment are implicated in some of the psychological distress experienced by young people. For instance, gender power inequity, violence, cultural expectations of respect from youth and women, compounded by financial dependence on relatives were sources of vulnerability especially in the face of maternal orphanhood. When ones mother was perceived to be under distress and honest and effective communication within families was lacking this caused distress.

Depressive symptoms were associated with risky sexual behaviours commonly found among rural young people such as intimate partner violence, boys' sexual victimisation by women, relationship conflict and involvement in transactional sex. Though HIV prevalence among young men is lower than in women in South Africa, consistent failure to use a condom at last intercourse among men with depressive symptoms may ultimately increase risk for HIV infection. Hence, sexual health youth-friendly clinics should be aware of the links between depressive symptoms and sexual expression.

The strength of this thesis is in the mixed method approach to exploring psychological distress through qualitative and quantitative data. The quantitative study used a large sample and had a prospective component, which enabled the impact of depressive symptoms on sexual risk-taking to be studied in temporal sequence. This is valuable and

unusual in a dataset. However, it has a volunteer sample and its findings cannot necessarily be generalised to all young South Africans. Nevertheless, there is no reason to expect the associations described to significantly differ from those that would be found in a non-volunteer sample. Qualitative research is inherently non-generalising, but the methodology used here enables a depth of understanding an exposure of nuance that is not attainable through quantitative methods.

Prevention of depressive symptoms among young people in South Africa should start with interventions to reduce exposure to childhood adversity. Some of this distress could be reduced if relationship violence was prevented for women, pregnancies acknowledged and disputes resolved on time by the putative fathers. This research suggests that a reduction in young people's depressive symptoms could have positive benefits for reduction of HIV risk taking behaviours.

ABBREVIATIONS AND ACRONYMS USED

AIDS: Acquired Immunodeficiency Syndrome

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition

GBV: Gender Based Violence

HIV: Human Immunodeficiency Virus

IPV: Intimate Partner Violence

SASAS: South African Social Attitudes Survey

SSA: sub-Saharan Africa

STATS SA: STATISTICS South Africa

SYR: Status of the Youth Report

CHAPTER 1: INTRODUCTION

1.1 Mental health research of young people in low to middle income countries

Mental health research from low and middle income countries (LMIC) is underrepresented in the world's body of mental health research, constituting only 3–6% of published research [1]. Within this only a small fraction of publications address mental health issues of young people [1-2]. The lack of research on the mental health of young people from low and middle income countries hampers the development of evidence-based policy frameworks and effective interventions [3]. This thesis seeks to expand evidence on sources of psychological distress, factors associated with depressive symptoms and the association between distress and risky sexual behaviour from South Africa so that services informed by scientific evidence can help young people.

1.2 Overview of psychological distress and depressive symptomatology

This thesis investigates psychological distress, the presence and factors associated with depressive symptoms and the relations to risky sexual behaviors among young people

aged 15 to 26. Stress, distress, depression and depressive symptoms are terms that are sometimes used interchangeably. The term 'stress' is commonly used to refer to a relationship between a person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well being [4]. In this thesis, the term 'psychological distress' refers to subjectively described emotions and 'depressive symptomatology' refers to objectively measured presence of symptoms.

Psychological distress

The concept 'psychological distress' is used in research and practice to mean a host of psychological and emotional states, often referring to symptoms that are features of both depression and anxiety [5-7]. Psychological distress is described by Ridner as a '*…unique discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person*.' (pg 539) [8]. Subjective and emotionally painful experiences are also captured in narrative-based medicine and are reported to have correspondence to the psychological concept of distress [8-10].

Depressive symptoms

Mood disorders, including depressive symptoms, are known to pose a serious health problem in high and low-to-middle income countries [1-2, 11]. Depressive symptoms are constituent of depression, but are also conceptually distinguished from clinically

diagnosed depression. Thus the presence thereof is not regarded as equivalent to the presence of a depressive disorder [12-13]. This distinction is clarified in Hyde, Mezulis and Abramson, and by others, who assert that depressive symptoms are typically measured on a continuous scale of items which indicate a depressed mood whilst depressive disorder diagnosis results from a diagnostic interview [13-14]. However, the terms depressive symptoms, depressive mood, psychological distress and depression are found used interchangeably in different papers and sometimes within the same paper [15-20]. Typically assessed with a continuous measure, a cut-off point is set wherein scores above the cut-off are used to indicate a presence of a significant constellation of depressive symptoms [5, 20-21]. This thesis will address the prevalence of the presence of depressive symptoms rather than clinical diagnosis of a depressive disorder.

Instruments used to measure the prevalence of the presence of depressive symptoms in the general population of young people include the Beck Depression Inventory (BDI) [21-28], the Brief Symptom Inventory [23, 29], the Kessler K-10 [30-31], the Hopkins Symptom Checklist-25 [5] and the Centre for Epidemiological Studies on Depression Scale (CESD- Scale) [15, 20, 32-33]. These tools are based on a medical model that conceptualises illness as demonstrated through signs and symptoms. Symptoms are assumed to be expressions of the experience of distress, communicated as an ordered set of complaints. The BDI contains 21 questions of current symptoms and attitudes which could be rated from 0 to 3 in terms of intensity answerable on a 4-point likert scale from 1 to 4. The Kessler-K10 consists of 10 items that ask about feelings and behaviours in the 30 days preceding the interview. Experiences are reported on a 5-point likert scale from

'none' to 'all' of the time. The score of symptoms experienced is summed and an increase in the score indicates an increase in the degree of psychological distress with heightened frequency and intensity of reports [30].The Brief Symptom Inventory (BSI) is the shortened version of the Symptoms Checklist-90 inquiring about depressive symptoms in nine dimensions: somatisation; obsession-compulsion; interpersonal sensitivity; depression; anxiety; hostility; phobic anxiety; paranoid ideation; and psychosis. It is also a self-report instrument and respondents rank each item on a 5-point scale ranging from 0 (not at all) to 4 (extremely). Rankings represent the intensity of distress over the past week [23].

The Centre for Epidemiological Studies on Depression Scale (CESD- Scale), used in this study, consists of 20 items scored from rarely experienced (0) to experienced most or all of the time (3) over the previous week [33]. Scores range from 0-60 with 16+ commonly used as a cut-off point to indicate presence of depressive symptoms, sometimes referred to as 'probable depressive caseness'. The CESD- Scale has the longest history of use in behavioural studies. It is widely used in studies of the prevalence of the presence of depressive symptoms among young people internationally and locally. Its use has been diverse, and with different cut-off points in different studies [12, 15, 20, 32, 34-40]. For example, in their study, Moon, Mo and Basham excluded two of the items, added one of their own and used the 75^{th} percentile as a cut-off point for probable depressive caseness with US adolescents [36]. Wickrama and Wickrama investigated the implications of adolescent depressive symptoms on young adults' risky lifestyle in the US using only nine of the items [41]. In a large study of 12, 771 high school students in Canada, the

CESD Scale tool was used with 12 items and categorised into three levels of depression risk [15]. In some studies that include samples of people living with Human Immunodeficiency Virus (HIV), only the cognitive and affective symptoms of depression are asked about because the medical sequelae of HIV can mimic some of the symptoms of depressive affect [13]. For example, in a study of the prevalence of the presence of depressive symptoms among people living with HIV in Cape Town, Simbayi and his colleagues only asked 11 items to limit confounding of depressive symptoms with HIV disease-related symptoms [42].

There is a large amount of research on depression and depressive disorders among young people especially from the West, but since depression as a disorder is not the focus of this research these studies are excluded in this discussion. In the African continent there has been few studies conducted and for instance a study from West Africa using the Hospital Anxiety and Depression Scale (HAD) show that 39.9% of 15 to 25 year olds living with HIV in Nigeria were “depressed” [43]. In East Africa, a Kenyan cross-sectional study of 3, 775 randomly sampled students drawn from a stratified sample of 34.7% of all public secondary schools in Nairobi used multiple instruments and different cut-off points to measure distress. Depressive mood was measured using a culturally sensitive and locally designed screening test for general emotional pathology called the Ndetei-Othieno-Kathuku (NOK) scale for Depression and Anxiety [44]. Using the Child Depression Inventory (CDI), 25.7% of the respondents scored for clinical depression and using the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV)-based

instruments, clinical diagnostic scores for depression were recorded in 43.7% of all the students enrolled [44]. These prevalence rates seem very high.

There is an indication from a study that reports data from national records from community clinical psychologists that mood disorders as the most frequently (78.8%) presenting psychological problem in primary health care clinics in South Africa [45]. South African studies that assessed the prevalence of current depression report it to be between 8% and 10%, much lower than from other African research [46]. The stringent definition referring to clinical depression in typical South African studies excludes undiagnosed sub- clinical depressive symptoms, which is the area of study pursued in this thesis [47-49]. To date, there is little research into psychological distress and the prevalence of the presence of depressive symptoms in the general population of young people in South Africa. As a result the magnitude of psychological distress in young people in South Africa is unknown and there is little understanding of factors that contribute to it. The next section gives an overview of the state of research on psychological distress and the prevalence of the presence of depressive symptoms in the general population of young people.

1.3 Prevalence of the presence of depressive symptoms among young people

The prevalence of the presence of depressive symptoms observed in studies from different geographical regions varies [21, 50]. However variations in data sources, selection criteria for study participants, versions of the scales and cut-off points used mean that it is difficult to get comparability in prevalence rates of depressive symptoms between samples of young people from different regions and countries within regions [13, 15, 51].

Prevalence of the presence of depressive symptoms among young people globally

Canada, a high income country, reports a prevalence of depressive symptoms among young people of less than 10% [15, 52]. A study of 2,189 high school students from New York aged 13 to 18 found that 11.1% scored above the BDI cut-off point of 16+ [21]. Globally, studies report a gender difference in prevalence rates, with more females reporting the presence of depressive symptoms than young men [15]. Evidence that females are more likely to have depressive symptoms than males emerges as early as age 11, but is mostly pronounced by age 15 [18, 32, 39, 44, 53-59]. Higher prevalence of elevated depressive symptoms was found in a Canadian study where 8.6% of female high school students reported elevated depressive symptoms compared to only 2.6% of the males [15]. In Swedish early adolescents aged 13 to 15, depressive symptoms were

reported using the child version of the CESD Scale and girls had higher levels of depressive symptoms compared to boys [16].

A cross-sectional, population-based study assessed the prevalence of depressive symptoms among 18–49 year-olds in five districts in Botswana with high HIV prevalence rates. Using the Hopkins Symptom Checklist for Depression (HSCL-D) [60], among the 1,268 adult participants surveyed, 25.3% of women and 31.4% of men had depressive symptoms. Because SSA studies tend to include older people and do not analyse and present data by age groups, in as far as the mental health of young people in Sub-Saharan Africa is concerned it is not known how extensive the problem of psychological distress and depressive symptoms is [61].

South African studies of the prevalence of the presence of depressive symptoms among young people

There are only four South African studies that have investigated the prevalence of the presence of depressive symptoms among the population of young people. A study by Reddy, James, Sewpaul, Koopman, Funani, Sifunda, et al. found that 23.6% of young people aged 11 to 20, reported 'feeling sad or hopeless' to the extent that it interfered with their daily activities in the six months prior to the survey [62]. Sadness, hopelessness, low levels of happiness and dissatisfaction with life reported in this study do not necessarily equate with depressive symptomatology. Mkhize and colleagues conducted a small clinic-based study among University students attending the University

of Transkei's Health Service to determine the prevalence of depressive symptoms using the Beck Depression Inventory. The Beck Depression Inventory, like the CESD Scale, measures the presence of depressive symptoms in a sampled population and can be used to determine probable caseness. 53% of their study participants reported experiencing mild to severe depressive symptoms [55]. In this study pre-existing illness could have affected the mental state of participants and inflated their feelings associated with a depressed mood. Similarly a high prevalence of depressive symptoms was reported in a cross-sectional study conducted in a peri-urban settlement outside Cape Town with participants aged 15 years and older. Here the prevalence of depressive symptoms was also high among females; 42.3% and 25% among males [32]. This study sample included adults and data analysis was not disaggregated by age. A study of South African high school pupils aged 17 to 24found that 12.6% had depressive symptoms [63]. In Cape Town 13 to 17 year-old girls had higher levels of depressive symptoms compared to boys [16, 64].

There have been a handful of other studies but these had very weak study designs and are not relevant to understanding young people in community settings [27-28, 32, 39, 65-67]. For example, two other South African studies included samples of the age group eighteen years and older and samples of those at high risk of distress such as micro-loan borrowers, and found the prevalence of depressive symptoms to be as high as 50 and 64% for men and women respectively [32, 39]. One study of suicide and depressive symptoms amongst young people in South Africa did not report the prevalence of depressive symptoms in the sample [25]. Thus many of these South African studies cannot be used

to understand distress and the proportion of young people that experience depressive symptoms.

1.4 Aim and objectives

This thesis describes the prevalence of, and factors associated with depressive symptoms and phenomenologically explore sources of psychological distress for young people. The thesis further describes the associations between depressive symptoms and risky sexual behaviour among young women and men aged 15 to26 in the Eastern Cape, South Africa. The specific objectives of this thesis are to:

1. describe the prevalence of depressive symptoms in a sample of young people aged 15-26 (Paper I)
2. describe factors associated with depressive symptoms in a sample of young people aged 15-26 (Paper I)
3. present and describe associations between depressive symptoms and risky sexual behaviors in a sample of young people aged 15-26 (Paper II)
4. explore and model phenomenologically identified sources of distress for young people (Paper III)

5. describe the role of undisclosed father's identity in distress among young people (Paper IV)

1.5 Thesis structure

Chapter 2 examines theories of adolescence in order to present an understanding of the developmental context of young people. This chapter also reviews literature on factors associated with distress, depressive symptoms and the association between these constructs and risky sexual behaviours for HIV infection.

Chapter 3 provides an extended description of the methods used to undertake the research. The two studies described here approached the subject from a public health perspective and used two methodological approaches that complement each other: Study 1 was a quantitative survey and study 2 an in-depth qualitative study. Each study is described; study limitations and ethical issues are also presented separately for each study.

Chapter 4 presents a group of four papers as a collective to further the understanding of psychological distress and depressive symptoms among young South Africans. At the time of submission of the final thesis, three of these papers were published and the other one was under review in a peer reviewed journal. Paper I presents the prevalence of and factors associated with depressive symptoms in a sample of young men and women

(Nduna et al., under review). Paper II explores the association between depressive symptoms and sexual behaviours (published, Nduna et al., 2010). Paper III explores young people's subjective experiences of distress (published, Nduna and Jewkes, 2012). Paper IV explores the role of undisclosed paternal identity in distress among young people (published, Nduna and Jewkes, 2011).

Chapter 5 presents a consolidated discussion of the contribution made by this collection of papers in advancing knowledge on sources of psychological distress and depressive symptoms among young people. In this chapter, the relationship between depressive symptoms and risky sexual behaviours is discussed in light of both the cross-sectional and prospective data. In conclusion, a summary of the results, recommendations for further research and interventions are provided.

CHAPTER 2: LITERATURE REVIEW

A literature search was conducted for this thesis using the MEDLINE, Ovid, Google scholar, and PscyhINFO databases for the past 15 years. When gaps were found in the literature the years were extended to include some older papers. The key words used were psychological distress, emotional distress, distress, depressive mood and depressive symptoms together with the words among young people, youth, young adults and adolescents. The term 'depression' and 'minor psychiatric disorders' were also included in the search because some reports of depressive symptoms, using a symptom scale, used these terms [19, 34, 46, 63].

The South African Department of Health's Policy guidelines consider people aged 10-19 years to be 'adolescents' and 20- 24 as 'youth' [68-69].This thesis focuses on young people. Different names such as youth, young adults, teenagers, adolescents, youngsters and emerging adults reflect the diverse perspectives on this group of people; notably varying by age, gender, lifestyle, culture, ethnicity, household roles, educational achievement, socio-economic conditions, civil status, different politico-religious contexts and times [70-86]. 'Young people' is a term that is commonly used in studies similar to this one which have included participants such as secondary school pupils, adolescents and youth between the ages of 14 and 24 years [63, 85, 87-88]. In some studies that report on participants aged 10 to 18, the term young people is used though they could be considered as adolescents [87, 89-90]. Other studies use the term adolescence, youth and young people in the same publication [16, 18]. This may be seen to be creating some

inconsistency about the actual meaning of these terms but it also reflects the fluidity of the definition of a 'young person' between authors, times and contexts. This fluidity allows for flexibility (and some interchangeability) in use of these terms. In this thesis I will use the term 'young people' which incorporates adolescents and youth aged 15 to 26.

This chapter presents an overview of prominent theories of adolescence, discusses factors associated with psychological distress and depressive symptoms and what is known about the association with young people's risky sexual behaviour. The focus is national with reference to the African continent, but also some global trends.

2.1 Theoretical perspectives on adolescence

It is relevant in this thesis to give a brief understanding of the developmental context of young people as this has an important impact on the development of distress and depressive symptoms in young people [16]. Adolescence is regarded as a processual transition period between childhood and adulthood [91]. It is characterised by pubertal biological changes, followed by qualitative cognitive and social changes. The social changes are subjective and yet contextual. A century ago, puberty, was branded a 'storm and stress' period by Hall [92-93]. Years later, different interpretations emerged rejecting this as misinterpretation and stereotyping. Prominent psychologists such as Piaget, Erickson, and Vygotsky, emerged and continue to influence worldviews on young

people's development. These theories are extensive and only the basic assumptions of each in relation to adolescent mental state and mood will be highlighted here.

2.1.1 Jean Piaget's Cognitive Development Theory

Piaget's theory accounts for adolescents' intelligible decision-making which results from qualitative cognitive development. Adolescence is at Piaget's fourth stage of cognitive development called Formal-Operations, which is from age 12 until adulthood [76, 94]. During this stage, adolescents achieve an ability to devise plans, generate hypotheses of possibilities, think critically and solve problems systematically by testing solutions and can arrive at correct conclusions if they are provided with concrete facts as evidence [76, 78]. Ego-centrism is characteristic of this stage. This is when adolescents develop a 'personal fable' - a belief in uniqueness and that experiences happening among others will never happen to them, coupled with a tendency to think that everyone is as preoccupied with them as they are with themselves [76].

Romer, concurs by saying that adolescent rise in impulsive behaviour is due to these neuropsychological qualitative brain changes, the confluence of developmental events and a relative inexperience in coping with novelty [95]. Interpersonally, adolescents develop abstract thought processes that allow them to examine their own thoughts, develop an increased awareness of others and interpret and monitor the social world around them for contextual or situational variability; this social monitoring is called social cognition [76, 78-79, 82, 96-102]. Young people would begin to compare

themselves to ideal characteristics and appear to ask a lot of questions as they begin to discuss a wide range of issues that are important to their becoming adults [76, 79]. Socially, during this period adolescents usually establish autonomy, full adult power, status and privileges but sometimes society's framing of them as children denies them this opportunity [75-76, 78]. At times, they find it challenging to plan for their future, and this is what makes some conclude that this is a 'crisis stage' [76, 79]. However, this reference to 'crisis' is not necessarily a reference to depressive mood.

2.1.2 Erick Erickson's Life-span Development Theory

Building on the cognitive development theory Erik Erickson launched a developmental theory that emphasises the achievement of identity as a milestone for young people and a stepping stone to adulthood [103]. Adolescents are at Erickson's fifth stage of life-span development called identity vs. identity confusion. According to Erickson, adolescence spans ages 10 to 20. Erikson describes identity as a 'sense' of a stable concept of oneself as a unique individual and further regards it as a stance of embracing an ideology or system of values that provides one with a sense of direction. The development of identity is observed to start before adolescence and extends beyond it but is particularly intense during this time as young people are confronted with many new roles of adult status. When developmentally appropriate young people at this stage should emerge with a socially integrated self-concept [96, 104].

Childhood cognitive development and pre-adolescence experiences of family relations set the scene for the achievement of a healthy identity. For example, adolescents who feel rejected, neglected or distanced from their parents tend to not achieve a fully integrated identity [79, 82, 104]. Ericksonians acknowledge the achievement of Piaget's formal operations as important in facilitating identity development, though critics such as Shaffer suggest that the use of higher level intellectual abilities: abstract thoughts, logical and sophisticated reasoning about identities may be peculiar to industrialised societies and not so much relevant to young people in the more traditional African, less industrialised settings [78].

In search of a coherent identity, adolescents question who they are and this may explain why those who grow up not knowing their fathers want to find them [105-106]. Some texts suggest that achieving identity means independence and autonomy wherein children stretch their social networks with friends relying more on peer acceptance than parents' advice, resulting in less structure and adult guidance [77, 79, 96]. This view has been disputed by others who argue that spending more time with peers does not necessarily mean family is less important, indeed young people may accept, rather than reject, parental and societal values, which is desirable and good for own identity [70, 74, 78, 82]. According to the Ericksonians, the turmoil that characterises adolescence results from the failure to develop adequately a coherent sense of self resulting in an unclear, fragmented sense of self that is constitutive of the 'identity crisis' [77, 94]. As with Piaget's discussion of 'crisis', there is no clearly established theoretical connection made between the identity crisis and common depressive mood in young people.

2.1.3 Lev Vygotsky's Social Development Theory

Piaget and Erickson's theories have made a significant contribution in psychology but underplay cultural influences. Lev Vygotsky later wrote extensively and argued that adolescents are not independent of social and cultural influences; the skills that they acquire and the identity they emerge with are specific to their culture rather than a result of universal cognitive structures [70, 74, 107]. Steinberg [108] and Graber et al. [91] concur that adolescent biological development is embedded in the social world, their physical maturity commensurate with behavioural expectations and influence from peers, parents, teachers and media. This is no where illustrated more effectively as in a South African text on the identity of white Afrikaner students [109]. In his book, Prof Jonathan Jansen illustrates how for nearly four and a half decades, until the end of Apartheid era in South Africa, white Afrikaans schools, universities, churches and sports shaped the identity of white Afrikaans young people[109]. According to Prof Jansen the cultural knowledge of being a '*volk*', an Afrikaner, which is embedded in the emotional, psychic, spiritual, social, economic, political and psychological lives of a white community and contributes to the identity of white Afrikaner young people in South Africa [109]. To support that young people's development is culturally relevant an examination of indigenous local material suggests constructions of young men (as opposed to teenage boys) are based on age-set differentiation in the Xhosa people of the Eastern Cape [51, 70, 74]. These are intricately linked to initiation rituals from boyhood to manhood, such as *ukwaluka*- a traditional ritual that includes circumcision as a mark of

growing into an adult man. Among white South Africans it is different as university education and associated accomplishments may indicate the transition from boyhood to young adulthood [110].

As adolescents begin to think differently about themselves, so do their parents and peers who act differently towards them [76, 96]. In support of this analysis, Arnett demonstrates that in middle-class America, adolescence may be characterised by storm, stress, rebellious or disagreeable character, an increased need for independence and decision-making, but not so in less industrialised societies [111]. According to Vygotsky's social development theory, and authors such as Fatusi & Hindin, the concept of self (during adolescence) is related to family as a moral guiding compass. The interaction of the adolescent and their family provides a social system with reciprocal relationships and alliances that are constantly evolving [78, 112-114]. For instance, family presence and support (i.e. cohesion, feeling valued by family and believing that one's family is there for advice and as confidants) is known to predict and prevent late adolescent mental health problems such as depressive symptoms in American Caucasian and some third world contexts [113-121]. Psychology literature that continues to brand the period between childhood and adulthood, in a stereotyped manner, as a time of 'stress and turmoil' are oblivious to this disconfirming evidence. What is known is that the inevitability of this is disputed by evidence from cross cultural studies [70, 75-77, 79, 82, 104].

Whilst these psychological theories continue to shape views on young people, there is a more recent advancement that aims to separate late adolescents as a distinct stage of 'emerging adults' [84, 122]. Arnett coined the term 'emerging adulthood' and in 2000 he formally proposed a theory aimed at separating emerging adults from adolescents [84]. According to Arnett most people during this stage have not fully settled into adult roles but may be spending their time trying to finish school; they reach legal age, attain decision-making, financial independence, gradually make their choices in love and may get married [72-73, 84]. Emerging adults have neither roles nor obligations that adolescents copy from their parents, nor do they have responsibilities of structured family, work and community [84, 123]. Arnett's theory is supported by research from Finland which found a shift during this stage to goals that are more family, career and health orientated [124].

However, accumulated evidence in contemporary South Africa indicates a common phenomenon of emerging adults living at home, often leaving school over the age of 18 and experiencing unemployment thus adulthood that was attainable at this age up to 40 years ago is not attainable now [51, 70, 125]. It may be possible that many young people feel some sort of expectation of fulfilling an adult role that actually isn't attainable due to unemployment and also cultural shifts in expectations that seem to be prolonging adolescence and delay 'adulthood'. These context specific factors may contribute to a sense of stagnation and distress among young people in South Africa. Though there is good scientific evidence to help increase responses to address young people's mental health issues, research response on mental health is still very weak in South Africa.

2.2 Factors associated with psychological distress and depressive symptoms among young people

Studies of risk factors for depressive symptomatology and psychological distress in young people recognise that the underlying problems are widespread and complex. From a public health perspective, psychological distress is viewed as a multifaceted phenomenon, a product of the intersecting of biological factors (personal/individual), structural factors (community/social risk), psychosocial factors (interpersonal/relationship, family, social support) and behavioural factors (substance use). The next section discusses factors associated with depressive symptoms following a framework informed by this public health perspective. It is important to keep in mind that there are a lot of intersections between and within these groups of factors. In the discussion gender differences are highlighted where there is information from gender analysis in the original papers. The biological factors are briefly introduced and details are presented in the discussion of the factors that are most relevant for this thesis: the structural and psychosocial factors.

In general very few qualitative papers have been published in Psychology publications in the past ten years. Lyons and colleagues report that in the PsychINFO database, during the years2000 and 2010, only 13 qualitative studies were published in the Journal of Black Psychology [126]. This translates into just one paper per year and these were not necessarily on distress among young people. In undertaking a review of literature for

qualitative studies on distress there were papers that presented exploratory models of distress in low income settings such as the sub-Saharan Africa and India. One such research from Zambia that followed a schedule for qualitative interviews with older married women broadly questioned about mental health [127]. Another qualitative study by Pereira and colleagues from India targeted 35 'ever married' women who were purposively sampled and were found, from pre-screening, to have a depressive disorder [128]. These results are not suitable as a reference point for this study as their experiences may be biased and different from those of young participants with no known mental health problem. Some qualitative studies that report sources of distress, though they may not have been specifically designed to answer this question are included in this review. This is so because of the dearth of qualitative studies specifically focussed on this topic as pertaining to young people. The most relevant qualitative papers for this study would have been those of the experiences of young black people with distress. Such studies are not well represented in published material.

Figure one shows a framework that demonstrates factors associated with depressive symptoms. The presentation of the literature review follows a structure that first presents global evidence, then moves to the sub-Saharan region (where there is evidence) and discusses in more detail literature from South Africa where it exists.

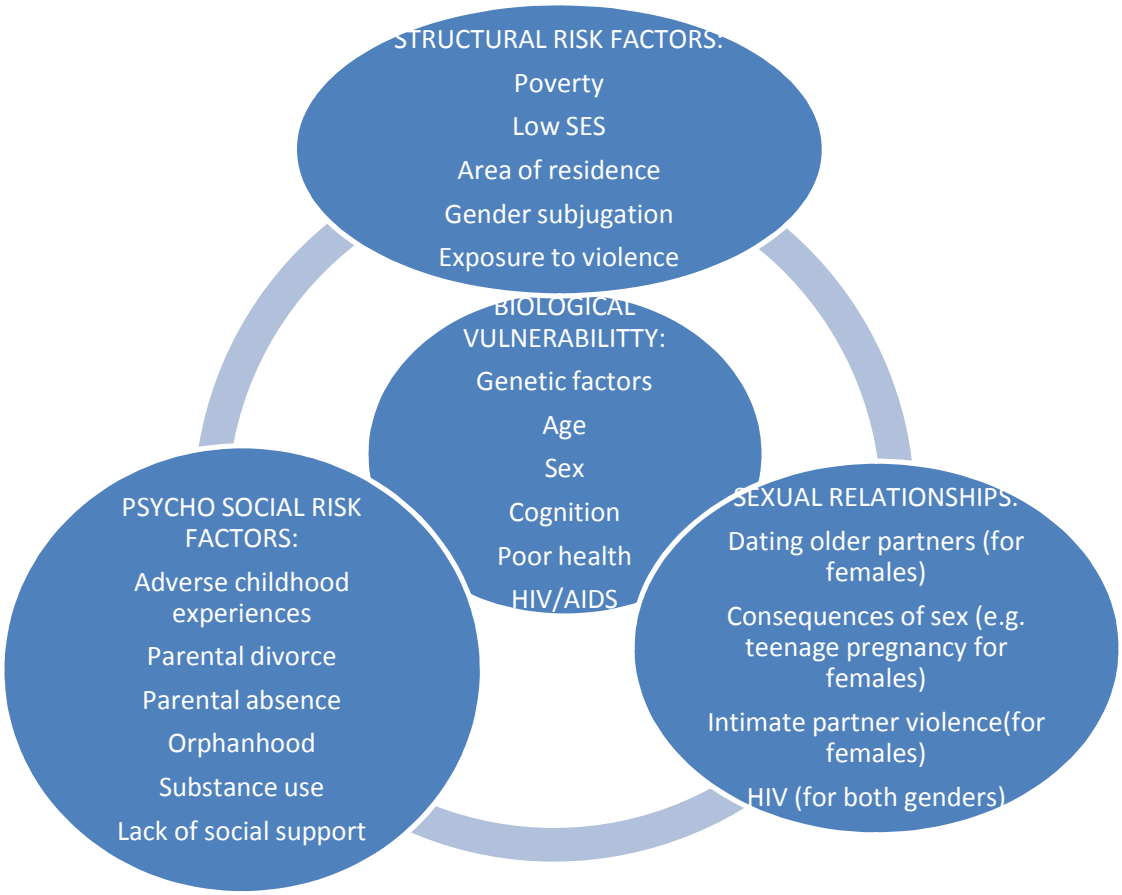


Figure 4: Framework for understanding risk for depressive symptoms among young people

2.2.1 Biological risk factors for depressive symptoms among young people

This section considers biological factors and their association with depressive symptoms among young people. Biological factors, including genetics, hormones and brain

development are known to contribute to depressive symptoms among young people [14]. In their review of literature, Colman and Ataullahjan bring to the fore the importance of neo-natal adversity on later development of depressive affect [129]. They emphasise that though findings from different studies conflict on the role of low birth weight and genetic factors, these remain important antecedents for later development of depressive symptomatology [129]. For men in a US study, neonatal and childhood health problems predicted depressive mood in young people [130].

Age is considered a risk factor for depressive symptoms in some studies. There is evidence of the presence of depressive symptoms from childhood [131] and literature on early adolescents suggests that at the beginning of this stage (around age 13) young people are already displaying depressive symptoms [16, 64]. However this should not be interpreted to fundamentally mean that distress and depressive symptoms are essential during this developmental stage. The current study is focused on a truncated age group but it is useful to mention that there is variability in observed associations between age and the prevalence of depressive symptoms in younger adolescents [15-16] and young people: a group that includes older adolescents and youth [14]. The differential impact of the risk factors discussed in this thesis start to be evident in adolescents aged 14 and younger [87].

Pubertal processes that reflect age appropriate and sex differential developmental changes during adolescence contribute to depressive symptoms in young people. Recent research from England shows that girls with early menarche (<11.5 years) have the highest level of

depressive symptoms at 13 and 14 years compared to those with normative and late onset of menarche [132]. Sex as a variable may be an indication of the differential impact of hormonal changes on mood during adolescence. One theory is that the rise in adrenal androgens, sex steroids and/or the gonadotropins in adolescents may cause the increased rate of depressive mood [14]. In addition, the various physical changes across the span of pubertal development impacts on a girl's body image and increases stress that may result in depressive symptoms [14]. A study reports that girls have more negative body esteem than boys and the tendency for girls to experience negative beliefs about their bodies is unhealthy and is argued to be a form of cognitive vulnerability that intensifies propensity for depressive symptoms in young people [14]. Another piece of evidence shows that among US female adolescents depressive symptoms are significantly associated with perceptions of low body satisfaction [133]. However, perceptions of low body satisfaction could be indicative of low self esteem that is associated with other psychological problems [133]. Hence it is likely that some of these negative self evaluations are symptoms of distress themselves.

These differences in males and females are noticeable in studies of other factors associated with depressive symptomatology. Hence, females are reported to have higher exposure to risk for depressive symptoms and this may lead to higher incidence, prevalence and a more severe disease development course in females [14-15, 26, 52, 87, 134].

Specific personality and cognitive factors such as trait inhibition and a tendency to generally expect negative outcomes are established to be associated with depressive symptoms in young people [14, 135]. A summary of research papers in Hyde, Mezulus and Abramson show that individuals with negative cognitive attributional styles are more prone to depressive symptoms. These are people who tend to ruminate over negative experiences, experience hopelessness and make negative inferences about self, causes of events and consequences [14]. Sometimes, as reported in a study of restrictive emotionality and depressive symptoms among New York high school students, young people who are unable to express their emotions also present with depressive symptoms [21]. This association could be bidirectional. The biological and personality vulnerability factors discussed here act as risk factors and predisposes one to depressive symptoms in the presence of negative events. Some specific personality and cognitive styles will influence how young people respond in the face of adversity resulting from experiences related to negative structural factors such as those discussed in the upcoming sections.

General poor health as a risk factor for depressive symptoms among young people

Studies show that depressive symptomatology sometimes coexists with other health problems [13, 136-137]. For instance, in the north of Vietnam self-rated poor general health predicted depressive mood in young men [121]. For example, depressive symptoms are significantly associated with lack of physical activity and irregular sleep

patterns [133]. It is also possible that being ill can result in depressive symptoms whilst depressive symptoms may make one feel physically ill. Hence distress has also been found following an unsuccessful suicide attempt, though it often precedes it too [138]. The impact of chronic illness on the development of depressive symptoms among young people emerges early [87]. During the literature review process for this study it became apparent that there is a lack of research from Southern Africa on the role of genetics, sex hormones and poor general health in the development of depressive symptoms specifically in young people.

HIV and AIDS as risk factors for depressive symptoms among young people

There is global evidence that HIV and AIDS are associated with depressive symptoms in different samples of people living with HIV. From a prospective, observational cohort study of 180 persons newly diagnosed with HIV infection, 67% screened positive for depressive symptoms on an administered battery of instruments including the CESD-Scale [19]. Sometimes, in samples of people living with HIV, the presence of depressive symptoms is associated with being female, having lower income and use of substances [19].

HIV prevalence is low among young people in sub-Saharan Africa but starts to rise in young adulthood. At this point a bi-directional relationship exists, with depressive symptoms predicting HIV risk taking (*discussed later in the section on depressive*

symptomatology and HIV risk) and vice versa. A study from Uganda shows that women older than 50 years who have a CD4 cell count of less than 50 cells/microl reported more depressive symptoms [139]. A CD4 cell count of less than 50 indicated that the participants would have been very ill. This sample was quite old [139] so in this study illness and old age may have confounded the risk of HIV on depressive symptoms. A cross-sectional population-based study conducted among 1,268 participants aged 18–49 years old in five districts in Botswana with high HIV prevalence rates yielded very high prevalence rates of participants with depressive symptoms. Using a Hopkins Symptom Checklist for Depression (HSCL-D) 25.3% of women and 31.4% of men were found to have symptoms of depression [60]. However, it is not clear if the respondents themselves were living with HIV in this Botswana study; what is reported is that the sample was drawn from a high HIV prevalent population. Therefore there is no conclusion that living with HIV was associated with reporting depressive symptoms, what is reported is that among other factors, anticipated HIV stigma (fearing discrimination if HIV status was revealed) was also independently associated with depressive symptoms(2.04 OR 1.27–3.29) [60].

HIV is an important and common health condition in South Africa that plays a role in influencing the presence of depressive symptoms [13, 42]. However, HIV prevalence is around 1.1% among South African adolescents 12–14 years of age and about 4.5% among teenagers 15–18 years, at which point it starts to mainly reflect sexually transmitted infections [140-141]. The prevalence then picks up and sex differences show it to be around 12% among young women and remains below 5% among young men

[142-143]. A longitudinal study of 65 recently diagnosed HIV positive patients in a public clinic in Cape Town, South Africa, reveals that 34.9% reported depressive symptoms at baseline and 26% six months later [144]. From this same data depressive symptoms were found to be associated with being female (OR1.23 95% CI 1.56-1.93), having more negative life events (OR 1.13; 95% CI 1.03-1.23) and disability (OR1.51 95% CI 1.28-1.80)[145]. There are underlying biological processes of HIV and immune activation involved that induce depressive symptoms in infected people as well as social variable correlates [13]. Simbayi et al. conducted a study among 420 men and 643 women attending an AIDS service in Cape Town. These participants were racially diverse and represented a broad spectrum of ages with some under 25 and over 36 years old. Using a shortened version of the CESD Scale Simbayi et al. found that internalised AIDS stigma accounted for 4.8% of the variance in cognitive-affective depressive symptoms [42]. This confirms an existing hypothesis that HIV/AIDS stigma leads to depressive symptoms [13]. The two studies referred to here have an older mean sample age (±30 years). It is possible that the associations may be different with younger samples. Currently, no study in Southern Africa has investigated the relationship between having HIV and depressive symptoms in a sample of young people specifically. Despite South Africa being a high HIV incidence and prevalence country, there is a lack of research on the association between perinatal transmitted HIV and the later development of depressive symptoms among young people living with HIV. The next discussion focuses on factors which are structural, behavioural and psychosocial, and which are relevant for this thesis.

2.2.2 Structural risk factors for depressive symptoms among young people

The next section is going to discuss structural factors associated with depressive symptoms such as area of residence, low socio-economic status, gender disadvantage, orphanhood, education, violence and gender-based violence.

Area of residence as a risk factor associated with depressive symptoms

There are differences observed in factors found to be associated with depressive symptoms among people who live in low- to middle- versus high income countries. To some extent these can arguably reflect access to resources for some populations in first world countries. Resources can buffer the distressing impact of adversity and can also facilitate access to prompt interventions and responses to early signs of distress. It is also possible that the between-country differences reflect not the income settings but cultural differences that are observed between the East and the West, and the North and the global South, which influence distress. It is important to note that in collectivist countries such as African and Black communities in the Pacific and Latin America there is not much

research coming out. Hence much of this review seems to lack factors that speak to community level relations and behaviours such as those that are mentioned for example in the study by Blignault et al. from the Solomon Islands [146]. In these Black collectivists communities variables such as respect for elders, meaningful involvement in community activities, cooperation at a community level and community leadership are important and lack thereof is considered to cause distress in members of the community [146]. For instance, men in these areas worry over man's lack of involvement in community activities to the extent that they describe this as causing mental distress in their communities [146].

Furthermore within countries there is evidence of differences in rural and urban residence which sometimes mask systemic political arrangements that put some ethnic groups within counties at higher risk of adversity than others. For instance, Walls and Whitbeck report that there is evidence of elevated and higher prevalence of psychological distress among American Indians and Alaska Natives in the United States compared to the rest of the population, and this is true for Canadian aboriginal communities [20]. A study of the presence of depressive symptoms among high school students in Canada found that females who lived in the Nova Scotia province of the Atlantic, which is more populous than other provinces in the same region, reported more elevated symptoms [15]. Again the within-country differences in areas of residence could be reflective of differences in other variables such as gender, ethnic groups and socio-economic status which tend to correlate with areas of residence [87]. Hence residence in more rural provinces, which

tend to be poorer in many countries, is shown to be associated with depressive symptoms in young people [15].

Sometimes it is not the area of residence per se that causes distress and depressive symptoms. For example in immigrant populations it could be a host of factors to do with trauma experienced in the original country, coupled with painful experiences of the present [147]. This is discussed further under exposure to violence as some immigrants actually flee away from violence in their own countries. The rural urban difference can also be a feature of macro wealth and poverty differences between and within countries. n Botswana, living in a rural area was associated with depressive symptoms in males [60].

South Africa is a low-to-middle class income country and young South Africans sampled in schools in Cape Town who reported a sense of meaningless in life had higher depressive scores [148]. In South Africa where findings have reported distress in urban areas this is also reported alongside adversarial features that are characteristic of township life here and are themselves risk factors for distress such as those reported by participants in Mabitsela's qualitative findings from a township outside Pretoria; these are crime, unemployment, retrenchments, poverty, hunger, AIDS, deaths, divorce, unknown parental identity and abuse [10]. However this study had serious limitations. It targeted five participants, reported on three interviews and data was not adequately analysed. The next section examines the micro level of family's socio-economic status.

Low family socio-economic status as a risk factor associated with depressive symptoms

Some studies suggest that low family income and family poverty are associated with distress [63, 149] whilst others found no significant association [150]. A longitudinal study that followed mother-child dyads in Australia for 21 years found that family poverty predicted depressive symptoms in this sample [151]. In addition, families with no financial stress seem to be protective of adolescent psychological distress [87]. In this thesis low socio-economic status and low family income are regarded as indicative of living in poverty, notwithstanding the disagreements in the field about what constitutes poverty [152].

Family low socio-economic status is considered a chronic stressor [129] and exposure to chronic poverty has mutually reinforcing links with mental distress [51, 153-154]. In low and middle socio-economic countries and low income communities within countries, life expectancy is low, a higher rate of parental death is found and this often leaves families with financial difficulties. Low socio-economic status and poverty (especially, but not necessarily, in the context of orphanhood) may force young people to drop out of school [155-156], compounding deprivation and creating a distressing situation [157]. Okello conducted a qualitative research among adults in Uganda, a low income African country, and reported a condition called '*illnesses of thought*'. The description provided by participants in Okello's study parallels the symptoms used to identify distress and depression in clinical terms [158]. Here distress was believed to be worrisome thoughts

caused by various socio-economic problems with symptoms manifesting in serious somatic physical pain. The view that being poor contributes to distress is shared by informants in a study from the Solomon Islands, another low income country in the Pacific region [146].

In a South African study involving young people aged 17 to 24, lack of finance is reported to contribute to distress [63]. Qualitative evidence that speaks to young people's troubled lives due to lacking financial stability and regular and adequate income has also been published in South Africa [10, 159-161]. The links between parental death and subsequent financial deficiency in affected families is further reviewed in the next section.

Gender as a risk factor associated with depressive symptoms

It is important to demonstrate that structural factors that are reported as risk for distress do not present uniformly for men and women. There is evidence of gender differences in factors associated with depressive symptoms among young people. Gender differences in factors associated with depressive symptoms stem from differential exposure to adversity for men and women [20, 60, 87]. In responding to pressures, research summarised in Hyde, Mezulis and Abramson suggests that young women are more likely to ruminate over their problems, display greater cognitive vulnerability, experience more stressors and that the vulnerability-stress-depression relationship is stronger for females than for

young men [14]. Hence women are regarded as more likely to internalise and men externalise response to adversity. Gender subjugation of women is more intense in less developed regions of the world and where patriarchal order is still prevalent. The next section continues with the review of other structural factors associated with depressive symptoms. This review will show, where there is evidence, how gender, gendered societal expectations and playing men and women gender roles intersect to create risk for distress and depressive symptoms in young men and women. This, however is not always possible as some of the research on risk factors associated with depressive symptoms among young people is not analysed and presented in a gender disaggregated fashion [21]. This prevents analysis of how gender may operate as a risk factor for depression.

Death of a parent as a risk factor associated with depressive symptoms

An adverse life event for young people that causes psychological distress is loss of a parent [150, 162-163]. A longitudinal study of 7-16 year old American adolescents found that fear of abandonment by the surviving caregiver was related to depressive symptoms in orphans six-years following baseline assessment [164]. In a Ugandan study, double orphanhood and living with a chronically ill adult were associated with depressive symptoms among males [165].

In South Africa, the prevalence of parental death reported among young people varies in different parts of the country. In a Sowetan study 11% of children in 4,501 households

had lost a parent [155], and in a nationally representative household survey of 11,904 fifteen to twenty four-year-old South Africans, parental death is reported to be 27.3% [166]. AIDS deaths are much more commonplace and are reported by the Medical Research Council data to be the leading cause of all deaths in South Africa [167]. This is very stressful to the surviving children [10, 155, 163]. Young people's troubled lives due to parental loss and the resultant separation with siblings to join large dysfunctional families are rife among orphaned youth and can be recognised as potential sources of distress [107, 149, 157, 161, 168-174]. It is to the extent that death has reached epidemic proportions that it is considered a structural factor here. More importantly in the South African context AIDS orphanhood seems to be a risk factor for psychological distress compared to orphanhood by other reasons [163]. In some circumstances, the impact of the death of a parent starts with care giving to the parent with a terminal illness. Young people living with a parent with an illness are known to report psychosocial impact compared to young people not caring for ailing family members [89]. A number of factors such as pain, body wasting, stigma associated with AIDS and participating in physical care of a dying parent that some adolescents are involved in, are all stressful [175]. This parallels findings in a study conducted on Pastor's perceptions of distress in a township outside Pretoria. It reported that the problems that people encountered such as AIDS deaths was the reason behind distress in the Soshanguve community [10]. Evidently, following the death of a parent or both, orphanhood poses a risk for curtailed education [163, 176] and the next review section supports the links of orphanhood to low levels of education as a risk factor for depressive symptoms. However this study had serious limitations. It targeted five participants, reported on three interviews and data was

not adequately analysed. Distress that is experienced by orphaned young people follows 'parentification' in the event of double orphanhood or death of one parent with no traces of the surviving parent [177]. It seems that worries about eminent parentification start even whilst parents are sick. In a study of the impact of living with a sick parent and or other member of the family adolescents are referred to as 'young carers'. Young carers display distress especially related to missing or dropping out of school, not having enough money or food to carry lunch at school and inability to concentrate at school due to worry about the sick person at home [178].

Low levels of educational achievement as a risk factor associated with depressive symptoms

Low levels of education, being out of school and other variables linked to studying such as dissatisfaction with school grades are found to be associated with depressive mood [18, 43, 53, 60, 63, 129]. In one qualitative study from the Pacific, worries from women of dropping out of school and struggling to make a living, which do not feature in men's descriptions of sources of distress are evident in research [146]. Some studies report associations with poor academic achievement and negative educational attainment for both genders [15, 179] and one U.S. study found this particularly important for young girls [121]. The predictive role of poor academic performance in later distress and depressive symptoms starts to appear early in elementary school [180]. Poor school performance is partly related to Low IQ, however, ironic findings on the association between high IQ scores during early puberty and late adolescent depressive symptoms are

reported in a study of 5,250 children and adolescents from the Avon Longitudinal Study in the UK. This ironic risk association of higher childhood IQ scores and depressive symptoms reported in this study was observed to decline in females by age 17, but persisted in males [181]. In their study, Blore and colleagues found that dissatisfaction with one's school grades was a risk factor for depressive symptoms [64].The association of special education needs and existence of psychological distress is evident early on adolescence [87].

A South African study of 622 Grade 11 pupils found low schooling attainment to be a contributory factor to distress [63], and in a non-random sample of 50 South Africans, low education was associated with higher distress scores [65]. There is a comparison in the quality of education among young people that shows that generally South African youth and not faring well [72]. The association between education and depressive symptoms may be confounded or mediated by a number of factors such as poverty, orphanhood, caring for chronically sick family members, and low levels of stress tolerance so that young people in lower socio-economic status homes with a lower IQ have limited resources to draw on when confronted with adversity and become depressed [163, 176, 178].

Exposure to violence as a risk factor associated with depressive symptoms

Young people exposed to violence are more likely to experience psychological distress and depressive symptoms [6, 147, 182]. There is abundant international and local evidence that young people are victims, perpetrators and witnesses of violence either at school, in the neighbourhood or at home [6, 20, 121, 147, 183-187]. This is reported for both men and women though there are slight variations in exposure and response; with men exposed more to peer/school violence and women exposed more to violent family conflicts, gender-based violence and sexual violence [20, 188]. A study of psychological distress among 625 racially diverse young men between the ages of 16 and 19 recruited from the general population in the U.S, found that there was a significant relationship between direct, often physically violent, victimisation and psychological distress reported using a symptom scale [6]. In this study, though important, vicarious victimisation was not associated with reports of distress [6].

The role of bullying is one of the sources of distress mentioned by young people in local research [149]. Other instances which may not necessarily be violent but cause extreme discomfort such as sexual harassment are also implicated in the development of psychological distress [179]. From a prospective longitudinal study of 1,010 teenagers from Minnesota in the US, sexual harassment, current and in recent years, was strongly associated with depressive affect measured using the General Well-being Scale [179].

Distress is common among political asylum seekers or young people who migrated from war torn areas [147]. In other low income overseas countries high levels of psychological distress among people exposed to violence are reported such as Vietnamese adolescents, unaccompanied minors and young adult refugees resident in camps in the Philippines [5]. International work on psychological distress that has used qualitative methods for collecting and analysing data reports that in in-depth interviews young people, typically displaced, seeking refuge or living in post conflict situations within their countries, identify violence as a stressor [146-147]. Pain experienced by refugees in their country of origin and the wider social context of present experiences among 76 young people interviewed in Australia reveals a life continuum of trauma that contributes to psychological distress [147]. In the Solomon Islands of the Pacific, where the population is Black and lives on collective values they associate fights and other socially unacceptable behaviours such as swearing and shouting in their community with mental distress [146].

A systematic review of studies on depressive symptomatology from low income countries, including some from the Sub Saharan Africa (SSA), shows associations between distress, presence of depressive symptoms and exposure to war, female genital mutilation, child labour and community violence not necessarily seen in developed countries [162]. The association between distress and war related sexual violence is also reported among displaced older rural women receiving medical attention from Northern Uganda [189]. Sexual violence is of concern for both males and females in the SSA even

outside the context of war. This is concerning as it may have negative consequences for young people's mental health. A population-based survey of young people in Nyeri, Kenya explored the prevalence and patterns of sexual coercion among married and unmarried males and females aged 10-24. Among the sexually experienced respondents, 21% of females and 11% of males had experienced sex under coercive conditions [190]. Most of the perpetrators were intimate partners, including boyfriends, girlfriends and husbands.

Gender based violence against women

Among young people exposed to violence is a large sub-set exposed to gender-based violence. Gender-based violence against women is a product of a social order founded upon the subordination of women. Supporting evidence of the link between sexual violence victimisation and mental distress is from a national college sample study of under graduate women where 93% of those who sought help (N=228) after rape sought mental health help [183]. Within young people exposed to gender-based violence is a sub set exposed to gender-based violence within sexual relationships, often referred to as intimate partner violence [190]. In studies from different parts of the world adolescents and young women who have experienced gender-based violence including intimate partner violence and sexual abuse are more likely to report higher levels of depressive symptoms [184, 188, 191]. For instance, in Paraguay, IPV was independently associated with increased risk for common mental disorders including depressive symptoms [192].

In Northeast Italy, university students of 25 years and younger reported that the distressing impact of intimate partner violence and sexual violence was larger for female study participants than males [188]. In a retrospective clinic-based case-note review of 58 female patients aged 13 to 18, 72% of them reported emotional problems that included depression [90]. It is not clear how depressive symptoms were measured in this sample but this study does shed some light on the burden of depressive symptoms among sexual violence survivors. Qualitative studies also confirm that women experience distress as a result of sexual violence victimisation [146]. Married young women aged 15-24 reported being very depressed and stressed as a consequence of coercive sexual experiences within their marriages in Nepal [85].

The character of gender based violence against women in South Africa is similar to that found in other settings [74, 193]. In a study of young women attending primary health care for antenatal purposes in Soweto, the estimated prevalence of physical/sexual partner violence was 55.5% [194]. Rates of adult sexual assault by non-partners, child sexual assault and forced first intercourse were between 7.3% and 8% in this sample [194]. Despite this, the association with depressive symptoms has been largely unexplored among young people. In a sample of 40 older battered women in a shelter, 63% reported depressive symptoms [17]. This high prevalence is expected because women resident in a shelter would have experienced extreme violence from their partners. However, depressive symptoms were not associated with the frequency and severity of physical abuse reported here [17].

2.2.3 Psychosocial risk factors for depressive symptoms among young people

Adverse childhood experiences as a risk factor associated with depressive symptoms

Childhood adversity is conceptualised differently in different studies but is generally agreed to encompass abuse, maltreatment and exposure to other traumatic experiences [20, 87]. Some childhood adversity factors such as long-term financial difficulties are structural [155]; whilst others such as family conflicts, childhood maltreatment and frequent fear of a family member, feature in interpersonal relations [20, 195]. In a Finnish study where half of the 16,877 participants reported experiencing childhood adversity, this was associated with an increased chance of having depressive symptoms later in life and it is possible that the onset of this distress may be during adolescence [195]. The impact of childhood adversity or stressful and negative life events on subsequent development of psychological distress may be acute or occur much later. Child abuse often precedes depressive symptoms in young people. This relationship is mediated by other factors, depends on the severity and length of exposure and is different for females and males [12, 20, 37, 87, 129, 162]. However, there is some evidence that this

relationship is rather weaker in some instances and more important for females than males [87].

Because the term adverse childhood experiences refer to a cluster of experiences within and outside the home, it is difficult to delineate these as a separate category but can be identifiable in the other factors to be discussed next. The effect of childhood maltreatment in a U.S. based sample was mediated and reduced by common family factors such as maternal education, family income and married parents, and increased with age [87]. Fletcher found that childhood physical and sexual abuse predicted the presence of depressive symptoms in late adolescence and young adulthood, more so for women [87]. A very strong association for women remained even after adjusting for family and neighbourhood characteristics [87].

Child abuse is highly prevalent in South Africa [155]. Though many adolescents identify family members as important in their lives, some research shows that children live in stressed, vulnerable, dysfunctional and conflictual family environments [112, 155, 168-169, 174, 196]. Young people's troubled lives due to excessive use of corporal punishment that borders on abuse are rife among orphaned youth and this is well recognised as sources of distress for youth. There are a multitude of situations that may be perceived as abusive and traumatic and some of these factors are discussed below.

Lack of social support as a risk factor associated with depressive symptoms

Social support refers to experienced or perceived support received from peers, family and the general community [12]. Lack of social support has consistently been found to be associated with an increased risk of depressive symptoms. Decreased social support, conceptualised as not having someone to confide in, that one can count on to give advice and makes one feel loved, is associated with increase in depressive symptoms among 12 to 19 year old youths in Canada [18]. Hence lack of good peer relationships and parent child relationships were also found to be associated with the presence of depressive symptoms starting early among immigrant family children in Taiwan [180].

There are two ways in which perceived lack of social support links to depressive mood. First, evident in a multitude of studies of young people, perceptions of lack of social support are associated with the risk of displaying depressive symptomatology [18, 43, 53, 56, 96, 197-198]. In a study from Sweden, young people with depressive symptoms reported more limited and unsatisfactory social interactions; negative evaluation of availability and adequacy of social interaction and attachment network [198]. Furthermore, even though it is generally agreed that experiences of negative emotions are more likely in young people [53, 57-58, 77, 104]; the Western cultural value placed on individualism is particularly blamed for increasing the likelihood of stress in young people who are predisposed to developing depressive symptoms [71, 74-76, 104, 111, 199]. It is difficult to say whether depressive symptoms are caused by lack of social

support as only longitudinal studies could show temporality of these associations and these are scarce. Hence it is possible that social withdrawal may erode positive feelings about community support. Young people with depressive symptoms may report negative views of their community support as a result of their emotional vulnerability or poor quality of relations with neighbours because they are socially withdrawn. Secondly, social support may buffer the impact of negative life events hence low social support is associated with an increased risk of depressive symptoms following an occurrence of negative life events [12]. The origin of distress in Okello's study was attributed to negative social circumstances such as family conflict as this erodes social support [158]. In support of this, a Ugandan study among young people who experienced death of a parent, perceptions of being treated differently from others and lack of family connectedness is reported to be associated with depressive symptoms [165]. Perceptions of being treated differently and unfairly and feeling weakly connected to one's family may speak to perceptions of lack of social support. In a local South African study it is confirmed that a conflictual relationship with parents, which could be used as an indicator of consistency in parental support, was found to be a risk factor for presence for depressive symptoms [64].

Family structure as a risk factor associated with depressive symptoms

The character of families is critical as pre-adolescent exposure to trauma, in or outside the home, is consistently reported to predict depressive symptoms in young adulthood [121, 133, 195, 200]. Living with one parent, lack of emotional support, conflict with parents, low-level of fathers' occupation, experiencing and witnessing domestic violence are adverse family circumstances found to be associated with depressive symptoms among young people [18, 43, 53, 75, 96, 121, 133, 184, 201-204]. A study that investigated family environments associated with depressive symptoms among 197 male and female runaway adolescents recruited from a runaway shelter in Texas, reported that the young women's depressive symptoms were predominately related to interpersonal relationships, such as family communication, conflict, and worry about these relationships. A Taiwan study of 676 school children shows that the impact of negative family relations and living without a close parent-child relationship on increased depressive symptoms start from as early as during elementary school [131].

The social meanings of divorce and living with one parent are interpreted by some as symbolizing a negative disorganized family and risk for distress [75, 204]. The association of reconstituted families with psychological distress is evident early on in adolescence [87]. Though divorce may be traumatic, there is evidence that single parenthood can have benign results and that much of the impact of divorce on families depends on the conditions before and post-divorce [184]. Nevertheless, this is not the case for all children as data from different samples show negative post-divorced family environments lacking in attachment, and this is associated with depressive symptoms in young people [150, 198, 201, 203]. Perhaps it is important to acknowledge that single

parenthood may be a marker for a range of other difficulties such as family disharmony, weak parental supervision, weak affective ties and poverty [156]. Of course, young people who are unable to regulate changes to family character that come with parents divorce may be at risk.

The impact of family variables on young people's depressive symptoms is not clearly established in South African literature chiefly because of the paucity of the research base. The South African Institute of Race Relations discusses the impact of family breakdown on the mental health of young people but lacked data linking family breakdown to depressive symptoms for young people [182]. Young people's troubled lives due to broken family structures is recognised as potential sources of distress for youth in South Africa [107, 161, 168-170, 205]. Breakdown in interpersonal relations, secrets and untruths within families, as reported in Mabitsela's thesis caused 'wounded', 'drained' and 'guilty' people and worrisome thoughts that manifested in somatic symptoms when people could not find answers [10]. Mabitsela's study looked at the spiritual perspective of psychological distress [10, 158].

Parental absence

Father absence is another adverse circumstance in children's lives and is hypothesised to cause emotional disturbances and distress. This is discussed in post-divorce literature in the U.S. as a feature of parental alienation [206]. Parental alienation involves emotional

manipulation of the child by a parent in order to turn the child against the other alienated parent. One of the immediate effects of parental alienation is distress and symptoms of depression rooted in the child's belief that they are unloved by the targeted parent and from the actual extended separation from that parent [206]. Parental alienation appears to share similar features to some cases of children born out-of-wedlock in some African cultures. Hence the origin of distress in Okello's study in Uganda was attributed to negative social circumstances such as lost kin for a child whose real biological father is not disclosed and the child is assigned to a wrong clan [158]. This is worrisome as in South Africa the proportion of children under the age of 15 years who live without a father increased between 1993 and 2002 from 40% to 50% [156]. Parental alienation is a very important phenomenon commonly affecting children raised by single parents. In qualitative research, young people's troubled lives due to parental absence are recognised as potential sources of distress for South African youth [107, 161, 168-171, 207]. Undisclosed paternal identity is mentioned as a source of distress [10, 177]. There is some suggestion from Botswana and South African studies of absent fathers that when paternal identity is undisclosed to young people, this bothers them as they start to ask questions and wanting to find their fathers during adolescence [105-106]. But research participants in these studies were older people speaking on behalf of what bothers young people. There have been few qualitative studies of experiences of psychological distress in young people in the African continent so this is drawn from family studies and studies of masculinity. In his study of masculinity from Alexandra Township north of Johannesburg, Langa describes emotional talk by 19 (out of 30) boys aged 14 to 18 who participated in his study and talked in a saddened manner about their absent and often

unknown fathers [177]. They referred to the pain, embarrassment and shame of feeling illegitimate in their families and yet being unable to discuss this private matter at home. Langa suggests that his participants' inability to express their distress associated with their absent fathers was related to gender constructions of being a man [177]. However, because this was a men's group there is no way of knowing that girls would have responded differently and displayed a different response to the issue.

Sexual relationships as risk factors associated with depressive symptoms

Research evidence suggests that female adolescents involved in sexual relationships are more likely to display depressive symptoms [208-209]. Research from high income countries suggest that a shift in attention from family, academic focus and substance abuse causes young people who are romantically involved to be emotionally distressed [210]. Some gender role pressures, lack of control in relationships and gendered response strategies to stressors may put women at a higher risk of depressive symptoms [60, 87]. For example, young women may feel disempowered when entering into dating relationships because of social norms that preclude girls from taking the lead in relationships. Recent evidence shows that involvement in relationships with older

partners predicts depressive symptoms in female adolescents [37]. It is believed that inequalities, perceived or real, and activities associated with having an older partner such as, experimental use of substances may confer additional risk for young women [37, 211]. In mainly low income third world countries some of which are in Eastern Europe, Asia and Africa, women marry young and the origin of distress is traceable to marital problems. In Okello's study from Uganda, in the SSA, distress was attributed to negative social circumstances such as difficulties in marriage [158] and married women in Nepal also cite marital problems including violence as a source of distress [85].

Dating older partners is common among young women in South Africa and elsewhere [37, 143, 194, 212]. Gender power differentials, normative gender roles and inability to resist pressure compromises young women's agency in relationships and this may contribute to distress [37, 209, 211, 213]. Local evidence also suggests that heartbreak and disappointments in relationships cause serious distress [214-215]. There is some evidence that women experienced stress as a result of their male partner's infidelity, even though men's multiple concurrent partnering seems normalised [216-217].

Sexual behaviour as a risk factor for distress

A study based on gender specific peer group discussions from the Solomon Islands, reports a difference in what men and women thought caused distress; with women identifying problems related to sexuality, gender and reproductive roles such as teenage

pregnancy, lack of respect, jealousy, single motherhood and sexual assault [146]. Adolescent sexual health is poor and of concern locally, regionally and in other countries beyond SSA [70, 81, 112, 218-221]. The median age of first sex may be slightly younger for girls in some SSA countries. A Malawian study shows that it is 17.5 for women and 18.8 for men [222]. This does not seem to be the case in South Africa with evidence that boys become sexually active earlier and young people from the rural villages become sexually active later than their urban counterparts [118, 218, 223]. There are between and within country differences here [51, 74, 141, 222-225] but notably important for this thesis is that first intercourse for girls is reported to be frequently coerced in the SSA [226-227]. Though coerced sex is traumatic, an association with depressive symptoms has not been studied. Some consequences of sexual behaviour are recognised as potentially contributing factors to distress and depressive symptoms among young people [217].

Unplanned teenage pregnancies

Though young people from South Africa marry relatively late, sexual activity is usually initiated before the age of eighteen, the median age of sexual debut is 18 years for South African women but teenage pregnancy is notably high [51, 125, 223, 228-229]. In a longitudinal study that tracks changes among learners in the Eastern Cape province, learner pregnancies appear to have increased from 2002 to 2007 by 244% [176]. Unplanned Teenage pregnancies and other consequences of engaging in unprotected

sexual intercourse are a bother to the society [230]. Young men and women from a qualitative study in the Pacific's Solomon Islands reported teenage pregnancy as a cause of mental distress [146]. Focus group discussion findings from women research participants cite teen motherhood as distressing [146, 230]. Female adolescent respondents aged between 13 and 20, from three South African provinces (Limpopo, Western Cape and Gauteng) reported that distress in teen parenthood is linked to the pain and bitterness associated with leaving school and being deserted by the partner [230]. This confirms findings from other overseas Black communities [146]. In a study that subsequently explored the experiences of adolescent girls who got pregnant whilst at high school in Soweto, it was not only infidelity, desertion and rejection by peers and mothers that cause them distress but also when their male partners did not acknowledge responsibility for their pregnancy [217]. When a young women's pregnancy is disputed or denied by the putative father, it causes distress [216-217]. Conjunctive assumptions recognise some consequences of sexual behaviour as potentially contributing to distress and depressive symptoms among young people [217]. What is not clear from the sub-Saharan literature is whether there is any evidence that experiences such as early unplanned pregnancies do cause distress and depressive symptoms among young people there. There is lack of evidence of temporality in studies of sexual behaviour and depressive symptoms hence it is not always possible to delineate from most papers the direction of the relationship. Due to lack of evidence of temporality in studies of sexual behaviour and depressive symptoms it is not always possible to delineate from most papers the direction of the relationship; hence the associations are discussed in detail in

the following section under the association between depressive symptom and sexual behaviour in young people.

Gender non-conformity

Young people with a non-conforming gender identity and who identify themselves as members of sexual minority groups such as lesbians, gays and transgender people, report experiencing distress associated with discrimination and violence meted against gender non-conforming people [231-232]. Young people's distress in terms of their gender identity and sexual orientation are related to internal challenges of accepting themselves and other lesbian women, inability to acknowledge their love for people of the same sex, wanting to know the reasons for their different sexual orientation and worrying that their sexual orientation may be a sickness [232]. Moreover, the context of homosexual oppression with a lack of acceptance by family, living in a heterosexual society and pressure from religious and cultural fundamentalists can be distressing [232-233]. There is qualitative work reporting from in-depth interviews that the distress which is felt by young lesbians aged 20-24, is in relation to coming out with their identity [234]. Challenges and the resultant distress is believed to be amplified for rural young lesbians [235].

Substance use as a risk factor associated with depressive symptoms

Substance abuse has been found to be associated with depressive symptoms in young people [26, 36, 64, 236-237]. A Canadian cross-sectional study reports alcohol to be associated with depressive symptoms in young women, and cannabis in both men and women [15]. It has also been noted that psychotic life experiences among young people are associated with depressive symptoms [238]. Symptoms of psychotic experiences such as auditory or visual hallucinations, or misplaced or delusional beliefs can occur in the context of substance use as well as in major psychiatric disorders. A study of U.S. adolescents reports that young people with specific alcohol expectations, such as that alcohol is a powerful agent associated with enhanced social behaviour, were more likely to have depressive symptoms [135]. Most studies reporting an association between alcohol use and depressive symptoms come from high income countries and from samples of adults [22].

Blignault and colleagues conducted qualitative research in the Solomon Islands, a rather low income country and found that young men and women were worried about substance abuse in their communities and attributed mental distress to these [146]. There is, historically, a dearth of information that links substance use with depression among young people in South Africa. This is bewildering considering that substance abuse is a

problem facing young people here [86]. In a comprehensive country report prepared by Prof Parry thirteen years ago, there is not a single study he reviewed that shows this link [86]. Binge drinking as a problem was identified. Increase in age, male gender, poverty, high school drop-out, falling real price, efficient marketing, family breakdown, increased trafficking and global production, residency in squatter camps (informal residence), metropolitan areas and in town are factors that were considered to be associated with alcohol abuse [86]. There are psychological factors such as attitudes towards alcohol, perceived control, subjective norms, self esteem and moral obligation, but no mention of the role of substance abuse in distress or the other way round [86]. Recently, there has been some work done on the association between the use of substances and depressive symptoms among young people in South Africa. One such study by Blore, Schulze and Lessing reports that depressive symptoms were positively correlated with early onset and current use of substances among South African high school students [64]. Another study of 620 students that reports that there is an association between smoking and self reported depressive symptoms on the Beck Depression Inventory suggests that this is evident in girls and not boys [26]. It is also not possible to determine temporality of the associations found from these two studies of depressive symptoms and substance use among young people in South Africa [26, 64]. Those that have described the association seem to suggest that depressive symptoms rather preceded substance use. A diligent analysis of the 'Substance abuse in South Africa: Country report focusing on young persons' published in 1998 find no mention of the associations between substance abuse and distress or depressive symptoms among this age group [86]. Also parents' alcohol abuse

is known to have association with children's distress. Male participants were particularly sensitive to father's alcohol abuse and worry about family relationships [191].

Notably, studies from the developed world dominate literature on underlying factors associated with depressive symptoms as research in Sub Saharan Africa is limited. Furthermore there are very few studies that analyse data by gender, making it hard to reflect on possible gender differences in factors associated with depressive symptoms among young people. Literature reviews for the purposes of informing this study was concerned with experiences of negative stressful life events whose impact is considered to be a source of psychological distress by young people. Studies of this nature are hard to be found in South Africa and in the rest of the sub-Saharan African region.

2.3 Distress, depressive symptoms and HIV risky sexual behaviours

This section of the review of literature is divided into two: a discussion of sexual behaviours and sexual relationship types commonly associated with distress, and a presence of depressive symptoms in young people. Risky sexual behaviours are behaviours that are likely to result in an unplanned pregnancy and or a sexually transmitted infection (STI) including HIV. There are relationship types that are considered risky because of high risk of non-condom use, gender based violence, pregnancy, STIs and HIV. Overwhelming evidence from developed countries suggests that distress is important in HIV sexual risk as lack of motivation to protect one's life, lacking self worth, lack of self-efficacy and compromised self regulation among young people with depressed symptoms, may lead to risky behaviours [13, 239].

2.3.1 Depressive symptoms contribute to risky sexual behaviours

International literature suggests a link between having depressive symptoms and HIV infection risk. A certain amount of sexual risk taking is normative among young people. In South Africa sexual activity before marriage is common, but some people may be more risky than others. Very high levels of risk taking and lower risk estimation may stem from higher levels of impulsivity, lack of inhibition, a rise in sensation seeking and a sense of invincibility [50, 79, 82, 95, 102, 108, 117, 240-244]. Psychoanalysts suggest

that excessive and uncontrollable sexual behaviours are inherent among young people [70, 75, 78, 82, 92, 94, 123, 245-247] and a presentation of being young as sexy and appealing by both popular media and some academic texts perpetuates this [77, 248-252]. Yet this essentialism dangerously normalises sexual risk taking despite a possibility that substantial risk taking may be a sign of psychological troubles; and sex may be a refuge for young people who are engulfed with feelings of hopelessness and helplessness [81, 253-262]. However, risky sex is worrying and to a large extent young women are overwhelmingly more likely to be infected with HIV than their male peers. This is mainly explained by sexual behaviours [140-141, 196, 263]; therefore, it is important to learn more about the associations between depressive symptoms and engagement in risky sexual behaviours.

International studies report that depressive symptoms among young people are associated with high-risk sexual behaviours such as early sexual debut, higher numbers of lifetime sexual partners and substance use at last sex [253-260, 262, 264]. Relatively young (mean age 34) African American men, regardless of HIV serostatus and sexual orientation, with higher levels of psychological distress, report higher sexual risk involvement [35]. Generally, men tend to report having more sexual experiences, a higher number of sexual partners, more permissive attitudes towards casual sex and multiple concurrent partners [141, 224, 244, 265-267]. In a sample of 850 young people recruited from an urban area in the US (80% African American; 50% female) greater psychological distress was associated with increased sexual intercourse frequency across adolescence [268]. Evidence from this twelve months longitudinal study of young people in New York

shows that depressive symptoms predicted more sexual intercourse and higher number of sexual partners at follow up [268].

Depressive symptoms and psychological distress are reported to be associated with increased risk of reporting negative evaluations of protected sex [40]. In half the population of young people first sexual intercourse is reported to be protected by a condom and a higher proportion of males report using a condom on their last sexual encounter [51, 115, 269]. However, sustaining consistency of condom use remains a challenge [270-275] . In a large longitudinal study of U.S. adolescents depressive symptoms were reported to be associated with increased likelihood of condom non-use for males, but not for females [276]. Alvy et al. found evidence that depressive symptoms, measured using seven items from the CESD-Scale, were related to HIV transmission risk in a national convenience volunteer sample (N = 1,540) of HIV-positive and HIV-negative men from the USA who have sex with men (MSM) and who reported unprotected sex and drug use with sex partners [34]. This study enrolled participants aged 18 to over 51 years old, data was not analysed and presented by age so the role of depressive symptoms could be confounded by old age [34].

As mentioned previously, there is not a lot of information on psychological distress and sexual behaviours from sub-Saharan Africa. A longitudinal prospective study with a 12-month follow up from Uganda found that depressive symptoms predicted condom non-use. This study's sample was older and the minimum age was 18 [277]. Notably, young people from different samples in South Africa , show adequate knowledge of HIV

transmission and preventative methods [269]. Knowledge or lack thereof, alone does not explain their HIV sexual risk behaviour [224, 272, 278-280]. There has been little research on high risk sexual behaviours and the presence of depressive symptoms among young people in the Southern Africa.

Some evidence from in-depth interviews with 47 young adults aged 18-24 in the KwaZulu Natal Province, SA, suggests that relationship distress is associated with women acquiring a secondary partner [216]. In this study suspicion of infidelity was identified as causing distress and in turn this distress led to a risky behaviour – multiple concurrent partnering [216]. In South Africa, the work of Peltzer [281] and Smit [32] are the only two South African studies that have reported on the association between young people's depressive symptoms and risky sexual behaviours. Peltzer's study enrolled rural high school pupils and university students in the Northern Province and his findings reflect that self reported depressive symptoms were associated with unprotected sex, though it is not mentioned how this study defined 'unprotected sex'[281]. Smith's study conducted in Cape Town reports that depressed participants were more likely to have had treatment for sexually transmitted diseases (aOR 2.14 95% CI 1.25-3.66) and to have been pressured or forced into sex (aOR 3.12 95% CI1.67-5.84). Smith's study was conducted with an older sample (mean age 30.3) that included 55.3% females and 39.1% males but was analysed by neither gender nor age [32]. Conversely, participants with depressed symptoms here were also more likely to have used a condom six months before the interview date (aOR 5.32 95% CI 2.74-10.29) [32]. Literature shows that where the sample size was small, and substance use highly prevalent, the association between

depressive symptoms and risky sexual behaviours was not seen [282]. This was most probably because of colinearity, as young people with psychological distress are also more likely to use substances [268].

2.3.2 Depressive symptoms and risky sexual relationships

A problem in sexual partnerships of some young women in SSA communities is that male partners are often much older than women [143, 196, 218, 265, 283]. In Kelly et al., a six province study, 20% of girls in the Eastern Cape and 16% in KwaZulu Natal reported their sexual debut at the age of 14 or lower with a partner who was three or more years older [218]. The other provinces had lower rates, around 3%. A national study reports that 26.4% of girls aged 12–18 years who were sexually active in the year prior to the study had sex with a man five years or more older than themselves [141]. Material incentives play a role in relationships even those that are non-commercial, this and age-disparate or intergenerational sex drives the HIV epidemic [140, 196, 212, 218, 227, 272, 284-286]. Relationships where transactional sex is a feature is of concern in young people and especially risky for girls [244]. A study of adolescents in the States found an association between depressive symptoms and a history of sexually transmitted disease for girls [276]. It is not clear if young people with depressive symptoms are more likely to be engaged in relationships with older partners. What is known is that risky behaviours such as engaging in transactional sex and multiple partnering are associated with depressive symptoms [41, 287]. Evidence from a prospective study suggests that

depressive symptoms may predict multiple sexual partnerships and more risky partners [288].

Concurrent partnerships, casual and once-off sexual encounters are reported by young people from African Americans to Indian adolescents in Eastern Europe [224, 289-290]. Because of higher risk for HIV exposure involved, multiple and concurrent sexual networks are worrying and this has led to a call for research to understand motivations for maintaining multiple sex partners, regardless of the temporal sequencing [140, 196, 272, 278, 285-286, 291-300]. 21% of sexually active young people in a sample of 4,752 aged 14-25 years living in Cape Town reported concurrent sexual partnerships [267]. This study sample, however, missed an opportunity to assess the role of depressive symptoms in young people's risky sexual behavior [267]. Consistency in condom use is associated with having one partner, less relationship conflict, higher gender equity, more communication about risk of infection, direct expression of a desire to use condoms and insistence on use [301-302]. Inconsistent condom use is associated with physical IPV [287, 303].

As previously mentioned research shows that gender-based violence is common in young people's relationships and this creates a risky environment for HIV acquisition [278, 304]. Despite evidence suggesting that depressive symptoms cause engagement in risky and violent relationships, many studies of risky sexual practices continue to exclude mental health variables and focus on social, cultural and economic factors [292].

Epidemiological studies have reported on a multitude of risk factors for sexually transmitted HIV; such as sexual coercion, violence against women [142, 305] and intimate partner violence [143, 278, 304-307]. Rarely are psychological factors considered yet these need to be integrated in young people's sexual health services [308]. Hence there is little information in the Sub-Saharan African region, a region with the highest prevalence of heterosexually transmitted HIV, on the association between depressive symptoms and risky sexual behaviours of men and women. The infection rate for HIV is higher among younger females compared to males of the same age group [140, 225, 263, 272, 309]. The analysis of the Status of the Youth data set (SYR) and the South African Social Attitudes Survey (SASAS) show that between 1997 and 2004 more young women died of AIDS than their male counterparts [51, 112]. This study will extend knowledge on depressive symptoms as a possible predictor of risky sexual behaviours among young men and women specifically in the South African context.

This chapter highlights that scientific research and hence our understanding of factors associated with distress and depressive symptoms and the role of psychological distress in risky sexual behaviours is very limited in South Africa. Attempts to address HIV prevention through lifeskills programmes may be inadequate unless they include addressing the impact of depressive symptomatology on health behaviour [13]. This is important especially in South Africa.

CHAPTER 3: METHODS

This thesis presents research on subjective descriptions of psychological distress, factors associated with depressive symptoms and their connections with risky sexual behaviours, and aims to study this from two methodological perspectives. Two separate studies have been undertaken to meet the aims and objectives of this thesis which are to contribute knowledge on psychological distress. Methods undertaken in these studies are discussed next.

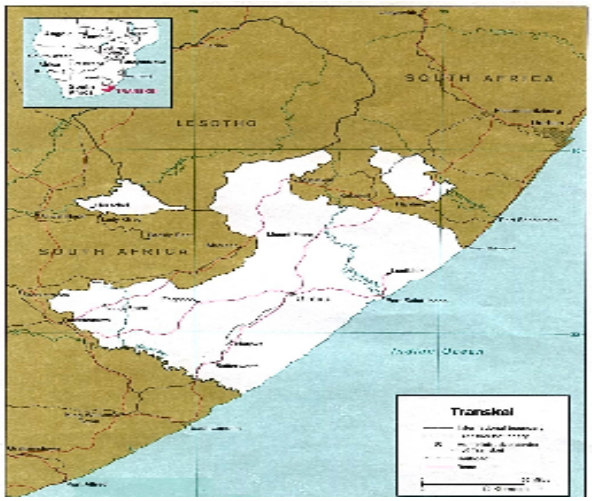
This thesis is based on two studies. Study 1 is the Stepping Stones study which was a cluster randomized controlled trial conducted between 2002 and 2006. The trial evaluated the effectiveness of a HIV prevention intervention called Stepping Stones. More information about the methods and the findings of the Stepping Stones study is published elsewhere [196, 310]. Papers I and II are based on analysis of data collected in the Stepping Stones study and aim to explore quantitatively the prevalence of the presence of depressive symptoms, associated factors and links with risky sexual behaviors. Study 2 was qualitative and aimed to provide an in-depth understanding of psychological distress. An in-depth qualitative study brings a perspective informed by participants' subjective experiences [311]. Papers III and IV have been written from this study. Both studies were set in the former Transkei region of the Eastern Cape, South Africa (Figures 2 and 3). The first section of this chapter describes the setting from which both studies were based, followed by a description of the research site, methods used and a discussion of ethical issues for each study.

Figure 5 and 3: Maps showing Eastern Cape

Figure 7: Map of South Africa. Downloaded from Google on 31/01/2011



Figure 6: Map showing Transkei, in the Eastern Cape. Downloaded from Google on 31/01/2011



The current [illegible] y followed by [illegible] supremacy through Apartheid [312-313]. A new dispensation of a democratically elected Government that included all races was established in 1994. The Eastern Cape (EC) covers 169,952 square kilometres taking up 13.9% of South Africa's land area [314]. It is the country's second largest province. 13.5% of the South African population lives here, the majority of who are Xhosa. In 2010 the mid-year population was estimated at 6,743, 800 [314]. The Eastern Cape has the highest annual population growth at 1.12% and a fertility rate of 2.7 (in 2006-2011) [314]. In 2006-2011 the Eastern Cape had a life expectancy that was lower than the national average for both males (51.3 vs. 52.2) and females (53.1 vs. 54.3). The prevalence of HIV is estimated at 11.5% and AIDS deaths from 2005 to 2010 are estimated at 49,811, that is 43.2% of all deaths in this province [314]. The number of double orphans in this province doubled in five years from 65,000 in 2002 to 129,000 in 2007 [314].

South Africa reports income inequalities between the different racial groups and between provinces with many African children and young people subjected to extreme poverty [51, 168, 312-313, 315-318]. The Eastern Cape is considered the poorest province in South Africa with more than two thirds of the households classified as living in poverty [319]. In 2009 10.5% of the population had severe inadequate access to food and 10.9% inadequate access to food [320]. This province reported the second highest TB deaths after KZN in 2006, 2007 and 2008 [320] . The same pattern (second highest) is seen in the number of young people aged 15-24 (185, 860, this is 20% of the EC population) living with HIV in July 2010.

60% of EC households reside in traditional dwellings with lack of access to basic services. In 2000, a large proportion of these relied on dams, rivers and springs as their main source of water. Only half of the households had access to electricity, only a third had access to sanitation and refuse removal, and fewer than 1 in 10 rural households used electricity for cooking [51, 315, 321]. Though unemployment had decreased nationally, in the Eastern Cape it remains above the national average at 32% [319]. People in the Eastern Cape face greater prospects of occupying the most vulnerable, exploitative and least paying jobs. This is illustrated in Lee and Woolrand's report that Black Africans in SA earn 46% less than Whites, workers in the rural areas earn 24% less than urban counterparts and those in the Eastern Cape earn 29% less than their counterparts in the Western Cape [318]. Eastern Cape dwellers live on lower income, are largely responsible for unpaid tasks, depend on social grants and remittances from wages earned by urban relatives. This leads to unemployed adults attaching themselves and their dependents to

pensioner households, creating dysfunctional, large families [51, 154, 156, 315-318, 322-324]. Even subsistence farming here is generally on a small scale and often refers to gardening, and keeping a few chickens [153, 323]. There is evidence that households who receive social grants are able to expand their agricultural activities whereas households that rely on farming for their main source of food are reportedly the poorest as cash is still needed to meet basic needs [153]. Regrettably, government benefits are sometimes not reaching the poorest, mostly rural and female-headed households [316]; as Watkinson and Orr report that in the rural Eastern Cape the "…*worst off you were, the less likely you were to receive a grant*…" (pg. 28)[317].

Young people in this province are also poor. Indicators show that the province with the poorest schools in the country is the Eastern Cape and this is where the highest number of no-fee schools are found (3,699) covering about 1,159,014 pupils in 2009 [325]. The highest proportion of learners assisted by government social grants is found in this province[176]. 27.9% and 30.6% of pupils in 2007 and 2008 respectively were recipients of social grants in the Eastern Cape Province [325]. Other undesirable outcomes for young people in this province are reported in a longitudinal study that tracks changes in learners such as increases in the pregnancy rate by 244%, increase in violent deaths by 27.7 and 19-21% of learners are living with just one parent in this poor province from 2003 to 2007 [176].

The 2001 pilot study

The Stepping Stones Randomised Controlled Trial was informed by a one-year pilot study conducted in Winterveldt, a township Northwest of Pretoria in Gauteng, in 2001. This was a proof of concept project conducted with a local NGO, the Planned Parenthood Association of South Africa. My role in this project was that of a project leader. I participated in the development and pre-testing of the questions and scales to be included in the questionnaire. This pilot was used to design the RCT study and make decisions about the scale of the project, field worker recruitment and field work management. Analysis of the pilot phase was presented at different meetings locally and internationally and feedback from these forums was used to inform the main study questionnaire.

3.1 Study design (Study 1)

This study was part of a bigger study that evaluated the effectiveness of a HIV prevention behavioural intervention called *Stepping Stones* [196, 310]. This was a randomised controlled trial with two years of follow up. Once participants were enrolled for the study they were considered a closed cohort and no new enrolments were made- thus the dataset potentially constituted longitudinal or follow-up study [326]. Study 1 of this thesis is based on analysis of baseline survey data collected prior to the Stepping Stones interventions being delivered in 2003 to 2004 and follow up data collected 12 months after the intervention in 2004 to 2005.

3.1.1 Study aim, objectives and hypothesis

The aim of Study 1 was to describe and explore factors associated with depressive symptoms among young people and describe the association between depressive symptoms with risky sexual behaviours

The specific objectives were to:

- quantitatively describe the prevalence of the presence of depressive symptoms among young men and women
- model factors associated with the presence of depressive symptoms among young men and women
- describe the association between experiences of depressive symptoms and risky sexual behaviours among young men and women

3.1.2 The study population

Statistics SA 2001 census data record that young people aged 14 to 24 account for 22.9% of the total population of South Africa, with an overwhelming majority (81.%) being African [125, 327]. The target population for this study were all young people who resided in the villages selected for the study. The term African is preferred and refers to the identity of the study population and participants who were Black. This term is used in other research reports [314] and in this thesis it denotes race. It

excludes Coloured, Indians and Chinese who, in South Africa, are also classified as black because of their non-White or non-European status. The villages from which participants were recruited are located in the O R Tambo District Municipality and the neighbouring municipalities to Butterworth in the South West, Port St John's on the East, Qumbu on the North and as far as Engcobo on the West of Umtata. The population potentially recruited in school or at a community meeting, were young people available at the time of recruitment.

3.1.3 The study sample

The study sample consisted of volunteers. The study sample was drawn from villages in and around the area within a 1.5 hours drive radius of Mthatha. This district municipality covers an area of 15,968 km^2 with 42 towns and a population of 1,862,224 [314]. The geographical area from which the villages were drawn covers the O.R Tambo District municipality, stretches to some parts of the Alfred Nzo District Municipality (e.g. Mt Ayliff and Mt Frere) on the N2 road to Mt Ayliff and to some parts of the Amathole District Municipality of Butterworth, for example, Willowvale, Idutywa and Butterworth [328].

In each potential village stakeholders were approached to seek permission to conduct the study. The stakeholders were visited to request a meeting to explain the study to parents and young people. These were in most cases the traditional chief, local ward counsellor, the school principal and the clinic staff. The study was announced and thoroughly

explained in community gatherings typically organised by traditional village chiefs to inform communities. A contact details sheet was completed to help locate participants for follow up interviews. This included physical addresses, telephone numbers, details of relatives and friends. Attempts were made to trace and interview as many participants as possible for follow up. Good follow up rates are used as a measure of the validity of prospective cohorts studies [326], in this study at 12 months 2,157 (77%) of the participants were re-interviewed. A more detailed profile of the participants has been published in an earlier report [196].

3.1.4 The sampling method

The villages were spread about 20 kilometres from each other for purposes of the RCT study. Participant recruitment excluded young people in institutions (such as prisons, hospitals or children's homes). Volunteers were sought in the gatherings but mainly in schools. Field workers held school assembly meetings to announce the study and seek volunteers. After listening to information presented to them, they were given about two weeks to make a decision to enrol; this was when the field workers came back to the schools or villages to collect baseline data. 2,801 volunteer participants aged 15-26 were enrolled. They were recruited because they normally resided in the study sites. In each of the seventy study sites, approximately twenty males and twenty females were included [196].

3.1.5 Data collection method

Field workers were used to collect data through face-to-face interviews using a questionnaire. Field workers were recruited locally, carefully selected and employed on the basis of both relevant qualifications and experience in working on community projects with young people. They all underwent an initial three-weeks training on sexual and reproductive health, HIV/AIDS and psychosocial support. They attended bi-weekly meetings to discuss problems with the questionnaire, to ensure quality control and resolve any fieldwork problems. Interviewers were gender-matched to respondents to achieve more honest disclosure of sexual behaviours. Employment of trained interviewers to conduct face-to-face, structured interviews is accepted in this field and has been used with young people in other studies [6]. Data were collected through self reports in one-on-one, face to face interviews conducted on site under conditions of both auditory and visual privacy. The questionnaire was translated and the questions were asked in Xhosa. All items were pre-coded and responses were recorded by the field worker.

The candidate's role in the study project management

My role in the main Stepping Stones RCT was that of a project manager for two years from 2002 to 2004. I was part of a team that designed the study and I contributed to the development and local adaptation of the research instruments. The PhD supervisor, Prof Rachel Jewkes was the study Principal Investigator for the Stepping Stones. I played a

significant role in setting up the office in Umthatha. I led the recruitment and training of office staff, project supervisors and field workers. I was responsible for stakeholder liaison with the community leaders, traditional leaders and municipal officials. I developed and maintained relationships with departmental officials, especially with the relevant local and provincial Departments of Social Development and Health. I developed the methodology for and led the community mobilisation and set up an active study Community Advisory Board [326]. I kept close contact with other key stakeholders in the research site; such as personnel at the local University of Transkei (now known as Walter Sisulu University), NGOs and the Departments of Health and Education in the districts and the province. I led the implementation of the Eastern Cape pilot study and played a significant role in revising and finalising the data collection tools. I supervised the data collection conducted by a team of about ten field workers and two nurses.

Relating to papers presented in this thesis, I was responsible for conducting data analysis and writing the papers under the supervision of Prof Rachel Jewkes and with advice from Dr Ian Colman. Other named co-authors commented on drafts of the papers as per publishing protocol from the Stepping Stones data set.

3.1.6 The Questionnaire

Use of questionnaire-based interviews, administered by trained personnel, especially for obtaining information such as sexual behaviour and depressive symptoms is well

established in epidemiological studies [13, 326]. Two structured questionnaires[i] with a few variations (as mirror images) for men and women were used for each round of interviews. Information at baseline was reported for lifetime, past year or current period. The twelve months follow up questionnaire differed slightly in that questions asked about the period 'since the last interview' rather than lifetime. Reference was made to previous research to find validated measures for inclusion where possible and most of the questions had been used in previous South African and international studies [35]. Content validity of the questions was ensured through an extensive process of reviewing published literature and consultation with experts in the field. In addition, the whole questionnaire was extensively worked through with the study staff. These were all young people who had grown up and lived in the study area and they engaged in an extensive process of critical scrutiny for cultural and social relevance. This process was one of cognitive interviewing, using small groups (n=7) rather than individual interviews and it has been established as a key methodology in ensuring that questions are understandable and relevant to research participants and thus valid for use in the local setting.

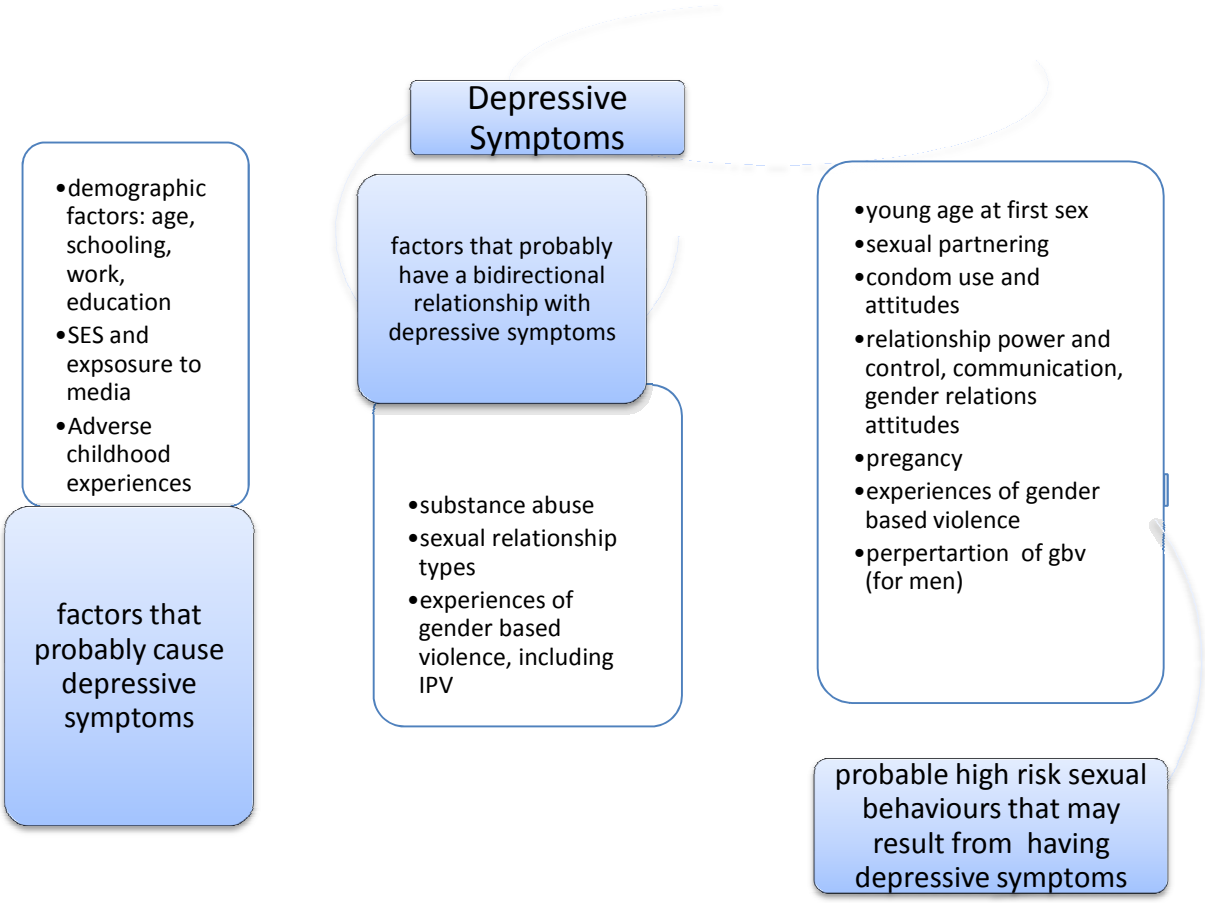
The questionnaire was carefully translated through collaboration of the study team and field workers. The questions were already translated from English to *Xhosa*. The *Xhosa* version was reviewed by study coordinators and field workers and any discrepancies were reviewed. A pre-test of the questions was conducted prior to the beginning of the study and a pilot study of the translated questionnaire was conducted in nearby sites which were not enrolled in the study two months before data collection began. This was

[i] See appendices for Study 1

to test the face validity of the questionnaire, that the questions worked and to test logistics related to field work.

Questions that were included in the questionnaire were carefully chosen for their relevance to the objectives of the study. A framework, presented in the figure below, was used as a guide for the selection of these variables.

Figure 3: A framework for the selection of variables for Study 1



Depressive symptoms

Presence of depressive symptomatology was assessed using a non-diagnostic scale used to measure community prevalence of the presence of depressive symptoms - the Centre for Epidemiological Studies on Depression (CES-D) Scale [33]. The scale was chosen after consideration of the validity and relevance of the different scales discussed in Chapter one. It is designed to be used in community research for purposes of measuring the prevalence of depressive symptoms. Though it was designed in the West, it has extensively yielded noteworthy findings about the existence of depressive symptoms in non-Western societies [13]. Its cross cultural application has yielded very high Cronbach's alphas such as .89 in indigenous North Americans [20]. This scale has been used in previous South African studies [39], and has been validated in South Africa [329] and in Zambia [330]. In preparation for this study the research team consulted with key team members, research staff and other experts in the area to seek both expert opinion and opinions on cultural relevance of the items in this Scale for this population group. During and after translation and after the pilot study, consultations continued to ensure that the questions as they appeared in the questionnaire asked what the Scale has intended to ask and that the meaning of the questions would be uniformly understood by all participants.

The scale consists of 20 items scored from rarely experienced (0) to experienced most or all of the time (3). Four of the items (4, 8, 12, and 16) which were positively worded were reversed and a summed score was created for each participant. A typical item reads

'*during the past week I was bothered by things that usually do not bother me'*. Scores ranged from 0-60 with 16+ used as a cut-off point for probable depressive caseness. This is a cut off that is normally used when the scale is used in its entirety [20]. To assess the internal consistency of the CESD symptom Scale in this sample I computed a Cronbach's alpha. This scale performed similarly for women and men with very high Cronbach's alphas of 0.90 for women and 0.91 for men.

Factors that could probably predict depressive symptoms

DEMOGRAPHIC VARIABLES

Participants were asked to report their date of birth, completed years of schooling and if they had ever done anything to earn money. The education variable was dichotomised for up to ten years of education versus more. This accounts meaningfully for the fact that those with higher than ten years of education were mainly out of school and older and as such would have had slightly different experiences. This follows an approach used in other papers [301, 305, 307, 331].

SOCIO ECONOMIC VARIABLES

Socio-economic status (SES) was measured on a scale containing six items capturing household goods ownership and ownership of a TV, radio and a car. They were also asked about access to food, income and access to a modest sum of money such as

R100.00 (±US$ 13.00 in 2010) for medical emergency purposes. The scale was developed for the purposes of the study. A typical item for this scale read '*does your home have a car'*. The study developed its own SES scale because of problems with the validity of most established measures of SES in the study area. The three components of this scale: household goods ownership, food security, and the ability to mobilise resources in an emergency are all recognised as important dimensions of SES and impact in different ways on subjective experiences of poverty.

A higher score meant a participant came from a wealthier home. To measure how well each individual item in this SES scale correlates with the sum of the remaining items, I calculated the Cronbach's alpha. For women, the Cronbach's alpha was 0.55 and for men it was slightly higher at 0.60. The alphas for this scale were not very high and this reflects the degree to which these dimensions of SES do not always operate in a linear and predictable fashion, especially in a context where the majority of homes rely on remittances from relatives or social grants and where the absence of electricity may influence household goods ownership independent of wealth. Exposure to media was assessed through questions on watching TV, listening to radio, reading a newspaper or a magazine in the last week.

ADVERSITY IN CHILDHOOD

Exposure to adversity in childhood was assessed using a modified and shortened version of the Childhood Trauma Questionnaire [332-333]. The Childhood Trauma Questionnaire

(CTQ) was used as a 17 item scale covering five dimensions of trauma. These were emotional abuse and neglect, physical abuse, physical neglect/hardships and sexual abuse. It asked about recall of experiences reflecting failure of parents or a guardian to give care that was deemed acceptable by community or professional standards as well as abuse. The scale also asks about direct victimisation through experiences of sexual abuse and about exposure to vicarious victimisation through witnessing one's mother being beaten by their husband or other male partner. This scale was shortened after the cognitive interviews as some items lacked face validity in this setting and some items, especially those on physical hardship, were modified. An example of the changes made during the validation was that, a statement that read '*someone tried to touch me in a sexual way or tried to make me touch them*' was modified to read '*someone touched my thighs, buttocks, breasts or genitals when I did not want him to or made me touch his private parts when I did not want to*'. There was a male mirror version for each of the items. Participants were asked whether before the age of eighteen they had experienced each act, and could answer never, sometimes, often or very often. A typical item from this scale read '*I lived in different households at different times*'. There was one additional question for women asking "*I was forced to have sex against my will by a boyfriend*". The scores for the CTQ ranged from 17 to 68 and the higher the score, the more trauma was experienced. The short version of the scale was tested during the development of the study instrument and was found to have high internal consistency. The Cronbach's alphas were quite high and comparable for both genders: 0.77 for women and 0.75 for men. The scale has been used in another study in South Africa [334] and subjected to scrutiny through cognitive interviewing and examination of its psychometric

properties in a further dataset [335]. The process of adaptation of the scale and its use has been acknowledged as acceptable by peer reviewers of the child abuse research community internationally and the measure has high predictive validity in terms of health consequences [331].

MEN'S EXPERIENCES OF SEXUAL ABUSE

All male participants were asked if a man or a woman has ever persuaded or forced them to have sex when he did not want to. They were further asked when was the first time this happened, who did it and how many times subsequent to that time have they experienced this.

CONNECTION WITH PARENTS AND SOCIAL SUPPORT

Participants were asked if they had lived with their biological mother and father for most of their childhood, if they had lost a mother, father or both parents and if they felt that people in their family were close to each other. They were asked if they belonged to a social club or were actively involved in church. For social support, participants were asked about their perceptions of lack of community support from neighbours. These perceptions of lack of social support from the community were measured using a five item scale developed for the study. The scale was developed after qualitative work with field staff in Mthatha and tested in the pilot study. The scale was a measure of whether

the participants felt that people around them were supportive and could be turned to in times of need. A typical item read '*in this area do most people generally trust each other in matters of lending and borrowing*'. Scores from the social support scale ranged from 4 to 20 and a higher score meant that a participant perceived less cohesion. The Cronbach's alpha was high and acceptable at 0.67 for women and 0.64 for men showing good internal consistency.

SUBSTANCE ABUSE

Alcohol use was measured using the Alcohol Use Disorders Identification Test (AUDIT) [336]. The AUDIT questionnaire is a screening tool comprised of ten questions that measure problematic alcohol use for detection of persons with harmful alcohol consumption. Each question is scored zero to four, yielding a maximum of 40 points. The questions evaluate drinking frequency, average quantities consumed on drinking occasions, the frequency of occasions on which the amount consumed exceeded six drinks. It yields information on symptoms of harmful use/alcohol abuse and dependence via questions regarding problems in control over drinking, loss of social and/or vocational functioning due to alcohol, feelings of guilt, possible physical harm to oneself or others due to drinking and it assesses concern by family, friends or medical personnel for one's alcohol use. A typical item from this scale reads '*how often do you have six or more drinks on one occasion*?" (Answerable as never/ less than monthly/ monthly/ weekly/ daily or almost daily) The AUDIT is widely used with a cut-off point of eight points to indicate alcohol problems [142, 305, 307, 310, 331, 336]. It has been used and validated in African countries including South Africa [32, 337-338]. With this cut-off

point, its sensitivity and specificity have been found to be over 80% [336]. In this study I retained use of this cut-off point. All participants were asked if they had ever used any of the common illicit drugs, such as marijuana, benzene, Mandrax or injection drugs. Drug use was considered if a participant reported ever used anyone of these. The questions measuring substance abuse differed in the way they were presented, answered and scored and as such do not constitute a scale; hence a Cronbach's alpha could not be computed.

Sexuality and related factors

SEXUAL EXPERIENCE

A set of questions asked about sexual behaviour. Participants were asked their age at first sex and whether their first sex was willing, persuaded, tricked, forced or raped. Age at first sex was dichotomised for younger than 15 versus older. First sex experience was dichotomised: 'willing' versus 'unwilling'. Unwilling was comprised of responses that indicated either having been persuaded, tricked, forced or raped. This dichotomisation was based on understanding that any sexual encounter where the participant did not report 'willing' was in fact 'unwilling'. Women were asked if they had ever been pregnant or pregnant at the time of the interview and men were asked if they had been told by any of their sexual partners that they had made them pregnant. Age at first

pregnancy was dichotomised for 17 or younger vs. older than 17 at the time of the pregnancy.

SEXUAL PARTNERING

Participants were asked about the number of lifetime sexual partners: casual, one-night stands and main partners. The variable was dichotomised for the analysis and having had three or more lifetime sexual partners was considered a high number of lifetime sexual partners. This follows on previous studies [143, 196, 310]. Women were asked the age of their main partner and were considered to have had an older partner if he was three or more years older [143].

Lifetime history of transactional sex with main and casual partners was assessed. Transactional relationships were defined as those where the exchange of clothes, money, food, gifts or fun times were identified by the participant as the key motivating factor underlying the existence of the relationship or sexual encounter with a main, casual or one-night stand partner [212, 310, 339]. For women we asked about receiving and for men both receiving and giving. A typical item reads '*have you become involved with a partner because s/he provided you or you expected that s/he would provide you with: food, clothes, transport, school fees, somewhere to sleep, cash*?' Participants would indicate yes or no to each of the items and this was asked for different types of partners: main, casual, one-night stands. These transactional sex questions were developed through a process of qualitative research in South Africa and validated in research with women in

antenatal care (ref) [194]. The analysis, following this principle, used a variable that measured 'ever had transactional sex' versus 'never' [310, 339].

Knowledge of partner concurrency was assessed by a question that asked "*how likely do you think it is that (NAME OF PARTNER) is having sex with someone else- would you say s/he definitely is, probably is, probably is not or definitely is not*". This was dichotomised into 'yes' if the partner is sleeping with another partner versus 'no'. This meant the respondent was in a non-monogamous relationship.

CONDOM USE AND ASSOCIATED ATTITUDES

All participants were asked if they have ever used a condom. Correct condom use with the main partner at last sexual intercourse was asked. Correctness of condom use was established if it was used for every round of sexual intercourse and by a 'no' answer if the condom did not break, slip, was only used half way through intercourse and condom removed in the sexual act. Ideas about condom use were asked using a 10 item scale developed for the study. A typical item read '*if a man and a woman trust each other they do not need to use a condom*'. Responses yielded a maximum point of 40. Attitudes towards gender relations were assessed using a scale with 12 items developed for the study. The statements in both the ideas about condom use and the ideas about gender relations were answerable on a 4-point Likert scale as '1 = strongly agree, 2 = agree, 3 = disagree or 4 = strongly disagree. A typical question here reads '*a woman can refuse to*

have sex with her husband if she does not want it for any reason'. The Cronbach's alpha for the condom attitudes scales for women was 0.68 and for men 0.62.

RELATIONSHIP DYNAMICS

Communication in relationship

Relationship communication was measured using two scales – one on content and the other on skills. The scales were developed for the study. The content scale asked whether the participant and his or her partner ever discuss sex, contraceptives, protecting each other from HIV etc. It contained four questions. The communication skills questions assessed openness of communication in the current relationships. An example of a typical question capturing communication skill was "*When I disagree with (NAME OF BOY/GIRLFRIEND) I usually keep quiet*". The Cronbach's alpha for men was .068 and 0.69 for women.

Gender relations attitudes and relationship control

Participants' gender relations attitudes were measured using questions that were drawn from internationally used instruments that had been subjected to the cognitive interviewing process locally. The scale contains12 items and a typical item read '*If a wife does something wrong she should expect her husband to punish her*'. The Cronbach's alpha was 0.62 for women. Relationship control was measured using the Sexual Relationship Power Scale that was developed by Pulerwitz and colleagues in the U.S

[340]. The 10-item modified Sexual Relationship Power Scale has been used in a previous study in Soweto, South Africa, and for this study it was adapted for meaning and cultural relevance by the study team [194, 340]. A typical item from the scale (answerable in SA, A, D, SD) was "*When (NAME OF BOYFRIEND) wants me to sleep over he expects me to agree*" and for men the reverse reads "*When I want (NAME OF GIRLFRIEND) to sleep over I expect her to agree*". A higher relationship power scale score meant there was equitable power sharing or liberal power dynamics in the relationship. The relationship control scales' Cronbach's alpha for women was 0.68 which is an acceptable value, but for men the Cronbach's alpha was 0.54, which was viewed as a little low.

Thus we noted that the gender relations and the relationship control scales performed differently for men and women, with the internal consistency of both being inadequate for men. For women, the 2 scale measured something largely distinct as one was their attitudes and the other the practices of their boyfriends, whereas for men it was their own attitudes and their own practices. Reflecting on this enabled the team to consider the logic of merging the two scales for men (and not women). This made conceptual sense. When this was done, a final set of 13 questions was retained, seven of these were gender attitude questions and six were controlling practices. A principle component factor analysis was performed and the set of variables loaded on one factor with highly acceptable factor loadings (almost all above 0.4) and an eigenvalue of 2.92. Thus the decision to merge these scales for men was well supported by the psychometric properties of the resulting scale. The face validity was tested by discussion of the items

and the merge strategy with the fieldwork team. The Cronbach's alpha for the combined gender relations attitudes and relationships control for men was 0.69. This was an acceptably high internal consistency.

GENDER-BASED VIOLENCE

Exposure to abuse was asked for both in intimate relationships and outside. Questions on gender-based intimate partner violence (IPV) were adapted from the WHO's established and widely used tool [341]. This tool is called the WHO Violence Against Women Instrument. The WHO Violence Against Women Instrument asked specific questions that captured abuse involving any partner over the past year or ever. The IPV questions contained specific, objective descriptions of violent behaviours in areas of physical violence, emotional and sexual abuse. Physically violent practices included being pushed, shoved, slapped, hit with fist, kicked, beaten up, strangled, burnt, hurt/threatened with a weapon, had something thrown at her that could hurt, and their frequency. Four items about sexual IPV asked about physically forced sex, sex performed because the woman was afraid of negative consequences and being forced to perform oral or anal sex. This tool has been used in previous studies. For example the Soweto study by Dunkle [194]. Before it was used in this study it was piloted in the Winterveldt Pilot study as other scales and validated through cognitive interviewing with field workers and other volunteers. Women were asked about experiencing and men about perpetrating in the past year and before the past year. A typical item reads '*in the past 12 months did you slap (NAME OF GIRLFRIEND) or any other girlfriend or throw something at her which court hurt her? Did this happen many times, a few times, once or did not happen*?'

Following Dunkle at al., and previous research conceptualisation of intimate partner violence (experience for women, and perpetration for men), IPV was coded into 'zero or only one event' versus 'two or more episodes' [194, 278, 310, 341].

Men were additionally considered to have raped a non-partner if they responded affirmatively to any question on individually, or group, perpetrated rape of a woman who was not a girlfriend. An example of items measuring non-partner rape is '*Was there a time when you made a woman or girl, other than your girlfriend at the time, have sex with you when she did not want to*?' Local idiom was used for participating in gang rape which referred to it as '*streamline*'. All were asked about experiencing sexual abuse before the age of 18, men were also asked if they have ever been coerced to have sex by a man or a woman and women were asked about rape outside an intimate relationship.

3.1.7 Data handling and analysis

Data used for this thesis were collected between 2003 and 2005. All questionnaires were edited in the field by the study coordinators and then re-edited by myself in the office before data entry. During the onsite checking, mistakes were immediately shown to the field worker to correct with the participant if s/he was still on site. Data were double entered in EpiInfo, verified and analysed using STATA/IC 11. Responses to items measuring experience of acts and knowledge as continuous variables were summed up to calculate a score and summarised as mean scores. Scales were derived from the continuous variable items by carrying out a principal component analysis. Continuous

variables that did not meet the normal distribution of variance assumption, such as education and number of lifetime sexual partners were transformed and used as categorical variables. This follows previous practice; it is explained in greater detail for each variable in the previous section and references provided where the derived categories followed previous practice. Some scales are used with a cut-off point and dichotomised. For example, with the CESD Scale respondents who scored below 16 were categorised as having '0' for having no depressive symptoms and above 16 they were scored '1' and categorised as having depressive symptoms, this follows a traditional way of handling this analysis [20]. Categorical variables were described as percentages. The internal consistency of scales which were used was assessed by examining their Cronbach's alpha and items removed if necessary to maximise the alpha. No scales had more than 1% missing data and so no efforts were made to replace missing data. 95% confidence intervals (CI) were presented.

Data were analysed separately for men and women as this is the preferred way in studies of mental health due to different gendered practices and possible variations in the absolute and relative magnitudes of associations for women and men [240, 243]. Data analysis took into account the study design which was a stratified, two-stage survey with participants clustered within villages [196, 342]. As samples from one village could be more highly correlated than otherwise expected, adjusted logistic regression models were used to examine the associations [342-343]. This is a method used in analysis of risk factors in similar studies [18]. When samples are obtained from clusters, to account for the fact that greater homogeneity is expected and that the effect of the predictor variable

to the response variable may not be uniform across clusters, random effects multilevel regression models are recommended [343]. This allowed the regression model to produce more accurate estimates and allowed the regression associations to vary across clusters [343]. For paper II, analysis was restricted to only those participants who have had sex at baseline. Choice of confounding variables was informed by existing literature. Details of data analysis and procedures for model building are presented in each paper.

3.1.8 Study strengths and limitations

Participants for this study were not randomly chosen and this may be a source of concern as it is possible that a volunteer sample could be biased on the basis of the presence of depressive symptoms in participants. It is possible that people feeling depressed withdraw from social activities and may not volunteer for a community study as a result the prevalence may be underestimated. However, the direction of this self-selection bias cannot be determined as others argue that depressed individuals are more likely to volunteer in health promotion trials, pushing the prevalence up [13]. In terms of the other variables measured, participants came from a similar background and presumably shared similar experiences, social norms, values and sexual behaviours. Another form of bias in this study could have been a result of sexual experience. As the study recruited for a HIV prevention trial, the possibility that participants' own sexual risk taking could have influenced their decision to partake in a RCT for a sexuality intervention cannot be

excluded. Sexual behaviour may have been a barrier or a motivation to participation for some and this may affect prevalence of sexual behaviours and distort the true picture.

At the time of writing this thesis, the candidate was aware that the CED Scale, the Childhood Trauma Questionnaire, AUDIT, the Sexual Relationship Power Scale and the WHO Violence Against Women Instrument have been used in cross cultural studies and previous South African studies and reference of their use is provided in the preceding discussion of each instrument.

In the follow up study, some people may have stopped being in a depressed mood during the course of the study and others may have developed the exposure (depressive symptoms) immediately after the baseline data collection. In such a case their classification at baseline may not reflect their emotional state 12 months later. In a prospective cohort study, normally members of the cohort should be at risk but should not have yet experienced the outcome of interest. The analysis presented in paper II differed somewhat from this in that the outcomes were sexual behaviours and multiple outcomes were considered in the analysis. Restricting each analysis to 'non-exposed' would have been an option but resulted in a messy paper with shifting denominators. An alternative option was to adjust for baseline exposure. Thus the baseline level of each sexual behaviour variable was controlled for in model building. This paper has been published and the analytic strategy has been accepted by peer reviewers and the journal's statistical staff.

To avoid measurement bias, all information was collected in exactly the same way under the same conditions by the same set of field workers who were unaware of the presence of depressive symptoms in participants. To reduce interviewer bias, all field workers were brought to the same level of competence in interviewing skills, and at 12 months they were masked to baseline disease status of subjects. It is always possible that participants may have forgotten some of the information that they were asked to recall or that for some reason they concealed information. Use of different questions asking about the current, most recent and past 12 months provided a robust way to increase recall on many of the variables of interest. For example to ask about rape, different questions such as in the table below were asked to each participant (see attached questionnaire for more examples).

Table 1: Examples of different questions measuring the same underlying construct to facilitate recall and accurate reporting.

In the past 12 months did you physically force your girlfriend or any other girlfriend to have sex with you when she did not want to?
In the past 12 months do you think your girlfriend or any other girlfriend had sex with you when she did not want to because she was afraid of what you might do?
In the past 12 months did you force your girlfriend or any other girlfriend to have oral sex with you when she did not want?
In the past 12 months did you force your girlfriend or any other girlfriend to have anal sex with you when she did not want to?
Was there a time when you made a woman or girl, other than your girlfriend at the time, have sex with you when she did not want to?
Was there a time when you made a woman or girl, other than your girlfriend at the time, have sex with you when she was too drunk to say whether she wanted it?

The biggest threat to a cohort's validity and one of the factors that affects the strength of a longitudinal study (paper II) is participant retention, especially if it is biased in relation to 'disease'. The population under study (young people) is dynamic which means some people could not be found at follow up, but a follow up rate of 77% is considered good for the validity of the study. For paper II it is highly unlikely that the results were much biased by participants who were lost to follow up a year later as these were found to be no different when examining their baseline characteristics from those who remained in the study in terms of their baseline measures. When I examined the presence of depressive symptoms in these groups I did not find the percentages to be significantly different. 18% of the lost to follow up women reported depressive symptoms above the cut-off point and 21% in the remaining sample. Whilst 15% of the lost to follow up men reported depressive symptoms above the cut-off point and this was 13% of the remaining sample. See paper II, page 26 for more details on the differences between the lost to follow up group and the remaining cohort of participants. The two groups (lost to follow up and retained) were examined in terms of their historical sexual behavior reported at baseline and were found to be comparable on important variables such as sexual debut, condom use, contraceptive use and others (see table 1 in paper II, Nduna et al.) [344]. In terms of reporting sexual behaviour, though efforts were made to accurately collect information about partner concurrency, unreliability of sexual history on concurrency cannot be absolutely ruled out. Reporting bias in sexual concurrency, as this is an unreliable question to answer, is documented [345].

3.1.9 Ethical considerations

The importance of ethical conduct in research involving human subjects cannot be overemphasised and recommendations for best ethical standards were observed here. The protocol for Study 1was approved by two university ethics committees: University of Pretoria (approval number: 5/200) and the University of the Witwatersrand's Ethics Committee for Research on Human Subjects (medical) (approval number: R14/49).

To allow time for prospective participants to make a decision about participation, written study information sheets were made available to potential volunteers about a week to two before the interview [326]. This included a summary of the purpose of the study, the design of the study, the selection of subjects and procedures to be undertaken, risks and benefits of participating in the study. All information produced for the study subjects was translated into isiXhosa for ease of comprehension. In translating the study objectives, care was taken to avoid scientific terms and at the same time explain the study fully in a one page summary [326]. Permission to participate was indicated by completing and signing an informed consent form[ii] at all times [326]. The names of the participants and contact details were stored separately from the data in lockable cabinets and password protected documents. There were no foreseeable risks for participating in the studies and at the time of writing this thesis no negative experiences had come to the attention of the

investigator. Participants were made aware that there were no direct benefits to them personally of engaging in the study. It was clarified that the study was for scientific purposes. Participants were reimbursed with R20.00, for making time and effort to come to the interview, to cover transport and or snacks. This amount was small and cannot be considered to have unduly induced participation.

Study 1 had a community advisory board (CAB) and a data safety monitoring board (DSMB). The CAB closely monitored the execution of the research field work to look after the interests of the participants and the community at large [196, 326]. Precise and detailed information about community mobilisation processes and data handling for this study are detailed in the paper published in 2006 [196]. The DSMB monitored adverse events and considered whether and in what respects they may have related to participation in this study. The study employed two young nurses; a male and female to follow up with participants who needed referral for medical and psycho-social support. Questionnaires from participants who reported feeling suicidal were flagged. As a project manger I was responsible for identifying these participants by matching their unique study identifying number to their contact details and hand these over to the study nurse. The study nurse would call the participants to offer telephone counselling and/ or referral to a clinic. All participants referred to a clinic through the study were provided with transport money for this purpose. Study 1 offered further benefits to participants because they went through HIV prevention workshops after baseline data collection. Participants with identified HIV related health problems that required a clinic visit were given referral letters, transport fares and lunch money to cover visit to the clinic. Adverse events were

[ii] Appendix 1.3 Information Sheet and the Informed Consent Form

monitored during the study and in the small number of cases where participants died during the follow up period (or even before) the study nurse followed up these cases to provide counselling to their families and to determine that the cause of death was unrelated to participation in the study. These cases were all scrutinised by the study's Data Safety and Monitoring Board, which was satisfied that there were no study related deaths. Study nurses were available on a cell phone 24 hours a day and offered advice and assistance to participants. All participants received a leaflet with the stop abuse and HIV toll-free phone numbers.

3.2 Study design (Study 2)

Study 2 was a phenomenological study that sought to explore distress among young people: sources, experiences and expressions. As a qualitative study it was inevitably small and was located in one area. In order to ensure that the findings could be considered as reflective of some of the processes that were underway in the population of Study 1, this study was based within the area that formed the field site for Study 1 and sought participants from a population that shared characteristics in a broad sense with those of the Study 1 population. Although Study 2 was conducted a couple of years after Study 1, there was no reason to expect that circumstances had significantly changed in the study area over the short period of time to an extent that would prevent the two studies' findings informing each other.

The study asked the question 'what makes young people distressed' and when explored in this way it covered experiences that incompletely and in uncertain ways overlap with depressive symptoms. This research question was chosen in order to better understand and interpret the findings from study 1. A phenomenological approach was chosen for its relevance in studies of subjective phenomena that are aimed at describing '…*phenomena as consciously experienced, without theories about causal explanations*…'(page 77) [346]. The approach is inductive and descriptive and its suitability for this study lies in its ability to present perceptions of the lived experience and cultural meanings of distress for participants [9]. These could be ideal or true, nonetheless the central tenet in studies using the philosophy of phenomenology is the participant's view [346]. The voices of the participants translated into written narratives, were used to elucidate young people's perception of distressing encounters.

3.2.1 Study aim and objectives

The aim of Study 2 was to explore sources of distress, ways in which distress was experienced and expressed and connections with sexual behaviours among young people.

Specific objectives for Study 2 were to:

- Describe sources of distress as subjectively identified in narratives from in depth interviews
- To explain the relationships between the different experiences discussed

- Explore ways in which distress was experienced and expressed by participants and how respondents coped with distress
- Describe participants' sexual behaviours in times of distress

3.2.2 The research site

Study 2 was carried out in the town of Butterworth, situated between the Kei River and *Idutywa* under the administration of *Mnquma* Municipality [347]. It is a relatively small town with about six townships, four big informal settlements and a number of villages that surround it. Butterworth was the second biggest town after *Mthatha* under the Transkei Bantustan regime. This town used to survive on both productive agricultural activities and a vibrant factory production-based industry that created employment. Few of the villages around town, the townships and the informal settlements have access to basic services such as tap water, electricity and sanitation [347]. There is mobility between the surrounding villages and the town as people come and look for employment. Butterworth is historically an *Mfengu* area, all participants spoke *isiXhosa*. Religious dualism is common here with people mainly following both Christianity and African traditional beliefs. With comparable access to services such as electricity and the close proximity to town for the rural communities, where some of the interviews were conducted, even participants who were residing in the village could not be characterised as exclusively rural.

Post 1994 the Transkei administration was integrated back into the Republic of South Africa. Factories that were supported by the Transkei administration, with large tax subsidies, were forced to close down and this meant a beginning of economic recession for Butterworth. Economic stagnation, coupled with poor municipal administration and political feuds resulted in the town being the dirtiest according to the ratings of local governments [347]. Changes of the political leadership in the Mnquma municipality, where Butterworth is located, happened noticeably more than once per year. An Eastern Cape meta-analysis of deprivation using the 2001 census information revealed that Mnquma municipality has about 20% of its wards in the lowest quartile of the most deprived wards in the province. In the same report Butterworth had some of the twenty most deprived wards in the Eastern Cape (pg.8) [348].

3.2.3 The study population

The study population from which a sample for Study 2 was recruited were young people from Butterworth [328]. Butterworth does not fall under the O. R. Tambo District municipality but some communities from Butterworth were also part of Study 1. One of the pilot sites for Study 1 was drawn here and a few research sites were villages that are under the administration of Mnquma Municipality. Butterworth is geographically closer to the O. R. Tambo district municipality and so this population shares a similar political history as the O. R. Tambo District. In the post-Apartheid government municipal demarcation Butterworth was incorporated into the Buffalo City Municipality which mainly comprised areas that previously were governed under the former Republic of

South Africa. However, the heritage and life experiences of the people in Butterworth resonate with those of others from the O.R. Tambo District Municipality. To this extent, life experiences of young people from Butterworth would be similar to those of participants coming from all the other communities that were enrolled in Study 1, as similarities of these municipalities are described in two reports about these two towns on this N2 belt in the Eastern Cape [347-348].

3.2.4 Locating the researcher within the study

Introducing the researcher and thereby allowing the readers to understand the lens through which this research is undertaken and interpreted is important in qualitative research. This is especially valued in competent qualitative research with people of African descent [126]. This is a technique known as bracketing [126]. The candidate for this PhD comes from this district. I spent all of my childhood there, attended school and worked as a teacher in the local high school. I still remember vividly the development of the four-roomed residential townships drawn by the successful running of factories. I bring an insider perspective and understanding of the socio-cultural context and lives of the participants. It is acknowledged in qualitative studies that researchers are themselves main instruments for data collection, analysis and gaining insight into the data [349]. That I come from this community helped with ease of conducting the interviews in the local language and gaining participants' trust since I was not perceived as a complete stranger. Recommendations that the interviewer should share similar biographical details such as race, culture, language etc. are emphasised in studies of qualitative nature as

these facilitate better dialogue during data collection and validity of the interpretation of findings [126, 346, 350].

3.2.5 The sampling strategy

In the same way as participants from Study 1, study participants for Study 2 were recruited as volunteers from the local high schools, the local University and from the townships. The sampling approach for this study was non-random, non-probability as participants self-selected into the study on the basis of their interest to the research topic. The age range from which participants were recruited was the same as Study 1and Study 2 was approved by the same ethics committee that approved the age of inclusion for Study 1. Criteria for inclusion into the study included no known clinical diagnosis of any mental ill health. Participants were older than 15 and not older than 26 meaning they were old and mature enough to understand the research and consent process and most importantly they had to be willing to volunteer time and share their personal stories. Some of the participants were obtained through snowballing.

Participant recruitment

The study, its purpose and methods were fully explained to an experienced research assistant from the locality. The research assistant was tasked to announce the study to

local high schools and hand out participant information sheets[iii] explaining the study fully to the school officials and learners. This allowed potential participants to consider in advance if they would like to volunteer and find an opportunity to get clarity about the study from the research assistance prior to making their decision [346, 351]. Interested volunteer participants made themselves available on the day of the interviews. Some participants, especially young people who were out-of-school, were drawn in by word of mouth [346]. Exploratory qualitative studies similar to this one have utilised between 25 and 31 interviews [158, 352]. There was no deliberate attempt to obtain the same number of males and females. In this study a sample of 40 participants between the ages of 16 and 24 years was obtained.

3.2.6 Data collection method

Data were collected in two phases over a period of four weeks. As the researcher I spent about two weeks in the field during each of the two visits. I conducted the first set of eighteen interviews in September 2007 and twenty-two in April 2008. Data collection was arranged so that the times and venues would suit the participants. Most of the interviews were held at an office arranged at the school, some in private rooms at a college, others in the researcher's car and one at a participant's home. On the day of the interview participants signed a consent form[iv] to have the interviews recorded. A scope of

[iii] See Study 2 appendices
[iv] See appendices for Study 2

inquiry with open ended questions was used as a data collection tool[v]. To strengthen trustworthiness of the findings careful attention was paid to consistency [346, 349, 352]. All the interviews were conducted, transcribed and analysed by the researcher herself under the supervision of Prof Jewkes.

3.2.7 The interview guide

The interview guide covered sources, responses and coping with distress. Flexibility in the presentation of terms and the order of the questions was permissible [351]. The broader scope of the interview guide was motivated by the question 'what bothers young people in this Eastern Cape area?' This question was of interest for two reasons. In the Stepping Stones (Study 1) cohort there were four deaths from suicide that came to my attention as the project manager. These were not due to participation in the Stepping Stones study but prompted a concern on my side. Secondly, in following on these suicidal deaths and the sources behind them, I read a few articles on suicide in this region by Prof Meel who worked at the Walter Sisulu University and investigated this subject [215, 353-354]. Further I referred to a report in a publication that suggested that Xhosa students reported higher depressive symptoms, measured using the Beck Depression Inventory, compared to others in the same study [66]. This study did not investigate reasons for these elevated depressive symptoms and I realised that qualitative research was needed to explore this. Determining the research questions from personal experience, relationships and observations of the phenomenon in the community followed by exploration of

[v] See Study 2 appendices

literature is acceptable and preferred by researchers who conduct qualitative studies with people of African descent [126].

3.2.8 Interviewing

One-on-one, face to face, in-depth interviews following a semi-structured interview guide[vi] were selected as a method of data collection [351-352]. All the interviews took place in the same communities where participants resided. This approach provides comfort for participants, referred to as 'home turf', and is recommended among qualitative researchers[126]. The choice of a data collection method was influenced by the exploratory and phenomenological nature of the research question and it was similar to one used in a previous and similar study[10]. Interviews took about an hour each. To minimise bias, the approach to the interviews, introductory remarks and demeanour were kept standard. I shied away from using Western clinical terms during the interviews, as established in narrative based-research [9]. There is great communality of meanings for most words here which meant that I was not short of words for probing and I used words such as 'bothered' 'painful experience' 'heartbroken' 'pained' 'emotional suffering' interchangeably to ask about distressing experiences. The semi-structured format of the interview with open ended questions allowed participants to follow their train of thoughts in answering the questions and this led to a more relaxed real-life conversation [346, 351].

The interview invariably started off with an easy rapport building question. The interviews varied in terms of the intensity of emotions showed by the participants. As an interviewer I was touched by some of the narratives as the respondents described their life circumstances. I was shocked by the confidence participants had in me and how they could talk about their innermost feelings with such spontaneity. Women who spoke of engaging in survival-sexual relationships confirmed the multiple risks that they face due to a lack of agency. Listening to experiences of sexual violence with no access to medical and legal recourse was painful for me, which at times evoked feelings of helplessness on my side. There were narratives with levels of intensity that made me cry inwardly to the extent that on a few occasions I could not hide my own distress. It is recognised that interviews where participants narrate traumatic experiences it affects researchers emotionally [355-356]. The courage and ability of these young people to move around stoically impressed me. Having been trained in psychology, I was able to respond with professional sensitivity to respondents' narratives of difficult experiences and to participants who displayed distress during the interview.

The interviews were restricted to no more than an hour each. Though most fell within this time, there were few who were interested in talking a little more. There was one that ended much earlier because the participant was so distressed that she cried for most of the time. The participant was referred to social workers for further counselling. When probing 'embarrassing' or 'most painful' issues I contextualised them and used fillers but I was careful not to minimise their experience. For example, I would offer that '*other young people share a similar experience, have you any similar experience and if yes*

[vi] Appendix 2.1 Interview guide

could you tell me more about it?' All interviews were audio-recorded and additional notes were recorded in a notebook to serve as back up in an event of a mishap with the recorder and to note any non-verbal behaviour that could assist in interpreting the interviews [352]. These were later added to the transcripts.

3.2.9 Data handling and analysis

Participants' real names, including all other names referred to in a narrative, were replaced with pseudonyms. Transcribed material was kept under password protected files in a computer that was only accessible to the researcher and her supervisor who adhered to the same principles. After transcription, all audio recordings were deleted from the recorder. It is recommended that phenomenological studies should, as far as possible, postpone literature review till after data analysis, use open ended techniques, audio record the responses, keep notes about the interviews and follow verbatim transcription in order to increase data accuracy [346]. I followed these principles.

Analysis followed the conventional qualitative phenomenological processes. Although the narratives reference to family and significant others was inevitable, individuals remained the unit of analysis [346, 357]. A brief but sufficient literature review was conducted prior to the decision to do the study to establish the necessity for the research question and the appropriateness of the chosen method for answering the question. Going into the field with minimal reading for this part of the study allowed the researcher to be open to *post hoc* identification of important phenomenon and this is deemed important in

culturally competent qualitative research with people of African descent [126]. This inductive approach means that the reality of psychological distress among African young people studied here is contextualised within their specific socio-cultural conditions, with little prior reference to outside literature to understanding their lives. During analysis more literature was consulted. Transcripts were read and re-read to get an understanding of the participants' conceptualisation of distress. All descriptions of experiences offered from the different transcripts and functional relations with family and significant others that potentially contributed to distress as described by participants were named and labelled in open coding. Using the constant comparison approach, similar events and happenings described as stressful by different participants were grouped together. These commonly referred to elements that were identified formed the essence from where to proceed with the analysis. Actions by participants and interactions with others were also grouped together and so were responses from others to the participants' distress. The volume of data was large and this informed different papers that are focused on specific topics published from this study. Paper III presents the overall findings and paper IV a focused presentation of undisclosed paternal identity.

The researcher's cultural knowledge was consistently used to imagine what participants could have been talking about. This is referred to as intuiting in phenomenology and rests in the researcher's ability to think creatively about the contents of the transcripts [346]. One of the most important aspects of a phenomenological approach that distinguishes this philosophy from others is the necessity for the researcher to be free of preconceived ideas by suspending beliefs, assumptions and biases about the phenomenon under study. This is

called phenomenological reduction [346]. This was important during analysis and it allowed me to isolate new findings from what is already known or assumed. This required awareness and separating my own understanding during analysis by remaining neutral with respect to my own beliefs; part of a process of bracketing [346].

Analysis was used to establish patterns of relationships between the events grouped in the process described above. This helped to present plausible explanations between sets of concepts and gave an understanding of how life operated for informants. From these, emerged common themes of experiences that started during childhood and of which some were still experienced at the time of the interview. To strengthen methodological rigour, an experienced supervisor with clinical and strong research background and familiarity with this context provided confirmation of the validity of the codes and her interpretation which allowed for triangulation.

3.2.10 About the participants

Of the forty participants there were 24 females and 16 males. They were aged 16 to 24 and the average age was 19 years. Three of the participants were out of school and not working; 27 were in high school. Ten were pursuing post matric education either at the local private college or at the local Walter Sisulu University. Eleven of the participants did not have a mother; nine were not living with their mothers. Fifteen of the participants did not have fathers; fifteen reported that they did not live with their fathers. Some participants either permanently lived with an adult caregiver in their own homes or have

been moving between relatives. Evidently, this sometimes caused disruptions in their school attendance as some 22-year olds were still in high school. There were step-siblings, cousins and other relatives in most of the home environments. Only four said there were no other related children in their homes except for their biological siblings. Nine participants reported having a previous suicide attempt or feeling suicidal in the past, none were suicidal at the time of interviews. The common denominator was that in eight of these suicidal attempts, their suicidality stemmed from family related problems. These eight informants lived with their mother. There was an exception of the one girl who lived with both parents and her suicide attempt resulted from discovering boyfriend infidelity.

3.2.11 Study strengths and limitations

The strength of this study was that the interviewer speaks the indigenous language of the participants, *IsiXhosa*. So the interviews were conducted in *IsiXhosa*. This gave participants the opportunity to express themselves in their own language. This aids in strengthening the validity of the findings as no meaning is lost in translation or misunderstanding of a foreign language. Language, as a cultural tool to communicate subject feelings is important in studies of emotional experience [13]. After a thorough explanation of the study to ensure that they understood what was expected of them all participants were enrolled on voluntary basis. This increased the possibility that participants who were enrolled in the study would be open to and honest in their

participation and that they were not unduly induced. Due to the nature of the study design, the findings in papers III and IV are not generalising but the information provided apart from describing the setting, inclusion and exclusion criteria is meant to allow the reader to visualise the context and type of setting in which the findings were generated so as to allow transferability in a similar context. The strength of this study is that it has a big sample size, though it is possible that perhaps another set of 40 people would have had slightly different experiences, as perhaps would those who did not volunteer for the study.

A limitation of interviews is that participants will decide what information they want to share with the researcher in relation to the questions posed to them [346]. The study design meant that the data available was that provided in the interviews and there was none other. The extent to which the interviews reflected the 'truth' of participants' lives is not known. It is inevitable that participants selected what they thought were suitable answers to the interview questions. The manner in which the interview questions were asked was uniform in order to make sure that all participants got the same message. The answers varied from one participant to another and were informed by their individual and subjective experiences. They ultimately constitute the participants' accounts of their distress. There are acknowledged limitations with interview-based qualitative research of this nature; however the methodology enables processes and intersections to be made visible through a rigorous process of data analysis. This cannot be done using quantitative data collection methods. The researcher's very extensive experience in the study area as a resident and teacher of young people strengthened her ability to reflect on the validity of

the data provided in the interviews and to bring a depth of understanding of context that otherwise would not be available in a purely interview-based qualitative study. In a study of this nature reliability of participants' emotional expressions in the narratives cannot be guaranteed as they could change how they feel about the events and people who were part of their narratives.

3.2.12 Ethical considerations

The University of Witwatersrand's Research Committee for research on Human Subjects (non-medical) approved the protocol for Study 2. Approval number: H070813. The study was entirely based on volunteers. Enough information about the study was provided to participants both in writing and verbally. To allow time for prospective participants to make a decision about participation, written study information sheets were made available to potential volunteers about a week to two before the interview [326]. This included a summary of the purpose of the study, the design of the study, the selection of subjects and procedures to be undertaken, risks and benefits of participating in the study. All information produced for the study subjects was translated into *isiXhosa* for ease of comprehension. In translating the study objectives, care was taken to avoid scientific terms and at the same time explain the study fully in a one page summary [326]. Permission to participate was always indicated by completing and signing an informed consent form. [326]. The names of the participants and contact details were stored separately from the data in lockable cabinets and password protected documents. There were no foreseeable risks for participating in the studies and at the time of writing this

thesis no negative experiences had come to the attention of the researcher. Participants were made aware that there were no direct personal benefits to them for participating in the study. It was clarified that the studies were for scientific purposes. Participants were reimbursed with R20.00 for making time and effort to come to the interview and to cover transport costs and or snacks. This was a small amount and could not be considered to have unduly induced participation.

The interviews from Study 2 provided an opportunity for participants to speak about issues that they were unable to discuss either with their parents or friends and this was regarded to be of benefit by participants. Some of the experiences were shared for the first time and it became clear that participants felt safe to confide in a 'familiar' stranger; familiar in the sense of sharing the same background but not known to them personally. The opportunity to share and find relief is one of the good things about research of this nature [85, 126, 177]. Despite being aware of the limitations of the interview process in advising and solving their problems, some participants mentioned afterwards that they felt relieved after the interview. Some interviewees who displayed distress were offered a referral to the social workers though participants invariably declined this referral. I learnt about referral declines from other similar studies [177, 352]. To respect participants' autonomy in deciding whether to use the referral or not, I could not force participants to accept an offer of referral, unless there were grounds for suspecting a certifiable mental illness. Toll free numbers for HIV & AIDS and help with gender-based violence formed

part of the information leaflet that described the study and was handed out to the community during recruitment.

CHAPTER 4: PUBLICATIONS

Papers presented in this PhD thesis examine the sources of distress with the aim of deepening our understanding of psychological distress among young people in South Africa. This PhD provided important information on factors that contribute to distress and depressive symptoms whilst also furthering our understanding of the role of distress and depressive symptomatology in explaining risky sexual behaviours among young people. The papers included here have been reprinted with the permission of the journals.

CHAPTER 5: DISCUSSION

The aim of this thesis was to investigate the prevalence and factors associated with depressive symptoms, explore sources of distress and consequences for risky sexual behaviour among young people in a rural South African community using two studies. This discussion highlights the main findings from the two studies which form the body of work of this thesis. In Study 1, 21% of females and 14% of males experienced depressive symptoms at the time of the interview.

Findings on sources of distress for young women and men

In answering the question what bothers young people in the Eastern Cape, findings of the two studies support each other in some very important conclusions. For example the role of structural factors was evident in both studies for women and men. These are poverty, financial difficulties at home, violence, substance misuse by parents, as well as victimisation through sexual violence. The use of alcohol and drugs by participants was reported in both studies and this seemed to be a response to distress rather than a precursor [358]. However, consequences associated with the use of alcohol seem to contribute to the web of factors associated with distress. Both studies provide evidence that early childhood adversity, loss of parents to death, witnessing domestic violence, negative and conflictual family circumstances and lack of communication within families led to feelings of inadequate family support and contributed to young people's distress. Perceived lack of support evidently caused distress.

This thesis contributes to knowledge about the role of interpersonal and sexual relationship dynamics in the development of depressive symptoms. Gender based violence, in particular intimate partner abuse, and knowledge of partner infidelity causes distress in young women. These featured strongly and distinctly in women's narratives pointing to the negative impact of early gender injustice on young women's mental health. It also featured in both papers I and III and in the quantitative and qualitative studies respectively.

There were some areas where there was lack of agreement or no mutually supportive evidence from the two studies. For example, Study 1 (paper I) shows that maternal loss was associated with depressive symptoms among men only, whilst Study 2 (paper III) did not show a gender difference. Though the role of sexual violence was not revealed in Study 2's findings for men, it is suggested in Study 1 (paper I) as associated with men's depressive symptom.

There are very important factors that were not included in the variables investigated in Study 1 that appear to be critical sources of distress for young people. These are incarceration of parents and other family members, undisclosed paternal identity and lack of connection with the father (Study 2, Papers III and IV). Study 1 did not ask about sexual orientation and worked from a heteronomative assumption; a bias that is a limitation in this study. Experience of distress related to minority sexual identity status and gender non-conforming behaviour was reported in paper II. However even if gender

identity and or sexual orientation were asked about in Study 1, the numbers would have been too small to do any meaningful analysis. Young people who lived with relatives as adoptees and had a sense that they were being overburdened with house chores and work outside the house were troubled by this. This of course happened in the context of other negative family dynamics, however it stood out and seemed to create a feeling of not being loved and accepted which distressed them. Lack of communication within families was reported in paper III from Study 2. This refers to failure to communicate pertinent information to young people especially about family matters as well as excluding young people from decision making. These distressing experiences informed the normative lives of many of the participants in Study 2. Lack of communication appeared to be bidirectional as the young people used silence as a response to distressing situations. However, though it appeared to be a safe strategy, it was the opposite, as living with unanswered questions was also distressing. Study 2 shows young people who were emotionally invested in their families and worried a lot about what their siblings got up to; when it was risky behaviours such as reckless sexual encounters and alcohol and drug use they were extremely worried. Also when their siblings' behaviours were contrastingly inconsistent with what was considered good family values they worried. For young women who had been pregnant, an unacknowledged or outright denied pregnancy was a source of distress. Unplanned pregnancy was asked about in Study 1 and did not seem to be associated with depressive symptoms but what the in-depth study shows is that it is when the pregnancy is denied that the experience becomes a source of much distress for the affected young women.

This thesis is the first large study to establish these associations from a country in sub-Saharan Africa but most importantly these associations are seen in young people, in particular from an impoverished, disadvantaged setting albeit within a low-to-middle income country.

Findings on distress as a risk factor for risky sexual practices by young women and men

In this thesis I further sought to investigate the role of distress and depressive symptoms in young people's risky sexual encounters. The overall findings are key as they show that involvement in risky sexual relationships and unsafe sexual practices by both women and men may be the result of distress (Paper II). Findings reported in Paper II confirm that depressive symptoms lead to risky sexual behaviours and dating risky male partners. This confirms finding from the international literature and local findings as reviewed in Chapter 2 and leads to the rejection of what would be a null hypothesis that there is no relationship between distress and risky sexual practices. Women having sexual relationships with older partners and for financial gain are described [358] and also significantly associated with depressive symptoms (Paper IV). For both men and women, having had a high number of sexual partners was significantly associated with depressive symptoms and was vividly described in the qualitative study as having been facilitated by moments of experiencing distress [358]. This became cyclical for some, confirming that this relationship is bidirectional and some incidents such as transactional sex, denied pregnancies and IPV cause distress as they are likely to happen to women with pre-

existing distress [358]. These two studies support each other in the role of depressive mood in women's engagement in sexual relationships for gain. Gender-based violence featured significantly with depressed men reporting perpetration and depressed women were living in abusive relationships. Men with depressive symptoms also either gave or received various items in exchange for sex. Distress seemed to intersect with the socially constructed gender identities, gender roles, and sexual behaviour scripts and especially for women who accepted ill treatment in sexual relationships [358]. Qualitative findings provide evidence from narratives of risky sexual escapades in the context of distress that parallels findings from study 1.The associations between depressive symptoms and non-use of condoms were evident in males but not among females (Paper II) whilst depressed women dated relatively older men (Paper IV).

5.1 The prevalence of depressive symptoms

The prevalence of depressive symptoms above the cut-off point was reported by 20% of the females and 13% of the males. This finding is comparable to that reported in a Kenyan and in a South African national study, albeit using different measures [44, 62]. Given that this was a sample of young people this percentage of young women and men reporting depressive symptoms above the cut-off point is high. Reddy and colleagues found, in a randomly selected sample of young people in South Africa that overall, 24% of females and 23% of males reported feelings of hopelessness and helplessness. Study 1 of this thesis reports a lower proportion of men with depressed symptoms in the Eastern Cape compared to 20.9% who reported feelings of hopelessness and helplessness from

the same province in Reddy et al. [62]. The high, and comparable to females, proportion of males reporting distress in Reddy's study is surprising and unusual and is perhaps due to differences in the measurement tool used as Reddy et al. [62] did not ask about depressive symptoms per se.

When interpreting study 1's prevalence, caution should be taken due to the non-probability, non- representative and volunteer nature of the sampling so the results of this study (1) are not be generalized to the population of young people neither in this province nor in the broader South Africa since bias is likely to result in an incorrect estimation of the scale of the problem. Nevertheless, the study was from a large sample and is useful as a contribution in understanding the problem of depressive symptoms among young people.

Research has long established that more women report depressive symptoms. This is suggested in local studies and this thesis confirmed it [163]. However, this gender difference is not essential in women. A number of factors that need to be looked at in future studies may account for it.

Firstly, Young women here disproportionately experience painful incidents and experiences in sexual relationships, as shown in paper III. This is discussed later under the discussion of the role of sexual relationships in causing distress. Another example is suggested in paper III that some young women in adoptive homes felt that their positions within those homes was that of domestic servitude. This was a peculiar experience to women.

Secondly, women, even if they face similar risk exposure to adversity as their male counterparts, may experience more trauma and lack of control due to gender subjugation and gender based violence especially in a traditional and patriarchal society such as South Africa [188, 191, 359]. This lack of control can be disempowering and may be an additional source of elevated depressive symptoms in women.

Thirdly, men and women respond to adversity differently. Social norms permit young women to respond to adversity at an emotional level and acknowledge feeling sad. Hence more women may report depressive symptoms that they experienced in the two weeks prior to the interview. Men, even if they were exposed to the same levels of adversity and pain as women, may not equally recall experiences of painful emotions as these are considered feminine. The use of recall interviews as a method of data collection is related to socialization. Since women pay more attention to their feelings they are more likely to recall how they felt in the recent past when completing the symptom check list as compared to men who have been socialized not to express or talk about their feelings and so may recall them less well or be reluctant to admit them. This recall-bias may lead to underreporting of negative affect and an underestimating of the prevalence of depressive symptoms in men.

Lastly, it is known that men tend to externalize their response to pain and adversity through anger and substance use. These are not captured in the CESD Scale [158]. Exclusion of externalizing behaviors means that depressive symptoms in young men are underestimated and misclassified in this study as a result of the scale that was used. Corollary to this is the fact that as the CESD symptoms scale, like others, contains more items about internalizing behaviors it means it's biased towards recording

symptoms that are usually considered 'feminine'. This excludes behaviors such as smoking, binge drinking, anger and violence which may be men's ways of expressing distress as suggested by the qualitative findings [358]. This may suggest that, to tap into men's emotional reactions different items are needed to constitute different scales measuring the presence of depressive symptoms in women and men. Even with these concerns that point to a potential to possible underestimation, a measured prevalence of depressive symptoms in 13% in a sample of young men is quite high.

5.2 Factors that contribute to psychological distress and depressive symptoms in young people

Poverty

First and foremost, structural factors are pertinent in understanding the results presented in this thesis. Chief amongst these is poverty. In the predominantly low socio-economic class of Eastern Cape communities, poverty is intricately linked to low family income, shortage of opportunities for quality education, lack of social support and little access to good jobs. As evident in Papers I and III, a '*difficult life'* was typical and distress is embedded in it. The samples of the current studies came from a generally poor province and low socio-economic status is already known to be associated with elevated depressive symptoms in South Africa [56]. South Africa is hard hit by unemployment and poverty thrives when unemployment rates are high. In 2008 only 34% of under 18's

reported living in a household with an employed adult [156]. In the qualitative study participants were acutely aware that they did not come from '*right*' families - a phrase that repeatedly surfaced in the findings communicating that as a result of poverty they did not achieve the standard of living acceptable in their communities. Features of participants' difficult lives and the way they crafted the link with their distress parallels poor mental health outcomes of Aboriginal young people from Canada and Australia in regions with a history of colonisation, oppression, racism and the reserve system which is similar to the Bantustan system. The legacy of this system continues to inform the low socio-economic standing of young people in the former Transkei region where participants were recruited for these studies [185, 360]. Limited access to services and benefits that would help improve status, education and lives is reported amongst children in poverty stricken SSA communities [72] and that is why these study findings are very important for the entire region. They echo the role of poverty in causing distress, or '*illnesses of thought*' as reported by adults from Uganda [158]. This is in keeping with Marx and Bosch that poor individuals suffer budget constrained economic participation in their community [152] and this can be distressing. The message about the association between poverty and mental distress which is reinforced by findings presented in this thesis are reported in explanatory models of psychological distress among adult women in Zambia [127] and adults in South Africa [56]. Social welfare support is low even with the government's increased social net including free and nominal fee basic health and education services and creative welfare grants (pension, child support, child fostering, disability etc.) this did not seem to make a significant improvement in the quality of lives for many in the poor province of the Eastern Cape [312, 361-363].

Child maltreatment and abuse

Over and above poverty, young people were confronted by distressing experiences in their homes. These were very stressful events and it is already known that experiences of stressful events is a risk factor for depressive symptoms among the young [64]. One of the main childhood-adverse experiences reported which was associated with the risk of depressive symptoms was childhood maltreatment and abuse. This took many forms such as physical abuse and neglect, emotional abuse and neglect, negative interpersonal familial relationships and sexual abuse. Qualitative findings refer to abusive experiences as 'hardship', negative actions and inactions by parents and guardians that parallel the items contained in the childhood trauma scale (Paper I) referring to family-based adversity. Findings from these two studies are consistent that child abuse affects later psychosocial development in young people. There is global evidence for the association between early sexual abuse and distress wherein youth with a history of sexual abuse are more likely to have depressive symptoms [191]. Other research has shown similar findings that child abuse is a problem facing many young people, common in families that are under stress or had significant changes such as death or loss of a job and leads to distress [78, 155-156, 188]. In an earlier report 89% and 94% of young women and men, respectively, reported that they experienced physical punishment before the age of 18. This is very high. In the same study, physical hardships before the age of 18, were reported by 65.8% of women and 46.8% of men [331].

It is known that emotional abuse and neglect are common. In this Eastern Cape sample 54.7% and 56.4% of young women and men respectively reported emotional abuse and 41.6% and 39.6% emotional neglect [331]. The qualitative study reports that participants faced abusive negative criticism, threats and use of violence especially from their guardians. Emotional abuse increased family strife, reduced emotional security and made the young people feel unloved. What we learn from this study is not unusual. For instance, in the U.S parents of young people from lower socio-economic classes such as these have been arguably observed to behave in ways that are edgy, irritable, critical, punitive, cold and unsupportive towards their children with little tolerance for disobedience and to some extent their attempts to enforce discipline are abusive [75, 78, 364]. Indeed this observation from the West can potentially reinforce stereotypes about black parenting whilst this may not be exclusive to lower socio-economic parents of Colour (Black). Essentialism of negativity in parents of low socio-economic status should be avoided. Negative and poor parenting skills point to a need for interventions with parents in order to foster positive relations and more constructive disciplinary measures. Another construct of an abusive home environment is one that is characterised by high levels of alcohol use. It is mentioned in paper I table 2 and in the qualitative findings (paper III) that growing up in a home with alcohol abuse disturbs children and it was evident from the qualitative study that alcohol misuse by parents resulted in violent conflicts and abusive behaviours towards children and this worried some participants. Where violence and substance abuse are embedded within families, interventions are needed to prevent and mitigate the violent impact of parental substance abuse. As this

discussion paints a picture of families hard hit by poverty, death, lack of connectedness and parental absence, alcoholism worsened the impact of these (Paper III).

The association between early childhood maltreatment and depressive symptoms was very strong here and it was evident for both females and males, contrary to some findings from the North, where in a U. S. based study, the impact of childhood maltreatment on depressive symptoms later in young people's lives seemed to be important to females [87]. Findings from paper I discuss ill-treatment of young people within adoptive families. This is discussed in the next paragraph under the heading '**Alternative care arrangements**'. However, it is important to note that not all situations of abuse resulting in distress occurred in adoptive homes. As the qualitative study shows, some of the participants' position in their own homes was not necessarily esteemed. A picture painted by the findings of the qualitative study fits a statement made by Moore in her discussion of family formations in societies organised around kinships such as the traditional homes in the Eastern Cape. Moore observed that, '…*women work for men, juniors work for seniors and the poor work for the rich*…' [365]. This places higher burden and vulnerability on young women, in particular, from poorer single-mother or women-headed households [71, 81].

Silence ruled the lives of these young people (Paper III). Even those that were unable to escape abusive environments kept silent at times when they should have called for support. They adopted adaptive roles in relation to their abusers and learnt to scan the environment for potentially explosive situations in an effort to keep the emotional climate

safer [366]. From a study of 2,189 high school students in the States, inability to express one's emotions, measured as restrictive emotionality was highly associated with reports of depressive symptoms with participants in the high restrictive emotionality group. They were 11 times more likely to report depressive symptoms compared to other young people in the same sample [21]. This speaks volumes about the association of silence with distress, which is an inability to express oneself and which was very strong in the family environment in paper III and it is discussed in another publication on silence [366].

Substance abuse

There is a very important finding here that points to use of substances by young women and men who reported experiencing depressive symptoms above the cut point (CES-D Scale). This is collaborated in particular by men's narrative accounts of young people's own misuse of alcohol and other drugs. The association between depressive symptomatology and alcohol and drug use was evident in paper I and III for both females and males. This supports conclusions in other reports [18, 64, 331]. Narratives of alcohol and drug use analysed in the qualitative study suggest that it was mainly a coping response to distress. Though South Africa has a legal age limit of 18 for the sale of alcohol and tobacco, this does not stop young people from experimenting with alcohol, cigarettes and other illicit drugs at a younger age [26, 367-372]. Turning to alcohol use as a coping mechanism for emotional distress is problematic for young people due to its

relatively wide availability [370] and potential to cyclically cause harmful and uncontrollable substance abuse and distress. Families, social policy and social agents need to strengthen supervision of young people's access to substances and enforce an intolerance of violence. Findings on excessive alcohol and marijuana use as sources of distress are reported by young people in international literature pointing to the importance of this [146].

Alternative care arrangements

Some orphans, poor and vulnerable children are usually informally adopted by relatives - a response strategy that is incredibly common here [174, 373]. Usually, the child is familiar with the adoptive parents. These are customary relatives. The adoptee remains in contact with their own parents (if alive) through visits during school holidays and will eventually go back to their natal homes. For some rural families in the face of penury, urban based adoptive families provide the much needed child-rearing assistance and material support with food, clothes and education for their children [78, 374]. It is evident in this setting, as elsewhere, that young people who move into alternative care arrangements bring with them a history of hardship, neglect, abuse or other special needs which set them up for distress [81, 155]. Inadvertently vulnerable children may be received by relatives in urban towns as a relief for cheap domestic labour and childcare [81, 365]. This corresponds with some participants' perceptions, in particular girls, that they were adopted by relatives for their cheap labour and this contributed as a source of distress to them (Study 2). In these traditional African communities subjective

experiences of penury are easily linked to perceptions of low support (Paper I and III): evidence that young people with depressive symptoms may not accrue benefits of social belonging. With so much adversity, it is no wonder that symptoms of depressive symptomatology were found in young people who held negative perceptions of the world around them (paper I).

In contemporary South Africa, some young people spend a great amount of their time on tasks such as cooking, cleaning, and looking after younger siblings, the elderly and the sick [155]. However, for some children this is becoming disproportionally burdensome especially as a legacy of the AIDS epidemic, as some young people mature earlier and head families not of their own making [125]. This is not to say that children should not help with household work as in many African homes young people have always been positively involved to varying degrees in different types of domestic work [71, 81]. Nonetheless, children involved in child labour have less time for leisure, sleep and school work, leading to threatened future opportunities [125]. Exploitative relationships involving adoptive parents and relatives, who take advantage of those who are financially stranded and dependent on them, were reflected in narratives of disempowerment. The stress also resulted when adopted children felt mistreated, faced financial challenges and school interruptions. As children move between households they often change schools and some eventually drop out [193]. The perception of thwarted opportunities for school advancement caused distress in young people.

Threatened life opportunities

Evidence of a '*difficult life*' from the qualitative study speaks to general high levels of lack of opportunity and risk of distress worsened by the carnage of AIDS deaths for orphans in particular [155]. Young people's disrupted schooling and limited educational opportunities have interconnections with AIDS orphanhood, isolation and poverty of opportunity among the lower socio-economic groups, all of which threaten their future and cause distress [155, 175]. There are reports that in South Africa, 32% of females and 27% of males would not be attending an educational institution at the age of 18 years and only 10. 3% of Africans successfully complete 12 years of schooling [51, 72, 125, 157]. The impact of taking on the care giving role on young people is reported in international studies to be negative and significant, compared to non carers [89]. Locally, worries about interruptions and inability to attend school are evident when living with a sick parent, even before parents die. This is reported in a study of the impact of being a young carer on school attendance from the Western Cape Province [178]. Given this backdrop it is understandable that young people's distress was marked by worry about their future opportunities. Paper I shows that young women who were educated up to grade 10 (compared to post grade 10's) had depressive symptoms. Two possible explanations for what contributes to this are that: arguably this age coincides with the age around which children whose parents were living with HIV die of AIDS and they become orphaned. Findings from a study by Cluver and her colleagues can support this as amongst AIDS orphaned young people from Cape Town, the age group10–19 year olds was the most affected [163]. Is it possible that as children grow, develop higher order intellectual

abilities and become young adults they become acutely aware of and interpret circumstances around them and may respond with distress if they realise that their future is at risk? However, these possible links need to be further investigated and so is the fact that this was evident in women but not men.

There is a need to further investigate when distress is more likely to follow maternal orphanhood. What is known is following the loss of a mother; many young people as a result experience disturbing, discouraging and distressing thoughts about their future (paper III). However if they came from family backgrounds that were better off they might be relatively protected from the depressing feelings. There needs to be more information that will help explain why and when the critical age is for orphanhood to increase risk associated with depressive symptoms among young women. It is not possible from the findings of this study to speculate on this gender differential impact of maternal orphanhood for women and men. The coming paragraphs will return to a discussion of orphanhood in.

Perceived lack of social support

Perceived lack of connectedness in particular with family is critical in contributing to distress among young people. Findings presented from the qualitative study are of young people whose frame of reference for their lives reflected acute awareness that they were

negatively affected by periods of non-nurturing behaviour that occurred within their families. Young people need some alliances for emotional support and experiences such as being treated differently. Being prevented from knowing important information and not receiving optimum support caused insecurity (Paper II & III). When connectedness to family and allegiance were not there, conflicts and perceptions of being alienated prevailed. It is clear from the narratives that sometimes poor quality of relations with family was traceable to childhood and early adolescence. The finding that lower-quality relationships with parents contribute to distress and depressive symptoms agrees with reports in a Swedish study [16], albeit these were slightly younger participants and the parents referred to were biological parents, whereas in this current study parents invariably included extended family members. The quality of the relationship between children and their parents is compromised with constant conflict and it is already known through another local study that conflict with parents is a risk factor for depressive symptoms among the young [64].

Lack of communication and being excluded from information was sometimes accompanied by conflict (Study 2). This secrecy about pertinent issues such as paternal identity, adoption and inheritance experienced by some young people in their families create disempowerment. At one level this was interpreted by the young people as implying that family was not ready to involve the 'child' in meaningful decision-making but when they were not allowed to decide for themselves what to believe, some of the young people felt disempowered and became distressed. To understand how this worked one has to reflect on the subjective feelings of the participants. It appeared that at another

level, family's resistance and refusal to answer questions created suspicions of sinister motives harboured by parents and guardians. Ironically, even these were moments of compliance for participants as they carefully tried to maintain respect despite feeling tension around situations that created a suppressive environment [366]. This seemed the same for both boys and girls.

This thesis presents a situation where there is a perception of inadequate support from some of the young people's siblings and other immediate relatives. Partly, lack of availability of immediate family relatives for support is attributable to movement of rural dwellers to more industrialised urban provinces of Gauteng and the Western Cape. This is usually in search of employment [51]. When relatives did not adequately support those left behind this broke traditional support systems. This was stressful to those affected. In this community, as in less independent cultures that put less value to verbal expression, it appears that support may not contain the same meaning as in Western cultures. In less independent cultures it may well be perceived rather than received support that is a stronger predictor of adjustment to stressful life events [375]. To support the current findings is a report from Canada that self reported perceptions that one did not have someone to confide in, count on for advice and who makes one feel loved and cared for were a risk factor for depressive symptoms [18]. So indeed the perceived availability of others for a young person is important across cultures and world's regions. This perceived support seemed to lack among these young people and hence distress featured in their lives (paper I and III and IV).

Understanding young peoples' inability to draw on support from relatives in this context is complex. Study 2 suggests that there was potential for some of the young people to draw on support but this was not used. This situation is parallel to that reported by Taylor and colleagues that social support remained unused sometimes even when it was available because participants felt that they had less to gain personally than they could lose socially by calling on others for help [375]. Evidence in papers III and IV and some unpublished data suggests that some participants were able to mention people that they could have turned to for support but did not [366]. Those participants who were silent about their painful experiences did so because they carefully observed and calculated the risks of expressing their feelings and came to the decision to be silent as they thought that they will not be received positively if they attempted to express themselves [366]. This perception could be true for indiscriminate associations but is compensated by carefully chosen friendships such as those of young people who understood that their vulnerabilities, problems and worries were not unique to them and selectively disclosed to others, including sexual partners, considered to be in the same situation, usually not extended to family [358]. In these friendships, peer empathy developed.

Description of stories involving suppressed distress related to problematic family relationships confirm the work of Ellis in the South African cultural context [9]. That depressive symptoms are related to, amongst other things, worry about family communication (papers III and IV) is reported also in other research [191]. A proposition by Piaget's theory suggests that from adolescence onwards this is a time of establishing autonomy, full adult power, status, privileges, increased decision making and that family

becomes less important at this stage [75-79, 96]. Findings presented in the qualitative study question the cross-cultural generalising of this and rather suggest that young peoples' maturity does not imply disinterest in family. Study 2 reveals young people who were emotionally invested in their family issues; they participated in complex relational drama and got frustrated and distressed when positive family life was threatened. This thesis posits a view that in South Africa connection to family may become even more important during this stage [70, 74, 78, 82].

Orphanhood

Parental loss (Papers I and III) was another area of negative family life that emerged as a source of distress. The main cause of orphanhood at a young age is AIDS [105, 155-157, 168, 174, 314]. With a 112% increase in double orphaned adolescents between the ages 12 and 17, from 195 000 in 2002 to 414 000 in 2007, orphanhood is one of the pressing issues facing South Africa. Papers I and III show that orphanhood leads to distress and depressive symptoms. An association that is found in other settings [376]. Orphanhood affects family relations, child supervision and financial security but its mental health sequelae is rarely studied in South Africa as important as they are. Two studies have been found on this topic from South Africa; both of these studies drew their samples from big metropoles: one from Soweto and another one from Cape Town [155, 163]. Nevertheless, the findings of this current thesis confirm the existence of an association reported in these two studies.

However this association between losing a parent through death and reports of depressive symptoms is not consistent here. Firstly, the distressing impact depended on which parent had been lost. Secondly, the impact was differential on women and men.

Evidently, losing a mother is more critical in this setting. In some cases the association between losing a mother and depressive symptoms can be attributable to the risk of not living with the surviving parent which is the father [156, 177]. Also mothers are objects of identification and their death spells permanent withdrawal of material support as discussed again under the sub heading 'No paternal connection and identity'. In a previous study though, losing a mother was not significantly associated with psychological distress [163] so this needs further investigation.

The lack of significant evidence that losing a father does not have a depressive effect can be attributable to high prevalence of father absence in these communities [177, 377]. Hence it could be possible that young people who lost an 'absent' father felt less painful impact as the death may not spell loss of emotional support [177, 378-379]. The limitation of interpreting this finding is in that participants were not asked if they lived with their deceased father.

Double orphanhood did not have a depressive effect here. It is possible that double orphans are restricted in terms of their ability to partake in community activities, such as this study, as they take on more domestic chores replacing their parents [177] and therefore they were underrepresented in the sample, making this cell smaller in the analysis and resulting in lack of significance. Nevertheless, this lack of statistically significant association is similarly to findings from a similar sample in Cape Town [163].

Secondly, inconsistent results were found on the impact of orphanhood on men and women: Paper I show that men, not women who had lost their mother were found to have depressive symptoms. In the interviews participants reported current depressive symptoms and this was analysed against reported loss, which is presumably earlier than the past two weeks when the interview took place. With regard to the lack of a statistically significant impact of parental death on women it could be possible that the society recognises girls as 'emotional' and therefore afford girls and young women more opportunities for psychosocial support at the time of loss than boys and women recovered from the loss. Boys may be less likely to receive psychosocial support because they are expected to be 'tough'. Whilst this lack of psychosocial support may leave them with extended grief they may also deal with the burden of looking after their sibling, a phenomenon known as 'parentification' as men tend be have a burdensome feeling that they should be breadwinners taking after deceased parents [177]. It is also possible that this finding may be spurious or is complex and needs to be further studied.

Parental absence

The negative mental health impact of parental absence on young people was evident here. Young people in South Africa do not always have both parents in the households even if they are alive [156, 207, 378, 380-382]. Statistics show that only about a third of

Africans, half of Coloured and two thirds of Indian and white children during the ages 0 - 19 live with both parents[vii][156]. In the 2001 country census report as many as 30,6% of African young people were living in a household where neither parent was present [125]. Prevalence of paternal absence is reported by Eddy to be higher as her analysis shows that in 2002 half of South Africa's children under 15 years lived without a father in the household [156]. Data presented in this thesis come from a province where the highest number of children living without one (usually the father) or both of their parents outnumber those who live with both [169]. Migrant labour is a historical cause of father absence for many children in this former Transkei region of the Eastern Cape [156]. Though men recruited to go and work in mines may be allowed to live with their families in the mine compounds, it is still the norm to leave families behind [156]. The other main contributing factor to children not living with both parents here is that children born out of wedlock are a norm.

The assumption that if children lived with both parents they would be protected from distress partly stems from the esteemed and hegemonic view of a nuclear family. This may certainly not be true, but it is a perception upheld. To understand the protective role of two-parent nuclear families in this context requires a complex analysis mainly because in non-Western societies such as in South Africa there are varying family formations including, matrifocal, female-headed, extended and single-parent families [155, 168, 174, 365, 383]. Sometimes the non-nuclear nature and the complexity of the outlook of these families allows for support to be extended to children who would otherwise not have

[vii] These are dominant racial groups used for classification referring to African people, decedents of mixed race, Indian descent and Europeans.

received proper support in their nuclear families. A corollary assumption from giving prestige to a nuclear family is that single parented and other family formation variations are seen to represent dysfunctional families. But as Krestan and Bepko argue in their work on alcoholism, labelling a family as dysfunctional is controversial as it is based on Western patriarchal family life that reflects predominantly middle-upper class values which too have been threatened by changes in family structures over the past four decades or more [384]. Single parented families are a norm not only in the South African context but young people are reported to stay with single parents in some developed states as well [6]. Growing up with a single mother may have critical negative effects on children but these are pronounced if the family experience material disadvantages and health and social support [155-156, 161, 193, 377, 385]. When the material conditions are inadequate in a single parent household, the parent may allow her child(ren) to be taken in by relatives to provide alternative care; a popular practice in this society albeit not without challenges.

In Study 2, participants often used the phrase not coming from the '***right*** *families'* to indicate that it was poverty and a 'complete and functional' family that they were lacking. Krestan and Bepko posed this important question as far back as 1997 asking what kind of family is dysfunctional, by whose standards are a family dysfunctional and for whom it is dysfunctional. [384]. Despite changes in family structure, fantasy is powerful and participants in Study 2 sometimes appeared to long for an idealised traditional two-parent family centred on an economically productive father and an emotionally supportive mother. It may be that some of the distress experienced by young

people result from a discrepancy of having an expectation of a particular family. This ideal family does not always exist as evolutionary processes have threatened it. So what is a functional family? Some of the characteristics of functional families as listed in Krestan and Bepko include '*...a family that can talk with one another, feelings are expressed and accepted; family operates without denial, without secrets, without need for shame and isolation*...[384] (p.221). Qualitative findings presented in this thesis suggest that the families that some of the participants came from functioned far from the ways suggested for 'functional families'.

These characteristics described by Krestan and Bepko are very relevant for this discussion for two reasons, one being that participants also seemed to expect these from their families. Both papers II and III suggest that young people have a need to talk with their family on important matters, they are keen to express their feelings in a context that is accepting, they are greatly worried when family operates with denial, secrets, and seem to harbour shame on matters such as circumstances around death, paternal identity etc. The second reason is that these positive aspects of family functioning can be achieved even in single parented, grandmother-led and extended families, therefore the myth that a functional family is a nuclear family of a married couple centred on an economically productive father and an emotionally supportive mother needs to be debunked. It is possible to achieve functional family setups but as evident from the qualitative study, family dynamics described here are largely affected by gross power imbalances between men and women, between the old and young and between the haves and the have-nots. Therefore young people in this context are bound by the implicit rules and roles which

often impede honest open communication between children and adults and males and females. In addition, implicit in the findings presented in Paper III, there was a pattern that conforms to intergenerational transmission of disempowerment as children of mothers described as disempowered often felt disempowered themselves. As result I conclude that it is not only the absence of one parent that is a risk factor for a dysfunctional family but also that poverty and maternal disempowerment negatively affects the composition and dynamics of single mother families. Single mother-only-parent families, with the right conditions, can have benign effects for children but does not negate the developmental needs of the child to have a father.

No paternal connection and identity

The body of knowledge about the role of absent fathers in emotional pain is starting to grow [177, 386]. Whilst it is known that children living in maternal homes may not have connection with their fathers [156, 160, 193, 365, 378, 387] and others may not know the fathers [177, 388], paper III was the first to publish a connection of undisclosed paternal identity and distress in South Africa. Development of self-awareness for young people is intersubjective and involves relations with others. It was in interactions with cousins and others where undisclosed paternity and unanswered questions caused endless curiosity and anxiety for those affected. The process of identity achievement with a socially integrated self-concept is a particularly intense milestone for young people [77, 79, 82, 94, 96, 103-104]. As reported in Paper III and in previous studies, this is when they start to ask questions of their paternal heritage [105-106, 177]. Research reports from a

Ugandan study prove that undisclosed information about one's true biological father is described as a cause of worrisome thoughts resulting from lost and misattributed kin in a cultural model of distress [158]. Living with undisclosed father identity means a lack of connection with him and that mothers become important as objects of identification and for providing materially [177]. Similar findings from a qualitative study conducted by a clinical psychologist on masculinities conducted in Alexandra, a township north of Johannesburg in the Gauteng province were published at the same time as paper III [177]. However, the gendered assumption of an aloof response to discussing this topic that is suggested by Langa [177] was not evident in this study as both males and females were similarly bothered and yet unable to discuss this. A possible reason for presence of depressive symptoms in response to the loss of a mother but not to the loss of a father (Study 1) is shown under the discussion of 'orphanhood' whereby maternal death is distressing to young people due to a close relationship that they may have with mothers but not with fathers..

The envisaged and missing financial contribution of the absent father was pronounced here. For the young people who faced hardships with their single mothers, an undisclosed paternal identity led to questioning the role of the father and this exacerbated distress. The socially recognised relationship through paternal identity recognition is an important prerequisite for effective paternal support; it legitimizes the child's claims and the father's responsibilities. Claims for support from the father cannot be made in cases of undisclosed paternal identity.

Linked to undisclosed paternal identity is a phenomenon of parental alienation that is evident and cannot be ignored. This is when one parent turns the child against the other [206]. This situation was found distressing by participants, especially when they were made aware that even interest in the father would be disloyal, hurtful and not tolerated by the mother - a feature described in parental alienation literature [206]. This is supported by information gathered during preliminary data feedback sessions from discussions with community based organisations in the Eastern Cape and Gauteng. Participants who did not know their father's identity repeatedly expressed feelings that their own independent thinking and decision-making was undermined and left them disempowered. In these cases the child is not even allowed to mourn the alienated parent-who, in this study, invariably was the father. It is in no way allowed to be spoken about in the homes [206]. This leads to unhealthy dependency on the mother or the maternal family and it does not serve the child's developmental needs for a father. This situation is a blatant denial of children's rights to parentage, which is assumed, though not clearly stated in the South African Constitution [389]. This is critical as parental alienation is known to result in depressive symptoms [206].

The factors discussed above are very interlinked. They could be considered to form the basis for a model that explains psychological distress among young people (presented in paper III). The model would have to recognise that sources of psychological distress are traceable to early childhood experience or what in Mabitsela is referred to as the person's 'background' [10]. The emphasis now shifts from circumstances endemic in childhood

and family experiences to exploring the role of sexual relationships in causing distress among young people.

Sexual relationships

Challenges experienced by young people in sexual relationships are implicated in distress and depressive symptoms. This warrants attention to encourage the positive exploration of sexuality to minimise levels of distress among the young in the country. Young women who are sexually involved, experience distress related to their relationships and this is reported in studies from high income countries [37, 208-211] and other low income countries overseas [146]. Some local evidence corroborates this [214-215]. Relationship distress did not seem pronounced for males and is consistent with Okello's qualitative findings among older married men and women in Uganda and findings by Blignault et al. from young people in the Solomon Islands [146, 158]. The presence of depressive symptoms associated with low stability in relationship satisfaction has been described in adult women [158, 216-217, 390]. Research by Whitton and Whisman suggests that satisfaction instability precedes rather than follow depressive symptoms [390]. This thesis also supports this, especially findings on unacknowledged pregnancies and gender-based intimate partner violence, both of which can be argued to stem from gender subjugation of females.

Unacknowledged pregnancies

Teenage pregnancies, often unplanned, are a source of distress for young women [146, 217]. In study 2, when a girl's pregnancy was not acknowledged by her male partner, this created a situation of unhappiness, dissatisfaction, and became a source of distress for young women. It would seem that distress associated with a denied or disputed pregnancy was related to mainly three things. First are societal expectations and pressures to disprove promiscuity. Second is the ensuing worry about not being able to access child maintenance and thirdly, the partner's withdrawal of emotional involvement with the woman. This is discussed in paper III and unpublished data [391]. With the exception of Kwazulu-Natal Province, that seems to have lower overall teenage pregnancy rates (2%), the rates in South Africa are between 12% and 16% [377]. Teenage pregnancy for pupils in ordinary schools is a concern especially in the EC province, which recorded 9,016 pregnant scholars in 2007 alone [325]. On a political level, denying responsibility for pregnancy is simply another tool in the oppression of women hence it should receive attention as a structural factor underlying distress in young women. This is another example of why women may be experiencing more depressive symptoms than men and explains and supports findings on prevalence from Study 1.

Alternative gender and sexual identity

Living in a society where heterosexuality is naturalised, participants who identified as alternative felt under pressure to prove their sexual and gender identity, a situation that

caused them much distress. This is discussed in a book chapter [358] and in paper III. Though there is knowledge of diverse gender and sexual identities in black urban townships [231-232], young people do experience distress associated with being conspicuously different. Distress that was experienced by participants here is related to coming out; a phenomenon similar to that of young black lesbians, even from the developed parts of the world [233-234, 392]. The challenges of self awareness, self actualisation and gender conformity as discussed in this thesis' publications are found to be similar to experiences of others in rural communities in developed countries [235]. It confirms that living with a constant need to justify one's sexual orientation, and perceptions of judgement and disapproval puts distressing pressure on young women [235, 393]. Though no gay young men participated in this study, the same would be expected. To the extent that this phenomenon is widely shared, the kind of responses such as, silence, deferment and avoidance seen in the two case studies of gender non-conforming young women, are similar to those of other young women going through the same [392].

Gender-based violence

Exposure of young people in South Africa to gender-based violence is concerning. An earlier report from the Stepping Stones study reported that 39% of women and 16% of men experienced sexual abuse before the age of 18 and this is associated with depressive symptoms [331]. Some of the violent experiences reported were within relationships

whilst others reported distressing sexual abuse and rape by relatives, acquaintances and strangers (paper I, II and III). Elsewhere, young women report being very worried about sexual violence in their communities [146]. Here, actual experiences of rape were associated with distress and depressive symptoms.

Internationally, there is a huge amount of literature on psychological effects of intimate partner abuse and distress. Rape of young people before the age of 18, even if reported within a relationship, is of serious concern due to gender power dynamics that disfavour girls in these relationships. Even here, intimate partner violence caused distress, an association that is consistent with findings from high income countries such as Italy [188]. Though exposure of young people to violence is consistently reported [394-395] this study pioneers the link with depressive symptoms among young people in the South African literature as no other study has been found to have reported this link. Swart and colleagues reported approximately half of 14-23 year old young men and over half of 13-21 year old females reporting involvement in a physically violent relationship either as a perpetrator or victim [395]. Findings in Paper III on gender power inequity seem to suggest that poverty, economic disempowerment and weak family connections places young women in a vulnerable position for gender power inequity and violence in and out of relationships. This is very critical in a context where old age is a pertinent variable in hierarchical power relations, generally, and dating older partners is a norm. What we have currently are notions of masculinity and femininity that are rooted in a patriarchal gender order with men having power over women [335]. Hence the old age of a male partner may contribute to disempowering gender power inequity on the woman and lead

to distress that result from the perception of lack of control in the face of relationship dissatisfaction [37, 143, 194, 209, 211, 213]. Hence sometimes physical IPV was down-toned and described as relationship conflict resulting from men finding their partners' betrayal unacceptable, upsetting and worthy of punishment. Young women in the qualitative interviews were acutely aware of this, distressed by it, but somehow felt trapped in the situation. Sexual violence against men receives less attention. Men too were victims of violence and this was associated with depressive symptoms. The results on the impact of forced sex for men (paper I), though this was not necessarily in intimate partnerships, are very important for development of interventions to prevent distress among young men.

5.3 Distress, depressive symptoms and risky sexual behaviours

The last objective of this thesis was to describe the association between distress, having depressive symptoms and participation is risky sexual behaviors and engagement in risky sexual relationships. This is answered through findings presented in paper II. The next section will discuss these findings in conjunction with those published in a book chapter that presented preliminary findings on distress and sexuality from the qualitative study. This chapter was written using the qualitative data Study 2 and is referenced here. Though sexual experience is exaggerated and presented as uncontrollable by some psychoanalysts, it is a widely recognised normal and healthy part of young people's sexual maturity [75, 78, 82, 92, 94, 247-252]. However, some young people are at greater risk of behavioural and psychological maladjustments than others, independent of the

typical developments seen during this period [396]. The discussion shows how this risk of distress and depressive symptoms is associated with participation is risky sexual behaviors and relationships.

Depressive symptoms are associated with risky sexual behaviours

Women who reported depressive symptoms at baseline also reported that they had dated an older partner and a year later had been involved in transactional sex in the 12 months after the initial baseline assessment of the presence of depressive symptoms.

This thesis reports that depressive symptoms were associated with current and future non-condom use for males but not for females. Reports of incorrect use of condoms at last sex, by men with depressive symptoms in both measurement points (paper II), is a very critical finding for efforts targeted at HIV prevention. For example, consistent with findings from US, young men with depressive symptoms seem to be at a risk for non-condom use [276]. In another US study greater psychological distress over time decreased condom use and was associated with an increase in the number of partners in young people for both genders [268]. Sexual behaviors such as non-use of condoms, multiple concurrent partnering, transactional sex and a woman dating a man five-years or older than herself, have been established in literature as either directly or indirectly carrying risk for HIV infection [142-143]. Sexual risk-taking is reported to have a

curvilinear relationship with sexual risk, subsiding during periods of experiencing severe depressive symptoms due to loss of interest in sex. When the CESD scale was used as a continuous measure, the findings were no different from when categorized into 'having depressive symptoms' and 'not having depressive symptoms'. When the analysis was conducted identify having severe depressive symptoms, the sample cell count for people with severe depressive symptoms was too low.

Though advocacy for extension of youth-friendly clinic services in order to achieve better sexual health for young people is advanced, limited access to clinics alone does not sufficiently explain young people's risky sexual behaviour [81]. For decision-makers and implementers of sexual health services for young people the link with the presence of distress and depressive symptoms proves that psycho-social variables are predictors of risky sexual behaviours [358, 372, 397]. The quantitative study findings presented in paper IV, supported by others [358, 398] extends theoretical evidence that young people's risky sexual behaviours may be mediated through depressive mood. The supportive findings from this thesis that distress plays a very important role in leading to risky sexual behaviors is contrary to an emphasis in beliefs of uniqueness, invincibility, lower risk estimation and experimenting with boundaries which many psychological theories assign to power [76, 79, 82, 102, 117, 240-243]. Evidence presented here that depressive mood predict risky sexual behaviours and relationships is important as HIV prevention depends, at least in part, on identifying vulnerable young people for targeted interventions. Therefore, young people's sexual health services should not only be extended in numbers but also qualitatively to include assessment of mental health state.

Depressive symptoms are associated with risky sexual relationships

Risky sexual relationships have been separated from risky behaviors in this study and involve relationships such as a woman dating an older partner, a relationship based on material gain and relationships characterized by physical and sexual violence. Findings in Study 1 speak volumes about the role of depressive mood in transactional sex for women and men. Involvement in relationships with older men and pursuit of material benefits, facilitated by social norms, are implicated in risk for unprotected sex, multiple sexual partnering and HIV infection in women [399]. What these findings suggest is that the state of women's mental health is also important. This association is important for men with depressive symptoms pointing to a possibility that distressed men may be using material provisions as a means to access and control female sexual partners.

Depressive symptoms predict gender-based violence

The prospective element in Study I enabled longitudinal modelling of the effect of depressive mood in violence against women. One of the important associations presented in this thesis, 12 months following and controlling baseline levels of violence, is that women with depressive symptoms were more likely to be in violent relationships and men with depressive symptoms were more likely to perpetrate violence against women.

This thesis shows some evidence that distress preceded involvement in relationships characterized by intimate partner violence which existed within the broader scripts determined by gender inequity. This was supported by findings from the qualitative study of men who described being reckless in becoming involved in relationships with young women to lessen their emotional pain [358]. In paper III distress and risky sexual expression seemed associated with masculine gender power, weak family structure and women's economic disempowerment and dependency, and these connections made young women vulnerable to violence in and out of relationships. Young men appeared to be victims of structural and especially family violence yet in relationships tended to inflict displaced pain on a target seen as weaker, a process that put themselves and the women that they are involved with at risk for HIV.

In the quantitative study men with depressive symptoms were more likely to report perpetration of intimate partner violence and rape. It was interesting in the qualitative study how the men were acutely aware of their power and that they misused it in times of emotional turmoil. What we have currently are notions of masculinity and femininity that are rooted in a patriarchal gender order with men having power over women [335]. Men with depressive symptoms displayed this through externalising behaviours such as substance abuse and violence. Maximum reduction of levels of distress is key to addressing violence against young women in our society.

5.4 Conclusions

The goals of this research were to explore the prevalence of depressive symptoms, factors associated with depressive symptoms, the associations between depressive symptoms and risky sexual encounters, and phenomenological experiences of distress among young people in the Eastern Cape, South Africa. This thesis used different research methods in studying the research question. This allowed the presentation of a comprehensive and holistic but problematical picture of young people's distress in this setting. This study makes an important contribution as it includes both males and females, which addresses limitations of previous studies that tended to exclude males or presented aggregated data. The findings challenge us to look at the underlying structural forces that underlie distress and critically suggest strengthening work around child security in this society. Carefully selected findings of importance to academics and policy makers are presented next with implications for public health, policy and research discussed thereafter.

The above discussion highlights that empirically proven risk factors at family, interpersonal and community level were evident here. Though the discussion is presented under conceptually meaningful sub-headings, they are very connected and evidently stem from economic vulnerability and patriarchal practices. Examples of family factors were childhood abuse, neglect, domestic violence, conflict in families, undisclosed father identity, parental substance misuse, low socio-economic status that spelt poverty for many and loss of a parent. In addition there was tolerance for adversity and when it

emanated from the family it is trivialised by adults and considered a private matter whilst vulnerable young people are expected to remain stoic at all costs.

Examples of interpersonal factors that are evident in sexual relationships were gender-based violence and the associated tolerance of abuse in relationships (for women). Depressive symptomatology is a particularly critical condition for women's health. The WHO published a report on women's mental health with a specific chapter focused on depression in women [376]. The coverage of young women in this report is elusive. The important arguments put forth in this report points to the social factors contributing to depressive symptoms as revealed in this thesis such as childhood adversity, loss, substance use, disempowered families and gender injustices. However, by excluding young women, it creates an impression that the impact of these adversities is not seen until much later in life [376]. This is not true. This thesis generated evidence from a low-middle income country that the impact of negative life events starts early in life for these young people. Gender injustice begins much earlier in life than when women join the world of work, marriage or motherhood; factors which are described by social theories as contributing to depressive symptoms in women [376]. This thesis shows gender injustice as contributing to young women's distress and this needs further research attention and continued advocacy for interventions to end all forms of gender injustice against girls and women. This thesis presented gender non-conformity as a source of distress for young people. Raising issues that face gender non-conforming young females is critical in this context. The number may seem small but it is in fact essential given that there is not enough research attention given to distress suffered by young gender non- conforming

and lesbian females [400-403]. Where research on lesbians is conducted, it tends to focus on older women and researchers working in this area record difficulty attracting participants. The shortcoming of Study 1 of this thesis is that it did not include an investigation of variables such as undisclosed paternal identity, unacknowledged pregnancies (for females) and experiences of being a member of a sexual minorities group and these came out as important themes in Study 2.

Clearly both the family and interpersonal factors behind distress are embedded in cultural and gender norms that are accepted in these communities and are a social ethos perpetuating stoicism in the face of extremely distressing experiences. Substance use by young people, lack of access to services, a sense of isolation, inadequate social support, community's oblivious attitudes and normalisation of childhood adversity all perpetuate family and interpersonal factors that drive distress and depressive symptoms in young people. At the onset of undertaking this research the candidate had identified a challenge in understanding which of young people's risk taking behaviours were potentially impacted upon by psychological distress and depressive symptoms. Though this study sheds important light, it is limited in its ability to establish causality. However, these findings are very important as the study has shown that depressive symptoms precede risky sexual behaviours. There is consistency of findings from different global regions showing the association between depressive symptoms and risky sexual behaviours. Replication of findings in different studies gives confidence that the associations are not spurious [326].

This thesis shows that there are similar experiences that predict depressive symptoms among young women and men such as childhood adversity but also that other variables such as loss operate differently. Gender differences for the association between depressive symptoms and sexual risk are also evident. Prevention efforts in South Africa have to take these factors into account in developing effective strategies to prevent and curb the impact of depressive symptoms in young people. This thesis is an important study of young people's distress in South Africa and the next section summarises the implications for prevention and intervention in public health.

5.5 Public health implications

South Africa is above other SSA states in the provision of mental health services, given the development of its public primary health care system and policy articulation, but it still lags far behind in meeting the needs of young people [404-406]. To date, the challenge that faces South Africa is developing evidence-based prevention strategies to prevent depressive symptoms in young people. The findings presented in this thesis are critical for informing policy and practice on factors leading to prevention of depressive symptoms. Even HIV prevention strategies have lacked an understanding of the role of depressive symptoms in accounting for HIV risk. When it comes to structural factors our society is key in addressing young people's mental health and requires a challenge of the current dominant constructions of culture, tradition, femininity and masculinity with interventions targeting families and young people themselves.

It is easy to think that investing in extending structural access to mental health clinics would increase access but research shows otherwise [407-408]. In South Africa even with the formulation of community service for clinical psychologists, many of these are placed in tertiary and secondary facilities and face cultural and language barriers when dealing with African clients and so remain inaccessible to many people without health insurance who need them [45, 320]. It is very important to increase education around mental health and change the public's attitude towards seeking help for distress.

Public health science plays an increasingly important role in developing a mental health research agenda for young people. This thesis amplifies the evidence that, for young people to thrive, they largely depend on opportunities, resources and actions afforded by their families [171]. The sample used in this study was recruited from a rural province where psychosocial assistance for both distress and depressive symptoms are weak. South African mental health services tend to be concentrated in urban centres, are specialised and are not part of the free primary health care package. As a result, informal systems fill this gap through non-specialised professionals within the health care, social workers, educators and juvenile services [404]. This raises the need to consider provision of emotionally supportive care outside of mental health services, to reinforce the capacity of informal systems and advocate for more attention to be paid to young people's mental health. Evidence from the Stepping Stones study that post intervention, depressive symptoms decreased in the intervention phase can, to some extent, be used as evidence that empowering life skills interventions can work to reduce the prevalence of depressive symptoms [310].

A range of negative family dynamics has been shown to increase the risk of depressive symptoms and this reinforces the message that strengthening families is crucial for better mental health outcomes. It may be easy to assume that the problem lies with single parented families. It is by no means family structure per se but rather, daily living circumstances that expose children to adversity. Strategies to strengthen families and living conditions for children should be intensified. The Children's Act No 38 (Republic of South Africa 2005) and the Children's Amendment Bill of 2007 provide a policy framework for the protection of children and needs to be turned into practical strategies. The various social grants and services aimed at harm reduction and creating opportunities for families and children in South Africa are commendable. These are well articulated on paper and reach the targeted beneficiaries to a reasonable extent but at times they have been found not to work [156]. For example, some learners who should be receiving fee exemption on the basis of their low income status are not and are threatened with school expulsion. The low income earners' disability grant does not appear to operate as intended leaving some disabled unemployed people who qualify excluded [409]. Advocacy for young people's mental health should include advocating for efficient disbursement of social security grants by the State.

5.6 Implications for future research

The most important variable in this study is presence of depressive symptoms, measured using the CES-D Scale. There are concerns around the meaningful use of scales

measuring presence of depressive symptoms that are imported from Anglo-American cultures to African countries. The main concern is that their continued use treats experiences, including signs and symptoms, defined as 'depressive symptoms' to mean the same thing across cultures and regards depressive mood as a universal experience that can be measured in the same way in all cultural contexts. Henceforth it becomes important that future research that is carried out to advance knowledge in this area should also include adaptation of the CESD Scale for use in the South African population. This would be worthwhile to enhance the validity of findings. One of the changes during adaptation could mean producing a symptom checklist that caters for the different and gendered ways in which women and men express their distress. The scale could retain some uniform items but also include different questions that are specific to men and women as per cultural context.

The factors shown here to be associated with depressive symptoms build on the already existing international evidence on this subject. However, establishing causation in terms of epidemiological criteria is difficult because these causes are social and a longer longitudinal study that follows subjects from a very young age would be needed to strengthen evidence. More research is needed to understand, monitor and develop interventions with the aim of reducing vulnerability within extended homes where power imbalances are not always in favour of the adoptees. This thesis suggests that when asking about social support in collectivists' cultures such as those found in sub-Saharan Africa it is important to focus on the availability of family, siblings and extended family as these continue to be important in the lives of the young people. Research is needed to

inform ways of maintaining positive family relations whilst young people grow, develop, establish separateness and independent thinking and develop their own needs as emerging adults in the face of their essential need for relatedness within family. A corollary assumption would be that a healthy family is the one in which the young people's needs are gratified and they remain resilient in the face of adversity. This is a very important research agenda emanating from this thesis.

REFERENCES

1. Patel, V. and A. Sumathipala, *International representation in psychiatric literature: Survey of six leading journals.* The British Journal of Psychiatry, 2001. **178**(5): p. 406-409.
2. Saxena, S., et al., *The 10/90 divide in mental health research: trends over a 10-year period.* The British Journal of Psychiatry, 2006. **188**(1): p. 81-82.
3. Sharan, P., et al., *Mental health research priorities in low- and middle-income countries of Africa, Asia, Latin America and the Caribbean.* British Journal of Psychiatry, 2009. **195**(4): p. 354-63.
4. Lazarus, R.S. and S. Folkman, *Stress, Appraisal, and Coping*. 1984, New York: Springer Publishing Co.
5. Felsman, J., et al., *Estimates of psychological distress among Vietnamese refugees: adolescents, unaccompanied minors and young adults.* Social Science and Medicine, 1990. **31**(11): p. 1251-6.
6. Hartinger-Saunders, R.M., et al., *Victimization, psychological distress and subsequent offending among youth.* Children and Youth Services Review. **In Press, Accepted Manuscript**.
7. Ross, C.E., J.R. Reynolds, and K.J. Geis, *The Contingent Meaning of Neighborhood Stability for Residents' Psychological Well-Being.* American Sociological Review, 2000. **65**(4): p. 581-597.
8. Ridner, S.H., *Psychological distress: concept analysis.* Journal of Advanced Nursing, 2004. **45**(5): p. 536-545.
9. Ellis, C.G., *Cross-cultural aspects of depression in general practice.* South African Medical Journal, 2003. **93**(5): p. 342-5.
10. Mabitsela, L. *Exploratory study of psychological distress as understood by Pentecostal pastors*. 2003 [cited 2011 14/01]; Available from: http://upetd.up.ac.za/thesis/submitted/etd-02182003-082847/unrestricted/00front.pdf.
11. Sharan, P., et al., *Mental health research priorities in low- and middle-income countries of Africa, Asia, Latin America and the Caribbean.* British Journal of Psychiatry, 2009. **195**(4): p. 354-63.
12. Juan, Y., et al., *The impact of stress on depressive symptoms is moderated by social support in Chinese adolescents with subthreshold depression: A multi-wave longitudinal study.* Journal of affective disorders, 2010. **127**(1): p. 113-121.
13. Simoni, J., et al., *Challenges in Addressing Depression in HIV Research: Assessment, Cultural Context, and Methods.* AIDS and Behavior, 2011. **15**(2): p. 376-388.
14. Hyde, J.S., A.H. Mezulis, and L.Y. Abramson, *The ABCs of Depression: Integrating Affective, Biological, and Cognitive Models to Explain the Emergence of the Gender Difference in Depression.* Psychological Review, 2008. **115**(2): p. 291-313.
15. Poulin, C., et al., *Gender differences in the association between substance use and elevated depressive symptoms in a general adolescent population.* Addiction, 2005. **100**: p. 525-535.

16. Overbeek, G., et al., *Co-Occurrence of Depressive Moods and Delinquency in Early Adolescence: The Role of Failure Expectations, Manipulativeness, and Social Contexts.* International Journal of Behavioral Development, 2006. **30**(5): p. 433-443.
17. Bean, J. and A. Möller, *Posttraumatic stress and depressive symptomatology in a sample of battered women from South Africa.* Psychological Reports, 2002. **90**(3): p. 750-2.
18. Galambos, N., B. Leadbeater, and E. Barker, *Gender differences in and risk factors for depression in adolescence: A 4-year longitudinal study.* International Journal of Behavioral Development, 2004. **28**(1): p. 16-25.
19. Bhatia, R., et al., *Persons Newly Diagnosed with HIV Infection are at High Risk for Depression and Poor Linkage to Care: Results from the Steps Study.* AIDS and Behavior, 2011. **15**(6): p. 1161-1170.
20. Walls, M.L. and L.B. Whitbeck, *Distress among Indigenous North Americans: Generalized and Culturally Relevant Stressors.* Society and Mental Health, 2011.
21. Jacobson, C., et al., *Restrictive Emotionality, Depressive Symptoms, and Suicidal Thoughts and Behaviors Among High School Students.* Journal of Youth and Adolescence, 2011. **40**(6): p. 656-665.
22. Levola, J., A. Holopainen, and M. Aalto, *Depression and heavy drinking occasions: A cross-sectional general population study.* Addictive Behaviors, 2011. **36**(4): p. 375-380.
23. Derogatis, L.R., *BSI Brief Symptom Inventory. Administration, scoring, and procedures manual. National Computer Systems: Minneapolis, MN*. 1993.
24. Beck, A.T., et al., *An Inventory for Measuring Depression.* Archives of General Psychiatry, 1961. **4**(6): p. 561-571.
25. Wild, L.G., A.J. Flisher, and C. Lombard, *Suicidal ideation and attempts in adolescents: associations with depression and six domains of self-esteem.* Journal of Adolescence, 2004. **27**(6): p. 611-624.
26. Fernander, A.G., et al., *Gender differences in depression and smoking among youth in Cape Town, South Africa.* Ethnicity and disease, 2006. **16**(1): p. 41-50.
27. Pillay, A., et al., *Depression among university students in South Africa.* Psychological Reports
2002. **91**(3): p. 725-8.
28. Westaway, M.S. and L. Wolmarans, *Depression and self-esteem: rapid screening for depression in black, low literacy, hospitalized tuberculosis patients.* Social Science and Medicine, 1992. **35**(10): p. 1311-5.
29. Sahin, H., A. Batiguen, and S. Ugurtas, *The validity, reliability and factor structure of the Brief Symptom Inventory (BSI).* Turkish Journal of Psychiatry, 2002. **13**: p. 125-135.
30. Kessler, R.C., et al., *Short screening scales to monitor population prevalences and trends in non-specific psychological distress.* Psychological medicine, 2002. **32**(6): p. 959-976.
31. Kessler, R.C., et al., *Screening for serious mental illness in the general population with the K6 screening scale: results from the WHO World Mental Health (WMH) survey initiative.* International Journal of Methods in Psychiatric Research, 2010. **19**(S1): p. 4-22.

32. Smit, J., et al., *Mental health and sexual risk behaviours in a South African township: A community-based cross-sectional study.* Public Health, 2006. **120**(6): p. 534-542.
33. Radloff, L.S., *The CES-D Scale: A self report depression scale for research in the general population.* Applied Psychological Measurement, 1977. **1**(3): p. 385-401.
34. Alvy, L., et al., *Depression is Associated with Sexual Risk Among Men Who Have Sex with Men, but is Mediated by Cognitive Escape and Self-Efficacy.* AIDS and Behavior, 2011. **15**(6): p. 1171-1179.
35. Myers, H.F., et al., *Psychosocial Predictors of Risky Sexual Behaviors in African American Men: Implications for Prevention.* AIDS Education and Prevention, 2003. **15**(A): p. 66-79.
36. Moon, S., B. Mo, and R. Basham, *Adolescent Depression and Future Smoking Behavior: A Prospective Study.* Child and Adolescent Social Work Journal, 2010. **27**(6): p. 405-422.
37. Haydon, A.A. and C.T. Halpern, *Older Romantic Partners and Depressive Symptoms During Adolescence* Journal of Youth and Adolescence 2010. **39**(10): p. 1240-1251.
38. Myers, J. and M. Weissman, *Use of a self-report symptom scale to detect depression in a community sample.* American Journal of Psychiatry, 1980. **137**(9): p. 1081-1084.
39. Hamad, R., et al., *Social and economic correlates of depressive symptoms and perceived stress in South African adults.* Journal of Epidemiology Community Health, 2008. **62**(6): p. 538-544.
40. Hall, K., et al., *Depressed Mood, Psychological Stress, and Eating Disordered Symptoms are Associated with Perceived Oral Contraceptive Side Effects in Minority Adolescents.* Journal of Adolescent Health, 2011. **48**(2, Supplement 1): p. S104-S104.
41. Wickrama, T. and K.A.S. Wickrama, *Heterogeneity in Adolescent Depressive Symptom Trajectories: Implications for Young Adults' Risky Lifestyle.* Journal of Adolescent Health, 2010. **47**(4): p. 407-413.
42. Simbayi, L.C., et al., *Internalized stigma, discrimination, and depression among men and women living with HIV/AIDS in Cape Town, South Africa.* Social Science & Medicine, 2007. **64**(9): p. 1823-1831.
43. Sale, S. and M. Gadanya, *Prevalence and factors associated with depression in HIV/AIDS patients aged 15-25 years at Aminu Kano Teaching Hospital, Nigeria.* Journal of Child and Adolescent Mental Health, 2008. **20**: p. 95-99.
44. Ndetei, D.M., et al., *The prevalence of anxiety and depression symptoms and syndromes in Kenyan children and adolescents.* Journal of Child and Adolescent Mental Health 2008 **20**(1): p. 33-51.
45. Pillay, A.L., *The experiences of the first South African community service clinical psychologists.* South African Journal of Psychology, 2006. **36**(2): p. 259-280.
46. Bhagwanjee, A., et al., *Prevalence of minor psychiatric disorders in an adult African rural community in South Africa.* Psychological Medicine, 2000. **28**(05): p. 1137 -1147.

47. Tomlinson, M., et al., *The epidemiology of major depression in South Africa: results from the South African Stress and Health study.* South African Medical Journal, 2009. **99**: p. 368-373.
48. Kleintjes, S., et al., *The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa.* South African Psychiatry Review, 2006. **9**: p. 157-160.
49. Pillay, A.L. and A.J. Kriel, *Mental health problems in women attending district-level services in South Africa.* Social Science & Medicine, 2006. **63**(3): p. 587-592.
50. Casey, B.J., et al., *The storm and stress of adolescence: Insights from human imaging and mouse genetics.* Developmental Psychobiology, 2010. **52**(3): p. 225-235.
51. Makiwane, M. and S. Kwizera, *Youth and Well-Being: A South African Case Study.* Social Indicators Research, 2008. **91**(2): p. 223-242.
52. Murphy, J.M., et al., *A 40-Year Perspective on the Prevalence of Depression: The Stirling County Study.* Arch Gen Psychiatry, 2000. **57**(3): p. 209-215.
53. Nguyen, C.T. and L. Fournier, *Depressive Disorders Among Young Canadians: Associated Factors of Continuity and Discontinuity.* Canadian Journal of Public Health, 2007. **98**(4): p. 326-30.
54. Cairney, J., *Gender differences in the prevalence of depression among Canadian adolescents.* Canadian Journal of Public Health, 1998. **89**(3): p. 181-2.
55. Mkize, L.P., N.F. Nonkelela, and D.L. Mkize, *Prevalence of depression in a university population.* Curationis, 1998. **21**(3): p. 32-7.
56. Myer, L., et al., *Social determinants of psychological distress in a nationally-representative sample of South African adults.* Social Science & Medicine (1982), 2008. **66**(8): p. 1828-40.
57. Wade, T.J. and J. Cairney, *Age and depression in a nationally representative sample of Canadians: a preliminary look at the National Population Health Survey.* Canadian Journal of Public Health, 1997. **88**(5): p. 297-302.
58. Wade, T.J. and J. Cairney, *The effect of sociodemographics, social stressors, health status and psychosocial resources on the age-depression relationship.* Canadian Journal of Public Health, 2000. **91**(4): p. 307-12.
59. Sweeting, H. and P. West, *Sex differences in health at ages 11, 13 and 15.* Social science & medicine (1982), 2003. **56**(1): p. 31-9.
60. Gupta, R., et al., *Depression and HIV in Botswana: A Population-Based Study on Gender-Specific Socioeconomic and Behavioral Correlates.* PLoS ONE, 2010. **5**(12): p. e14252.
61. Kaaya, S.F., et al., *Socio-economic and partner relationship factors associated with antenatal depressive morbidity among pregnant women in Dar es Salaam, Tanzania.* Tanzania Journal of Health Research, 2010. **12**(1): p. online first.
62. Reddy, S., et al., *Umthente Uhlaba Usamila - The 2nd South African National Youth Risk Behaviour Survey 2008.* 2010, South African Medical Research Council: Cape Town.
63. Peltzer, K., V. Cherian, and L. Cherian, *Minor psychiatric morbidity in South African secondary school pupils.* 85, 1999. **Psychological Reports**(2): p. 397-402.

64. Blore, L.G., S. Schulze, and A.C. Lessing, *The relationship between adolescent depressive symptomatology and substance abuse.* Curationis, 2004. **27** (10): p. 12-22.
65. Pillay, A. and C. Sargent, *Relationship of age and education with anxiety, depression, and hopelessness in a South African community sample.* Percept Mot Skills, 1999. **89**(3): p. 881-4.
66. Lester, D. and A. Akande, *Patterns of Depression in Xhosa and Yoruba Students.* Journal of Social Psychology, 1997. **137**.
67. Lester, D. and A. Akande, *Depression and suicidal preoccupation in South African students.* Psychological Reports, 1999. **85**(1): p. 242.
68. National Department of Health, *Policy Guidelines: Child and Adolescent Mental Health*, Health, Editor. 2008: Pretoria.
69. Department of Health, *Policy guidelines for Youth and Adolescent Health*, D.o. Health, Editor. 2001: Republic of South Africa.
70. Dasen, P.R., *Rapid Social Change and the Turmoil of Adolescence: A Cross-Cultural Perspective* International Journal of Group Tensions, 2000. **29**(1-2): p. 17-49.
71. Elam, Y., *Family and Polity in Ankole: The Hima Household and the Absence of Age-Sets.* Ethnology, 1975. **14**(2): p. 163-171.
72. Blum, R.W., *Youth in Sub-Saharan Africa.* Journal of Adolescent health : official publication of the Society for Adolescent Medicine, 2007. **41**(3): p. 230.
73. Arnett, J.J., *Emerging Adulthood: What Is It, and What Is It Good For?* Child Development Perspectives, 2007. **1**(2): p. 68-73.
74. Mager, A., *Youth Organisations and the Construction of Masculine Identities in the Ciskei and Transkei, 1945-1960.* Journal of Southern African Studies, 1998. **24**(4): p. 653-667.
75. Rice, F.P., *The adolescent: development, relationships, and culture*. 4th ed ed. 1984, USA: Allyn and Bacon.
76. Santrock, J.W., *Life-span development*. 4th ed. 1992, U.S.A: WCB Publishers.
77. Zimardo, P., et al., *Psychology: a European text*. 1993, UK: Harper Collins.
78. Shaffer, D.R., *Developmental psychology: Childhood and Adolescence*. Sixth edition ed. 2002: Wadsworth.
79. Plotnik, R., *Introduction to Psychology*. 5th edition ed. 1999, USA: Brooks/Cole Wadsworth.
80. Higginbottom, G., et al., *An Exploration of the Teenage Parenting Experiences of Black and Minority Ethnic Young People in England*. 2005, University of Sheffield School of Nursing and Midwifery: UK.
81. Scheper-Hughes, N., *Death Without Weeping: The violence of everyday life in Brazil*. 1992, Oxford: University of California Press.
82. Santrock, J.W., *Life-Span Development*. 10th ed. 2005: McGraw Hill.
83. Silverman, J.G., et al., *Social Norms and Beliefs Regarding Sexual Risk and Pregnancy Involvement among Adolescent Males Treated for Dating Violence Perpetration.* Journal of Urban Health 2006. **83**(4): p. 723-735.
84. Arnett, J.J., *Emerging adulthood: A theory of development from the late teens through the twenties.* American Psychologist, 2000. **55**(5): p. 469-480.

85. Puri, M., J. Tamang, and I. Shah, *Suffering in silence: consequences of sexual violence within marriage among young women in Nepal.* BMC Public Health, 2011. **11**(1): p. 29.
86. Parry, C.D.H., *Substance Abuse In South Africa:Country report focussing on young persons*, in *Prepared for the WHO/UNDCP Regional Consultation - Global Initiative on Primary Prevention of Substance Abuse Among Young People, Harare, Zimbabwe*. 1998, Mental Health & Substance Abuse, Medical Research Council: Tygerberg; South Africa.
87. Fletcher, J.M., *Childhood mistreatment and adolescent and young adult depression.* Social Science & Medicine, 2009. **68**(5): p. 799-806.
88. Song, Y. and C.-Y. Ji, *Sexual intercourse and high-risk sexual behaviours among a national sample of urban adolescents in China.* Journal of Public Health, 2010. **32**(3): p. 312-321.
89. Pakenham, K.I., et al., *The Psychosocial Impact of Caregiving on Young People Who Have a Parent With an Illness or Disability: Comparisons Between Young Caregivers and Noncaregivers.* Rehabilitation Psychology, 2006. **51**(2): p. 113-126.
90. Sacks, R.J., B.A. Cybulska, and G.E. Forster, *Referral of young people attending a sexual assault referral centre to mental health services.* International Journal of STDs and AIDS, 2008. **19**(8): p. 557-558.
91. Graber, J.A., T.R. Nichols, and J. Brooks-Gunn, *Putting pubertal timing in developmental context: Implications for prevention.* Developmental Psychobiology, 2010. **52**(3): p. 254-262.
92. Freud, A., *Adolescence*, in *Adolescence: Contemporary studies*, A.E. Winder and D. Angus, Editors. 1968, American Book: New York. p. 13-24.
93. Hall, S.G., *Adolescence: Its psychology and its relation to physiology, anthropology, sociology, sex, crime, religion and education*. Vol. 1&2. 1904, Englewood Cliffs, NJ: Prentice-Hall.
94. Thomas, R.M., *Comparing theories of child development*. Third edition ed. 1992, California: Wadsworth.
95. Romer, D., *Adolescent risk taking, impulsivity, and brain development: Implications for prevention.* Developmental Psychobiology, 2010. **52**(3): p. 263-276.
96. Sebastian, C., S. Burnett, and B. Sarah-Jayne, *Development of the self-concept during adolescence.* Trends in Cognitive Sciences, 2008. **12**(11): p. 441-446.
97. Thompson, A.M. and K.E. Chad, *The relationship of pubertal status to body image, social physique anxiety, preoccupation with weight and nutritional status in young females.* Canadian Journal of Public Health, 2000. **91**(3): p. 207-11.
98. Cohen, B., et al., *Smoking, physical activity and breakfast consumption among secondary school students in a southwestern Ontario community.* Canadian Journal of Public Health, 2003. **94**(1): p. 41-4.
99. Winter, A.L., et al., *The relationship between body weight perceptions, weight control behaviours and smoking status among adolescents.* Canadian Journal of Public Health, 2002. **93**(5): p. 362-5.

100. Amosun, S.L., et al., *Are students in public high schools in South Africa physically active?: Outcome of the 1st South African National Youth Risk Behaviour Survey*. 2007. 2007.
101. Allison, K.R. and E.M. Adlaf, *Age and sex differences in physical inactivity among Ontario teenagers.* Canadian Journal of Public Health, 1997. **88**(3): p. 177-180.
102. Crocker, P., et al., *Smoking behaviour and dietary restraint in young adolescent women: the role of physical self-perceptions.* Canadian Journal o Public Health, 2001. **92**(6): p. 428-32.
103. Erikson, E., *Childhood and society*. 1950, New York: Norton.
104. Weiten, W., *Psychology: Themes and Variations*. 5th Edition ed. 2001, U.S.A: Wadsworth Thomson Learning.
105. Denis, P. and R. Ntsimane, *Absent fathers: why men don't feature in stories of familes affected by HIV/AIDS in Kwazulu-Natal?*, in *Baba: Men and Fatherhood in South Africa*, L. Richter and R. Morrell, Editors. 2006, HSRC Press: Cape Town: South Africa. p. 237-249.
106. Datta, K., *"In the eyes of a child, a father is everything": Changing constructions of fatherhood in urban Botswana?* Women's Studies International Forum, 2007. **30**(2): p. 97-113.
107. Mekoa, I., *Traditional African social organization and governance.* New Agenda: South African Journal of Social and Economic Policy, 2003. **24** p. 36-40.
108. Steinberg, L., *A dual systems model of adolescent risk-taking.* Developmental Psychobiology, 2010. **52**(3): p. 216-224.
109. Jansen, J.D., *Knowledge in the Blood: Confronting Race and the Apartheid Past*. 2009, USA: Stanford University Press.
110. Morrell, R., *Pissed and punching: Masculinity, Politics and the Extra-Curriculum at Rhodes in the 1970s.*, in *Rhodes University History Department Centenary Colloquium, Grahamnstown*. 2011, University of Cape Town: Cape Town.
111. Arnett, J.J., *Adolescent storm and stress, reconsidered.* The American psychologist, 1999. **54**(5): p. 317-26.
112. Fatusi, A.O. and M.J. Hindin, *Adolescents and youth in developing countries: Health and development issues in context.* Journal of Adolescence, 2010. **33**(4): p. 499-508.
113. Carbonell, D.M., H.Z. Reinherz, and R.M. Giaconia, *Risk and Resilience in Late Adolescence.* Child and Adolescent Social Work Journal, 1998. **15**(4): p. 251-272.
114. Reinherz, H.Z., R.M. Giaconia, and A.D. Paradis, *Family Matters: The Importance of Family Social Support, Feeling Valued, and Family Cohesion in Promoting Positive Adolescent Development*. 2007, Simmons Longitudinal Study, Simmons College School of Social Work: Boston.
115. Langille, D.B., et al., *Socio-economic factors and adolescent sexual activity and behaviour in Nova Scotia.* Canadian Journal of Public Health, 2005. **96**(4): p. 313-8.
116. Kan, M.L., et al., *Longitudinal Predictors of Change in Number of Sexual Partners across Adolescence and Early Adulthood.* Journal of Adolescent Health, 2010. **46**(1): p. 25-31.

117. Langille, D.B., et al., *Association of socio-economic factors with health risk behaviours among high school students in rural Nova Scotia.* Canadian Journal of Public Health 2003. **94**(6): p. 442-7.
118. Thomas, B.H., A. DiCenso, and L. Griffith, *Adolescent sexual behaviour: results from an Ontario sample. Part 1: Adolescent sexual activity.* Canadian Journal of Public Health, 1998. **89**(2): p. 90-3.
119. Fanga, L., S.P. Schinkec, and K.C. Colec, *Underage Drinking Among Young Adolescent Girls: The Role of Family Processes.* Psychology of Addictive Behaviors, 2009. **23**(4): p. 708-714.
120. Reinherz, H.Z., et al., *Health-Promoting Influences of the Family on Late Adolescent Functioning.* Child and Adolescent Social Work Journal, 2008. **25**(6): p. 517-530.
121. Nguyen, H.T., M.P. Dunneb, and A.V. Lea, *Multiple types of child maltreatment and adolescent mental health in Viet Nam.* Bulletin of the World Health Organisation, 2010. **88**(1): p. 22-30.
122. Richter, L. and S. Panday, *Youth Conceptions of the Transition to Adulthood in South Africa: Barriers and Opportunities.* Sexuality in Africa Magazine, 2006. **3**: p. 3-5.
123. Arnett, J.J., *Suffering, Selfish, Slackers? Myths and Reality about Emerging Adults.* Journal of Youth and Adolescence, 2007. **36**(1): p. 23-29.
124. Salmela-Aro, K., K. Aunola, and J.-E. Nurmi, *Personal Goals During Emerging Adulthood: A 10-Year Follow Up.* Journal of Adolescent Research, 2007. **22**(6): p. 690-715.
125. Statistics South Africa, *Stages in the life cycle of South Africans*, S.S.C. 2001, Editor. 2005, Statistics South Africa: Pretoria.
126. Lyons, H.Z., et al., *Culturally Competent Qualitative Research With People of African Descent.* Journal of Black Psychology, 2011.
127. Aidoo, M. and T. Harpham, *The explanatory models of mental health amongst low-income women and health care practitioners in Lusaka, Zambia.* Health Policy and Planning, 2001. **16**(2): p. 206-213.
128. Pereira, B., et al., *The explanatory models of depression in low income countries: Listening to women in India.* Journal of Affective Disorders, 2007. **102**(1-3): p. 209-218.
129. Colman, I. and A. Ataullahjan, *Life course perspectives on the epidemiology of depression.* The Canadian Journal of Psychiatry, 2010. **55**(10): p. 622-631.
130. Reinherz, H.Z., et al., *Psychosocial Risks for Major Depression in Late Adolescence: A Longitudinal Community Study.* Journal of the American Academy of Child & Adolescent Psychiatry, 1993. **32**(6): p. 1155-1163.
131. Lin, J.-D., et al., *Interactive effects of delayed bedtime and family-associated factors on depression in elementary school children.* Research in Developmental Disabilities. **32**(6): p. 2036-2044.
132. Joinson, C., et al., *Timing of menarche and depressive symptoms in adolescent girls from a UK cohort.* The British Journal of Psychiatry, 2011. **198**(1): p. 17-23.
133. Reinherz, H.Z., et al., *Major depression in the transition to adulthood: Risks and impairments.* Journal of Abnormal Psychology, 1999. **108**(3): p. 500-510.

134. Essau, C., A., et al., *Gender differences in the developmental course of depression.* Journal of affective disorders, 2010. **127**(1): p. 185-190.
135. Anderson, K. and G. Smith, *Specificity in Personality and Cognitive Factors Associated with Drinking and Depressive Symptoms.* Cognitive Therapy and Research, 2006. **30**(6): p. 711-722.
136. Hong, X., et al., *Physical activity inversely associated with the presence of depression among urban adolescents in regional China.* BMC Public Health 2009. **9**(148).
137. Allgöwer, A., J. Wardle, and A. Steptoe, *Depressive symptoms, social support, and personal health behaviors in young men and women.* Health Psychology, 2001. **20**(3): p. 223-227.
138. Petersen, I., *Primary level psychological services in South Africa.* Health Policy and Planning, 2004. **19** (1): p. 33-40.
139. Kaharuza, F., et al., *Depression and CD4 Cell Count Among Persons with HIV Infection in Uganda.* AIDS and Behavior, 2006. **10**(0): p. 105-111.
140. Shisana, O., et al., *South African National HIV Prevalence, Behaviour and Communication Survey of 2008: A turning tide among teenagers.* 2009, Human Sciences Research Council: Pretoria.
141. Shisana, O., et al., *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008: The health of our children.* 2010, Human Sciences Reearch Council: Cape Town.
142. Jewkes, R., et al., *Factors associated with HIV sero-positivity in young, rural South African men.* International Journal of Epidemiology, 2006. **35**(6): p. 1455-1460.
143. Jewkes, R., et al., *Factors associated with HIV sero-status in young rural South African women: connections between intimate partner violence and HIV.* Int. J. Epidemiol., 2006. **35**(6): p. 1461-1468.
144. Olley, B.O., S. Seedat, and D.J. Stein, *Persistence of psychiatric disorders in a cohort of HIV/AIDS patients in South Africa: A 6-month follow-up study.* Journal of Psychosomatic Research, 2006. **61**(4): p. 479-484.
145. Olley, B.O., et al., *Predictors of Major Depression in Recently Diagnosed Patients with HIV/AIDS in South Africa.* AIDS Patient Care and STDs, 2004. **18**(8): p. 481-487.
146. Blignault, I., et al., *Community perceptions of mental health needs: a qualitative study in the Solomon Islands.* International Journal of Mental Health Systems, 2009. **3**(1): p. 6.
147. Brough, M., et al., *Young Refugees Talk about Well-Being: A Qualitative Analysis of Refugee Youth Mental Health from Three States.* Australian Journal of Social Issues, 2003. **38**.
148. Morojele, N.K. and J.S. Brook, *Sociodemographic, sociocultural, and individual predictors of reported feelings of meaninglessness among South African adolescents.* Psychological Reports, 2004. **95**(3f): p. 1271-1278.
149. Cluver, L. and M. Orkin, *Cumulative risk and AIDS-orphanhood: Interactions of stigma, bullying and poverty on child mental health in South Africa.* Social Science & Medicine, 2009. **69**(8): p. 1186-1193.

150. Benjet, C., G. Borges, and M.E. Medina-Mora, *Chronic childhood adversity and onset of psychopathology during three life stages: Childhood, adolescence and adulthood.* Journal of Psychiatric Research, 2010. **44**(11): p. 732-740.
151. Najman, J.M., et al., *Family poverty over the early life course and recurrent adolescent and young adult anxiety and depression: A longitudinal study.* American Journal of Public Health, 2010. **100**(9): p. 1719-1723.
152. Marx, I. and K. Van Den Bosch, *On poverty measurement in an enlarged EU context: conventional and alternative appraoches*, in *How poverty differes from inequality.*, Centre for Social Policy: Belgium.
153. Aliber, M., et al., *Small-scale agriculture: best hope for the rural poor.* New Agenda: South African Journal of Social and Economic Policy, 2007. **25**: p. 30-31.
154. Du Toit, A., *A challenge of chronic poverty.* New Agenda: South African Journal of Social and Economic Policy, 2004. **16**: p. 28-31.
155. Gray, G.E., et al., *The effects of adult morbidity and mortality on household welfare and the well-being of children in Soweto.* Vulnerable Children and Youth Studies: An International Interdisciplinary Journal for Research, Policy and Care, 2006. **1**(1): p. 15 - 28.
156. Eddy, G., *First steps to healing the South African family.* Fast Facts, in press.
157. Operario, D., et al., *Orphanhood and Completion of Compulsory School Education among Young People in South Africa: Findings from a National Representative Survey.* Journal of Research on Adolescence, 2008. **18** (1): p. 173-186.
158. Okello, E.S., *Cultural explanatory models of depression in Uganda*, in *College of Health Sciences* 2006, Makerere University: Uganda.
159. McLoyd, V.C., *The impact of economic hardship on black families and children: psychological distress, parenting, and socioemotional development.* Child Development Perspectives, 1990. **61**(2): p. 311-46.
160. May, J. and A. Norton, *A Difficult Life: The Perceptions and Experience of Poverty in South Africa.* Social Indicators Research, 1997. **41**(1/3): p. 95-118.
161. Låftman, S.B., *Family structure and children's living conditions. A comparative study of 24 countries.* Child Indicators Research, 2010. **3**: p. 127-147.
162. Benjet, C., *Childhood adversities of populations living in low-income countries: prevalence, characteristics, and mental health consequences.* Current Opinion in Psychiatry, 2010. **23**(4): p. 356-362.
163. Cluver, L., F. Gardner, and D. Operario, *Psychological distress amongst AIDS-orphaned children in urban South Africa.* Journal of Child Psychology and Psychiatry, 2007. **48**(8): p. 755-763.
164. Schoenfelder, E., et al., *Quality of Social Relationships and the Development of Depression in Parentally-Bereaved Youth.* Journal of Youth and Adolescence, 2011. **40**(1): p. 85-96.
165. Kaggwa, E.B. and M.J. Hindin, *The psychological effect of orphanhood in a matured HIV epidemic: An analysis of young people in Mukono, Uganda.* Social Science & Medicine, 2010. **70**(7): p. 1002-1010.

166. Operario, D., et al., *Prevalence of Parental Death Among Young People in South Africa and Risk for HIV Infection.* Journal of Acquired Immune Deficiency Syndromes, 2007. **44**(1): p. 93-98 10.1097/01.qai.0000243126.75153.3c.
167. Bradshaw, D., et al., *Cause of death statistics for South Africa: Challenges and possibilities for improvement*. 2010, Burden of Disease Research Unit, MRC: Tygerberg, Cape Town.
168. Eddy, G., *Unhappy families.* Fast Facts: South African Institute of Race Relations, 2009. **7**: p. 2-12.
169. Kane-Berman, J., *A risk not recognised.* Fast Facts: South African Institute of Race Relations, 2009. **7**(1): p. 1.
170. Holborn, L., *Broken families breaking youth.* Fast Facts: South African Institute of Race Relations, 2011. **5**(May): p. 2-11.
171. Jonsson, J.O., *Child well-being and intergenerational inequality.* Child Indicators Research, 2010. **3**: p. 1-10.
172. Cluver, L. and F. Gardner, *The psychological well-being of children orphaned by AIDS in Cape Town, South Africa.* Annals of General Psychiatry, 2006. **5**(1): p. 8.
173. Cluver, L. and F. Gardner, *The mental health of children orphaned by AIDS: a review of international and southern African research.* Journal of Child and Adolescent Mental Health, 2007. **19**(1): p. 1-17.
174. Freeman, M. and N. Nkomo, *Guardianship of orphans and vulnerable children. A survey of current and prospective South African caregivers.* AIDS Care, 2006. **18**(4): p. 302-310.
175. Freeman, M., *HIV/AIDS in developing countries: heading towards a mental health and consequent social disaster?* South African Journal of Psychology, 2004. **34**(1): p. 139-159.
176. Province of the EASTERN CAPE Department of Education, *School and Learner Quantitative Study*, in *Comprehensive Evaluation Programme*, Quality Promotion & Standards Directorate and EMIS, Editors. 2008.
177. Langa, M., *Adolescent boys' talk about absent fathers.* Journal of Psychology in Africa, 2010. **20**(4): p. 519-526.
178. Cluver, L., et al., *"I Can't Go to School and Leave Her in So Much Pain": Educational Shortfalls Among Adolescent 'Young Carers' in the South African AIDS Epidemic.* Journal of Adolescent Research, 2011.
179. Houle, J.N., et al., *The Impact of Sexual Harassment on Depressive Symptoms during the Early Occupational Career.* Society and Mental Health, 2011. **1**(2): p. 89-105.
180. Lin, F.-G., et al., *Interactive influences of family and school ecologies on the depression status among children in marital immigrant families.* Research in Developmental Disabilities. **32**(6): p. 2027-2035.
181. Glaser, B., et al., *Age- and puberty-dependent association between IQ score in early childhood and depressive symptoms in adolescence.* Psychological Medicine, 2011. **41**: p. 333-343
182. Holborn, L. (2011) *Broken Families breaking youth*. Fast Facts: First steps to healing the South African family.

183. Amstadter, A.B., et al., *Prevalence and correlates of service utilisation and help seeking in a national college sample of female rape victims.* Journal of Anxiety Disorders, 2010. **online first**.
184. Lai, D.W., *Violence exposure and mental health of adolescents in small towns: an exploratory study.* Canadian Journal of Public Health, 1999. **90**(3): p. 181-5.
185. van der Woerd, K.A., D.N. Cox, and T. McDiarmid, *A Preliminary Look at Aggressive and Violent Behaviour in Aboriginal Adolescent Girls.* Pimatisiwin: A Journal of Indigenous and Aboriginal Community Health 2006. **4**(1): p. 119-134.
186. Trocmé, N.M., et al., *Canadian Incidence Study of Reported Child Abuse and Neglect: methodology.* Canadian Journal of Public Health, 2001. **92**(4): p. 259-63.
187. Madu, S.N., *Prevalence of child psychological, physical, emotional, and ritualistic abuse among high school students in Mpumalanga Province, South Africa.* Psychological Reports, 2001. **89**(2): p. 431-44.
188. Romito, P. and M. Grassi, *Does violence affect one gender more than the other? The mental health impact of violence among male and female university students.* Social Science & Medicine, 2007. **65**(6): p. 1222-1234.
189. Kinyanda, E., et al., *War related sexual violence and it's medical and psychological consequences as seen in Kitgum, Northern Uganda: A cross-sectional study.* BMC International Health and Human Rights, 2010. **10**(1): p. 28.
190. Erulkar, A.S., *The Experience of Sexual Coercion Among Young People in Kenya.* International Family Planning Perspectives, 2004. **30**(4): p. 182-189.
191. Thompson, S., K. Bender, and J. Kim, *Family Factors as Predictors of Depression Among Runaway Youth: Do Males and Females Differ?* Child and Adolescent Social Work Journal, 2011. **28**(1): p. 35-48.
192. Ishida, K., et al., *Exploring the associations between intimate partner violence and women's mental health: Evidence from a population-based study in Paraguay.* Social Science & Medicine, 2010. **71**(9): p. 1653-1661.
193. Bourgois, P., *In Search of Respect: Selling Crack in El Barrio*. 2 edition ed. 2002: Cambridge University Press. 432
194. Dunkle, K.L., et al., *Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa.* Lancet, 2004. **363**: p. 1415-1421.
195. Jyrki, K., et al., *Childhood adversities, adulthood life events and depression.* Journal of affective disorders, 2010. **127**(1): p. 130-138.
196. Jewkes, R., et al., *A cluster randomized-controlled trial to determine the effectiveness of Stepping Stones in preventing HIV infections and promoting safer sexual behaviour amongst youth in the rural Eastern Cape, South Africa: trial design, methods and baseline findings.* Tropical Medicine & International Health, 2006. **11**(1): p. 3-16.
197. Stewart, R.C., et al., *Common mental disorder and associated factors amongst women with young infants in rural Malawi.* Social Psychiatry and Psychiatric Epidemiology, 2009. **EPub ahead of print**(Online First).
198. Olsson, G.I., et al., *Adolescent Depression: Social Network and Family Climate—A Case-control Study.* The Journal of Child Psychology and Psychiatry and Allied Disciplines, 1999. **40**(02): p. 227-237.

199. Utomo, I.D. and P. McDonald, *Adolescent Reproductive Health in Indonesia: Contested Values and Policy Inaction.* Studies in Family Planning, 2009. **40**: p. 133-146.
200. Thompson, A.H. and X. Cui, *Increasing childhood trauma in Canada: findings from the National Population Health Survey, 1994/95.* Canadian Journal of Public Health, 2000. **91**(3): p. 197-200.
201. Jewkes, R., et al., *Associations between childhood adversity and depression, susbtance abuse & HIV & HSV2 incident infections in rural South African youth.* Child Abuse & Neglect, 2010. **Accepted for publication**(In Press).
202. Silverman, A.B., H.Z. Reinherz, and R.M. Giaconia, *The long-term sequelae of child and adolescent abuse: A longitudinal community study.* Child Abuse & Neglect, 1996. **20**(8): p. 709-723.
203. Reinherz, H.Z., et al., *Childhood and Adolescent Predictors of Major Depression in the Transition to Adulthood.* The American Journal of Psychiatry, 2003. **160**(12): p. 2141-2147.
204. Frost, A.K. and B. Pakiz, *The effects of marital disruption on adolescents: Time as a dynamic.* American Journal of Orthopsychiatry, 1990. **60**(4): p. 544-555.
205. Pillay, A.L. and D.R. Wassenaar, *Recent stressors and family satisfaction in suicidal adolescents in South Africa.* Journal of Adolescence, 1997. **20**(2): p. 155-162.
206. Baker, A.J.L., *The long-term effects of parental alienation on adult children: A qualitative research study.* The American Journal of Family Therapy, 2005. **33**: p. 289-302.
207. Posel, D. and R. Devey, *The demographics of fatherhood in South Africa: an analysis of survey data, 1993-2002*, in *Baba: Men and fatherhood in South Africa*, R. Morrell and L. Richter, Editors. 2006, HSRC Press: Pretoria: South Africa. p. 38-52.
208. Joyner, K. and J.R. Udry, *You don't bring me anything but down: Adolescent romance and depression.* Journal of Health and Social Behavior, 2000. **41**(4): p. 369-391.
209. Welsh, D.P., et al., *Discrepancies in adolescent romantic couples' and observers' perceptions of couple interaction and their relationship to depressive symptoms.* Journal of Youth and Adolescence, 1999. **28**(6): p. 645-666.
210. Davila, J., et al., *Romantic involvement and depressive symptoms in early and late adolescence: The role of a preoccupied relational style.* Personal Relationships, 2004. **11**(2): p. 161-178.
211. Charles G. Bentley, R.V. Galliher, and T.J. Ferguson, *Associations Among Aspects of Interpersonal Power and Relationship Functioning in Adolescent Romantic Couples* Sex Roles 2007. **57**(7-8): p. 483-495.
212. Feldman-Jacobs, C. and H. Worley, *Cross-generational sex: risks and opportunities*. 2008, Population Reference Bureau: Washington DC.
213. Gowen, L.K., et al., *A Comparison of the Sexual Behaviors and Attitudes of Adolescent Girls with Older Vs. Similar-Aged Boyfriends.* Journal of Youth and Adolescence, 2004. **33**(2): p. 167-175.
214. Jewkes, R., *Suicides among the Stepping Stones cohort.* Unpublished notes, Personal communication.

215. Meel, B.L., *Suicide among teenagers and young adults in the Transkei. Case reports.* Anil Aggrawal's Internet Journal of Forensic Medicine and Toxicology, 2004. **5**(2).
216. Harrison, A. and L.F. O'Sullivan, *In the absence of marriage: Long-term concurrent partnerships, pregnancy, and HIV risk dynamics among South African adults.* AIDS Behaviour, 2010. **14**: p. 991-1000.
217. Nduna, M. and V. Maseko, *Discontinued Intimacy, denied paternity.* Sexuality in Africa Magazine, 2008. **4**(4): p. 11-14.
218. Kelly, K. and P. Ntlabati, *Early Adolescent Sex in South Africa: HIV Intervention Challenges.* Social Dynamics: A journal of African studies, 2002. **28**(1): p. 42 - 63.
219. *Act No. 92 OF 1996: Choice On Termination Of Pregnancy Act*, in *1891*. 1996, PRESIDENT'S OFFICE: South Africa.
220. Schuler, S., E. Rottach, and M. Peninah, *Gender norms and family planning decisionmaking in Tanzania: A qualitative study*. 2009, DC: C-Change.: Washington.
221. Evans, S.J., et al., *Teen sexuality. Reaching out in the malls.* Canadian Journal of Public Health, 2002. **93**(1): p. 47-51.
222. Glynn, J.R., et al., *Age at Menarche, Schooling, and Sexual Debut in Northern Malawi.* PLoS ONE, 2010. **5**(12): p. e15334.
223. Buga, G.A., D.H. Amoko, and D.J. Ncayiyana, *Sexual behaviour, contraceptive practice and reproductive health among school adolescents in rural Transkei.* South African Medical Journal, 1996. **86**(5): p. 523-7.
224. Kasenda, M., et al., *Correlates of condom use in the young adult population in Ontario.* Canadian Journal of Public Health, 1997. **88**(4): p. 280-5.
225. Sahai, V. and P. Demeyere, *Sexual health: are we targeting the right age groups?* Canadian Journal of Public Health, 1996 **87**(1): p. 40-1.
226. Buga, G.A., D.H. Amoko, and D.J. Ncayiyana, *Adolescent sexual behaviour, knowledge and attitudes to sexuality among school girls in Transkei, South Africa.* East Africa Medical Journal, 1996. **73**(2): p. 95-100.
227. Wagman, J., et al., *Experiences of Sexual Coercion Among Adolescent Women: Qualitative Findings From Rakai District, Uganda.* Journal of Interpersonal Violence, 2009. **24**(12): p. 2073-2095.
228. Makiwane, M.B., *Adolescent pregnancy and reproductive health in Transkei (rural South Africa).* African Journal of Reproductive Health, 1998. **2**(1): p. 41-8.
229. Bakilana, A., *Age at sexual debut in South Africa.* African Journal of AIDS Research, 2005. **4**: p. 1-6.
230. Planned Parenthood Association of South Africa, *Teen parent programme: a baseline survey and needs assessment for adolescents and teen parents in South Africa*. 2003, PPASA: Johannesburg.
231. Salo, E., et al., *Living Our Lives on the Edge: Power, Space and Sexual Orientation in Cape Town Townships, South Africa.* Sexuality Research and Social Policy, 2010. **7**(4): p. 298-309.
232. van Dyk, D., *"Lesbian Lives Unlimited"*, in *A REPORT FROM THE STUDY "THE PSYCHO"SOCIAL" SEXUAL EXPERIENCES OF LESBIAN WOMEN IN*

TSHWANE (PRETORIA):A QUALITATIVE ANALYSIS". year unspecified, OUT Wellbeing: Pretoria.
233. Llera, D.J. and E. Katsirebas, *Remapping the Journey of Lesbian Youth Through Strength and "Truth Telling"*. Journal of Lesbian Studies 2010. **14**(1): p. 26-35.
234. Robinson, A., *Living For the City: Voices of Black Lesbian Youth in Detroit.* Journal of Lesbian Studies 2010. **14**(1): p. 61-70.
235. Cohn, T.J. and S.L. Hastings, *Resilience Among Rural Lesbian Youth.* Journal of Lesbian Studies, 2010. **14**(1): p. 71-79.
236. Hallfors, D.D., et al., *Adolescent depression and suicide risk: association with sex and drug behavior.* American Journal of Preventive Medicine, 2004. **27**(3): p. 224-231.
237. Hallfors, D.D., et al., *Which comes first in adolescence-Sex and drugs or depression?* . American Journal of Preventive Medicine, 2005. **29**(3): p. 163-170.
238. Mackie, C., N. Castellanos-Ryan, and P. Conrod, *Developmental trajectories of psychotic-like experiences across adolescence: impact of victimisation and substance use.* Psychological Medicine, 2011. **41**: p. 47-58.
239. Bhana, A. and I. Petersen, *HIV and Youth: A Behavioural Perspective* in *HIV/AIDS in South Africa 25 Years On*, P. Rohleder, et al., Editors. 2009, Springer: New York. p. 55-68.
240. Gliksman, L., et al., *Heavy drinking on Canadian campuses.* Canadian Journal of Public Health, 2003. **94**(1): p. 17-21.
241. Evers, S., et al., *Eating and smoking behaviours of school children in southwestern Ontario and Charlottetown, PEI.* Canadian Journal of Public Health, 2001. **92**(6): p. 433-6.
242. Johnson, J.L., et al., *Socio-demographic correlates of cigarette smoking among high school students: results from the British Columbia youth survey on smoking and health.* Canadian Journal of Public Health, 2004. **95**(4): p. 268-71.
243. Hay, D.A., *A multivariate regression analysis of adolescent multiple drug use in two western Canadian provinces.* Canadian Journal of Public Health, 1999. **90**(5): p. 304-8.
244. Maticka-Tyndale, E. and E.Y. Tenkorang, *A multi-level model of condom use among male and female upper primary school students in Nyanza, Kenya.* Social Science & Medicine, 2010. **71**(3): p. 616-625.
245. Offer, D., *The psychological world of the teenager*. 1969, New York: Basic Books.
246. Offer, D. and K.A. Schonert-Reichl, *Debunking the myths of adolescence: findings from recent research.* Journal of the American Academy Child Adolescent Psychiatry, 1992. **31**(6): p. 1003-14.
247. Freud, A., *Adolescence*, in *Psychoanalytic Study of the Child*. 1958, International Universities Press Inc.: New York. p. 255-278.
248. Shilumani, C., *Changes in adolescent sexuality communication among the Shangaan of Dzumeri, South Africa*, in *A tapestry of human sexuality in Africa*, O. Obono, Editor. 2010, Fanele, an imprint of Jacana Media: Pretoria. p. 63-72.
249. Nchogu, S.N., *Young women's views of Female Genital Circumcision among the Kisii of Kenya*, in *A Tapestry of Human Sexuality in Africa*, O. Obono, Editor.

2010, Famele, an imprint of Jacana Media (PTY) Ltd: Pretoria: South Africa. p. 13-28.
250. Shilabukha, K., *The persistence of Female Genital Cutting among the Abagusii and Maasai communities of Kenya*, in *A Tapestry of Human Sexuality in Africa*, O. Obono, Editor. 2010, Fanele, an imprint of Jacana Media(PTY) Ltd: Pretoria. p. 73-86.
251. Yasein, Y.A.-A., *Motives for Mutilation among women in Cairo, Egypt*, in *A Tapestry of Human Sexuality in Africa*, O. Obono, Editor. 2010, Fanele, an imprint of Jacana Media(PTY) Ltd: Pretoria. p. 137-150.
252. Mavundla, T.R., et al., *Rationalization of Indigenous Male Circumcision as a Sacred Religious Custom: Health Beliefs of Xhosa Men in South Africa.* Journal of Transcultural Nursing 2009. **OnlineFirst**.
253. Borowsky, I.W., M. Ireland, and M.D. Resnick, *Health status and behaviourol outcomes for youth who anticipate a high likelihood of early death.* Pediatrics, 2009. **124**(1): p. e81-e88.
254. Keller, S.E., et al., *HIV-relevant sexual behavior among a healthy inner-city heterosexual adolescent population in an endemic area of HIV.* Journal of Adolescent Health, 1991. **12**(1): p. 44-48.
255. Kloep, M., et al., *Motives for risk taking in adolescence: a cross cultural study.* Journal of Adolescence, 2007. **13**(1): p. 135-155.
256. Kosunen, E., et al., *Risk taking sexual behaviour and self reported depression in middle adolescence-a school based survey.* Child Care, Health and Development, 2003. **29**(5): p. 337-344.
257. Lehrer, J.A., et al., *Depressive symptoms as a longitudinal predictor of sexual risk behaviours among US middle and high school students.* Pediatrics, 2006. **118**(1): p. 189-200.
258. Mazzaferro, K.E., et al., *Depression, Stress, and Social Support as Predictors of High-Risk Sexual Behaviors and STIs in Young Women.* Journal of Adolescent Health, 2006. **39** (3): p. 601-603
259. Paxton, K.C. and W.L. Robison, *Depressive symptoms, gender and sexual risk behaviour among African-American adolescents: Implications for prevention and intervention.* Journal of Prevention and Intervention in Community, 2008. **35**(2): p. 49-62.
260. Ramrakha, S., et al., *Psychiatric disorders and risky sexual behaviours in young adulthood: cross sectional study in birth cohort.* British Medical Journal, 2000. **321**: p. 263-266.
261. Rubin, A., M. Gold, and B. Primack, *Associations between depressive symptoms and sexual risk behavior in a diverse sample of female adolescents.* Journal of pediatric and adolescent gynecology, 2009. **22**(5): p. 306-312.
262. Seth, P., et al., *Psychological distress as a correlate of a biologically confirmed STI, risky sexual practice, self efficacy and communication with male sex partners in African-American female adolescents.* Psychology, Health and Medicine, 2009. **14**(3): p. 291-300.
263. Shisana, O., et al., *South African National HIV Prevalence, Behaviour and Communication Survey of 2005*. 2005, Human Sciences Research Council: Pretoria.

264. Rubin, A., M. Gold, and B. Primack, *Associations between depressive symptoms and sexual risk behavior in a diverse sample of female adolescents.* Journal of pediatric and adolescent gynecology, 2009. **22**(5): p. 306-12.
265. Kazaura, M.R. and M.C. Masatu, *Sexual practices among unmarried adolescents in Tanzania.* BioMed Central Public Health, 2009. **9**(373).
266. Petersen, J.L. and J.S. Hyde, *A Meta-Analytic Review of Research on Gender Differences in Sexuality, 1993-2007.* Psychological Bulletin, 2010. **136**(1): p. 21-38.
267. Kenyon, C. and M. Badri, *"I don't use a condom (with my regular partner) because i know that I'm faithful, but with everyone else i do"; The cultural and socioeconomic determinants of concurency in young South Africans*, in *5th International AIDS Society Conference on HIV Pathogenesis and Treatment*. 2009, 5th IAS Conf HIV Pathog Treat 2009: Abstract No. MOPEC022: Cape Town.
268. Elkington, K., J. Bauermeister, and M. Zimmerman, *Psychological Distress, Substance Use, and HIV/STI Risk Behaviors Among Youth.* Journal of Youth and Adolescence, 2010. **39**(5): p. 514-527.
269. Langille, D.B., et al., *Sexual health knowledge of students at a high school in Nova Scotia.* Canadian Journal of Public Health., 1998. **89**(2): p. 85-9.
270. Langille, D.B. and J.A. Rigby, *Factors associated with PAP testing in adolescents in northern Nova Scotia.* Canadian Journal of Public Health, 2006. **97**(3): p. 183-6.
271. Thomas, B.H., A. DiCenso, and L. Griffith, *Adolescent sexual behaviour: results from an Ontario sample. Part II: Adolescent use of protection.* Canadian Journal of Public Health, 1998. **89**(2): p. 94-7.
272. loveLife, *A Gauge of HIV Prevention in South Africa: October 2008*. 2008.
273. Othero, D.M., P. Aduma, and C.O. Opil, *Knowledge, attitudes and sexual practices of university students for advancing peer HIV education.* East Africa Medical Journal, 2009. **86**(1): p. 11-5.
274. Mulwo, A.K., K.G. Tomaselli, and L. Dalrymple, *Condom brands, perceptions of condom efficacy and HIV prevention among university students in KwaZulu-Natal, South Africa.* African Journal of AIDS Research, 2009. **8**: p. 311-320.
275. Nduna, M. and J. Mendes, *Sterotypes in HIV discourse.* SAHARA Journal, 2010. **in press**(3).
276. Shrier, L.A., et al., *Associations of Depression, Self-Esteem, and Substance Use with Sexual Risk among Adolescents.* Preventive Medicine, 2001. **33**(3): p. 179-189.
277. Wagner, G.J., et al., *Factors associated with condom use among HIV clients in stable relationships with partners at varying risk for HIV in Uganda.* AIDS Behaviour, 2010. **14**: p. 1055-1065.
278. Jewkes, R., et al., *Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study.* THE LANCET, 2010. **D-09-06472R2.**
279. Chersich, M.F. and H.V. Rees, *Causal links between binge drinking patterns, unsafe sex and HIV in South Africa: its time to intervene.* Int J STD AIDS, 2010. **21**(1): p. 2-7.

280. Mpofu, E., et al., *Sexual Partners in a Rural South African Setting.* AIDS and Behavior, 2006. **10**(4): p. 399-404.
281. Peltzer, K., *Stress, psychological symptoms, social support and health behaviour among Black students in South Africa.* Journal of Child and Adolescent Mental Health, 2004. **16**(1): p. 19-23.
282. Wingood, G.M. and R.J. DiClemente, *The influence of psychosocial factors, alcohol, drug use on African-American women's high-risk sexual behavior.* American Journal of Preventive Medicine, 1998. **15**(1): p. 54-59.
283. Chapman, R., et al., *Do behavioural differences help to explain variations in HIV prevalence in adolescents in sub-Saharan Africa?* Tropical Medicine & International Health, 2010. **15**(5): p. 554-566.
284. Dunkle, K.L., et al., *Transactional sex with casual and main partners among young South African men in the rural Eastern Cape: Prevalence, predictors, and associations with gender-based violence.* Social Science & Medicine, 2004. **65**(6): p. 1235-1248.
285. UNAIDS, *2008 Report on the global AIDS epidemic*. 2009, United Nations Program on HIV/AIDS: Switzerland.
286. Leclerc-Madlala, S., *Age disparate and intergenerational sex in Southern Africa: dynamics of hypervulnerability.* AIDS, 2008. **22**(4): p. s17-s25.
287. Townsend, L., et al., *HIV Risk Behaviours and their Relationship to Intimate Partner Violence (IPV) Among Men Who Have Multiple Female Sexual Partners in Cape Town, South Africa.* AIDS and Behavior, 2011. **15**(1): p. 132-141.
288. DiClemente, R.J., et al., *A Prospective Study of Psychological Distress and Sexual Risk Behavior Among Black Adolescent Females.* Pediatrics, 2001. **108**(5): p. e85-.
289. Eyre, S.L., V. Hoffman, and A.E. Fraser, *African American Late Adolescent Cultural Models of Infidelity.* Journal of Adolescent Health, 2010. **46**(2, Supplement 1): p. S3-S4.
290. Joshi, A., A. Basu, and S. Marhefka, *If it is Kept Secret, it is Acceptable: Cultural Norms and Sexual Risk Behavior Among Tribal Adolescents in Vadodara, India.* Journal of Adolescent Health, 2010. **46**(2, Supplement 1): p. S5-S5.
291. Carter, M.W., et al., *A bull cannot be contained in a single kraal: concurrent sexual partnerships in Botswana.* AIDS Behaviour, 2007. **11**(6): p. 822-830.
292. Green, E.C., et al., *A framework for sexual relationships: risks and implications for HIV prevention in Africa.* Studies in Family Planning, 2009. **40**(1): p. 63-70.
293. Halperin, D.T. and H. Epstein, *Why is HIV so severe in Southern Africa? The role of multiple concurent partnerships and lack of male circumcision: Implications for AIDS prevention.* The Southern Africa Journal of HIV Medicine, 2007. **26**: p. 19-25.
294. Helleringer S, K.H.P., *Sexual networks structure and the spread of HIV in Africa: evidence from Likoma Island, Malawi.* AIDS, 2000. **21**(17): p. 2323-2332.
295. Mah T L, H.D.T., *Concurrent sexual partnerships and the HIV epidemics in Africa: Evidence to move forward.* AIDS and Behaviour, 2008. **22**(Epub ahead of print).
296. Morris, M. and M. Kretzschmar, *Concurrent partnerships and the spread of HIV.* AIDS, 1997. **11**(5): p. 641-648.

297. Morris, M., S.M. Goodreau, and J. Moody, *Sexual networks, concurrency, and STD/HIV, Sexually transmitted diseases*. 2007: New York.
298. Parker, W., et al., *Concurrent sexual partnerships amongst young adults in South Africa: Challenges for HIV prevention communication*. 2007, CADRE.
299. Mah, T.L. and D.T. Halperin, *Concurrent sexual partnerships and the HIV epidemics in Africa: Evidence to move forward.* AIDS and Behaviour, 2008. **22**(Epub ahead of print).
300. Kalichman, S.C. and T. Grebler, *Reducing numbers of sex partners: do we really need special interventions for sexual concurrency?* AIDS Behaviour, 2010. **14**: p. 987-990.
301. Shai, N.J., et al., *Factors associated with consistent condom use among rural young women in South Africa.* AIDS Care, 2010. **iFirst**.
302. Fortenberry, D.J., *Fate, desire, and the centrality of the relationship to adolecent condom use.* Journal of Adolescent Health, 2010. **47**: p. 219-220.
303. Frye, V., et al., *Intimate Partner Violence Perpetration and Condom Use-Related Factors: Associations with Heterosexual Men's Consistent Condom Use.* AIDS and Behavior, 2010. **15**(1): p. 153-162.
304. Jewkes, R., et al., *Rape of girls in South Africa.* Lancet, 2002. **359**(9303): p. 319-20.
305. Dunkle, K.L., et al., *Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa.* AIDS, 2006. **20**(16): p. 2107-2114.
306. Jewkes, R.K., J.B. Levin, and L.A. Penn-Kekana, *Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study.* Social Science & Medicine, 2003. **56**(1): p. 125-134.
307. Jewkes, R., et al., *Rape perpetration by young, rural South African men: Prevalence, patterns and risk factors.* Social Science & Medicine, 2006. **63**(11): p. 2949-2961.
308. Andrew, G., V. Patel, and J. Ramakrishna, *Sex, Studies or Strife? What to Integrate in Adolescent Health Services.* Reproductive Health Matters, 2003. **11**(21): p. 120-129.
309. UNAIDS/WHO, *Uniting the world against AIDS. Sub-Saharan Africa: Latest epidemiological trends*, in *FACT SHEET 0 9*, UNAIDS/WHO, Editor. 2009: Geneva.
310. Jewkes, R., et al., *Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial.* British Medical Journal, 2008. **337**(7666).
311. Bhui, K. and D. Bhugra, *Explanatory models for mental distress: implications for clinical practice and research.* The British Journal of Psychiatry, 2002. **181**(1): p. 6-7.
312. Davies, R., *Overcoming structural unemployment.* New Agenda: South African Journal of Social and Economic Policy, 2003. **11**.
313. Turok, B., *Poverty and inequality.* New Agenda: South African Journal of Social and Economic Policy, 2004. **13**(25-26).

314. South African Institute of Race Relations, *South African Survey 2009/2010: Demographics*, in *South African Survey*. 2010, South African Institute of Race Relations: Johanesburg.
315. Leibbrandt, M., et al., *Changes in inequality and poverty.* New Agenda: South African Journal of Social and Economic Policy, 2006. **23**(20-25).
316. Van der Berg, S., *The evidence in poverty.* New Agenda: South African Journal of Social and Economic Policy, 2005. **17**(21-25).
317. Watkinson, E. and L. Orr, *Poverty and unemployment.* New Agenda: South African Journal of Social and Economic Policy, 2003. **12**(27-29).
318. Lee, D. and I. Woolard, *Women and employment.* New Agenda: South African Journal of Social and Economic Policy, 2003. **12**(30-34).
319. Centre for the study of industrial relations, *2004 Eastern Cape State of the Environment Report*. 2004, Eastern Cape Department of Economic Affairs, Environment and Tourism: Durban, South Africa.
320. South African Institute of Race Relations, *South African Survey 2009/2010: Health and Welfare*. 2010, South African Institute of Race Relations: Johhanesburg.
321. Nkwinti, G., *Challenges facing the Eastern Cape.* New Agenda: South African Journal of Social and Economic Policy, 2003. **11**: p. 28-29.
322. Ethier, K.A., et al., *Self-esteem, emotional distress and sexual behavior among adolescent females: Inter-relationships and temporal effects.* Journal of Adolescent Health, 2006. **38**(3): p. 268-274
323. Cousins, B., *Not rural development, but agrarian reform: beyond the neo-liberal agenda.* New Agenda: South African Journal of Social and Economic Policy, 2003. **11**.
324. Kuckertz, H., *Creating order: The image of the homestead in Mpondo social life.* 1990, South Africa: Witwatersrand University Press.
325. South African Institute of Race Relations, *South African Survey 2009/2010: Education*. 2010, South African Institute of Race Relations: Johhanesburg.
326. Aschengrau, A. and G.R. Seage III, *Essentials of Epidemiology In Public Health*. Second Edition ed. 2008, Sudbury, Massachusetts: Jones and Bartlett Publishers.
327. Parliament of the Republic of SA, *No. 54 of 2008: National Youth Development Agency Act, 2008.*, P.o.t.R.o. SA, Editor. 2009, REPUBLIC OF SOUTH AFRICA: Cape Town.
328. Department of Cooperative Governance, *Municipalities of the Republic of South Africa: Contact Details and Council Information*, D.o.C. Governance, Editor. 2010, Department of Cooperative Governance Republic of South Africa: Pretoria.
329. Pretorius, T., *Cross-cultural application of the Center for Epidemiological Studies Depression Scale: a study of black South African students.* Psychol Rep, 1991. **69**(3 Pt 2): p. 1179-85.
330. Chishinga, N., et al., *Validation of brief screening tools for depressive and alcohol use disorders among TB and HIV patients in primary care in Zambia.* BMC Psychiatry, 2011. **11**(1): p. 75.
331. Jewkes, R.K., et al., *Associations between childhood adversity and depression, substance abuse and HIV and HSV2 incident infections in rural South African youth.* Child Abuse & Neglect, 2010. **34**: p. 833-841.

332. Bernstein, D., et al., *Initial reliability and validity of a new retrospective measure of child abuse and neglect.* American Journal of Psychiatry, 1994. **151**(8): p. 1132-1136.
333. Bernstein, D.P., et al., *Development and validation of a brief screening version of the Childhood Trauma Questionnaire.* Child Abuse & Neglect, 2003. **27**(2): p. 169-190.
334. Savitz J, et al., *The Relationship Between Childhood Abuse and Dissociation. Is it influenced by catechol-o-methyltransferase (COMT) activity?* . International Journal of Neuropsychopharmacology, 2008. **11**(2): p. 149-61.
335. Jewkes, R., et al., *Understanding men's health and use of violence: Interface of rape and HIV in South Africa.*, in *Policy Brief*. 2009, Medical Research Council.
336. Allen, J.P., D.F. Reinert, and R. Volk, *The Alcohol Use Disorders Identification Tests: An aid to recognition of alcohol problems in primary care patients.* Preventive Medicine, 2001. **33**: p. 428-433.
337. Adwwuya, A.O., *Validation of the alcohol use disorders identification test (AUDIT) as a screening tool for alcohol-related problems among Nigerian university students.* Alcohol and Alcoholism, 2005. **40**(6): p. 575-577.
338. Pengpid, S., K. Peltzer, and H. Van der Heever, *Prevalence of Alcohol Use and Associated Factors in Urban Hospital Outpatients in South Africa.* International Journal of Environmental Research and Public Health, 2011. **8**(7): p. 2629-2639.
339. Dunkle K L, J.R.K., Brown H C, Gray G E, McIntryre J A, Harlow S D, *Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa.* Lancet, 2004. **363**: p. 1415-1421.
340. Pulerwitz, J., S.L. Gortmaker, and W. DeJong, *Measuring Sexual Relationship Power in HIVSTD Research.* Sex Roles, 2000. **42**: p. 637-660.
341. World Health Organization, *WHO Multi-country study on Women's health and Domestic Violence: Core questionnaire and WHO Instrument - Version 9*. 2000, World Health Organization: Geneva, Switzerland.
342. Bursac, Z., et al., *Purposeful selection of variables in logistic regression.* Source Code for Biology and Medicine, 2008. **3**(17).
343. Austin, P.C., V. Goel, and C. van Walraven, *An introduction to multilevel regression models.* Canadian Journal of Public Health, 2001. **92**(2): p. 150-154.
344. Nduna, M., et al., *Associations between depressive symptoms, sexual behaviour and relationship characteristics: a prospective cohort study of young women and men in the Eastern Cape, South Africa.* Journal of the International Association of AIDS, 2010. **13**(44).
345. Helleringer, S. and H.P. Kohler, *Sexual networks structure and the spread of HIV in Africa: evidence from Likoma Island, Malawi.* AIDS, 2000. **21**(17): p. 2323-2332.
346. Speziale, H.J.S. and D.R. Carpenter, *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. Fourth ed. 2007, USA: Lippincott Williams & Wilkins.
347. Jaffer, Z. *A Case Study: Mnquma Municipality in the Eastern Cape, Overcoming serious local government challenges*. 2008 [cited 2009 25 November 2009]; Mnquma Municipality in the Eastern Cape]. Available from:

http://www.zubeidajaffer.co.za/index.php/zubeidas-blog/Mnquma-Municipality-in-the-Eastern-Cape.html?blogger=admin.
348. Wright, G., M. Noble, and W. Magasela (2001) *Towards a democratic definition of poverty: socially perceived necessities in South Africa. The Eastern Cape provincial index of multiple deprivation*.
349. Hill, C.E., B.J. Thompson, and E.N. Williams, *A Guide to Conducting Consensual Qualitative Research.* The Counseling Psychologist, 1997. **25**(4): p. 517-572.
350. O'Connor, H. and N. Gibson, *A Step-by-Step Guide to Qualitative Data Analysis.* Pimatisiwin: A Journal of Indigenous and Aboriginal Community Health 2003. **1**(1): p. 63-90.
351. Maccoby, E.E. and N. Maccoby, *The interview: a tool of social science.* , in *Handbook of social psychology: Theory and method.* , G. Lindzey, Editor. 1954, Addison-wesley publishing company Inc: Cambridge.
352. Carbonell, D.M., H.Z. Reinherz, and W.R. Beardsle, *Adaptation and Coping in Childhood and Adolescence for those at Risk for Depression in Emerging Adulthood.* Child and Adolescent Social Work Journal, 2005. **22**(5-6).
353. Meel, B.L., *Incidence of suicide among teenagers and young adults in Transkei, South Africa.* African Journal of Primary Health Care & Family Medicine, 2009. **1**(1): p. 71-75.
354. Meel, B.L., *Determinants of suicide in the Transkei sub-region of South Africa.* Journal of Clinical Forensic Medicine, 2003. **10**(2): p. 71-76.
355. Campbell, R., T. Sefl, and C.E. Ahrens, *The impact of rape on women's sexual health risk behaviours.* Health Psychology, 2004. **23**: p. 67-74.
356. Alexander, J.G., et al., *Parallel reactions in rape victims and rape researchers.* Violence and Victims, 1989. **4**: p. 57-62.
357. Babbie, E., *The basics of social research.* Fourth Edition ed. 2008, Belmont: United States of America: Thompson Wadsworth Publishers.
358. Nduna, M., *Distress and dating in Butterworth, the Eastern Cape, South Africa*, in *A Tapestry of human sexuality in Africa*, O. Obono, Editor. 2010, Fanele, an imprint of Jacana Media (PTY) Ltd: South Africa. p. 87-104.
359. UN, Global Coalition on Women and AIDS, and UNAIDS, *Facing the Future Together: Report of the Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa* 2004, UNAIDS: Sunninghill, Johhanesburg.
360. Ralph, N., K. Hamaguchi, and M. Cox, *Transgenerational Trauma, Suicide and Healing from Sexual Abuse in the Kimberley Region, Australia.* Pimatisiwin: A Journal of Indigenous and Aboriginal Community Health 2006. **4**(2): p. 117-136.
361. Van Zyl, A., *Social service delivery under GEAR.* New Agenda: South African Journal of Social and Economic Policy, 2003. **12**: p. 12-15.
362. Department of Social Development. *List of Services offered to the public*. [cited 2010 27/03/2010]; Available from: http://www.dsd.gov.za/index.php?option=com_content&task=view&id=91&Itemid=130.
363. South African Social Secuity Agency, *You and Your Grants 2009/10: Types of grants and their qualifying requirements*, D.o.S. Development, Editor. 2009: Pretoria.

364. Wall, S.W. (2008) *Can we do without prisons?* The Wiser review: Crime and Punishment **3**.
365. Moore, H.L., *Feminism and Anthropology*. 1988, Minneapolis: University of Minnesota Press.
366. Nduna, M. and R. Jewkes, *Silence: A strategy to deal with psychological distress among young people in the Eastern Cape, South Africa.* Vulnerable Child and Youth Studies, 2011. **6**(4): p. 360-372.
367. Peltzer, K., *Tobacco use trends among adolescents and adults in South Africa.* Journal of Psychology in Africa, 2008. **18**(2): p. 339-346.
368. Panday, S., et al., *Determinants of smoking among adolescents in the Southern Cape-Karoo region, South Africa.* Health Promotion International, 2007. **22**(3): p. 207-217.
369. Brook, J., et al., *Predictors of cigarette use among South African adolescents.* International Journal of Behavioral Medicine, 2005. **12**(4): p. 207-217.
370. Parry, C.D.H., et al., *Trends in adolescent alcohol and other drug use: findings from three sentinel sites in South Africa (1997-2001).* Journal of Adolescence, 2004. **27**(4): p. 429-440.
371. Amoateng, A.Y., I. Kalule-Sabiti, and P. Narayanan, *Substance use and sexual behaviour among African adolescents in the North West province of South Africa.* African Journal of Drug and Alcohol Studies, 2007. **6**(1): p. 27-38.
372. Peltzer, K., *Early sexual debut and associated factors among in-school adolescents in eight African countries.* Acta Pædiatrica, 2010. **99**(8): p. 1242-1247.
373. Freeman, M. and N. Nkomo, *Assistance needed for the integration of orphaned and vulnerable children - views of South African family and community members.* Journal of the Social Aspects of HIV/AIDS: SAHARA, 2006. **3**(3): p. 503-509.
374. Arnett, J.J. and G.H. Brody, *A Fraught Passage: The Identity Challenges of African American Emerging Adults.* Human Development, 2008. **51**(5-6): p. 291-293.
375. Taylor, S.E., et al., *Culture and social support: Who seeks it and why.* Journal of Personality and Social Psychology, 2004. **87**(3): p. 354-362.
376. World Health Organisation, *Women`s mental health - an evidence based review*. 2000, Department of Mental health and Substance Dependence, WHO: Geneva, Switzerland.
377. SAIRR, *South African families: Demographics*. 2010, South African Institute of Race Relations: Johannesburg.
378. Madhavan, S., N.W. Townsend, and A.I. Garey, *'Absent breadwinners': Father-child connections and paternal support in rural South Africa.* Journal of Southern African Studies, 2008. **34**(3): p. 647-663.
379. Nduna, M. and R. Jewkes, *Undisclosed paternal identity in narratives of distress among young people in the Eastern Cape, South Africa.* Journal of Child and Family Studies, 2011. **20**(3): p. 303.
380. Department of Health, Medical Research Council, and Measure DHS+, *South African Demographic and Health Survey - 1998.*, D.o. Health, Editor. 2002, Department of Health: Pretoria.

381. Department of Health, Medical Research Council, and OrcMacro, *South African Demographic and Health Survey 2003 (SADHS)* D.o. Health, Editor. 2007: Pretoria: South Africa. p. 11-42.
382. Townsend, N.W., S. Madhavan, and A.I. Garey, *Father presence in rural South Africa: Incorporating social connection and life course experience*, in *2005 Meeting of the American Sociological Association*. 2005, August: Marriott Hotel, Loews Philadelphia Hotel, Philadelphia, PA.
383. Mkhize, N., *African traditions and the social, economic and moral dimensions of fatherhood*, in *Baba: Men and Fatherhood in South Africa*, L. Richter and R. Morrell, Editors. 2006, HSRC Press: Cape Town, South Africa. p. 183-198.
384. Krestan, J.-A. and C. Bepko, *Codependency: The social reconstruction of female experience.* Smith College Studies in Social Work, 1990. **60**(3): p. 216-232.
385. Hanson, T.L., et al., *Trends in Child Support Outcomes.* Demography, 1996. **33**(4): p. 483-496.
386. Nduna, M., et al., *Prevalence and Characteristics of Unresolved Paternal Identity in Families of a South African Community.* Journal Of Psychology In Africa, 2011. **21**(4): p. 589-594.
387. Ramphele, M. and L. Richter, *Migrancy, family dissolution and fatherhood*, in *Baba: Men and Fatherhood in South Africa*, L. Richter and R. Morrell, Editors. 2006, HSRC Publication: Cape Town. p. 73-81.
388. Commission for Gender Equality, *Virginity testing*, C.f.G. Equality, Editor. 2008 South African Government Information.
389. *Constitution of the Republic of South Africa, 1996*. 1996, Parliament: Cape Town.
390. Whitton, S.W. and M.A. Whisman, *Relationship satisfaction instability and depression.* Journal of Family Psychology, 2010. **24**(6): p. 791-794.
391. Nduna, M. and R.K. Jewkes, *Denied and disputed pregnancies in the lives of young women from the Eastern Cape Province, South Africa*. unpublished data, Department of Psychology, University of the Witwatersrand: Johannesburg.
392. Pendragon, D.K., *Coping Behaviors among Sexual Minority Female Youth.* Journal of Lesbian Studies, 2010. **14**(1): p. 5-15.
393. Bedard, K.K. and A.K. Marks, *Current Psychological Perspectives on Adolescent Lesbian Identity Development.* Journal of Lesbian Studies 2010. **14**(1): p. 16-25.
394. Peltzer, K. and S. Pengpid, *Sexual abuse, violence and HIV risk among adolescents in South Africa.* Gender and Behaviour, 2008. **6**(1): p. 1462-1278.
395. Swart, L.-A., et al., *Violence in adolescents' romantic relationships: findings from a survey amongst school-going youth in a South African community.* Journal of Adolescence, 2002. **25**(4): p. 385-395.
396. Lalor, K. and R. McElvaney, *Child Sexual Abuse, Links to Later Sexual Exploitation/High-Risk Sexual Behavior, and Prevention/Treatment Programs.* Trauma, Violence, & Abuse, 2010. **11**(4): p. 159-177.
397. Jones, D.J., et al., *Trajectories of childhood sexual abuse and early adolescent HIV/AIDS risk behaviours: The role of other maltreatment, witnessed violence , and child gender.* Journal of Clinical Child and Adolescent Psychology, 2010. **39**(5): p. 667-680.
398. Romeo, R.D., *Adolescence: A central event in shaping stress reactivity.* Developmental Psychobiology, 2010. **52**(3): p. 244-253.

399. Samara, S., *Something-for-something love: the motivations of young women in Uganda.* Journal of Health Organisation and Management, 2010. **24**(5): p. 512-9.
400. Reddy, V., *Identity, Law, Justice: Thinking about sexual rights and citizenship in post-apartheid South Africa*, in *Perspectives. Political Analysis and Commentary from Africa. Struggle for equality: Sexual orientation, gender identity and human rights in Africa*, A.K. Nord and J. Luckscheiter, Editors. 2010, Heinrich Böll Stiftung. p. 18-23
401. Sanger, N., *Women's rights and lesbian rights: Feminist principles, identities, and heteronormativity in the South African women's movement*, in *Perspectives. Political Analysis and Commentary from Africa. Struggle for equality: Sexual orientation, gender identity and human rights in Africa*, A.K. Nord and J. Luckscheiter, Editors. 2010, Heinrich Böll Stiftung. p. 24-28.
402. Hames, M., *The Women's Movement and Lesbian and Gay Struggles in South Africa.* Feminist Africa, 2003(2).
403. Ndashe, S., *The battle for the recognition of LGBTI rights as human rights*, in *Perspectives. Political Analysis and Commentary from Africa: Struggle for equality: Sexual orientation, gender identity and human rights in Africa*, A.K. Nord and J. Luckscheiter, Editors. 2010, Heinrich Böll Stiftung.
404. Robertson, B., *Challenges for child and adolescent mental health service development in sub-Saharan Africa.* Journal of Child & Adolescent Mental Health, 2004. **16**(2): p. 3 - 4.
405. Ensink, K., et al., *Post-traumatic stress disorder in children exposed to violence.* South African Medical Journal (SAMJ), 1997. **87**(11): p. 1526 - 1530.
406. National Department of Health, *The policy guidelines for Child and Adolescent Mental Health*. 2008: Pretoria.
407. Sareen, J., et al., *Perceived Barriers to Mental Health Service Utilization in the United States, Ontario, and the Netherlands.* Psychiatr Serv, 2007. **58**(3): p. 357-364.
408. Mojtabai, R., et al., *Barriers to mental health treatment: results from the National Comorbidity Survey Replication.* Psychological Medicine, 2010. **FirstView Article**
409. Venkataramani, A.S., et al., *Social grants, welfare, and the incentive to trade-off health for income among individuals on HAART in South Africa.* AIDS and Behaviour, 2010. **14**: p. 1393-1400.

APPENDICES

Appendix 1.1: Women's questionnaire

THE STEPPING STONES STUDY

(ENGLISH)

WOMEN'S QUESTIONNAIRE

BASELINE

COVER

Study ID number: _____

Field Edit _____ (initial) **Study ID Checked: _____ (initial)**



STEPPING STONES STUDY

WOMEN'S (ENGLISH) QUESTIONNAIRE

Study identification number	**[ ] [ ] [ ] [ ]**
Visit Number	**[1]**
Interviewer name	**1 = Sanele 6= Yandisa 11=** **2 = Bongwekazi 7= Nkululeko 12=** **3 = Nwabisa 8= Sandisiwe 13=** **4=Nelisiwe 9= 14=** **5 = Mthokozisi 10= 15=**
Date of interview	

	__ __ / __ __ / 200 __ **D D M M Y**
Interview Site	Specify:
Cluster number:	[ ] [ ]
Start Time of Interview	_____h_____

Data Entry:

First Entry: __ __ / __ __ / 200 __ **D D M M Y** _____ **Initials**

Second Entry: __ __ / __ __ / 200__ **D D M M Y** _____ **Initials**

Notes and Queries:

SECTION ONE: BACKGROUND

The first questions I want to ask you are about yourself, your home and your childhood. Please try and relax, there are no right or wrong answers. Remember that everything you tell me will be kept secret. If there is a question you do not want to answer please tell me and we will skip to the next question.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

101	What is your date of birth?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y	
102	What is the highest standard or grade you have completed at school?	SUBA/GRADE 1 ……..……1 SUB B/GRADE 2……...2 STD 1/GRADE 3……3 STD 2/GRADE 4……4 STD 3/GRADE 5……5 STD 4/GRADE 6……6 STD 5/GRADE 7……..…7 STD 6/GRADE 8……..…8 STD 7/GRADE 9……..…9 STD 8/GRADE 10……10 STD 9/GRADE 11……11 STD 10/GRADE 12……12 INCOMPLETE FURTHER DEGREE OR QUALIFICATION……..…..13 COMPLETED FURTHER DEGREE OR QUALIFICATION……..…14 NO SCHOOL……15	
103	Are you currently studying?	YES.....1 NO.....0	
104	Apart from your involvement in this project, are you a member of any clubs or groups or societies?	YES.....1 NO……0	→106
105	How many other clubs or groups or societies are you a member of?	[ ] [ ] number	
106	**Would you describe yourself as active in your church?**	YES……1 NO ……0	
107	Have you done anything to earn money in the last 12 months?	YES ……1 NO……..……0	→109

108	Have you ever done anything to earn money?	YES ……1 NO……..…….0	
109	Have you read a newspaper or magazine in the last week?	YES.....1 NO.....0	
110	Do you listen to the radio at least once a week?	YES.....1 NO.....0	
111	Do you watch TV at least once a week?	YES.....1 NO.....0	
112	Does your home have a television?	YES.....1 NO.....0	
113	Does your home have a radio?	YES.....1 NO……0	
114	Does your home have a car?	YES.....1 NO……0	
115	Would you say that the people in your home often, sometimes, seldom or never go without food?	OFTEN……..……..…..……1 SOMETIMES……2 SELDOM……..……..……..3 NEVER……..……..….4	
116	Would you say that people in your home often, sometimes, seldom or never have a day when they do not eat meat?	OFTEN HAS NO MEAT……..…..……1 SOMETIMES……2 SELDOM……..……..……..3 ALWAYS HAS MEAT……..……..….4 VEGETARIAN…….5	
117	If a person became ill in your home and R100 was needed for treatment or medicines, would you say it would be very easy, easy, quite difficult or very difficult to find the money?	VERY DIFFICULT……..……..…..……1 QUITE DIFFICULT……2 EASY……..……..3 VERY EASY……..……..….4	
118	How many people, including all the children, live in your home?	[ ] [ ] NUMBER	

119	Have either your mother or father died?	NEITHER.....1 FATHER…….2 MOTHER……3 BOTH…..……4	→124 →122
120	Which year did your mother die?	[ ] [ ] [ ] [ ] YEAR	
121	What did she die of? _____ (cause) IF WITCHCRAFT MENTIONED, PROBE IF PERSON WENT TO HOSPITAL AND WHAT THE DOCTOR SAID AND RECORD THIS	HIV/AIDS……..…1 TB……2 CANCER (BREAST /WOMB)……...……3 OTHER CANCER…….4 DIARRHOEA……5 PNEUMONIA……6 ASTHMA……7 HEART PROBLEMS/ HIGH BLOOD PRESSURE/STROKE……8 DIABETES……9 OTHER ILLNESS……10 SUICIDE……11 ACCIDENT, POISON OR OTHER INJURY……12 KILLED BY PERSON OTHER THAN BOYFRIEND/HUSBAND.....13 KILLED BY BOYFRIEND/HUSBAND……14	IF ONLY MUM IS DEAD →124
122	Which year did your father die?	[ ] [ ] [ ] [ ] YEAR	

123	What did he die of? _____ (cause) IF WITCHCRAFT MENTIONED, PROBE IF PERSON WENT TO HOSPITAL AND WHAT THE DOCTOR SAID AND RECORD THIS	HIV/AIDS……..…1 TB……2 CANCER (PROSTATE)……..……...……3 OTHER CANCER…….4 DIARRHOEA…….5 PNEUMONIA…….6 ASTHMA……..7 HEART PROBLEMS/ HIGH BLOOD PRESSURE/STROKE…….……8 DIABETES……9 OTHER ILLNESS……10 SUICIDE……11 ACCIDENT, POISON OR OTHER INJURY……12 KILLED BY A PERSON.....13	
124	What level of schooling did your mother complete?	NO SCHOOLING.....1 PRIMARY SCHOOL INCOMPLETE……2 PRIMARY SCHOOL COMPLETE (STD4)……3 HIGH SCHOOL INCOMPLETE……4 HIGH SCHOOL COMPLETE…..……5 POST SCHOOL QUALIFICATION……6 DON'T KNOW……..7	

CHILDHOOD EXPERIENCES (FROM BIRTH TO 18 YEARS)

I want to ask you some questions about your childhood and teenage years. Can you tell me how often the following things happened to you? I will read out some statements and I want to know if each one was never true, sometimes true, often true or very often true.

		Never 1	Sometimes 2	Often 3	Very Often	

					4	
125	I was told I was beautiful or good by someone in my family	1	2	3	4	
126	I was punished at home by being beaten	1	2	3	4	
127	I did not have enough to eat	1	2	3	4	
128	I lived in different households at different times	1	2	3	4	
129	I saw or heard by mother beaten by her husband or boyfriend	1	2	3	4	
130	I was not washed	1	2	3	4	
131	I was told I was lazy or stupid or ugly by someone in my family	1	2	3	4	
132	I was punished at home by being beaten every day or every week	1	2	3	4	
133	I lived with my biological mother	1	2	3	4	
134	Someone touched my thighs, buttocks, breasts or genitals when I did not want him to or made me touch his private parts when I did not want to	1	2	3	4	
135	My clothes were very dirty	1	2	3	4	
136	I was insulted or humiliated by someone in my family in front of other people	1	2	3	4	
137	I was beaten at home with a belt or stick or whip or something else which was hard	1	2	3	4	
138	I lived with my biological father	1	2	3	4	

139	I was never warm enough	1	2	3	4	
140	I had sex with a man who was more than 5 years older than me	1	2	3	4	
141	One or both of my parents were too drunk to take care of me	1	2	3	4	
142	I was encouraged to make something of my life by someone in my family	1	2	3	4	
143	I was beaten so hard at home that it left a mark or bruise	1	2	3	4	
144	I had a very long way to walk to school each day	1	2	3	4	
145	People in my family felt close to each other	1	2	3	4	
146	I spent time outside the home and none of the adults at home knew where I was	1	2	3	4	
147	I had sex with someone who was not my boyfriend because I was threatened or frightened or forced	1	2	3	4	
148	I was forced to have sex against my will by a boyfriend	1	2	3	4	

SECTION TWO: KNOWLEDGE OF REPRODUCTIVE HEALTH AND HIV AND ATTITUDES TOWARDS HIV, CONDOM USE AND GENDER RELATIONS

I would like to ask you a few questions about reproductive health and HIV. I am going to read out some statements and for each I would like to know if it is true, probably true, probably false or false.

		True 1	Probably true 2	Probably false 3	False 4	

201	The most common cause of infertility is a sexually transmitted disease	1	2	3	4	
202	A woman who is not using contraception and has sex during her period will probably get pregnant	1	2	3	4	
203	A woman can become sterile if she uses NurIsterate	1	2	3	4	
204	If a woman does not menstruate the dirt will build up in her body and make her ill	1	2	3	4	
205	Abortion is allowed by law up to 5 months of pregnancy	1	2	3	4	
206	If a person has a STD there will always be a sign	1	2	3	4	
207	A woman who takes contraceptive pills after she discovers she is pregnant will have an abortion	1	2	3	4	
208	A man who has sex with a menstruating woman will get ill	1	2	3	4	
209	Most women get pregnant right in the middle of their menstrual cycle	1	2	3	4	
210	If a woman has not got pregnant within 4 months after she stops contraception the couple are probably sterile	1	2	3	4	
211	A condom does not benefit the health of a person who already has HIV	1	2	3	4	
212	There are several ways a person can get i-drop (gonorrhoea)	1	2	3	4	
I am going to read out some statements about protection against HIV/AIDS. For each statement please tell me whether it is true, probably true, probably false or false: **People can protect themselves from HIV by:**						
213	Not mixing with people who look like they have HIV or do have HIV	True 1	Probably True 2	Probably False 3	False 4	

214	choosing their partners well	1	2	3	4	
215	using a condom until you trust or are comfortable with a partner	1	2	3	4	
216	choosing partners who look plump and healthy	1	2	3	4	
217	always using a condom	1	2	3	4	
218	not sharing razor blades or toothbrushes	1	2	3	4	
219	not eating food cooked by someone who looks as if they may have HIV or is known to have HIV	1	2	3	4	
220	wearing plastic gloves or bags on your hands when they help someone who is bleeding	1	2	3	4	
221	not dating someone who has been sick recently	1	2	3	4	
	Are the following statements true, probably true, probably false or false?					
222	I know someone personally who has HIV or died of AIDS	1	2	3	4	
223	I have had sex with someone who had a girlfriend who had HIV or died of AIDS	1	2	3	4	
224	I have had sex with someone who has HIV or AIDS	1	2	3	4	

IDEAS ABOUT CONDOM USE

Now I would like to ask you some questions about using condoms can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

225	Using a condom for sex would be embarrassing	SA 1	A 2	D 3	SD 4	

226	If I was going to have sex, I would not use a condom because I want it 'flesh to flesh'	1	2	3	4	
227	I know how to use a condom	1	2	3	4	
228	If you have been using condoms but miss them one or two times there is no point using them any more with that partner	1	2	3	4	
229	A condom may come off in a woman's vagina but it is impossible to lose one there	1	2	3	4	
230	If a man and woman trust each other they do not need to use a condom	1	2	3	4	
231	If a person wants to use a condom you know they probably have HIV	1	2	3	4	
232	If my partner suggested we used a condom I would think he was having sex with other people	1	2	3	4	
233	If I asked my partner to use a condom, he would think I am having sex with other people.	1	2	3	4	
234	I could definitely ask my current boyfriend to use a condom	1	2	3	4	
THE RESPONDENT AND HER PEERS Now I would like to read out some statements, can you tell me if you strongly agree, agree, disagree or strongly disagree:						
235	I am left out if I do not have a boyfriend because all my friends have one	SA 1	A 2	D 3	SD 4	
236	I have to have sex because all my friends are doing it	1	2	3	4	

237	I am under pressure to have a Khwapheni because all my friends do	1	2	3	4	
238	I am under pressure to get something from my boyfriend for my friends	1	2	3	4	
239	Would you say that the people in your Stepping Stones group are already mostly good friends of yours, or that some are good friends or that it is a few or none of them?	NONE……..1 A FEW…….2 SOME…….3 MOST……..4				

The Stepping Stones interventions are designed to change some of the ways we live our lives. It is very useful for us to know whether you have already thought about things you might want to change in yours. I am going to read out a list of some aspects of our lives and for each I would like to know whether you have thought of doing them, whether you have decided you want to do them, whether you have actually done it recently or whether it's not a problem for you. Please remember there are no right or wrong answers here.

		Not a problem 1	Thought About it 2	Wants to change 3	Recent change 4	
240	Stop drinking alcohol before it gets me into trouble	1	2	3	4	
241	Always carry a condom	1	2	3	4	
242	Always use a condom	1	2	3	4	
243	Speak out about how you feel when your girlfriend upsets you	1	2	3	4	
244	Always use a condom with casual partners	1	2	3	4	
245	Reduce the number of people you have sex with	1	2	3	4	

246	Learning to understand that others are different from me	1	2	3	4	

IF I HAD HIV

I am now going to ask you some questions about what you would do if you discovered you had HIV. I am not going to ask you whether or not you have HIV. That is a private matter for you but most of us sometimes think about what we would do if we discovered we had HIV, this is what I want to ask you about. I will read out some statements and I would like to know if you would do the following. Please say if the answer is definitely ye, probably yes, probably no or definitely no.

		Definitely Yes 1	Probably Yes 2	Probably No 3	No 4	
247	I would keep it secret from main partner	1	2	3	4	
248	I would tell all my recent sexual partners	1	2	3	4	
249	I would keep it secret from my family	1	2	3	4	
250	I would feel my life was over	1	2	3	4	
251	I would spread it to as many people as I could	1	2	3	4	
252	I would try to kill myself	1	2	3	4	
253	I would be frightened of the illnesses that I may get with AIDS	1	2	3	4	
254	I would always use condoms to protect other people	1	2	3	4	
255	I would educate others to help them protect themselves	1	2	3	4	

256	I would be open about my status to help others know HIV is real	1	2	3	4	
258	Have you ever had an HIV test apart from the ones for this study?	YES ……1 NO……...……0				→260
259	Did you collect your result?	YES ……1 NO……...……0				

IDEAS ABOUT GENDER RELATIONS

Now I would like to ask your opinion on some statements on relations between men and women, can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

260	A woman should listen to her husband	SA 1	A 2	D 3	SD 4	
261	A woman has to teach her man to respect her	1	2	3	4	
262	A woman should chose her own friends even if her boyfriend or husband disapproves	1	2	3	4	
263	Men should share the work around the home such as doing the dishes or cleaning or cooking	1	2	3	4	
264	Sometimes a man may have good reason to hit his girlfriend	1	2	3	4	
265	A woman can refuse to have sex with her husband if she does not want it for any reason	1	2	3	4	
266	If a wife does something wrong she should expect her husband to punish her	1	2	3	4	
267	A woman has to know how to look after herself as she cannot rely on her man to care for her	1	2	3	4	
268	A man cannot control himself when he gets sexually aroused	1	2	3	4	

269	A woman should expect to be taught how to behave by her boyfriend	1	2	3	4	
270	A woman should not expect the fathers of her children to give her money	1	2	3	4	
271	If a woman drinks alcohol and wears miniskirts she is asking for trouble	1	2	3	4	

SECTION THREE: PREGNANCY AND CHILDREN

The next sets of questions are about different aspects of your health and any children you may have.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301	Which year did you first see your period?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y WRITE 06 IF MONTH NOT KNOWN	
302	Have you ever had sex?	YES.....1 NO…….0	→401
303	When did you first have sexual intercourse?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
304	Which of the following statements most closely describes your experiences the first time you had sexual intercourse? I was willing; I was persuaded; I was tricked; I was forced; I was raped.	I was willing…….1 I was persuaded……2 I was tricked ……3 I was forced …….4 I was raped ……5	

305	Who was this with?	BOYFRIEND……..1 FATHER OR FAMILY MEMBER……2 TEACHER…….3 BOY FROM SCHOOL/AREA……4 MAN FROM AREA…….5 STRANGER/UNKNOWN PERSON…….6 FRIEND OF THE FAMILY……..7 OTHER……8	
306	Have you ever used a condom?	YES.....1 NO…….0	→308
307	Can you remember the month and year when you first had sex with a condom?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
308	Are you currently doing something or using any method to delay or avoid getting pregnant?	YES..... 1 NO..... 0	→310
309	Which method are you using?	INJECTION……..1 PILL…….2 CONDOM……3 IUD……4 HERB/OTHER TRADITIONAL METHOD…….5 CONDOM & PILL/INJECTION…..…….6 OTHER_____ 7 (specify)	→311 →311 →311 →311 →311 →311 →311
310	Have you ever used contraception?	YES..... 1 NO..... 0	→312
311	When did you first use contraceptives from the clinic?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
312	Have you ever been pregnant?	YES.....1 NO……..0	→316

313	Which year did you first become pregnant?	15 06 [ ] [ ] [ ] [ ] YEAR	
314	At the time you became pregnant did you want to become pregnant then, did you want to wait until later, or did you not want to have any children at all?	THEN……..1 LATER……2 NOT WANT ANY CHILDREN…….3	
315	How many children have you given birth to?	CHILDREN [ ] If none, enter 0	
316	Are you pregnant now?	YES..... 1 NO..... 2 DO NOT KNOW 3	 →319 →319
317	How many months pregnant are you?	Months [ ]	
318	At the time you became pregnant did you want to become pregnant then, did you want to wait until later, or did you not want to have any children at all?	THEN……..1 LATER……2 NOT WANT ANY CHILDREN…….3	
319	Now I have some questions about the future. Would you like to have a child (or another child) or would you prefer not to have any (or any more) children?	HAVE CHILD IN FUTURE ……..1 NO MORE/NONE……2 CANNOT GET PREGNANT……..…3 UNDECIDED/DON'T KNOW……..4	 →401 →401 →401
320	How long would you like to wait from now before the birth of your (next) child?	WITHIN TWO YEARS……..……. 1 TWO TO FIVE YEARS …… 2 MORE THAN FIVE YEARS……..3 UNTIL MARRIED……..4 OTHER_____ 5 (specified)	

SECTION FOUR: MALE PARTNER

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Do you currently have a boyfriend or are you married or living with a man or do you not have one now?	MARRIED ..... 1 LIVING WITH MAN..... 2 BOYFRIEND..... 3 NO BOYFRIEND..... 4	→ chk5 → chk5 → chk5
402	Have you ever had a boyfriend?	YES.....1 NO.....0	→ CHK3
403	When did your most recent relationship start?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
404	When did your most recent relationship end?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	→ CHK4
CHK3	IF SHE HAS NEVER HAD A BOYFRIEND SKIP TO QUESTION 556 (SEXUAL ABUSE BY A NON-PARTNER)		
CHK4	IF RELATIONSHIP ENDED MORE THAN 12 MONTHS AGO SKIP TO Q. 516 (EMOTIONAL ABUSE)		
CHK5	**I'd now like to ask you some questions about your current boyfriend and your relationship with him. If you have more than one I would like us to talk about the main one. It will help us talk about him if you can tell me his name or initials or a name we can use to talk about him even if it is one we make up for this purpose.** IF A PERSON DOES NOT HAVE A CURRENT 5-60 THEN ASK ABOUT THE MOST RECENT 5-60 – IF THERE HAS NEVER BEEN A 5-60 THEN ASK IF THEY CAN TALK ABOUT A RECENT CASUAL PARTNER.		

405	Is _____ also involved in this study?	NO……...0 YES.....1 DON'T KNOW……...2	
406	Which year was _____ born in?	30 06 [ ] [ ] [ ] [ ] Y Y Y Y DON'T KNOW	→408 →407
407	How old is he?	Years: [ ] [ ]	
408	Did _____ ever attend school?	NO……...0 YES.....1 DON'T KNOW……...2	→411 →411
409	What is the highest level of education that _____achieved?	SUBA/GRADE 1 ……..……1 SUB B/GRADE 2……...2 STD 1/GRADE 3……3 STD 2/GRADE 4……4 STD 3/GRADE 5……5 STD 4/GRADE 6……6 STD 5/GRADE 7…….……..…7 STD 6/GRADE 8…….……..…8 STD 7/GRADE 9……..……..…9 STD 8/GRADE 10……..……10 STD 9/GRADE 11……..……11 STD 10/GRADE 12…….……12 INCOMPLETE DEGREE /QUALIFICATION...13 COMPLETED DEGREE / QUALIFICATION...14 DON'T KNOW……15	
410	**Is _____ currently studying?**	YES.....1 NO.....0	

411	**Does _____ currently do anything to earn money?**	YES.....1 NO.....0	
412	**Does _____ drink alcohol? How often?**	EVERY DAY/NEARLY EVERY DAY...1 ONLY AT WEEKENDS.....2 A FEW TIMES IN A MONTH .....3 LESS THAN ONCE A MONTH.....4 NEVER .....5 DON'T KNOW……...6	→ 414 → 414
413	**Have you ever quarrelled or had any other conflict over his drinking?**	YES……1 NO …….0	
414	**Does _____ smoke dagga or take other drugs? How often?**	EVERY DAY/NEARLY EVERY DAY...1 ONLY AT WEEKENDS.....2 A FEW TIMES IN A MONTH .....3 LESS THAN ONCE A MONTH.....4 NEVER .....5 DON'T KNOW……...9	
415	**Do you and _____ ever discuss together you using contraception?**	YES……1 NO …….0	
416	**Do you and _____ ever discuss together methods to protect each other from HIV?**	YES……1 NO …….0	
417	**Do you and _____ ever discuss sex together?**	YES……1 NO …….0	
418	**Do you and _____ ever discuss having children together?**	YES……1 NO …….0	

419	In what month and year did your relationship with _____ start?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y DON'T KNOW MONTH = 06	
420	Have you had sex with _____?	YES……1 NO …….0	→422
421	In what month and year did you first have sex with _____?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y DON'T KNOW MONTH = 06	
422	How likely do you think it is that_____ is having sex with someone else? Would you say he definitely is, probably is, probably is not or definitely is not?	DEFINITELY IS ……1 PROBABLY IS……..…….2 PROBABLY NOT ……3 DEFINITELY NOT……...…….4	
423	Is _____ your 5-60/ main partner?	YES……1 NO …….0	
424	Are you his 5-60/ main partner?	NO……...0 YES ..... 1 DON'T KNOW……...2	
425	Is _____ or has he ever been a gang member?	YES……1 NO …….0	
426	**Does _____have a preference for girl or boy children?**	BOY……1 GIRL…….2 NO PREFERENCE…….. …….3 DON'T KNOW……..4	
427	**Would you describe _____ as active in his church?**	NO……...0 YES ..... 1 DON'T KNOW……...2	

RELATIONSHIP CONTROL

I **would now like to read out some statements and I would like you to think about your relationship with _____and for each statement to tell me if you strongly agree, agree, disagree or strongly disagree**

428	_____ is quite comfortable when I greet men I know	SA 1	A 2	D 3	SD 4
429	_____expects me to be at home when he comes to check me	1	2	3	4
430	_____becomes jealous when I wear things that make me look too beautiful	1	2	3	4
431	_____ has more to say than I do about important decisions that affect us.	1	2	3	4
432	_____ never tells me who I can spend time with.	1	2	3	4
433	I could leave our relationship any time I wanted to.	1	2	3	4
434	_____does what he wants, even if I don't want him to?	1	2	3	4
435	When _____ and I disagree, he gets his way most of the time.	1	2	3	4
436	_____always wants to know where I am.	1	2	3	4
437	_____ expects me to do everything for him	1	2	3	4
438	Because _____ buys me things he expects me to please him.	1	2	3	4
439	_____ lets me know that I am not his only girlfriend	1	2	3	4
440	_____ expects me to sleep over whenever he chooses	1	2	3	4

SECTION 5: RELATIONSHIPS AND VIOLENCEError! Bookmark not defined.

The next questions are also about your relationship with _____. We all have good and bad times in our relationships, these questions ask about some of these.

SOME OF THE QUESTIONS ASK ABOUT "ANY" PARTNER AND THESE ARE REFERRING TO ALL OF THE PARTNERS THE PERSON HAS HAD IN THEIR WHOLE LIFE.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	In your relationship with _____ how often would you say that you have quarrelled? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …… 2 SOMETIMES …… 3 OFTEN …… 4	
501a	Do you talk to a friend or relative about problems in your relationship?	YES……1 NO ……0	
502	Would you say your relationship with _____ is it excellent, i-right, nje/just or ayiko right?	EXCELLENT……1 IRIGHT……2 NJE/JUST……..…….3 AYEKO RIGHT…….4	
503	How often do you argue about money? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …… 2 SOMETIMES ……..…… 3 OFTEN …… 4	

504	Do you argue because you suspect that he is having an affair? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …….. 2 SOMETIMES …….. 3 OFTEN …… 4	
505	Do you argue because he thinks you are having an affair? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …….. 2 SOMETIMES…….. 3 OFTEN …… 4	
506	Do you argue because you want him to spend more time with you? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …….. 2 SOMETIMES …….. 3 OFTEN …… 4	
507	Do you argue because he thinks you try to control him? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …….. 2 SOMETIMES …….. 3 OFTEN …… 4	
	I want to read out some statements. Can you tell me if you strongly agree, agree, disagree, or strongly disagree with them?		
508	When I disagree with _____ I usually keep silent	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
509	When I disagree with _____ I try to talk the problem through with him	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	

510	When I disagree with _____ we usually end up shouting	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
511	When I disagree with _____I try to say what I feel	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
512	I feel free to discuss my hopes, fears and future plans with _____	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
513	I would feel free to tell _____ if I had HIV	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
514	I would feel free to tell _____ if I had an STD	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
515	I would feel free to tell _____ if I discovered I was pregnant	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
	EMOTIONAL ABUSE **In any relationship there are good times and bad times. I now want to ask you about some of the bad times we have in relationships and what has happened. Remember there are no right or wrong answers and anything you say will be kept confidential.**		

516	In the past 12 months did _____ or any other boyfriend insult you or make you feel bad about yourself? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
517	In the past 12 months _____ or any other boyfriend belittle or humiliate you in front of other people? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
518	In the past 12 months did _____ or any other boyfriend do things to scare or intimidate you on purpose for example by the way he looked at you, by yelling and smashing things? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
519	In the past 12 months did_____ or any other boyfriend threaten o hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
520	In the past 12 months were you stopped by _____ or any other boyfriend from seeing any of your friends? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
CHK6	IF ANY EMOTIONAL ABUSE IS REPORTED GO TO THE NEXT QUESTION. IF NOT SKIP TO Q. 522		
521	Was _____ one of the boyfriends who did these things to you?	YES……1 NO……..0	
	PHYSICAL ABUSE Men are often fighting with their girlfriends and often these fights get physical. I am going to ask some questions about this because we want to learn more about what women experience in their lives. I want you to speak freely and remember that everything you say will be confidential.		

522	In the past 12 months, did _____ or any other boyfriend slap you or throw something at you which could hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
523	In the past 12 months, did _____ or any other boyfriend push or shove you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
524	In the past 12 months, did _____ or any other boyfriend hit you with a fist or with something else which could hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
525	In the past 12 months, did _____ or any other boyfriend kick, drag, beat, choke or burn you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
526	In the past 12 months, did _____ or any other boyfriend threaten to use or actually use a gun, knife or other weapon against you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
CHK7	IF ANY PHYSICAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q.530		
527	When was the most recent time you had an argument with a boyfriend that got physical?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
528	In the past 12 months on how many occasions in did you have an argument with any boyfriend that got physical?	[ ] [ ] NUMBER	
529	In the past 12 months did you have an argument with _____ that got physical?	YES……1 NO……..0	

SEXUAL ABUSE			
530	In the past 12 months did _____ or any other boyfriend physically force you to have sex when you did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
531	In the past 12 months did you have sex with _____ or any other boyfriend when you did not want to because you were afraid of what he might do? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
532	In the past 12 months did _____ or any other boyfriend force you to have oral sex with him? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
533	In the past 12 months did _____ or any other boyfriend force you to have anal sex with him? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
CHK 8	IF ANY SEXUAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 536		
534	When was the most recent time you were made to have sex with a boyfriend when you did not want it?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
535	In the past 12 months were you made to have sex with _____ when you did not want it?	YES……1 NO……..0	

	BEFORE THE PAST TWELVE MONTHS **The next questions ask about things which happened in your relationships before the last 12 months, both with _____ if you were with him then and any other boyfriend you have ever had.**		
536	Before the past 12 months did _____ or any other boyfriend insult you or make you feel bad about yourself? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
537	Before the past 12 months _____ or any other boyfriend belittle or humiliate you in front of other people? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
538	Before the past 12 months did _____ or any other boyfriend do things to scare or intimidate you on purpose for example by the way he looked at you, by yelling and smashing things? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
539	Before the past 12 months did_____ or any other boyfriend threaten o hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
540	Before the past 12 months were you stopped by _____ or any other boyfriend from seeing any of your friends? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
CHK9	DID SHE REPORT ANY EMOTIONAL ABUSE BEFORE THE PAST YEAR? IF NOT GO TO Q. 542		
541	Was _____ one of the boyfriends who did these things to you?	YES……1 NO……..0	

542	Before the past 12 months, did _____ or any other boyfriend slap you or throw something at you which could hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
543	Before the past 12 months, did _____ or any other boyfriend push or shove you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
544	Before the past 12 months, did _____ or any other boyfriend hit you with a fist or with something else which could hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
545	Before the past 12 months, did _____ or any other boyfriend kick, drag, beat, choke or burn you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
546	Before the past 12 months, did _____ or any other boyfriend threaten to use or actually use a gun, knife or other weapon against you? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
CHK 10	IF ANY PHYSICAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 550		
547	When was the first time you had an argument with a boyfriend that got physical?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
548	Before the past 12 months did you have an argument with _____ that got physical?	YES……1 NO……..0	

549	Before the past 12 months on how many occasions in did you have an argument with any boyfriend that got physical?	[ ] [ ] NUMBER	
550	Before the past 12 months did _____ or any other boyfriend physically force you to have sex when you did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
551	Before the past 12 months did you have sex with _____ or any other boyfriend when you did not want to because you were afraid of what he might do? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
552	Before the past 12 months did _____ or any other boyfriend force you to have oral sex with him? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
553	Before the past 12 months did _____ or any other boyfriend force you to have anal sex with him? Did this happen many times, a few times, once or did it not happen?	NEVER ..... 1 ONCE ..... 2 FEW ..... 3 MANY 4	
CHK 11	IF ANY SEXUAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q.556		
554	When was the first time you were made to have sex with a boyfriend when you did not want it?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
555	Before the past 12 months were you made to have sex with _____ when you did not want it?	YES……1 NO……..0	

ALL WOMEN, EVEN THOSE WHO

HAVE NEVER HAD A BOYFRIEND, SHOULD BE ASKED THE FOLLOWING QUESTIONS

SEXUAL VIOLENCE PERPETRATED BY A PERSON OTHER THAN A BOYFRIEND

IF INTERVIEWEES HERE MENTION BEING FORCED TO HAVE SEX BY A BOYFRIEND, CHECK THAT THIS WAS REPORTED IN RESPONSE TO QUESTIONS 530 & 531 OR 550 &551. IF SHE DID NOT MENTION IT THEN, GO BACK TO QUESTIONS 530 & 531 AND 550 & 551 AND ASK THE QUESTIONS AGAIN AND RECORD THE RESPONSES.

THEN ASK QUESTION 556 AGAIN AND PROBE BY SAYING "DID ANYONE WHO OTHER THEN YOUR BOYFRIEND DO THIS TO YOU"

556	**Was there a time when you were forced or persuaded to have sex against you will with a man who has not your boyfriend?**	**YES ..... 1** **NO 0**	**→ 562**
557	When was the first time this happened?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	

558	Can you tell me who did this the first time?	FATHER OR FAMILY MEMBER……1 TEACHER…….2 BOY FROM NEIGHBOURHOOD……..3 MAN FROM NEIGHBOURHOOD……..4 STRANGER/UNKNOWN PERSON…….5 FRIEND OF THE FAMILY……..6 EX-BOYFRIEND……...7 OTHER……..8 Specify:	
559	How many times has this happened?	[ ] [ ] Number of times	IF 1 → 562
560	When was the most recent time this happened?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
561	Can you tell me who did this the last time?	FATHER OR FAMILY MEMBER……1 TEACHER…….2 BOY FROM NEIGHBOURHOOD……..3 MAN FROM NEIGHBOURHOOD……..4 STRANGER/UNKNOWN PERSON…….5 FRIEND OF THE FAMILY……..6 EX-BOYFRIEND……...7 OTHER……..8 Specify:	
562	**Was there a time when a man who was not a boyfriend tried to make you have sex when you did not want to, but did not succeed in doing this?**	**YES ..... 1** **NO 0**	**→ 568**

563	When was the first time this happened?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
564	Can you tell me who did this the first time?	FATHER OR FAMILY MEMBER……1 TEACHER……2 BOY FROM NEIGHBOURHOOD……..3 MAN FROM NEIGHBOURHOOD……..4 STRANGER/UNKNOWN PERSON…….5 FRIEND OF THE FAMILY……..6 EX-BOYFRIEND……...7 OTHER……..8 Specify:	
565	How many times did this happen to you?	[ ] [ ] Number of times	IF 1 → 568
566	When was the most recent time this happened?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
567	Can you tell me who did this the last time?	FATHER OR FAMILY MEMBER……1 TEACHER……2 BOY FROM NEIGHBOURHOOD……..3 MAN FROM NEIGHBOURHOOD……..4 STRANGER/UNKNOWN PERSON…….5 FRIEND OF THE FAMILY……..6 EX-BOYFRIEND……...7 OTHER……..8 Specify:	

568	**Was there an occasion when more than one man forced your to have sex?**	**YES……1** **NO ……0**	
569	**Have you ever experienced streamlining?**	**YES……1** **NO ……0**	
570	**How many men who were not your boyfriend have forced you to have sex with them?**	**[ ] [ ]** **WRITE 0 0 IF NONE**	
1.	IF THE WOMAN HAS NEVER HAD SEX SKIP TO SECTION 7 – MENTAL HEALTH		

SECTION 6: SEXUAL BEHAVIOUR

The next questions are about your sexual relationships. I know that these questions can be embarrassing. Please remember that everything you say will be kept secret and your name will not appear anywhere on the questionnaire. We are asking over 1000 women the same questions, and we know that women have a wide range of experiences. Some start having sex in their early teens; some start a bit later. Most of us have more than one partner.

601	When was the last time you had sex?	[ ] [ ]DAYS (IF LESS THAN 14 DAYS) [ ] WEEKS (IF 2-8 WEEKS) [ ] [ ] MONTHS (IF OVER 8 WEEKS)	
602	The last time you had sex did you use a condom?	YES ..... 1 NO……..0	→ 606

603	Did you use a condom for every round?	YES ..... 1 NO…….0	
604	Who brought the condom, was it you or your partner?	SELF..... 1 PARTNER……..2 BOTH……..3	
605	Did you experience: a) condom breaking b) condom slipped off c) condom only put on half way d) condom was removed	a) CONDOM BROKE ..... ……..YES =1 NO=0 b) SLIPPED OFF ……..…YES=1 NO=0 c) ONLY PUT IT ON HALF WAY…….....YES =1 NO=0 d) CONDOM REMOVED WHEN LOVE MAKING CONTINUED…..YES =1 NO=0	
	We know that people have different types of affairs. We have our 5-60s or main partners, our Khwapheni and sometimes we have sex with a person who we never see again or never have sex with again, let's call these one-off partners		
606	The last time you had sex was it with a 5-60, Khwapheni or one off partner or ex-partner?	MAIN PARTNER……..1 KWAPENI…….. 2 ONE OFF…….3 EX-PARTNER……..4	→ 607
CHK 13	CHECK Q. 420 HAS SHE HAD SEX WITH HER 5-60? YES → 607 NO→ 611		
607	Have you used condoms with your 5-60 in the past year? Would you say you used them always, often or sometimes?	NO USE ..... 1 ALWAYS ..... 2 OFTEN..... 3 SOMETIMES…….4	 → 611 → 611 → 611

608	Have you ever suggested to your 5-60 that you use a condom to protect you from HIV?	YES ..... 1 NO 0	→ 610
609	How did he respond? RECORD ALL MENTIONED	AGREE TO USE ONE…… YES =1 NO=0 BECAME ANGRY ……..YES =1 NO=0 SAID HE DID NOT LIKE THEM… YES =1 NO=0 HE WAS OFFENDED…… YES =1 NO=0 OTHER……YES =1 NO=0 SPECIFY_____	ALL TO → 611
610	What is the main reason why you have not suggested condom use? RECORD ALL MENTIONED	NEVER THOUGHT OF ASKING….YES =1 NO=0 TRUST EACH OTHER … ……..YES =1 NO=0 DOES NOT KNOW HOW TO ASK…YES =1 NO=0 FEAR HE WOULD LEAVE……. YES =1 NO=0 SHE DOES NOT LIKE THEM……. YES =1 NO=0 TRYING TO GET PREGNANT…… YES =1 NO=0 OTHER…… YES =1 NO=0 SPECIFY_____	
611	Where can you get condoms in this area? RECORD ALL MENTIONED	CLINIC…… YES =1 NO=0 SHOP…… YES =1 NO=0 SHEBEEN…… YES =1 NO=0 SCHOOL……..…… YES =1 NO=0 CHIEF/COUNSELOR…… YES =1 NO=0 OTHER……. YES =1 NO=0	
612	Would you say that getting a condom in this area is very easy, easy, quite difficult or very difficult?	VERY EASY……..1 EASY……2 QUITE DIFFICULT……..…3 VERY DIFFICULT……4	

613	How many 5-60s have you had sex with in the last year?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
614	How many Khwapheni have had sex with during the past year?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
615	How many men have you had sex with just once during the past year?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
CHK 14	ANY KWAPHENI OR ONE OFF PARTNERS MENTIONED? IF YES go to Q. 616 OTHERWISE go to CHK 15		
616	Over the last year have you used condoms with Khwapheni and one off partners? Would you say you used them always, often or sometimes?	NO USE ..... 1 ALWAYS ..... 2 OFTEN..... 3 SOMETIMES 4	 → 621 → 621 → 621
617	Have you ever suggested to Khwapheni or one off partner that you use a condom to protect you from HIV?	YES ..... 1 NO 0	 → 620
618	How many times have you suggested condom use to Khwapheni or one off partners?	[ ] [ ] NUMBER	
619	What responses did you get?	AGREE TO USE ONE…… YES =1 NO=0 BECAME ANGRY ……..YES =1 NO=0 SAID HE DID NOT LIKE THEM… YES =1 NO=0 HE WAS OFFENDED…… YES =1 NO=0 OTHER……YES =1 NO=0 SPECIFY_____	ALL TO → CHK15

620	What is the main reason why you have not suggested condom use?	NEVER THOUGHT OF ASKING….YES =1 NO=0 TRUST EACH OTHER … ……..YES =1 NO=0 DOES NOT KNOW HOW TO ASK…YES =1 NO=0 FEAR HE WOULD LEAVE……. YES =1 NO=0 SHE DOES NOT LIKE THEM……. YES =1 NO=0 TRYING TO GET PREGNANT…… YES =1 NO=0 OTHER…… YES =1 NO=0 SPECIFY_____	
CHK 15	CHECK QUESTIONS 607 AND 616 HAS HE USED CONDOMS IN THE PAST YEAR? YES GO TO 621 NO GO TO 622		
621	Over the last year how often have you experienced the condom breaking or slipping off or only put it on half way through or have you taken it off and continued love making?	EVERY TIME USED ..... 1 OFTEN..... 2 SOMETIMES ..... 3 NEVER……4 NO USE……..5	
	I would like to ask you about the number of sexual partners you have had in your whole life including this year. I want to know about the number of different partners.		
622	How many 5-60s have you had sex with in your life?	[ ] [ ] NUMBER ENTER 00 IF NONE	
623	How many Khwapheni have you had sex with in your life?	[ ] [ ] NUMBER ENTER 00 IF NONE	

624	How many people have you had sex with just once in your life?	[ ] [ ] NUMBER ENTER 00 IF NONE	
We as women often find ourselves in situations where we need someone to help us.			
625	Have you ever become involved with a 5-60 because he provided you with or you expected that he would provide you with: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to stay? Cash? Status? Cosmetics? Items for your children or family such as clothes, food, school fees?	FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES..... YES =1 NO=0 PLACE TO STAY..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 COSMETICS ..... YES =1 NO=0 CHILDREN/FAMILY ..... YES =1 NO=0 NEVER HAD SEX WITH 5-60 ☐	

626	Have you ever become involved with a Khwapheni because he provided you with or you expected that he would provide you with: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to stay? Cash? Status? Cosmetics? Items for your children or family such as clothes, food, school fees? Drink/Good time?	FOOD..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT..... YES =1 NO=0 SCHOOL FEES..... YES =1 NO=0 PLACE TO STAY..... YES =1 NO=0 CASH..... YES =1 NO=0 STATUS..... YES =1 NO=0 COSMETICS..... YES =1 NO=0 CHILDREN/FAMILY..... YES =1 NO=0 DRINK/ GOOD TIME..... YES =1 NO=0 NEVER HAD KWAPENI ☐	→ 628
627	Did you have sex with him?	YES……1 NO……0	

628	Now I would like you to think about men you have had sex with only once. Have you ever had sex with a such a man because he gave you or you expected that he would give you: Food? Clothes? A lift, a ticket, or money for transport? A place to sleep for the night? Cash? Status? Drink/Good time?	 FOOD..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 DRINK/ GOOD TIME..... YES =1 NO=0 NEVER HAD ONCE OFF PARTNER ☐	
CHK 16	CHECK QUESTIONS 625, 626 & 628 IF NO "YES" ANSWERS SKIP TO Q.650		
629	When was the last time you had sex with a man because he gave you or you expected that he would give you money or something else?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
SECTION: DRY SEX			
650	**In the last six months have you used anything to dry, clean or tighten your vagina before having sex? Have you done this every time, some times, just once or not at all?**	EVERY TIME……1 SOME TIMES……2 ONCE……3 NEVER……..4	 → 652
651	**What have you used?** **MARK ALL**	SOAP..... YES =1 NO=0 HERBS/SNUFF..... YES =1 NO=0 ICE/WATER..... YES =1 NO=0	

		OTHER ..... YES =1 NO=0 Specify_____	
652	**Before the last six months did you ever use anything to dry, clean or tighten your vagina before having sex? Have you done this every time, some times, just once or not at all?**	EVERY TIME……1 SOME TIMES……2 ONCE……3 NEVER……4	→ 701
653	**What have you used?** **MARK ALL**	SOAP..... YES =1 NO=0 HERBS/SNUFF..... YES =1 NO=0 ICE/WATER..... YES =1 NO=0 OTHER ..... YES =1 NO=0 Specify_____	

SECTION 7: MENTAL HEALTH STATUS QUESTION - CES-D Scale

Thank you very much for answering all these questions we are now getting towards the end of the questionnaire and I would like to ask you some questions about how you have been feeling in the past week. I am going to read out some statements and ask you to say how many days you have had particular feelings or ideas or whether you have not had them at all.

		Rarely or none of the time	Some or a little of the time (1-2 days)	Moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	
701	During the past week I was bothered by things that usually don't bother me	0	1	2	3	
702	During the past week I did not feel like eating, my appetite was poor	0	1	2	3	

703	During the past week I felt I could not cheer myself up even with the help of family and friends	0	1	2	3	
704	During the past week I felt I was just as good as other people	0	1	2	3	
705	During the past week I had trouble keeping my mind on what I was doing	0	1	2	3	
706	During the past week I felt depressed	0	1	2	3	
707	During the past week I felt that everything I did was an effort	0	1	2	3	
708	During the past week I felt hopeful about the future	0	1	2	3	
709	During the past week I thought my life had been a failure	0	1	2	3	
710	During the past week I felt fearful	0	1	2	3	
711	During the past week my sleep was restless	0	1	2	3	
712	During the past week I was happy	0	1	2	3	
713	During the past week I talked less than usual	0	1	2	3	
714	During the past week I felt lonely	0	1	2	3	
715	During the past week people were unfriendly	0	1	2	3	
716	During the past week I enjoyed life	0	1	2	3	
717	During the past week I had crying spells	0	1	2	3	
718	During the past week I felt sick	0	1	2	3	
719	During the past week I felt that people dislike me	0	1	2	3	
720	During the past week I could not get ‘going’	0	1	2	3	

721	During the past week I have been thinking too much	0	1	2	3	
722	During the past week my heart has been painful	0	1	2	3	
723	During the past week my spirit has been low	0	1	2	3	
724	Now I want to ask you a question about the past **four weeks**, Has the thought of ending your life been in your mind?	YES……1 NO…….……0				

	SECTION EIGHT: SUBSTANCE USE		
801	How often do you have a drink containing alcohol?	NEVER …….1 MONTHLY OR LESS……...2 2-4 TIMES A MONTH……3 2-3 TIMES A WEEK……4 4 + TIMES A WEEK……5	 → 804 → 804 → 804 → 804
802	Have you ever drunk alcohol?	YES……..1 NO……..0	 → 815
803	Have you drunk alcohol in the past 12 months?	YES……..1 NO……..0	→806 → 812
804	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 OR 2……1 3 OR 4……2 5 OR 6……3 7 OR 9……4 10 OR MORE……5	
805	How often do you have six or more drinks on one occasion?	NEVER ……1 LESS THAN MONTHLY …….2 MONTHLY…….…….3 WEEKLY……4 DAILY OR ALMOST DAILY……..….5	

806	How often in the past year did you find you were not able to stop drinking once you started?	NEVER ……..…..…1 LESS THAN MONTHLY ……....2 MONTHLY……...3 WEEKLY……..….4 DAILY OR ALMOST DAILY…….5	
807	How often during the past year did you find you need a drink in the morning to get you going after a heavy drinking session?	NEVER ……1 LESS THAN MONTHLY ……..….2 MONTHLY…….……3 WEEKLY……4 DAILY OR ALMOST DAILY…….5	
808	How often in the past year have you failed to do what was normally expected from you because of drinking?	NEVER ……1 LESS THAN MONTHLY ……2 MONTHLY……...3 WEEKLY……..……4 DAILY OR ALMOST DAILY…….5	
809	How often in the past year have you had a feeling of guilt or remorse after drinking?	NEVER ……1 LESS THAN MONTHLY ……...2 MONTHLY……..3 WEEKLY……...4 DAILY OR ALMOST DAILY…….5	
810	How often in the past year were you unable to remember what happened the night before because of your drinking?	NEVER ……1 LESS THAN MONTHLY ……2 MONTHLY…….……3 WEEKLY……4 DAILY OR ALMOST DAILY……..5	
811	How often in the past year did you have sex without a condom because of your drinking? Was it once, a few times or many times?	NEVER ……..……1 ONCE……..…….. ……2 FEW TIMES……..…….3 MANY TIMES……4	

812	Have you or someone else been injured as a result of your drinking?	NO……...1 YES, BUT NOT IN THE LAST YEAR…….2 YES, IN THE LAST YEAR ……..3	
813	Has a friend or relative or doctor or health worker been concerned about your drinking and suggested that you cut down?	NO……...1 YES, BUT NOT IN THE LAST YEAR…….2 YES, IN THE LAST YEAR ……..3	
814	Have you ever quarrelled with any of your male sexual partners about your drinking?	YES ……1 NO ……..0	
815	Have you ever used … Dagga? Benzene or petrol? Mandrax? Drugs that you inject? Any other drug?	 DAGGA ..... YES =1 NO=0 BENZENE……..YES=1 NO=0 MANDRAX..... YES =1 NO=0 INJECTED DRUG ..... YES =1 NO=0 OTHER DRUG..... YES =1 NO=0	
CHK 18	DID SHE REPORT HAVING HAD A BOYFRIEND? IF SO PROCEED TO Q. 816 OTHERWISE SKIP TO Q. 901		
	I would like you to think about the entire end you have had sex with in your life, including your current boyfriend(s).		
816	**Have you ever had conflict with any partner over his drinking or drug use?**	YES……1 NO ……..0	
817	**Have you had a boyfriend who has been in prison?**	YES……1 NO ……..0	
818	**Have you had a boyfriend who has been a taxi driver?**	YES……1 NO ……..0	
819	Have you had a boyfriend who has been in a gang?	YES……1 NO ……..0	

SECTION NINE: YOU AND YOUR COMMUNITY

The last set of questions I want to ask are about your community. Thank you very much for your time, we are nearly finished now. I am going to ask these questions and for each I would like to know whether the answer is definitely yes, probably yes, probably no or no.

901	Do neighbours in this area tend to know each other well?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO…….4	
902	In this area do most people generally trust each other in matters of lending and borrowing?	DEFINITELY YES…….1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4	
903	If there was a fistfight in this area would people do something to stop it?	DEFINITELY YES……..1 PROBABLY YES…….2 PROBABLY NO…….3 DEFINITELY NO……..4	
904	If you were away from home for some time and on coming back you found that your home was broken in to, would you think it likely that your neighbour would give you some help with food or blankets or clothes?	DEFINITELY YES…….1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4	
905	If you were going out on a trip and didn't have enough provision would you expect the other group members to share what they had with you?	DEFINITELY YES……1 PROBABLY YES…….2 PROBABLY NO……..3 DEFINITELY NO…….4	

FINISH

I would like to thank you very much for helping us. We have talked about some very difficult things today. I appreciate the time you have taken. I realise that these questions may have been difficult for you to answer, but it is only by hearing about women's lives that we can really begin to understand them. We really appreciate your openness with us. Most women have difficult times in their lives and it's good to share them and remember we did not bring them on ourselves. We really appreciate your participation in this study. By sharing this personal information with us and attending the Stepping Stones group you are helping us with our research and that will ultimately help many other people in the country.

End Time of Interview: _____ h _____

THE STEPPING STONES STUDY

(ENGLISH)

WOMEN'S QUESTIONNAIRE

12 MONTHS FOLLOW UP

COVER

Study ID number: _____

ID Number verification (please circle method used):

1 Photo ID Card

2 Comparison with photo on file

3 Verification by a respected older person

4 Verification by participant's friends

5 Other

Field Edit _____ (initial) **Study ID Checked: _____ (initial)**



STEPPING STONES STUDY

WOMEN'S (ENGLISH) QUESTIONNAIRE

Study identification number	**[ ] [ ] [ ] [ ]**
Visit Number	**[3]**
Interviewer name	**1 = Sanele 6= Yandisa 11= Andiswa 16=Philiswa** **2 = Bongwekazi 12= Nocawe 17=Mvuyo** **3 = Nwabisa 8= Sandisiwe 13= Ayanda 18=Khanyi** **4=Nelisiwe 9= Veliswa 14= Lizo 19=** **5 = Mthokozisi 10= Lungelo 15= Posti 20=**
Date of interview	**__ __ / __ __ / 200 __** **D D M M Y**
Interview Site	Specify:
Cluster number:	[ ] [ ]
Start Time of Interview	

	_____h_____

Data Entry:

First Entry: **__ __ / __ __ / 200 __ _____ Initials**

Second Entry: **__ __ / __ __ / 200__ _____ Initials**

D D M M Y **D D M M Y**

Notes and Queries:

SECTION ONE: BACKGROUND

Thank you very much for agreeing to participate again in the study. Most of the questions in this questionnaire are ones you have been asked previously. Please try and relax, and remember that there are no right or wrong answers. Remember that everything you tell me will be kept secret. Many of the questions will ask you about things which have happened since the first time we interviewed you for this study last year.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	What is your date of birth?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y	
103	Are you currently studying?	YES..... 1 NO 0	
104	Apart from your involvement in this project, are you a member of any clubs or groups or societies?	YES..... 1 NO……0	→106
105	How many other clubs or groups or societies are you a member of?	[ ] [ ] number	

106	**Would you describe yourself as active in your church?**	YES……1 NO ……0	
107	Have you done anything to earn money since your first interview for this study, apart from the R20 we gave you for the last interview?	YES ……1 NO……...……0	
107a	Are you a migrant scholar?	YES ……1 NO……...……0	
118a	How many places have you lived in for a month or more in the last 5 years?	[ ] [ ] number	
118b	In the last 5 years have you stayed in a town for a month or more?	Yes……1 No……0	
119	Since the first interview, have either your mother or father died?	NEITHER..... 1 FATHER……2 MOTHER……3 BOTH…..……4	→151 →123

121	What did she die of? _____ (cause) IF WITCHCRAFT MENTIONED, PROBE IF PERSON WENT TO HOSPITAL AND WHAT THE DOCTOR SAID AND RECORD THIS	HIV/AIDS……..…1 TB……2 CANCER (BREAST /WOMB)……..……3 OTHER CANCER……4 DIARRHOEA……5 PNEUMONIA……6 ASTHMA……7 HEART PROBLEMS/ HIGH BLOOD PRESSURE/STROKE……8 DIABETES……9 OTHER ILLNESS……10 SUICIDE……11 ACCIDENT, POISON OR OTHER INJURY……12 KILLED BY PERSON OTHER THAN BOYFRIEND/HUSBAND ..... .13 KILLED BY BOYFRIEND/HUSBAND……14	IF ONLY MUM IS DEAD →151
123	What did he die of? _____ (cause) IF WITCHCRAFT MENTIONED, PROBE IF PERSON WENT TO HOSPITAL AND WHAT THE DOCTOR SAID AND RECORD THIS	HIV/AIDS……..…1 TB……2 CANCER (PROSTATE)……..……...……3 OTHER CANCER……4 DIARRHOEA……5 PNEUMONIA……6 ASTHMA……7 HEART PROBLEMS/ HIGH BLOOD PRESSURE/STROKE…….……8 DIABETES……9 OTHER ILLNESS……10 SUICIDE……11 ACCIDENT, POISON OR OTHER INJURY……12 KILLED BY A PERSON..... .13	

	I would like to ask you about Stepping Stones sessions that you may have attended.		
151	Did you attend a session where condoms were handed out?	Yes……1 No……0	
152	Did you attend a session that was all about HIV?	Yes……1 No……0	
153	Did you attend a session which was all about woman abuse?	Yes……1 No……0	
154	Did you attend a session where you were shown different types of contraceptives?	Yes……1 No……0	
155	Did you attend a session which discussed how we communicate and whether we attack, avoid or manipulate?	Yes……1 No……0	
156	Did you attend a session that was all about cholera?	Yes……1 No……0	

SECTION TWO: KNOWLEDGE OF REPRODUCTIVE HEALTH AND HIV AND ATTITUDES TOWARDS HIV, CONDOM USE AND GENDER RELATIONS

I would like to ask you a few questions about reproductive health and HIV. I am going to read out some statements and for each I would like to know if it is true, probably true, probably false or false.

		True 1	Probably true 2	Probably false 3	False 4	
201	The most common cause of infertility is a sexually transmitted disease	1	2	3	4	
202	A woman who is not using contraception and has sex during her period will probably get pregnant	1	2	3	4	
203	A woman can become sterile if she uses NurIsterate	1	2	3	4	
204	If a woman does not menstruate the dirt will build up in her body and make her ill	1	2	3	4	
205	Abortion is allowed by law up to 5 months of pregnancy	1	2	3	4	

206	If a person has a STD there will always be a sign	1	2	3	4	
207	A woman who takes contraceptive pills after she discovers she is pregnant will have an abortion	1	2	3	4	
208	A man who has sex with a menstruating woman will get ill	1	2	3	4	
209	Most women get pregnant right in the middle of their menstrual cycle	1	2	3	4	
210	If a woman has not got pregnant within 4 months after she stops contraception the couple are probably sterile	1	2	3	4	
211	A condom does not benefit the health of a person who already has HIV	1	2	3	4	
212	There are several ways a person can get i-drop (gonorrhoea)	1	2	3	4	
I am going to read out some statements about protection against HIV/AIDS. For each statement please tell me whether it is true, probably true, probably false or false: **People can protect themselves from HIV by:**						
213	Not mixing with people who look like they have HIV or do have HIV	True 1	Probably True 2	Probably False 3	False 4	
214	choosing their partners well	1	2	3	4	
215	using a condom until you trust or are comfortable with a partner	1	2	3	4	
216	choosing partners who look plump and healthy	1	2	3	4	
217	always using a condom	1	2	3	4	
218	not sharing razor blades or toothbrushes	1	2	3	4	

219	not eating food cooked by someone who looks as if they may have HIV or is known to have HIV	1	2	3	4	
220	wearing plastic gloves or bags on your hands when they help someone who is bleeding	1	2	3	4	
221	not dating someone who has been sick recently	1	2	3	4	
	Are the following statements true, probably true, probably false or false?					
222	I know someone personally who has HIV or died of AIDS	1	2	3	4	
223	I have had sex with someone who had a girlfriend who had HIV or died of AIDS	1	2	3	4	
224	I have had sex with someone who has HIV or AIDS	1	2	3	4	

IDEAS ABOUT CONDOM USE

Now I would like to ask you some questions about using condoms can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

225	Using a condom for sex would be embarrassing	SA 1	A 2	D 3	SD 4	
226	If I was going to have sex, I would not use a condom because I want it 'flesh to flesh'	1	2	3	4	
227	I know how to use a condom	1	2	3	4	
228	If you have been using condoms but miss them one or two times there is no point using them any more with that partner	1	2	3	4	
229	A condom may come off in a woman's vagina but it is impossible to lose one there	1	2	3	4	

230	If a man and woman trust each other they do not need to use a condom	1	2	3	4	
231	If a person wants to use a condom you know they probably have HIV	1	2	3	4	
232	If my partner suggested we used a condom I would think he was having sex with other people	1	2	3	4	
233	If I asked my partner to use a condom, he would think I am having sex with other people.	1	2	3	4	
234	I could definitely ask my current boyfriend to use a condom	1	2	3	4	
THE RESPONDENT AND HER PEERS Now I would like to read out some statements, can you tell me if you strongly agree, agree, disagree or strongly disagree:						
235	I am left out if I do not have a boyfriend because all my friends have one	SA 1	A 2	D 3	SD 4	
236	I have to have sex because all my friends are doing it	1	2	3	4	
237	I am under pressure to have a Khwapheni because all my friends do	1	2	3	4	
238	I am under pressure to get something from my boyfriend for my friends	1	2	3	4	
I am going to read out a list of some aspects of our lives and for each I would like to know whether you have thought of doing them, whether you have decided you want to do them, whether you have actually done it recently or whether it's not a problem for you. Please remember there are no right or wrong answers here.						
		Not a problem 1	Thought About it 2	Wants to change 3	Recent change 4	
240	Stop drinking alcohol before it gets me into trouble	1	2	3	4	

241	Always carry a condom	1	2	3	4	
242	Always use a condom	1	2	3	4	
243	Speak out about how you feel when your girlfriend upsets you	1	2	3	4	
244	Always use a condom with casual partners	1	2	3	4	
245	Reduce the number of people you have sex with	1	2	3	4	
246	Learning to understand that others are different from me	1	2	3	4	

IF I HAD HIV

I am now going to ask you some questions about what you would do if you discovered you had HIV. I am not going to ask you whether or not you have HIV. That is a private matter for you but most of us sometimes think about what we would do if we discovered we had HIV, this is what I want to ask you about. I will read out some statements and I would like to know if you would do the following. Please say if the answer is definitely ye, probably yes, probably no or definitely no.

		Definitely Yes 1	Probably Yes 2	Probably No 3	No 4	
247	I would keep it secret from main partner	1	2	3	4	
248	I would tell all my recent sexual partners	1	2	3	4	
249	I would keep it secret from my family	1	2	3	4	
250	I would feel my life was over	1	2	3	4	

251	I would spread it to as many people as I could	1	2	3	4	
252	I would try to kill myself	1	2	3	4	
253	I would be frightened of the illnesses that I may get with AIDS	1	2	3	4	
254	I would always use condoms to protect other people	1	2	3	4	
255	I would educate others to help them protect themselves	1	2	3	4	
256	I would be open about my status to help others know HIV is real	1	2	3	4	
258	Have you ever had an HIV test apart from the ones for this study?	YES ……1 NO……...……0				→260
259	Did you collect your result?	YES ……1 NO……...……0				

IDEAS ABOUT GENDER RELATIONS

Now I would like to ask your opinion on some statements on relations between men and women, can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

260	A woman should listen to her husband	SA 1	A 2	D 3	SD 4	
261	A woman has to teach her man to respect her	1	2	3	4	
262	A woman should chose her own friends even if her boyfriend or husband disapproves	1	2	3	4	
263	Men should share the work around the home such as doing the dishes or cleaning or cooking	1	2	3	4	
264	Sometimes a man may have good reason to hit his girlfriend	1	2	3	4	

265	A woman can refuse to have sex with her husband if she does not want it for any reason	1	2	3	4	
266	If a wife does something wrong she should expect her husband to punish her	1	2	3	4	
267	A woman has to know how to look after herself as she cannot rely on her man to care for her	1	2	3	4	
268	A man cannot control himself when he gets sexually aroused	1	2	3	4	
269	A woman should expect to be taught how to behave by her boyfriend	1	2	3	4	
270	A woman should not expect the fathers of her children to give her money	1	2	3	4	
271	If a woman drinks alcohol and wears miniskirts she is asking for trouble	1	2	3	4	

SECTION THREE: PREGNANCY AND CHILDREN

The next set of questions is about different aspects of your health and any children you may have. I am particularly interested in what has happened since the first time you were interviewed for the study.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301a	**The first time you were interviewed had you seen your period?**	YES ..... 1 NO…….0	→302
301b	**Have you started menstruating since then?**	YES ..... 1 NO…….0	→302
301	When did you first see your period?	15 [ ] [ ] 200 [ ] M M Y	

302	**The first time you were interviewed had you had sex?**	YES ..... 1 NO…….0	→306
302a	**Have you had started having sex since then?**	YES ..... 1 NO…….0	→319
303	When did you first have sexual intercourse?	15 [ ] [ ] 200 [ ] M M Y	
304	Which of the following statements most closely describes your experiences the first time you had sexual intercourse? I was willing; I was persuaded; I was tricked; I was forced; I was raped.	I was willing.……1 I was persuaded……2 I was tricked ……3 I was forced ……4 I was raped ……5	
305	Who was this with?	BOYFRIEND……..1 FATHER OR FAMILY MEMBER……2 TEACHER…….3 BOY FROM SCHOOL/AREA……4 MAN FROM AREA……5 STRANGER/UNKNOWN PERSON…….6 FRIEND OF THE FAMILY……..7 OTHER……8	
306	**The first time you were interviewed, had you used a condom?**	YES ..... 1 NO…….0	→308
306a	**Have you used a condom since then?**	YES ..... 1 NO…….0	→308
307	Can you remember the month and year when you first had sex with a condom?	15 [ ] [ ] 200 [ ] M M Y	
308	**Are you currently doing something or using any method to delay or avoid getting pregnant?**	YES .....1 NO 0	→310

309	Which method are you using?	INJECTION……1 PILL……2 CONDOM……3 IUD……4 HERB/OTHER TRADITIONAL METHOD…….5 CONDOM & PILL/INJECTION…..…….6 OTHER_____ 7 (specify)	
310	The first time you were interviewed, had you used contraception?	YES .....1 NO 0	→312
310a	Have you used contraception since then?	YES .....1 NO 0	
312	**Since the first interview have you become pregnant?**	YES ..... 1 NO……..0	→319
313	When did you become pregnant?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
314	At the time you became pregnant did you want to become pregnant then, did you want to wait until later, or did you not want to have any children at all?	THEN……..1 LATER……2 NOT WANT ANY CHILDREN…….3	
315a	Did you give birth?	YES ..... 1 NO……..0	
316	Are you pregnant now?	YES .....1 NO .....2 DO NOT KNOW.....3	 →319 →319
317	How many months pregnant are you?	Months [ ]	

318	At the time you became pregnant did you want to become pregnant then, did you want to wait until later, or did you not want to have any children at all?	THEN……..1 LATER……2 NOT WANT ANY CHILDREN…….3	
319	Now I have some questions about the future. Would you like to have a child (or another child) or would you prefer not to have any (or any more) children?	HAVE CHILD IN FUTURE ……..1 NO MORE/NONE……2 CANNOT GET PREGNANT……..…3 UNDECIDED/DON'T KNOW……..4	 →321a →321a →321a
320	How long would you like to wait from now before the birth of your (next) child?	WITHIN TWO YEARS……..……. 1 TWO TO FIVE YEARS …… 2 MORE THAN FIVE YEARS……..3 UNTIL MARRIED……..4 OTHER_____ 5 (specified)	
321a	Have you ever had a blood transfusion?	YES ..... 1 NO 0	
321b	Since the first interview have you had an injection or had blood taken?	YES ..... 1 NO 0	
321c	Since the first interview have you been cut with a razor by a Sangoma?	YES ..... 1 NO 0	
321d	Since the first interview have you been involved in an accident or a fight when someone else's blood got on your wounds?	YES ..... 1 NO 0	
321e	Since the first interviews have you been told by the clinic you have a sexually transmitted disease?	YES ..... 1 NO 0	

SECTION FOUR: MALE PARTNER

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

401	Do you currently have a boyfriend or are you married or living with a man or do you not have one now?	MARRIED.....1 LIVING WITH MAN.....2 BOYFRIEND.....3 NO BOYFRIEND.....4	→ chk5 → chk5 → chk5
402	Have you ever had a boyfriend?	YES..... 1 NO..... 0	→ CHK3
403	When did your most recent relationship start?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
404	When did your most recent relationship end?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	→ CHK4
CHK3	IF SHE HAS NEVER HAD A BOYFRIEND SKIP TO QUESTION 556 (SEXUAL ABUSE BY A NON-PARTNER)		
CHK4	IF RELATIONSHIP ENDED MORE THAN 12 MONTHS AGO SKIP TO Q. 556 (SEXUAL ABUSE BY A NON-PARTNER)		
CHK5	**I'd now like to ask you some questions about your current boyfriend and your relationship with him. If you have more than one I would like us to talk about the main one. It will help us talk about him if you can tell me his name or initials or a name we can use to talk about him even if it is one we make up for this purpose.** IF A PERSON DOES NOT HAVE A CURRENT 5-60 THEN ASK ABOUT THE MOST RECENT 5-60 – IF THERE HAS NEVER BEEN A 5-60 THEN ASK IF THEY CAN TALK ABOUT A RECENT CASUAL PARTNER.		
405	Is _____ also involved in this study?	NO……..0 YES..... 1 DON'T KNOW……...2	
405a	Was _____your main partner when you were first interviewed?	NO……..0 YES..... 1 DON'T REMEMBER……..2	

406	Which year was _____ born in?	30 06 [ ] [ ] [ ] [ ] Y Y Y Y DON'T KNOW	→408 →407
407	How old is he?	Years: [ ] [ ]	
408	Did _____ ever attend school?	NO……...0 YES ..... 1 DON'T KNOW……...2	→411 →411
409	What is the highest level of education that _____achieved?	SUBA/GRADE 1 ……..……1 SUB B/GRADE 2……...2 STD 1/GRADE 3……3 STD 2/GRADE 4……4 STD 3/GRADE 5……5 STD 4/GRADE 6……6 STD 5/GRADE 7……..…7 STD 6/GRADE 8……..…8 STD 7/GRADE 9……..…9 STD 8/GRADE 10……10 STD 9/GRADE 11……11 STD 10/GRADE 12…….12 INCOMPLETE DEGREE /QUALIFICATION...13 COMPLETED DEGREE / QUALIFICATION...14 DON'T KNOW……15	
410	**Is _____ currently studying?**	YES ..... 1 NO 0	
411	**Does _____ currently do anything to earn money?**	YES ..... 1 NO 0	

412	**Does _____ drink alcohol? How often?**	EVERY DAY/NEARLY EVERY DAY .. 1 ONLY AT WEEKENDS ..... 2 A FEW TIMES IN A MONTH ..... 3 LESS THAN ONCE A MONTH ..... 4 NEVER ..... 5 DON'T KNOW……...6	 → 414 → 414
413	**Have you ever quarrelled or had any other conflict over his drinking?**	YES……1 NO ……0	
414	**Does _____ smoke dagga or take other drugs? How often?**	EVERY DAY/NEARLY EVERY DAY .. 1 ONLY AT WEEKENDS ..... 2 A FEW TIMES IN A MONTH ..... 3 LESS THAN ONCE A MONTH ..... 4 NEVER ..... 5 DON'T KNOW……...9	
415	**Do you and _____ ever discuss together you using contraception?**	YES……1 NO ……0	
416	**Do you and _____ ever discuss together methods to protect each other from HIV?**	YES……1 NO ……0	
417	**Do you and _____ ever discuss sex together?**	YES……1 NO ……0	
418	**Do you and _____ ever discuss having children together?**	YES……1 NO ……0	
419	In what month and year did your relationship with _____ start?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y DON'T KNOW MONTH = 06	

420	Have you had sex with _____?	YES……1 NO …….0	→422
421a	Do you ever have sex with him when you are menstruating?	YES……1 NO …….0	
422	How likely do you think it is that_____ is having sex with someone else? Would you say he definitely is, probably is, probably is not or definitely is not?	DEFINITELY IS ……1 PROBABLY IS……..…….2 PROBABLY NOT ……3 DEFINITELY NOT……...…….4	
423	Is _____ your 5-60/ main partner?	YES……1 NO …….0	
424	Are you his 5-60/ main partner?	NO……..0 YES.....1 DON'T KNOW……...2	
425	Is _____ or has he ever been a gang member?	YES……1 NO …….0	
426	**Does _____have a preference for girl or boy children?**	BOY……1 GIRL…….2 NO PREFERENCE…….. …….3 DON'T KNOW……..4	
427	**Would you describe _____ as active in his church?**	NO……..0 YES.....1 DON'T KNOW……...2	
427a	**Is _____a taxi driver?**	YES.....1 NO 0	
427c	Is _____a business man or professional?	YES.....1 NO 0	

RELATIONSHIP CONTROL

I **would now like to read out some statements and I would like you to think about your relationship with _____and for each statement to tell me if you strongly agree, agree, disagree or strongly disagree**

428	_____ is quite comfortable when I greet men I know	SA 1	A 2	D 3	SD 4
429	_____expects me to be at home when he comes to check me	1	2	3	4
430	_____becomes jealous when I wear things that make me look too beautiful	1	2	3	4
431	_____ has more to say than I do about important decisions that affect us.	1	2	3	4
432	_____ never tells me who I can spend time with.	1	2	3	4
433	I could leave our relationship any time I wanted to.	1	2	3	4
434	_____does what he wants, even if I don't want him to?	1	2	3	4
435	When _____ and I disagree, he gets his way most of the time.	1	2	3	4
436	_____always wants to know where I am.	1	2	3	4
437	_____ expects me to do everything for him	1	2	3	4
438	Because _____ buys me things he expects me to please him.	1	2	3	4
439	_____ lets me know that I am not his only girlfriend	1	2	3	4
440	_____ expects me to sleep over whenever he chooses	1	2	3	4

SECTION 5: RELATIONSHIPS AND VIOLENCE

The next questions are also about your relationship with _____. We all have good and bad times in our relationships, these questions ask about some of these.

SOME OF THE QUESTIONS ASK ABOUT "ANY" PARTNER AND THESE ARE REFERRING TO ALL OF THE PARTNERS THE PERSON HAS HAD IN THEIR WHOLE LIFE.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

501	In your relationship with _____ how often would you say that you have quarrelled? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …… 2 SOMETIMES …….. 3 OFTEN…… 4	
501a	Do you talk to a friend or relative about problems in your relationship?	YES……1 NO ……0	
502	Would you say your relationship with _____ is it excellent, i-right, nje/just or ayiko right?	EXCELLENT…….1 IRIGHT……2 NJE/JUST…….3 AYEKO RIGHT…….4	
503	How often do you argue about money? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …… 2 SOMETIMES …….. 3 OFTEN …… 4	
504	Do you argue because you suspect that he is having an affair? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …… 2 SOMETIMES …….. 3 OFTEN …… 4	
505	Do you argue because he thinks you are having an affair? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …… 2 SOMETIMES …….. 3 OFTEN …… 4	
506	Do you argue because you want him to spend more time with you? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY …… 2 SOMETIMES …….. 3 OFTEN …… 4	

507	Do you argue because he thinks you try to control him? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
	I want to read out some statements. Can you tell me if you strongly agree, agree, disagree, or strongly disagree with them?		
508	When I disagree with _____ I usually keep silent	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
509	When I disagree with _____ I try to talk the problem through with him	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
510	When I disagree with _____ we usually end up shouting	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
511	When I disagree with _____I try to say what I feel	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
512	I feel free to discuss my hopes, fears and future plans with _____	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
513	I would feel free to tell _____ if I had HIV	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	

514	I would feel free to tell _____ if I had an STD	STRONGLY AGREE……1 AGREE…….……2 DISAGREE……3 STRONGLY DISAGREE……...4	
515	I would feel free to tell _____ if I discovered I was pregnant	STRONGLY AGREE……1 AGREE…….……2 DISAGREE……3 STRONGLY DISAGREE……...4	
	EMOTIONAL ABUSE **In any relationship there are good times and bad times. I now want to ask you about some of the bad times we have in relationships and what has happened. Remember there are no right or wrong answers and anything you say will be kept confidential.**		
516	Since the first interview, did _____ or any other boyfriend insult you or make you feel bad about yourself? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
517	Since the first interview, did_____ or any other boyfriend belittle or humiliate you in front of other people? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
518	Since the first interview, did _____ or any other boyfriend do things to scare or intimidate you on purpose for example by the way he looked at you, by yelling and smashing things? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
519	Since the first interview, did_____ or any other boyfriend threaten o hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	

520	Since the first interview, were you stopped by _____ or any other boyfriend from seeing any of your friends? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
CHK6	IF ANY EMOTIONAL ABUSE IS REPORTED GO TO THE NEXT QUESTION. IF NOT SKIP TO Q. 522		
521	Was _____ one of the boyfriends who did these things to you?	YES……1 NO……..0	
	PHYSICAL ABUSE Men are often fighting with their girlfriends and often these fights get physical. I am going to ask some questions about this because we want to learn more about what women experience in their lives. I want you to speak freely and remember that everything you say will be confidential.		
522	Since the first interview, did _____ or any other boyfriend slap you or throw something at you which could hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
523	Since the first interview, did _____ or any other boyfriend push or shove you? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
524	Since the first interview, did _____ or any other boyfriend hit you with a fist or with something else which could hurt you? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
525	Since the first interview, did _____ or any other boyfriend kick, drag, beat, choke or burn you? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	

526	Since the first interview, did _____ or any other boyfriend threaten to use or actually use a gun, knife or other weapon against you? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
CHK7	IF ANY PHYSICAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q.530		
527	When was the most recent time you had an argument with a boyfriend that got physical?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
528	Since the first interview on how many occasions in did you have an argument with any boyfriend that got physical?	[ ] [ ] NUMBER	
529	Since the first interview, did you have an argument with _____ that got physical?	YES……1 NO……..0	
SEXUAL ABUSE			
530	Since the first interview, did _____ or any other boyfriend physically force you to have sex when you did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
531	Since the first interview, did you have sex with _____ or any other boyfriend when you did not want to because you were afraid of what he might do? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
532	Since the first interview, did _____ or any other boyfriend force you to have oral sex with him? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	

533	Since the first interview, did _____ or any other boyfriend force you to have anal sex with him? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE.....2 FEW.....3 MANY.....4	
CHK 8	IF ANY SEXUAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 556		
534	When was the most recent time you were made to have sex with a boyfriend when you did not want it?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
535	Since the first interview, were you made to have sex with _____ when you did not want it?	YES……1 NO……..0	
ALL WOMEN, EVEN THOSE WHO HAVE NEVER HAD A BOYFRIEND, SHOULD BE ASKED THE FOLLOWING QUESTIONS			
SEXUAL VIOLENCE PERPETRATED BY A PERSON OTHER THAN A BOYFRIEND IF INTERVIEWEES HERE MENTION BEING FORCED TO HAVE SEX BY A BOYFRIEND, CHECK THAT THIS WAS REPORTED IN RESPONSE TO QUESTIONS 530 & 531. IF SHE DID NOT MENTION IT THEN, GO BACK TO QUESTIONS 530 & 531 AND ASK THE QUESTIONS AGAIN AND RECORD THE RESPONSES. THEN ASK QUESTION 556 AGAIN AND PROBE BY SAYING "DID ANYONE WHO OTHER THEN YOUR BOYFRIEND DO THIS TO YOU"			
556	**Since the first interview, have you been forced or persuaded to have sex against you will with a man who was not your boyfriend?**	**YES .....1** **NO 0**	**→ 562**
559	How many times has this happened?	[ ] [ ] Number of times	

560	When was the most recent time this happened?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
561	Can you tell me who did this the last time?	FATHER OR FAMILY MEMBER……1 TEACHER……2 BOY FROM NEIGHBOURHOOD……..3 MAN FROM NEIGHBOURHOOD……..4 STRANGER/UNKNOWN PERSON…….5 FRIEND OF THE FAMILY……..6 EX-BOYFRIEND……...7 OTHER……..8 Specify:	
562	**Since the first interview, did a man who was not a boyfriend tried to make you have sex when you did not want to, but did not succeed in doing this?**	**YES .....1** **NO 0**	**→ 568**
565	How many times did this happen to you?	[ ] [ ] Number of times	
566	When was the most recent time this happened?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	

567	Can you tell me who did this the last time?	FATHER OR FAMILY MEMBER……1 TEACHER…….2 BOY FROM NEIGHBOURHOOD……..3 MAN FROM NEIGHBOURHOOD……..4 STRANGER/UNKNOWN PERSON…….5 FRIEND OF THE FAMILY……..6 EX-BOYFRIEND……...7 OTHER……..8 Specify:	
568	**Since the first interview, was there an occasion when more than one man forced your to have sex?**	**YES…….1** **NO ……0**	
569	**Since the first interview, have you ever experienced streamlining?**	**YES…….1** **NO ……0**	
570	**Since the first interview, how many men who were not your boyfriend have forced you to have sex with them?**	**[ ] [ ]** **WRITE 0 0 IF NONE**	
CHK 12	***IF THE WOMAN HAS NEVER HAD SEX SKIP TO SECTION 7 – MENTAL HEALTH***		

SECTION 6: SEXUAL BEHAVIOUR

The next questions are about your sexual relationships. I know that these questions can be embarrassing. Please remember that everything you say will be kept secret and your name will not appear anywhere on the questionnaire. We are asking over 1000 women the same questions, and we know that women have a wide range of experiences. Some start having sex in their early teens; some start a bit later. Most of us have more than one partner.

601	When was the last time you had sex?	[ ] [ ]DAYS (IF LESS THAN 14 DAYS) [ ] WEEKS (IF 2-8 WEEKS) [ ] [ ] MONTHS (IF OVER 8 WEEKS)	
602	The last time you had sex did you use a condom?	YES ..... 1 NO……..0	→ 606
603	Did you use a condom for every round?	YES ..... 1 NO……..0	
604	Who brought the condom, was it you or your partner?	SELF..... 1 PARTNER……..2 BOTH……..3	
605	Did you experience: e) condom breaking f) condom slipped off g) condom only put on half way h) condom was removed	a) CONDOM BROKE ..... ……..YES =1 NO=0 b) SLIPPED OFF ……..…YES=1 NO=0 c) ONLY PUT IT ON HALF WAY…….....YES =1 NO=0 d) CONDOM REMOVED WHEN LOVE MAKING CONTINUED…..YES =1 NO=0	
	We know that people have different types of affairs. We have our 5-60s or main partners, our Khwapheni and sometimes we have sex with a person who we never see again or never have sex with again, let's call these one-off partners		

606	The last time you had sex was it with a 5-60, Khwapheni or one off partner or ex-partner?	MAIN PARTNER……..1 KWAPENI……..2 ONE OFF…….3 EX-PARTNER……..4	→ 607
CHK13	CHECK Q. 420 HAS SHE HAD SEX WITH HER 5-60? YES → 607 NO→ 612		
607	Have you used condoms with your 5-60 since the first interview? Would you say you used them always, often or sometimes?	NO USE ..... 1 ALWAYS ..... 2 OFTEN..... 3 SOMETIMES…….4	 → 612 → 612 → 612
608	Have you suggested to your 5-60 that you use a condom to protect you from HIV since the first interview?	YES ..... 1 NO 0	 → 610
609	How did he respond? RECORD ALL MENTIONED	AGREE TO USE ONE…… YES =1 NO=0 BECAME ANGRY ……..YES =1 NO=0 SAID HE DID NOT LIKE THEM… YES =1 NO=0 HE WAS OFFENDED…… YES =1 NO=0 OTHER……YES =1 NO=0 SPECIFY_____	ALL TO → 612

610	What is the main reason why you have not suggested condom use? RECORD ALL MENTIONED	NEVER THOUGHT OF ASKING….YES =1 NO=0 TRUST EACH OTHER … ……..YES =1 NO=0 DOES NOT KNOW HOW TO ASK…YES =1 NO=0 FEAR HE WOULD LEAVE……. YES =1 NO=0 SHE DOES NOT LIKE THEM……. YES =1 NO=0 TRYING TO GET PREGNANT…… YES =1 NO=0 OTHER…… YES =1 NO=0 SPECIFY_____	
612	Would you say that getting a condom in this area is very easy, easy, quite difficult or very difficult?	VERY EASY……..1 EASY……2 QUITE DIFFICULT……..…3 VERY DIFFICULT…….4	
612a	Havre you been on holiday since the first interview?	YES ..... 1 NO 0	
612b	Did you have a sexual partner when you were on holiday?	YES ..... 1 NO 0	
613	How many 5-60s have you had sex with since the first interview?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
614	How many Khwapheni have had sex with since the first interview?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
615	How many men have you had sex with just once since the first interview?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
CHK 14	ANY KWAPHENI OR ONE OFF PARTNERS MENTIONED? IF YES go to Q. 616 OTHERWISE go to CHK 15		

616	Since the first interview have you used condoms with Khwapheni and one off partners? Would you say you used them always, often or sometimes?	NO USE ..... 1 ALWAYS ..... 2 OFTEN..... 3 SOMETIMES 4	 → 621 → 621 → 621
617	Have you suggested to Khwapheni or one off partner that you use a condom to protect you from HIV since the first interview?	YES ..... 1 NO 0	 → 620
618	How many times have you suggested condom use to Khwapheni or one off partners since the first interview?	[ ] [ ] NUMBER	
619	What responses did you get?	AGREE TO USE ONE…… YES =1 NO=0 BECAME ANGRY ……..YES =1 NO=0 SAID HE DID NOT LIKE THEM… YES =1 NO=0 HE WAS OFFENDED…… YES =1 NO=0 OTHER……YES =1 NO=0 SPECIFY_____	ALL TO → CHK15
620	What is the main reason why you have not suggested condom use?	NEVER THOUGHT OF ASKING….YES =1 NO=0 TRUST EACH OTHER … ……..YES =1 NO=0 DOES NOT KNOW HOW TO ASK…YES =1 NO=0 FEAR HE WOULD LEAVE……. YES =1 NO=0 SHE DOES NOT LIKE THEM……. YES =1 NO=0 TRYING TO GET PREGNANT…… YES =1 NO=0 OTHER…… YES =1 NO=0 SPECIFY_____	

CHK 15	CHECK QUESTIONS 607 AND 616 HAS HE USED CONDOMS IN THE PAST YEAR? YES GO TO 621 NO GO TO Q.100ai		
621	Since the first interview, how often have you experienced the condom breaking or slipping off or only put it on half way through or have you taken it off and continued love making?	EVERY TIME USED ..... 1 OFTEN..... 2 SOMETIMES ..... 3 NEVER……4 NO USE……..5	
	I would like to ask you some questions about the partners you have had since the first interview. NOTE IF THERE ARE 9 OR FEWER (INCLUDING THE CURRENT ONE) START WITH ANY CURRENT PARTNERS AND THEN WORK BACKWARDS. IF THERE ARE MORE THAN 9 TAKE THE MAIN PARTNERS AND THEN THE MOST RECENT ROLL-ONS AND ONLY TAKE ONE OFFS AFTERWARDS. WE DO NOT NEED THESE COMPLETED FOR MORE THAN 8 PARTNERS. COPY THE TOTAL NUMBER OF PARTNERS FROM THE PREVIOUS PAGE Q.613 + Q.614+Q.615) HERE _____. Who was there apart from your main partner?		
No.	Write the initials →	_____	
100a1	How old was this partner?	[ ][ ] years	

100b2	**When did you have sex for the first time?**	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c3	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d4	Did he live in the same village or place as you?	YES ..... 1 NO 0	
No.	Write the initials →	_____	
100a5	How old was this partner?	[ ][ ] years	
100b6	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c7	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d8	Did he live in the same village or place as you?	YES ..... 1 NO 0	

No.	Write the initials →	_____	
100a9	How old was this partner?	[ ][ ] years	
100b10	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c11	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d12	Did he live in the same village or place as you?	YES ..... 1 NO 0	
No.	Write the initials →	_____	
100a13	How old was this partner?	[ ][ ] years	
100b14	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c15	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	

100d16	Did he live in the same village or place as you?	YES ..... 1 NO 0	
No.	Write the initials →	_____	
100a17	How old was this partner?	[ ][ ] years	
100b18	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c19	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d20	Did he live in the same village or place as you?	YES ..... 1 NO 0	
No.	Write the initials →	_____	
100a21	How old was this partner?	[ ][ ] years	
100b22	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	

100c23	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d24	Did he live in the same village or place as you?	YES ..... 1 NO 0	
No.	Write the initials →	_____	
100a25	How old was this partner?	[ ][ ] years	
100b26	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c27	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d28	Did he live in the same village or place as you?	YES ..... 1 NO 0	
No.	Write the initials →	_____	
100a29	How old was this partner?	[ ][ ] years	

100b30	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c31	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d32	**Did he live in the same village or place as you?**	YES ..... 1 NO 0	
We as women often find ourselves in situations where we need someone to help us.			
625	Since the first interview, have you been involved with a 5-60 because he provided you with or you expected that he would provide you with: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to stay? Cash? Status? Cosmetics? Items for your children or family such as clothes, food, school fees?	FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES..... YES =1 NO=0 PLACE TO STAY..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 COSMETICS ..... YES =1 NO=0 CHILDREN/FAMILY ..... YES =1 NO=0 NEVER HAD SEX WITH 5-60 ☐	

626	Since the first interview, have you been involved with a Khwapheni because he provided you with or you expected that he would provide you with: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to stay? Cash? Status? Cosmetics? Items for your children or family such as clothes, food, school fees? Drink/Good time?	FOOD..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT..... YES =1 NO=0 SCHOOL FEES..... YES =1 NO=0 PLACE TO STAY..... YES =1 NO=0 CASH..... YES =1 NO=0 STATUS..... YES =1 NO=0 COSMETICS..... YES =1 NO=0 CHILDREN/FAMILY..... YES =1 NO=0 DRINK/ GOOD TIME..... YES =1 NO=0 NEVER HAD KWAPENI ☐	→ 628
627	Did you have sex with him?	YES……1 NO……0	

628	Now I would like you to think about men you have had sex with only once since the first interview. Have you had sex with a such a man because he gave you or you expected that he would give you: Food? Clothes? A lift, a ticket, or money for transport? A place to sleep for the night? Cash? Status? Drink/Good time?	 FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 DRINK/ GOOD TIME..... YES =1 NO=0 NEVER HAD ONCE OFF PARTNER ☐	
CHK16	CHECK QUESTIONS 625, 626 & 628 IF NO "YES" ANSWERS SKIP TO Q.650		
629	When was the last time you had sex with a man because he gave you or you expected that he would give you money or something else?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
630	In what month and year did you first have sex with a man because he gave you or you expected that he would give you money or something else?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
631	How many men have you ever had sex with because he gave you or you expected that he would give you money or something else?	[ ] [ ] NUMBER ENTER 00 IF NONE	
632	How old was the oldest one?	[ ] [ ] YEARS	
633	How old was the youngest one?	[ ] [ ] YEARS	

SECTION 7: MENTAL HEALTH STATUS QUESTION - CES-D Scale

Thank you very much for answering all these questions we are now getting towards the end of the questionnaire and I would like to ask you some questions about how you have been feeling in the past week. I am going to read out some statements and ask you to say how many days you have had particular feelings or ideas or whether you have not had them at all.

		Rarely or none of the time	Some or a little of the time (1-2 days)	Moderate amount of time (3-4 days)	Most or all of the time (5-7 days)	
701	During the past week I was bothered by things that usually don't bother me	0	1	2	3	
702	During the past week I did not feel like eating, my appetite was poor	0	1	2	3	
703	During the past week I felt I could not cheer myself up even with the help of family and friends	0	1	2	3	
704	During the past week I felt I was just as good as other people	0	1	2	3	
705	During the past week I had trouble keeping my mind on what I was doing	0	1	2	3	
706	During the past week I felt depressed	0	1	2	3	
707	During the past week I felt that everything I did was an effort	0	1	2	3	
708	During the past week I felt hopeful about the future	0	1	2	3	
709	During the past week I thought my life had been a failure	0	1	2	3	

710	During the past week I felt fearful	0	1	2	3	
711	During the past week my sleep was restless	0	1	2	3	
712	During the past week I was happy	0	1	2	3	
713	During the past week I talked less than usual	0	1	2	3	
714	During the past week I felt lonely	0	1	2	3	
715	During the past week people were unfriendly	0	1	2	3	
716	During the past week I enjoyed life	0	1	2	3	
717	During the past week I had crying spells	0	1	2	3	
718	During the past week I felt sick	0	1	2	3	
719	During the past week I felt that people dislike me	0	1	2	3	
720	During the past week I could not get 'going'	0	1	2	3	
724	Now I want to ask you a question about the past **four weeks**, Has the thought of ending your life been in your mind?	YES……1 NO…….……0				

	SECTION EIGHT: SUBSTANCE USE		
801	How often do you have a drink containing alcohol?	NEVER ……1 MONTHLY OR LESS……...2 2-4 TIMES A MONTH……3 2-3 TIMES A WEEK……4 4 + TIMES A WEEK……5	 → 804 → 804 → 804 → 804
802	Have you ever drunk alcohol?	YES……..1 NO……..0	 → 815
803	Have you drunk alcohol in the past 12 months?	YES……..1 NO……..0	→806 → 812

804	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 OR 2……1 3 OR 4……2 5 OR 6……3 7 OR 9……4 10 OR MORE……5	
805	How often do you have six or more drinks on one occasion?	NEVER ……1 LESS THAN MONTHLY …….2 MONTHLY…….…….3 WEEKLY…….4 DAILY OR ALMOST DAILY……..….5	
806	How often in the past year did you find you were not able to stop drinking once you started?	NEVER ……..…..…1 LESS THAN MONTHLY ……....2 MONTHLY……...3 WEEKLY……..….4 DAILY OR ALMOST DAILY…….5	
807	How often during the past year did you find you need a drink in the morning to get you going after a heavy drinking session?	NEVER ……1 LESS THAN MONTHLY ……..….2 MONTHLY…….……3 WEEKLY……4 DAILY OR ALMOST DAILY…….5	
808	How often in the past year have you failed to do what was normally expected from you because of drinking?	NEVER ……1 LESS THAN MONTHLY ……2 MONTHLY……...3 WEEKLY……..…….4 DAILY OR ALMOST DAILY…….5	
809	How often in the past year have you had a feeling of guilt or remorse after drinking?	NEVER ……1 LESS THAN MONTHLY ……...2 MONTHLY……..3 WEEKLY……..4 DAILY OR ALMOST DAILY…….5	

810	How often in the past year were you unable to remember what happened the night before because of your drinking?	NEVER ……1 LESS THAN MONTHLY ……2 MONTHLY…….……3 WEEKLY……4 DAILY OR ALMOST DAILY……..5	
811	How often in the past year did you have sex without a condom because of your drinking? Was it once, a few times or many times?	NEVER …….……1 ONCE…….…….. ……2 FEW TIMES……..……3 MANY TIMES…….4	
812	Have you or someone else been injured as a result of your drinking?	NO……...1 YES, BUT NOT IN THE LAST YEAR…….2 YES, IN THE LAST YEAR …….3	
813	Has a friend or relative or doctor or health worker been concerned about your drinking and suggested that you cut down?	NO……...1 YES, BUT NOT IN THE LAST YEAR…….2 YES, IN THE LAST YEAR …….3	
814	Since the first interview, have you quarrelled with any of your girlfriends about your drinking?	YES ……1 NO ……..0	
815	Have you ever used … Dagga? Benzene or petrol? Mandrax? Drugs that you inject? Any other drug?	DAGGA ..... YES =1 NO=0 BENZENE……..YES=1 NO=0 MANDRAX..... YES =1 NO=0 INJECTED DRUG ..... YES =1 NO=0 OTHER DRUG..... YES =1 NO=0	
CHK 18	DID SHE REPORT **EVER** HAVING HAD A BOYFRIEND? IF SO PROCEED TO Q. 816 OTHERWISE SKIP TO Q. 901		
	I would like you to think about all the men you have had sex with in your life, including your current boyfriend(s).		

816	**Since the first interview, have you had conflict with any partner over his drinking or drug use?**	YES……1 NO ……0	
817	**Since the first interview, have you had a boyfriend who has been in prison?**	YES……1 NO ……0	
818	**Since the first interview, have you had a boyfriend who has been a taxi driver?**	YES……1 NO ……0	
819	Since the first interview, have you had a boyfriend who has been in a gang?	YES……1 NO ……0	
820a	Since the first interview, have you ever had a boyfriend who was a business man or a professional?	YES……1 NO ……0	
820	Have you ever had a boyfriend who was a business man or a professional?	YES……1 NO ……0	

SECTION NINE: YOU AND YOUR COMMUNITY

The last set of questions I want to ask are about your community. Thank you very much for your time, we are nearly finished now. I am going to ask these questions and for each I would like to know whether the answer is definitely yes, probably yes, probably no or no.

901	Do neighbours in this area tend to know each other well?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……4	
902	In this area do most people generally trust each other in matters of lending and borrowing?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……..4	
903	If there was a fistfight in this area would people do	DEFINITELY YES……..1 PROBABLY YES……2	

	something to stop it?	PROBABLY NO…….3 DEFINITELY NO……..4	
904	If you were away from home for some time and on coming back you found that your home was broken in to, would you think it likely that your neighbour would give you some help with food or blankets or clothes?	DEFINITELY YES…….1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4	
905	If you were going out on a trip and didn't have enough provision would you expect the other group members to share what they had with you?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO…….4	
906	In this area, is it safe to walk around at night?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4	
907	In this area, do women fear being raped?	DEFINITELY YES…….1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4	
908	In this area do men fear being robbed?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4	
909	Would people in this area say there is a lot of crime?	DEFINITELY YES…….1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4	

FINISH

I would like to thank you very much for helping us. We have talked about some very difficult things today. I appreciate the time you have taken. I realise that these questions may have been difficult for you to answer, but it is only by hearing about women's lives that we can really begin to understand them. We really appreciate your openness with us. Most women have difficult times in their lives and it's good to share them and remember we did not bring them on ourselves. We really appreciate your participation in this study. By sharing this personal information with us you are helping us with our research and that will ultimately help many other people in the country.

End Time of Interview: _____ h _____

Appendix 1.2: Men's questionnaire

THE STEPPING STONES STUDY

(ENGLISH)

MEN'S QUESTIONNAIRE

BASELINE

COVER

Study ID number: _____

Field Edit _____ (initial) **Study ID Checked: _____ (initial)**

STEPPING STONES STUDY

MEN'S (ENGLISH) QUESTIONNAIRE

Study identification number	[ ] [ ] [ ] [ ]
Visit Number	[1]
Interviewer name	1 = Sanele 6= Yandisa 11= 2 = Bongwekazi 7= Nkululeko 12= 3 = Nwabisa 8= Sandisiwe 13= 4=Nelisiwe 9= 14= 5 = Mthokozisi 10= 15=
Date of interview	__ __ / __ __ / 200 __ D D M M Y
Interview Site	Specify:
Cluster number:	[ ] [ ]
Start Time of Interview	

	_____h_____

Data Entry:

First Entry: **__ __ / __ __ / 200 __** **_____** **Initials** **D D M M Y**

Second Entry: **__ __ / __ __ / 200__** **_____** **Initials** **D D M M Y**

Notes and Queries:

SECTION ONE: BACKGROUND

The first questions I want to ask you are about yourself, your home and your childhood. Please try and relax, there are no right or wrong answers. Remember that everything you tell me will be kept secret. . If there is a question you do not want to answer please tell me and we will skip to the next question.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	What is your date of birth?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y	

102	What is the highest standard or grade you have completed at school?	SUBA/GRADE 1 ……..……1 SUB B/GRADE 2……...2 STD 1/GRADE 3……3 STD 2/GRADE 4……4 STD 3/GRADE 5……5 STD 4/GRADE 6……6 STD 5/GRADE 7……..…7 STD 6/GRADE 8……..…8 STD 7/GRADE 9……..…9 STD 8/GRADE 10……10 STD 9/GRADE 11……11 STD 10/GRADE 12……12 INCOMPLETE FURTHER DEGREE OR QUALIFICATION……..13 COMPLETED FURTHER DEGREE OR QUALIFICATION……..…14 NO SCHOOL…….15	
103	Are you currently studying?	YES.....1 NO.....0	
104	Apart from your involvement in this project, are you a member of any clubs or groups or societies?	YES.....1 NO…….0	→106
105	How many other clubs or groups or societies are you a member of?	[ ] [ ] number	
106	**Would you describe yourself as active in your church?**	YES……1 NO ……..0	
107	Have you done anything to earn money in the last 12 months?	YES ……1 NO……...……0	→109
108	Have you ever done anything to earn money?	YES ……1 NO……...……0	

109	Have you read a newspaper or magazine in the last week?	YES.....1 NO.....0	
110	Do you listen to the radio at least once a week?	YES.....1 NO.....0	
111	Do you watch TV at least once a week?	YES.....1 NO.....0	
112	Does your home have a television?	YES.....1 NO.....0	
113	Does your home have a radio?	YES.....1 NO……0	
114	Does your home have a car?	YES.....1 NO……0	
115	Would you say that the people in your home often, sometimes, seldom or never go without food?	OFTEN……..……..…..……1 SOMETIMES……2 SELDOM……..……..……..3 NEVER……..……..….4	
116	Would you say that people in your home often, sometimes, seldom or never have a day when they do not eat meat?	OFTEN HAS NO MEAT……..…..……1 SOMETIMES……2 SELDOM……..……..……..3 ALWAYS HAS MEAT……...……..….4 VEGETARIAN…….5	
117	If a person became ill in your home and R100 was needed for treatment or medicines, would you say it would be very easy, easy, quite difficult or very difficult to find the money?	VERY DIFFICULT……..……..…..……1 QUITE DIFFICULT……..…2 EASY……..…..……..3 VERY EASY……..……..….4	
118	How many people, including all the children, live in your home?	[ ] [ ] NUMBER	
119	Have either your mother or father died?	NEITHER.....1 FATHER……2 MOTHER……3 BOTH.……4	→124 →122

120	Which year did your mother die?	[ ] [ ] [ ] [ ] YEAR	
121	What did she die of? _____ (cause) IF WITCHCRAFT MENTIONED, PROBE IF PERSON WENT TO HOSPITAL AND WHAT THE DOCTOR SAID AND RECORD THIS	HIV/AIDS……..…1 TB……2 CANCER (BREAST /WOMB)……...……3 OTHER CANCER……4 DIARRHOEA……5 PNEUMONIA……..6 ASTHMA……7 HEART PROBLEMS/ HIGH BLOOD PRESSURE/STROKE……8 DIABETES……9 OTHER ILLNESS……10 SUICIDE……11 ACCIDENT, POISON OR OTHER INJURY……12 KILLED BY PERSON OTHER THAN BOYFRIEND/HUSBAND.....13 KILLED BY BOYFRIEND/HUSBAND……14	IF ONLY MUM IS DEAD →124
122	Which year did your father die?	[ ] [ ] [ ] [ ] YEAR	

123	What did he die of? _____ (cause) IF WITCHCRAFT MENTIONED, PROBE IF PERSON WENT TO HOSPITAL AND WHAT THE DOCTOR SAID AND RECORD THIS	HIV/AIDS……..…1 TB……2 CANCER (PROSTATE)……..……...……3 OTHER CANCER…….4 DIARRHOEA……5 PNEUMONIA…….6 ASTHMA…….7 HEART PROBLEMS/ HIGH BLOOD PRESSURE/STROKE……8 DIABETES……9 OTHER ILLNESS……10 SUICIDE……11 ACCIDENT, POISON OR OTHER INJURY……12 KILLED BY A PERSON.....13	
124	What level of schooling did your mother complete?	NO SCHOOLING.....1 PRIMARY SCHOOL INCOMPLETE…….2 PRIMARY SCHOOL COMPLETE (STD 4)…..…3 HIGH SCHOOL INCOMPLETE……..……4 HIGH SCHOOL COMPLETE…..……5 POST SCHOOL QUALIFICATION……6 DON'T KNOW……..7	

CHILDHOOD EXPERIENCES (FROM BIRTH TO 18 YEARS)

I want to ask you some questions about your childhood and teenage years. Can you tell me how often the following things happened to you? I will read out some statements and I want to know if each one was never true, sometimes true, often true or very often true.

		Never 1	Sometimes 2	Often 3	Very Often 4	
125	I was told I was strong or good by someone in	1	2	3	4	

	my family					
126	I was punished at home by being beaten	1	2	3	4	
127	I did not have enough to eat	1	2	3	4	
128	I lived in different households at different times	1	2	3	4	
129	I saw or heard by mother beaten by her husband or boyfriend	1	2	3	4	
130	I was not washed	1	2	3	4	
131	I was told I was lazy or stupid or weak by someone in my family	1	2	3	4	
132	I was punished at home by being beaten every day or every week	1	2	3	4	
133	I lived with my biological mother	1	2	3	4	
134	Someone touched my thighs, buttocks or genitals or made me touch them when I did not want to	1	2	3	4	
135	My clothes were very dirty	1	2	3	4	
136	I was insulted or humiliated by someone in my family in front of other people	1	2	3	4	
137	I was beaten at home with a belt or stick or whip or something else which was hard	1	2	3	4	
138	I lived with my biological father	1	2	3	4	
139	I was never warm enough	1	2	3	4	

140	I had sex with a woman who was more than 5 years older than me	1	2	3	4	
141	One or both of my parents were too drunk to take care of me	1	2	3	4	
142	I was encouraged to make something of my life by someone in my family	1	2	3	4	
143	I was beaten so hard at home that it left a mark or bruise	1	2	3	4	
144	I had a very long way to walk to school each day	1	2	3	4	
145	People in my family felt close to each other	1	2	3	4	
146	I spent time outside the home and none of the adults at home knew where I was	1	2	3	4	
147	I had sex with someone because I was threatened or frightened or forced	1	2	3	4	

SECTION TWO: KNOWLEDGE OF REPRODUCTIVE HEALTH AND HIV AND ATTITUDES TOWARDS HIV , CONDOM USE AND GENDER RELATIONS

I would like to ask you a few questions about reproductive health and HIV. I am going to read out some statements and for each I would like to know if it is true, probably true, probably false or false.

		True 1	Probably true 2	Probably false 3	False 4
201	The most common cause of infertility is a sexually transmitted disease	1	2	3	4
202	A woman who is not using contraception and has sex during her period will probably get pregnant	1	2	3	4
203	A woman can become sterile if she uses Nuristerate	1	2	3	4

204	If a woman does not menstruate the dirt will build up in her body and make her ill	1	2	3	4
205	Abortion is allowed by law up to 5 months of pregnancy	1	2	3	4
206	If a person has a STD there will always be a sign	1	2	3	4
207	A woman who takes contraceptive pills after she discovers she is pregnant will have an abortion	1	2	3	4
208	A man who has sex with a menstruating woman will get ill	1	2	3	4
209	Most women get pregnant right in the middle of their menstrual cycle	1	2	3	4
210	If a woman has not got pregnant within 4 months after she stops contraception the couple are probably sterile	1	2	3	4
211	A condom does not benefit the health of a person who already has HIV	1	2	3	4
212	There are several ways a person can get i-drop (gonorrhoea)	1	2	3	4

I am going to read out some statements about protection against HIV/AIDS. For each statement please tell me whether it is true, probably true, probably false or false:

People can protect themselves from HIV by:

		True	Probably True	Probably False	False
213	Not mixing with people who look like they have HIV or do have HIV	1	2	3	4
214	choosing their partners well	1	2	3	4
215	using a condom until you trust or are comfortable with a partner	1	2	3	4

216	choosing partners who look plump and healthy	1	2	3	4
217	always using a condom	1	2	3	4
218	not sharing razor blades or toothbrushes	1	2	3	4
219	not eating food cooked by someone who looks as if they may have HIV or is known to have HIV	1	2	3	4
220	wearing plastic gloves or bags on your hands when they help someone who is bleeding	1	2	3	4
221	not dating someone who has been sick recently	1	2	3	4
	Are the following statements true, probably true, probably false or false?				
222	I know someone personally who has HIV or died of AIDS	1	2	3	4
223	I have had sex with someone who had a boyfriend who had HIV or died of AIDS	1	2	3	4
224	I have had sex with someone who has HIV or AIDS	1	2	3	4

IDEAS ABOUT CONDOM USE

Now I would like to ask you some questions about using condoms can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

225	Using a condom for sex would be embarrassing	SA 1	A 2	D 3	SD 4	
226	If I was going to have sex, I would not use a condom because I want it 'flesh to flesh'	1	2	3	4	

227	I know how to use a condom	1	2	3	4	
228	If you have been using condoms but miss them one or two times there is no point using them any more with that partner	1	2	3	4	
229	A condom may come off in a woman's vagina but it is impossible to lose one there	1	2	3	4	
230	If a man and woman trust each other they do not need to use a condom	1	2	3	4	
231	If a person wants to use a condom you know they probably have HIV	1	2	3	4	
232	If my partner suggested we used a condom I would think she was having sex with other people	1	2	3	4	
233	If I asked my partner to use a condom, she would think I am having sex with other people.	1	2	3	4	
234	I could definitely ask my current girlfriend to use a condom	1	2	3	4	
THE RESPONDENT AND HIS PEERS Now I would like to read out some statements, can you tell me if you strongly agree, agree, disagree or strongly disagree:						
235	I am left out if I do not have a girlfriend because all my friends have one	SA 1	A 2	D 3	SD 4	
236	I have to have sex because all my friends are doing it	1	2	3	4	
237	I am under pressure to have many partners because all my friends do	1	2	3	4	
239	Would you say that the people in your Stepping Stones group are already mostly good friends of yours, or that some are good friends or that it is a few or none of them?	NONE……..1 A FEW…….2 SOME…….3 MOST……..4				

The Stepping Stones interventions are designed to change some of the ways we live our lives. It is very useful for us to know whether you have already thought about things you might want to change in yours. I am going to read out a list of some aspects of our lives and for each I would like to know whether you have thought of doing them, whether you have decided you want to do them, whether you have actually done it recently or whether it's not a problem for you. Please remember there are no right or wrong answers here.

		Not a problem 1	Thought About it 2	Wants to change 3	Recent change 4	
240	Stop drinking alcohol before it gets me into trouble	1	2	3	4	
241	Always carry a condom	1	2	3	4	
242	Always use a condom	1	2	3	4	
243	Speak out about how you feel when your girlfriend upsets you	1	2	3	4	
244	Always use a condom with casual partners	1	2	3	4	
245	Reduce the number of people you have sex with	1	2	3	4	
246	Learning to understand that others are different from me	1	2	3	4	

IF I HAD HIV

I am now going to ask you some questions about what you would do if you discovered you had HIV. I am not going to ask you whether or not you have HIV. That is a private matter for you but most of us sometimes think about what we would do if we discovered we had HIV, this is what I want to ask you about. I will read out some statements and I would like to know if you would do the following. Please say if the answer is definitely ye, probably yes, probably no or definitely no.

		Definitely	Probably	Probably	No	

		Yes 1	Yes 2	No 3	4	
247	I would keep it secret from my main partner	1	2	3	4	
248	I would tell all my recent sexual partners	1	2	3	4	
249	I would keep it secret from my family	1	2	3	4	
250	I would feel my life was over	1	2	3	4	
251	I would spread it to as many people as I could	1	2	3	4	
252	I would try to kill myself	1	2	3	4	
253	I would be frightened of the illnesses that I may get with AIDS	1	2	3	4	
254	I would always use condoms to protect other people	1	2	3	4	
255	I would educate others to help them protect themselves	1	2	3	4	
256	I would be open about my status to help others know HIV is real	1	2	3	4	
257	I would have sex with a virgin to see if I could be cured	1	2	3	4	
258	Have you ever had an HIV test apart from the ones for this study?	YES …….1 NO……...…….0				→260
259	Did you collect your result?	YES …….1 NO……...…….0				

IDEAS ABOUT GENDER RELATIONS

Now I would like to ask your opinion on some statements on relations between men and women, can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

260	A woman should listen to her husband	SA 1	A 2	D 3	SD 4	
261	A woman has to teach her man to respect her	1	2	3	4	
262	A woman should chose her own friends even if her boyfriend or husband disapproves	1	2	3	4	
263	Men should share the work around the home such as doing the dishes or cleaning or cooking	1	2	3	4	
264	Sometimes a man may have good reason to hit his girlfriend	1	2	3	4	
265	A woman can refuse to have sex with her husband if she does not want it for any reason	1	2	3	4	
266	If a wife does something wrong she should expect her husband to punish her	1	2	3	4	
267	A woman has to know how to look after herself as she cannot rely on her man to care for her	1	2	3	4	
268	A man cannot control himself when he gets sexually aroused	1	2	3	4	
269	A woman should expect to be taught how to behave by her boyfriend	1	2	3	4	
270	A woman should not expect the fathers of her children to give her money	1	2	3	4	
271	If a woman drinks alcohol and wears miniskirts she is asking for trouble	1	2	3	4	

SECTION THREE: MEN'S HEALTH AND CHILDREN

The next set of questions is about different aspects of your health and any children you may already have.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
302	Have you ever had sex?	YES.....1 NO……..0	→321
303	When did you first have sexual intercourse with a woman or girl?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
304	Which of the following statements most closely describes your experiences the first time you had sexual intercourse? I was willing; I was persuaded; I was tricked; I was forced; I was raped.	I was willing.……1 I was persuaded……2 I was tricked ……3 I was forced ……4 I was raped ….……5	
305	Who was this with?	GIRLFRIEND……..1 FAMILY MEMBER……..……2 TEACHER……3 GIRL FROM SCHOOL/AREA……4 WOMAN FROM AREA……5 STRANGER/UNKNOWN PERSON…….6 FRIEND OF THE FAMILY……..7 OTHER……8	
306	Have you ever used a condom?	YES.....1 NO……..0	→312
307	Can you remember the month and year when you first had sex with a condom?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	

312	Have you ever been told by a girlfriend that you made her pregnant?	YES.....1 NO……..0	→319
313	Can you remember which year it was the first time this happened?	15 06 [ ] [ ] [ ] [ ] YEAR	
314	At the time this happened did you want her to become pregnant then, did you want to wait until later, or did you not want to have a child?	THEN……..1 LATER……2 NOT WANT ANY CHILDREN…….3	
314 a	Did you agree you were responsible for the pregnancy?	YES.....1 NO……..0	
315	How many times have girlfriends said you made them pregnant?	PREGNANCIES [ ] If none, enter 0	
316 a	When was the most recent time you were told you made a woman pregnant?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
319	Now I have some questions about the future. Would you like to have a child (or another child) or would you prefer not to have any (or any more) children?	HAVE CHILD IN FUTURE ……..1 NO MORE/NONE……2 UNDECIDED/DON'T KNOW……..3	→321 →321
320	How long would you like to wait from now before the birth of your (next) child?	WITHIN TWO YEARS……..……. 1 TWO TO FIVE YEARS …… 2 MORE THAN FIVE YEARS……..3 UNTIL MARRIED……..4 OTHER_____ 5 (specified)	
321	During the last three months have you been injured in any way?	YES.....1 NO……..0	→325

322	Thinking about the most serious injury. What type of injuries did you have? a) broken bone b)large cut / wound c) small cut d) head injury resulting in loss of consciousness e) bruising/soreness f) other	a) broken bone……YES=1 NO=0 b) large cut / wound……....YES=1 NO=0 c) Small cut…….…… YES=1 NO=0 d) Head injury resulting in loss of consciousness…….…….. YES=1 NO=0 e) bruising/soreness…….……...… YES=1 NO=0 f) Other…….……..…..… YES=1 NO=0 Specify_____	
323	How did you get it?	FIGHT WITH A MAN…….……..1 FIGHT WITH A WOMAN……..2 ATTACKED BY A MAN…….3 WHEN DRIVING A VEHICLE ……..……..4 PASSENGER IN A VEHICLE……...…5 ACCIDENT AT HOME OR IN COMMUNITY ……..……6 HIT BY A VEHICLE WHEN WALKING……7 OTHER……..……..8	→325 →325 →325 →325 →325 →325
324	Did you hit the person you were fighting with first?	YES.....1 NO……..0	
325	**Do you have a preference for girl or boy children?**	BOY……1 GIRL…….2 NO PREFERENCE…….. …….3 DON'T KNOW……..4	

	SUBSTANCE USE The next questions are about alcohol drinking		
801	How often do you have a drink containing alcohol?	NEVER ……1 MONTHLY OR LESS……...2 2-4 TIMES A MONTH……3 2-3 TIMES A WEEK……4 4 + TIMES A WEEK……5	 → 804 → 804 → 804 → 804
802	Have you ever drunk alcohol?	YES……..1 NO……..0	 → 815
803	Have you drunk alcohol in the past 12 months?	YES……..1 NO……..0	→806 → 812
804	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 OR 2……1 3 OR 4……2 5 OR 6……3 7 OR 9……4 10 OR MORE……5	
805	How often do you have six or more drinks on one occasion?	NEVER ……1 LESS THAN MONTHLY …….2 MONTHLY…….…….3 WEEKLY…….4 DAILY OR ALMOST DAILY……..….5	
806	How often in the past year did you find you were not able to stop drinking once you started?	NEVER ……..……1 LESS THAN MONTHLY ……....2 MONTHLY……...3 WEEKLY…….…4 DAILY OR ALMOST DAILY……5	

807	How often during the past year did you find you need a drink in the morning to get you going after a heavy drinking session?	NEVER ……1 LESS THAN MONTHLY ……..….2 MONTHLY…….…….3 WEEKLY…….4 DAILY OR ALMOST DAILY…….5	
808	How often in the past year have you failed to do what was normally expected from you because of drinking?	NEVER ……1 LESS THAN MONTHLY ……2 MONTHLY……...3 WEEKLY……..…….4 DAILY OR ALMOST DAILY…….5	
809	How often in the past year have you had a feeling of guilt or remorse after drinking?	NEVER ……1 LESS THAN MONTHLY ……...2 MONTHLY……..3 WEEKLY……..4 DAILY OR ALMOST DAILY…….5	
810	How often in the past year were you unable to remember what happened the night before because of your drinking?	NEVER ……1 LESS THAN MONTHLY ……2 MONTHLY……..…….3 WEEKLY…….4 DAILY OR ALMOST DAILY……..5	
811	How often in the past year did you have sex without a condom because of your drinking? Was it once, a few times or many times?	NEVER …….……1 ONCE……..…….. ……2 FEW TIMES…….…….3 MANY TIMES…….4	
812	Have you or someone else been injured as a result of your drinking?	NO……...1 YES, BUT NOT IN THE LAST YEAR…….2 YES, IN THE LAST YEAR …….3	
813	Has a friend or relative or doctor or health worker been concerned about your drinking and suggested that you cut down?	NO……...1 YES, BUT NOT IN THE LAST YEAR…….2 YES, IN THE LAST YEAR …….3	

814	Have you ever quarrelled with any of your girlfriends about your drinking?	YES ……1 NO ……..0	
815	Have you ever used … Dagga? Benzene? Mandrax? Drugs that you inject? Any other drug?	 a) DAGGA..... YES =1 NO=0 b) BENZENE……ES=1 NO=0 c) MANDRAX ..... YES =1 NO=0 d) IDU ..... YES =1 NO=0 e) OTHER DRUG ..... YES =1 NO=0	
	CIRCUMCISION Now some last health questions		
326	Have you been circumcised?	YES ……1 NO ……..0	→401
327	In what month and year were you circumcised?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
328	Was it done by a traditional surgeon using traditional or modern methods or in hospital?	TRADITIONAL SURGEON OLD METHODS……..…….1 TRADITIONAL SURGEON MODERN METHOD……..……2 HOSPITAL…… ...3	
329	At the time you were circumcised was it your choice to go, would you have liked to have gone earlier or later, or did you not want to go at all?	THEN……..…….1 WANTED TO GO EARLIER.…….2 LATER…….3 DID NOT WANT TO GO AT ALL……. ...4	

330	Afterwards did you experience…. Delay in healing? Dehydration? Scarring? Infection? Anything else?	a) delayed healing……..YES=1 NO=0 b) dehydration..... YES =1 NO=0 c) scarring ..... YES =1 NO=0 d) infection..... YES =1 NO=0 e) other ..... YES =1 NO=0 Specify_____	
331	Did you have to attend hospital or the clinic because of problems after the circumcision?	YES ……1 NO ……..0	→401
332	Did you have to sleep a night or more in hospital because of problems after the circumcision?	YES ……1 NO ……..0	

SECTION FOUR: PARTNER

The next set of questions is about girlfriends.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Do you currently have a girlfriend or are you married or living with a woman or do you not have one now?	MARRIED .....1 LIVING WITH WOMAN .....2 GIRLFRIEND .....3 NO GIRLFRIEND 4	→ chk5 → chk5 → chk5
402	Have you ever had a girlfriend?	YES ..... 1 NO 0	 → chk3
403	When did your most recent relationship start?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
404	When did your most recent relationship end?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	→ CHK4
CHK3	IF HE HAS NEVER HAD A GIRLFRIEND SKIP TO QUESTION 571 (SEXUAL ABUSE BY A NON-PARTNER)		

CHK4	IF RELATIONSHIP ENDED MORE THAN 12 MONTHS AGO SKIP TO Q. 516 (EMOTIONAL ABUSE)		
CHK 5	**I'd now like to ask you some questions about your current girlfriend and your relationship with her. If you have more than one I would like us to talk about the main one. It will help us talk about her if you can tell me her name or initials or a name we can use to talk about her even if it is one we make up for this purpose.** IF A PERSON DOES NOT HAVE A CURRENT 5-60 THEN ASK ABOUT THE MOST RECENT 5-60 – IF THERE HAS NEVER BEEN A 5-60 THEN ASK IF THEY CAN TALK ABOUT A RECENT CASUAL PARTNER.		
405	Is _____ also involved in this study?	NO……..0 YES ..... 1 DON'T KNOW……...2	
406	Which year was _____ born in?	30 06 [ ] [ ] [ ] [ ] Y Y Y Y DON'T KNOW	→408 →407
407	How old is she?	Years: [ ] [ ]	
408	Did _____ ever attend school?	NO……..0 YES ..... 1 DON'T KNOW……...2	→411 →411

409	What is the highest level of education that _____achieved?	SUBA/GRADE 1 ……..……1 SUB B/GRADE 2……...2 STD 1/GRADE 3……3 STD 2/GRADE 4……4 STD 3/GRADE 5……5 STD 4/GRADE 6……6 STD 5/GRADE 7……..…7 STD 6/GRADE 8……..…8 STD 7/GRADE 9……..…9 STD 8/GRADE 10……10 STD 9/GRADE 11……11 STD 10/GRADE 12…….12 INCOMPLETE DEGREE / QUALIFICATION.13 COMPLETED DEGREE / QUALIFICATION.14 DON'T KNOW……15	
410	**Is _____ currently studying?**	YES ..... 1 NO 0	
411	**Does _____ currently do anything to earn money?**	YES ..... 1 NO 0	
412	**Does _____ever drink alcohol? How often?**	EVERY DAY/NEARLY EVERY DAY .. 1 ONLY AT WEEKENDS ..... 2 A FEW TIMES IN A MONTH ..... 3 LESS THAN ONCE A MONTH ..... 4 NEVER ..... 5 DON'T KNOW……...6	→ 415 → 415
413	**Have you ever quarrelled or had any other conflict over her drinking?**	YES……1 NO …….0	

415	**Do you and _____ ever discuss together you using contraception?**	YES……1 NO ……0	
416	**Do you and _____ ever discuss together methods to protect each other from HIV?**	YES……1 NO ……0	
417	**Do you and _____ ever discuss sex together?**	YES……1 NO ……0	
418	**Do you and _____ ever discuss having children together?**	YES……1 NO ……0	
419	In what month and year did your relationship with _____ start?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y DON'T KNOW MONTH = 06	
420	Have you had sex with _____?	YES……1 NO ……0	→422
421	In what month and year did you first have sex with _____?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y DON'T KNOW MONTH = 06	
422	How likely do you think it is that_____ is having sex with someone else? Would you say she definitely is, probably is, probably is not or definitely is not?	DEFINITELY IS ……1 PROBABLY IS……...…….2 PROBABLY NOT ……3 DEFINITELY NOT……...…….4	
423	Is _____ your 5-60/ main partner?	YES……1 NO ……0	
424	Are you her 5-60/ main partner?	NO……...0 YES.....1 DON'T KNOW……...2	

RELATIONSHIP CONTROL

I would now like to read out some statements and I would like you to think about your relationship with _____and for each statement to tell me if you strongly agree, agree, disagree or strongly disagree

		SA	A	D	SD
428	I am quite comfortable when _____ greets men she knows	1	2	3	4
429	I like _____ to be at home when I come to check her, it bothers me if she is not there	1	2	3	4
430	I become jealous when _____ wears things that make her look too beautiful	1	2	3	4
431	I have more to say than _____ does about important decisions that affect us.	1	2	3	4
432	I never tell _____ who she can see or spend time with.	1	2	3	4
433	It might make me sad but _____ is free to leave our relationship any time she wants to	1	2	3	4
434	I like to do what I want, even if _____ doesn't want me to.	1	2	3	4
435	When _____and I disagree, I gets my way most of the time.	1	2	3	4
436	I like to know where _____ is most of the time	1	2	3	4
437	I expect _____ to do things for me like my ironing and cooking	1	2	3	4
438	Because I buy _____ things I expect her to please me	1	2	3	4
439	I let _____ know that she is not the only girlfriend I have or could have	1	2	3	4
440	When I want _____ to sleep over I expect her to agree	1	2	3	4

SECTION 5: RELATIONSHIPS AND VIOLENCE

The next questions are about your relationship with _____. We all have good and bad times in our relationships, these questions ask about some of these.

SOME OF THE QUESTIONS ASK ABOUT "ANY" PARTNER AND THESE ARE REFERRING TO ALL OF THE PARTNERS THE PERSON HAS HAD IN THEIR WHOLE LIFE.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
501	In your relationship with _____ how often would you say that you have quarrelled? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
502	Would you say your relationship with _____ is it excellent, i-right, nje/just or ayiko right?	EXCELLENT……. 1 IRIGHT……2 NJE/JUST……..…….3 AYEKO RIGHT…….4	
503	How often do you argue about money? Would you say never, rarely, sometimes or often?	NEVER…….. 1RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
504	Do you argue because she suspects that you are having an affair? Would you say never, rarely, sometimes or often?	NEVER…….. 1RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	

505	Do you argue because you think she is having an affair? Would you say never, rarely, sometimes or often?	NEVER…….. 1RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
506	Do you argue because she wants you to spend more time with her? Would you say never, rarely, sometimes or often?	NEVER…….. 1RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
507	Do you argue because she thinks you try to control her? Would you say never, rarely, sometimes or often?	NEVER…….. 1RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
	I want to read out some statements. Can you tell me if you strongly agree, agree, disagree, or strongly disagree with them?		
508	When I disagree with _____ I usually keep silent	STRONGLY AGREE…….……1 AGREE……..……2 DISAGREE……3 STRONGLY DISAGREE……...4	
509	When I disagree with _____ I try to talk the problem through with her	STRONGLY AGREE…….……1 AGREE……..……2 DISAGREE……3 STRONGLY DISAGREE……...4	

510	When I disagree with _____ we usually end up shouting	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
511	When I disagree with _____I try to say what I feel	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
512	I feel free to discuss my hopes, fears and future plans with _____	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
513	I would feel free to tell _____ if I had HIV	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
514	I would feel free to tell _____ if I had an STD	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
515	I would feel free to tell _____ if I wanted the relationship to end.	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……...4	
	EMOTIONAL ABUSE **In any relationship there are good times and bad times. I now want to ask you about some of the bad times we have in relationships and what has happened. Remember there are no right or wrong answers and anything you say will be kept confidential. I want to first ask you about what happened in the past 12 months.**		

516	In the past 12 months did you insult _____ or any other girlfriend or made her feel bad about herself? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
517	In the past 12 months did you belittle or humiliate _____ or any other girlfriend front of other people? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
518	In the past 12 months did you do things to scare or intimidate _____ or any other girlfriend on purpose for example by the way you looked at her, by yelling and smashing things? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
519	In the past 12 months have you threatened to hurt _____ or any other girlfriend? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
520	In the past 12 months have you stopped _____ or any other girlfriend from seeing any of her friends? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
CHK6	IF ANY EMOTIONAL ABUSE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 522		
521	Was _____ one of the girlfriends who you did these things to?	YES…….1 NO……..0	

PHYSICAL ABUSE

Men are often fighting with their girlfriends and often these fights get physical. I am going to ask some questions about this. I want you to speak freely and remember that everything you say will be confidential. Again I am going to ask you first about the last 12 months.

522	In the past 12 months, did you slap _____ or any other girlfriend or throw something at her which could hurt her? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
523	In the past 12 months, did you push or shove _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
524	In the past 12 months, did you hit _____ or any other girlfriend with a fist or with something else which could hurt her? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
525	In the past 12 months, did you kick, drag, beat, choke or burn _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
526	In the past 12 months, did you threaten to use or actually use a gun, knife or other weapon against _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
CHK 7	IF ANY PHYSICAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 530		
527	When was the most recent time you had an argument with a girlfriend that got physical?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
528	In the past 12 months on how many occasions in did you have an argument with any girlfriend that got physical?	[ ] [ ] NUMBER	

529	In the past 12 months did you have an argument with _____ that got physical?	YES……1 NO……..0	
3.1.9.1.1.1.1.1.1 SEXUAL ABUSE			
530	In the past 12 months did you physically force _____ or any other girlfriend to have sex with you when she did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
531	In the past 12 months do you think _____ or any other girlfriend had sex with you when she did not want to because she was afraid of what you might do? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
532	In the past 12 months did you force _____ or any other girlfriend to have oral sex with you when she did not want? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
533	In the past 12 months did you force _____ or any other girlfriend to have anal sex with you when she did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
CHK 8	IF ANY SEXUAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 536		
534	When was the most recent time you forced a girlfriend to have sex when she did not want it?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
535	In the past 12 months did you force _____ to have sex when she did not want it?	YES……1 NO……..0	

	BEFORE THE PAST TWELVE MONTHS **The next questions ask about things which happened in your relationships before the last 12 months, both with _____ if you were with her then and any other girlfriend you have ever had.**		
536	Before the past 12 months did you insult _____ or any other girlfriend or made her feel bad about herself? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
537	Before the past 12 months did you belittle or humiliate _____ or any other girlfriend front of other people? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
538	Before the past 12 months did you do things to scare or intimidate _____ or any other girlfriend on purpose for example by the way you looked at her, by yelling and smashing things? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
539	Before the past 12 months have you threatened to hurt _____ or any other girlfriend? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
540	Before the past 12 months have you stopped _____ or any other girlfriend from seeing any of her friends? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
CHK9	DID HE REPORT ANY EMOTIONAL ABUSE BEFORE THE PAST YEAR? IF NOT GO TO Q. 542		
541	Was _____ one of the girlfriends who you did these things to?	YES……1 NO……..0	

542	Before the past 12 months, did you slap _____ or any other girlfriend or throw something at her which could hurt her? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
543	Before the past 12 months, did you push or shove _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
544	Before the past 12 months, did you hit _____ or any other girlfriend with a fist or with something else which could hurt her? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
545	Before the past 12 months, did you kick, drag, beat, choke or burn _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
546	Before the past 12 months, did you threaten to use or actually use a gun, knife or other weapon against _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
CHK 10	IF ANY PHYSICAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 550		
547	When was the first time you ever had an argument with a girlfriend that got physical?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
548	Before the past 12 months did you have an argument with _____ that got physical?	YES……1 NO……..0	

549	Before the past 12 months on how many occasions in did you have an argument with any girlfriend that got physical?	[ ] [ ] NUMBER	
550	Before the past 12 months did you physically force _____ or any other girlfriend to have sex with you when she did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
551	Before the past 12 months do you think _____ or any other girlfriend had sex with you when she did not want to because she was afraid of what you might do? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
552	Before the past 12 months did you ever force _____ or any other girlfriend to have oral sex with you when she did not want? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
553	Before the past 12 months did you ever force _____ or any other girlfriend to have anal sex with you when she did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY 4	
CHK 11	IF ANY SEXUAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q.571		
554	When was the first time you forced a girlfriend to have sex when she did not want it?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
555	Before the past 12 months did you force _____ to have sex when she did not want it?	YES……1 NO……..0	

ALL MEN, EVEN THOSE WHO HAVE NEVER HAD A GIRLFRIEND, SHOULD BE ASKED THE FOLLOWING QUESTIONS

SEXUAL VIOLENCE AGAINST NON-GIRLFRIENDS

We all know that boys in our communities are sometimes pressurized to do sexual things when they do not want to and sometimes make girls do sexual things they do not want to. I would now like to ask you some questions about this. The next set of questions is about situations you may have been in with women who were not girlfriends.

IF HE MENTIONS FORCING A GIRLFRIEND, CHECK THAT THIS WAS REPORTED IN RESPONSE TO Q.s 530 & 531 OR 550 & 551. IF NOT, GO BACK TO Q.s 530 & 531 AND 550 & 551 AND ASK THEM AGAIN. THEN RETURN TO Q.s 571 & 572 AGAIN AND PROBE BY SAYING "DID YOU DO THIS WITH ANYONE OTHER THAN YOUR GIRLFRIEND"

571	**Was there a time when you made a woman or girl, other than your girlfriend at the time, have sex with you when she did not want to?**	**YES.....1** **NO 0**	
572	**Was there a time when you made a woman or girl, other than your girlfriend at the time, have sex with you when she was too drunk to say whether she wanted it?**	**YES.....1** **NO 0**	**IF NO TO 571 & 572 → 577**
573	When was the first time you did either of these things?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
574	The first time, were you the only one having sex with her or was it more than one man?	ONLY HIM……..……1 MORE THAN ONE…….2	
575	Did it happen once, a few times or many times?	ONCE …….1 FEW..... …….2 MANY……3	→ **577**

576	When was the most recent time this happened?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
577	**Have you ever done streamlining?**	YES……1 NO ……0	
578	**Was there ever an occasion when you and other men had sex with a woman against her will or when she was too drunk to stop you?**	YES……1 NO ……0	
570	**How many women who were not your girlfriend have you made to have sex with you?**	**[ ] [ ]** **WRITE 0 0 IF NONE**	
579	**Was there a time when you tried to make a woman or girl, other than your girlfriend at the time, have sex with you when she did not want to but did not actually have sex with her?**	**YES.....1** **NO 0**	**→ 583**
580	When was the first time you did this?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
581	Did it happen once a few times or many times?	ONCE……1 FEW..... …….2 MANY……3	**→ 583**
582	When was the most recent time this happened?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	

SEXUAL ABUSE OF THE RESPONDENT

583	**Did a MAN ever persuade or force you to have sex when you did not want to?**	**YES ..... 1** **NO 0**	**→ 589**
584	When did it first happen?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	

585	Can you tell me who did this?	FATHER OR FAMILY MEMBER .....1 TEACHER .....2 PASTOR./ MAN FROM CHURCH .....3 MAN FROM NEIGHBOURHOOD .....4 BOY FROM NEIGHBOURHOOD .....5 STRANGER/UNKNOWN PERSON .....6 FRIEND OF THE FAMILY .....7 OTHER .....8 Specify:	
586	Is this something which has happened to you just once, a few times or many times?	ONCE ..... 1 FEW..... 2 MANY..... 3	→ **589**
587	When was the most recent time that it happened?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
588	Can you tell me who did this the last time?	FATHER OR FAMILY MEMBER .....1 TEACHER .....2 PASTOR./ MAN FROM CHURCH .....3 MAN FROM NEIGHBOURHOOD .....4 BOY FROM NEIGHBOURHOOD .....5 STRANGER/UNKNOWN PERSON .....6 FRIEND OF THE FAMILY .....7 OTHER .....8 Specify:	
589	**Did a WOMAN ever persuade or force you to have sex when you did not want to?**	**YES ..... 1** **NO 0**	→ **CHK12**
590	When did it first happen?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	

591	Can you tell me who did this?	MOTHER OR FAMILY MEMBER.....1 TEACHER.....2 DOMESTIC WORKER.....3 WOMAN FROM NEIGHBOURHOOD.....4 GIRL FROM NEIGHBOURHOOD.....5 STRANGER/UNKNOWN PERSON.....6 FRIEND OF THE FAMILY.....7 OTHER.....8 Specify:	
592	Is this something which has happened to you just once, a few times or many times?	ONCE.....1 FEW.....2 MANY.....3	→ **CHK12**
593	When was the most recent time that it happened?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
594	Can you tell me who did this the last time?	MOTHER OR FAMILY MEMBER.....1 TEACHER.....2 DOMESTIC WORKER.....3 WOMAN FROM NEIGHBOURHOOD.....4 GIRL FROM NEIGHBOURHOOD.....5 STRANGER/UNKNOWN PERSON.....6 FRIEND OF THE FAMILY.....7 OTHER.....8 Specify:	
CHK 12	***IF THE MAN HAS NEVER HAD SEX SKIP TO SECTION 7 – MENTAL HEALTH***		

SECTION 6: SEXUAL BEHAVIOUR

The next questions are about your sexual relationships. Please remember that everything you say will be kept secret and your name will not appear anywhere on the questionnaire.

601	When was the last time you had sex?	[ ] [ ]DAYS (IF LESS THAN 14 DAYS) [ ] WEEKS (IF 2-8 WEEKS) [ ] [ ] MONTHS (IF OVER 8 WEEKS)	
602	The last time you had sex did you use a condom?	YES ..... 1 NO……..0	→ 606
603	Did you use a condom for every round?	YES ..... 1 NO……..0	
604	Who brought the condom, was it you or your partner?	SELF..... 1 PARTNER……..2 BOTH……..3	
605	Did you experience: i) condom breaking j) condom slipped off k) condom only put on half way l) condom was removed	a) CONDOM BROKE……..YES =1 NO=0 b) SLIPPED OFF ……..…YES=1 NO=0 c) ONLY PUT IT ON HALF WAY….YES =1 NO=0 d) CONDOM REMOVED WHEN LOVE MAKING CONTINUED…..YES =1 NO=0	
	We know that people have different types of affairs. We have our 5-60s or main partners, our Khwapheni and sometimes we have sex with a person who we never see again or never have sex with again, let's call these one-off partners		
606	The last time you had sex was it with a 5-60, or Khwapheni or one off partner or ex-partner?	MAIN PARTNER……..1 KWAPENI……..2 ONE OFF……..3 EX-PARTNER……..4	→ 607

CH K13	CHECK Q. 420 HAS HE HAD SEX WITH HIS 5-60? YES → 607 NO→ 611		
607	Have you used condoms with your 5-60 in the past year? Would you say you used them always, often or sometimes?	NO USE ..... 1 ALWAYS ..... 2 OFTEN..... 3 SOMETIMES…….4	→ 611 → 611 → 611
608	Have you ever suggested to your 5-60 that you use a condom to protect you from HIV?	YES ..... 1 NO 0	→ 610
609	How did she respond? RECORD ALL MENTIONED	AGREE TO USE ONE……. YES =1 NO=0 BECAME ANGRY ……..YES =1 NO=0 SAID SHE DID NOT LIKE THEM...YES =1 NO=0 SHE WAS OFFENDED…… …….YES =1 NO=0 OTHER……YES =1 NO=0 SPECIFY_____	AL L TO → 611
610	What is the main reason why you have not suggested condom use? RECORD ALL MENTIONED	NEVER THOUGHT OF ASKING….YES =1 NO=0 TRUST EACH OTHER … ……....YES =1 NO=0 DOES NOT KNOW HOW TO AS…YES =1 NO=0 FEAR SHE WOULD LEAVE……. YES =1 NO=0 HE DOES NOT LIKE THEM……. YES =1 NO=0 TRYING TO GET PREGNANT… YES =1 NO=0 OTHER…… YES =1 NO=0 SPECIFY_____	

611	Where can you get condoms in this area? RECORD ALL MENTIONED	CLINIC…… YES =1 NO=0 SHOP…… YES =1 NO=0 SHEBEEN…… YES =1 NO=0 SCHOOL……..…… YES =1 NO=0 CHIEF/COUNSELOR…… YES =1 NO=0 OTHER……. YES =1 NO=0	
612	Would you say that getting a condom in this area is very easy, easy, quite difficult or very difficult?	VERY EASY……..1 EASY……2 QUITE DIFFICULT……..…3 VERY DIFFICULT……4	
613	How many 5-60s have you had sex with in the last year?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
614	How many Khwapheni have you had sex with during the past year?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
615	How many women have you had sex with just once during the past year?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
CHK 14	ANY KWAPHENI OR ONE OFF PARTNERS MENTIONED? IF YES go to Q. 616 OTHERWISE go to CHK 15		
616	Over the last year have you used condoms with Khwapheni and one off partners? Would you say you used them always, often or sometimes?	NO USE ..... 1 ALWAYS ..... 2 OFTEN..... 3 SOMETIMES 4	ALL USERS → 621
617	Have you ever suggested to Khwapheni or one off partner that you use a condom to protect you from HIV?	YES ..... 1 NO 0	→ 620
618	How many times have you suggested condom use to Khwapheni or one off partners?	[ ] [ ] NUMBER	

619	What responses did you get? RECORD ALL MENTIONED	AGREE TO USE ONE……. YES =1 NO=0 BECAME ANGRY ……..YES =1 NO=0 SAID SHE DID NOT LIKE THEM… YES =1 NO=0 SHE WAS OFFENDED…….. YES =1 NO=0 OTHER……YES =1 NO=0 SPECIFY_____	ALL TO → CHK15
620	What is the main reason why you have not suggested condom use? RECORD ALL MENTIONED	NEVER THOUGHT OF ASKING….YES =1 NO=0 TRUST EACH OTHER … ……..YES =1 NO=0 DOES NOT KNOW HOW TO ASK…YES =1 NO=0 FEAR SHE WOULD LEAVE……. YES =1 NO=0 HE DOES NOT LIKE THEM……. YES =1 NO=0 TRYING TO GET PREGNANT…… YES =1 NO=0 OTHER…… YES =1 NO=0 SPECIFY_____	
CHK 15	CHECK Q.s 607 AND 616 HAS HE USED CONDOMS IN THE PAST YEAR? YES GO TO 621 NO GO TO 622		
621	Over the last year how often have you experienced the condom breaking or slipping off or only put it on half way through or have you taken it off and continued love making?	EVERY TIME USED.....1 OFTEN .....2 SOMETIMES.....3 NEVER……4 NO USE……..5	
	I would like to ask you about the number of sexual partners you have had in your whole life including this year. I want to know about the number of different partners.		
622	How many 5-60s have you had sex with in your life?	[ ] [ ] NUMBER ENTER 00 IF NONE	

623	How many Khwapheni have you had sex with in your life?	[ ] [ ] NUMBER ENTER 00 IF NONE	
624	How many people have you had sex with just once in your life?	[ ] [ ] NUMBER ENTER 00 IF NONE	
Most of us like nice things. We as men often give presents to our girlfriends or give some money to women we have had sex with; sometimes we find we are given presents by women who desire us. Sometimes we know these relationships or the sex would not happen if we did not give or receive money or presents.			
625a	Have you ever become involved with a woman as a 5-60 because she provided you with or you expected that she would provide you with: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to stay? Cash?	FOOD ..... YES =1 NO=0 CLOTHES ..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES ..... YES =1 NO=0 PLACE TO STAY ..... YES =1 NO=0 CASH ..... YES =1 NO=0 ☐ NEVER HAD SEX WITH 5-60	

626a	Have you ever become involved with a griza because she provided you with or you expected that she would provide you with: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to sleep? Cash? Alcohol or a good time?	 FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 DRINK/ GOOD TIME..... YES =1 NO=0 ☐ NEVER HAD GRIZA	 → 628a
627a	Did you have sex with her?	YES……1 NO……0	
628a	Now I would like you to think about women you have had sex with only once. Have you ever had sex with a such a woman because she gave you or you expected that she would give you: Food? Clothes? A lift, a ticket, or money for transport? A place to sleep for the night? Cash? Drink/Good time?	 FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 DRINK/ GOOD TIME…..YES =1 NO=0 NEVER HAD ONCE OFF PARTNER ☐	
CH K16 a	CHECK QUESTIONS 625a, 626a & 628a IF NO "YES" ANSWERS SKIP TO Q.625		

629a	When was the last time you had sex with a woman because she gave you or you expected that she would give you money or something else?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
625	Thinking about the 5-60s that you have had. Do you think any of them may have become involved with you because they expected you to provide them with, or because you provided them with, any of the following: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to stay? Cash? Status? Cosmetics? Items for her children or family such as clothes, food, school fees?	FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES ..... YES =1 NO=0 PLACE TO STAY..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 COSMETICS ..... YES =1 NO=0 CHILDREN / FAMILY .... YES =1 NO=0 ☐ NEVER HAD SEX WITH 5-60	

626	Thinking about the Khwapheni that you have had. Do you think any of them may have ever become involved with you because they expected you to provide them with (or because you provided them with) any of the following: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to sleep? Cash? Status? Cosmetics? Items for her children or family such as clothes, food? Drink/good time?	FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 COSMETICS ..... YES =1 NO=0 CHILDREN / FAMILY .... YES =1 NO=0 DRINK/ GOOD TIME..... YES =1 NO=0 NEVER HAD KWAPHENI ☐	→ 628
627	Did you have sex with this partner?	YES……1 NO……0	

628	Now I would like you to think about women you have had sex with only once. Have you ever had sex with such a woman because you gave her or she expected that you would give her: Food? Clothes? A lift, a ticket, or money for transport? A place to sleep for the night? Cash? Status? Drink or a good time?	 FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 DRINK/GOOD TIME……YES =1 NO=0 ☐ NEVER HAD ONCE OFF PARTNER	
CH K16	CHECK QUESTIONS 625, 626 & 628 IF NO "YES" ANSWERS SKIP TO Q.701		
629	When was the last time you had sex with a woman because you gave her or she expected that you would give her money or something else?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	

SECTION 7: MENTAL HEALTH STATUS

Thank you very much for answering all these questions we are now getting towards the end of the questionnaire and I would like to ask you some questions about how you have been feeling in the past week. I am going to read out some statements and ask you to say how many days you have had particular feelings or ideas or whether you have not had them at all.

		Rarely or none of the time	Some or a little of time (1-2 days)	Moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
701	During the past week I was bothered by things that usually don't bother me	0	1	2	3
702	During the past week I did not feel like eating, my appetite was poor	0	1	2	3
703	During the past week I felt I could not cheer myself up even with the help of family and friends	0	1	2	3
704	During the past week I felt I was just as good as other people	0	1	2	3
705	During the past week I had trouble keeping my mind on what I was doing	0	1	2	3
706	During the past week I felt depressed	0	1	2	3
707	During the past week I felt that everything I did was an effort	0	1	2	3
708	During the past week I felt hopeful about the future	0	1	2	3
709	During the past week I thought my life had been a failure	0	1	2	3
710	During the past week I felt fearful	0	1	2	3
711	During the past week my sleep was restless	0	1	2	3
712	During the past week I was happy	0	1	2	3
713	During the past week I talked less than usual	0	1	2	3
714	During the past week I felt lonely	0	1	2	3

715	During the past week people were unfriendly	0	1	2	3
716	During the past week I enjoyed life	0	1	2	3
717	During the past week I had crying spells	0	1	2	3
718	During the past week I felt sick	0	1	2	3
719	During the past week I felt that people dislike me	0	1	2	3
720	During the past week I could not get 'going'	0	1	2	3
721	During the past week I have been thinking too much	0	1	2	3
722	During the past week my heart has been painful	0	1	2	3
723	During the past week my spirit has been low	0	1	2	3
724	Now I want to ask you a question about the past **four weeks,** has the thought of ending your life been in your mind?	YES……1 NO……0			
	Can I just ask you the last of the questions about yourself; remember all the information will be confidential.				
725	**Have you ever been a member of a gang?**	YES……1 NO ……0			
726	**Have you ever been in prison or held in a police cell overnight?**	YES……1 NO ……0			
727	Have you ever had sex with another man?	YES……1 NO ……0			→ 901
728	When you did this were you his wife or was he your wife, was it both or did you just have thigh sex?	HE WAS WIFE……1 OTHER MAN WAS WIFE……2 BOTH WAYS……3 THIGH OR NON-PENETRATIVE SEX ONLY……4			

CHK 17	IF ANAL SEX WITH A MAN IS REPORTED HERE CHECK Q. 583 – WAS IT DESCRIBED THERE? IF NOT ASK QUESTIONS 583 – 588 AND THEN PROCEED WITH Q. 901	

SECTION NINE: YOU AND YOUR COMMUNITY

The last set of questions I want to ask are about your community. Thank you very much for your time, we are nearly finished now. I am going to ask these questions and for each I would like to know whether the answer is definitely yes, probably yes, probably no or no.

901	Do neighbours in this area tend to know each other well?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4
902	In this area do most people generally trust each other in matters of lending and borrowing?	DEFINITELY YES…….1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4
903	If there was a fistfight in this area would people do something to stop it?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4
904	If you were away from home for some time and on coming back you found that your home was broken in to, would you think it likely that your neighbour would give you some help with food or blankets or clothes?	DEFINITELY YES…….1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4
905	If you were going out on a trip and didn't have enough provision would you expect the other group members to share what they had with you?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO…….3 DEFINITELY NO……..4

FINISH

I would like to thank you very much for helping us. We have talked about some very difficult things today. I appreciate the time you have taken. I realise that some of these questions may have been difficult for you to answer, but we have to ask them if we are to really understand men's lives. We really appreciate your participation in this study. By sharing this personal information with us and attending the Stepping Stones group you are helping us with our research and that will ultimately help many other people in the country.

End Time of Interview: _____ h _____

THE STEPPING STONES STUDY

(ENGLISH)

MEN'S QUESTIONNAIRE

12 MONTHS FOLLOW UP

COVER

Study ID number: _____

ID Number verification (please circle method used):

6 Photo ID Card

7 Comparison with photo on file

8 Verification by a respected older person

9 Verification by participant's friends

10 Other

Field Edit _____ (initial) **Study ID Checked: _____ (initial)**



STEPPING STONES STUDY

MEN'S (ENGLISH) QUESTIONNAIRE

Study identification	[ ] [ ] [ ] [ ]

number	
Visit Number	**[3]**
Interviewer name	**1 = Sanele 6= Yandisa 11= Andiswa 16=Philiswa** **2 = Bongwekazi 12= Nocawe 17=Mvuyo** **3 = Nwabisa 8= Sandisiwe 13= Ayanda 18=Khanyi** **4=Nelisiwe 9= Veliswa 14= Lizo 19=** **5 = Mthokozisi 10= Lungelo 15= Posti 20=**
Date of interview	**__ __ / __ __ / 200 __** **D D M M Y**
Interview Site	Specify:
Cluster number:	[ ] [ ]
Start Time of Interview	**_____h_____**

Data Entry:

First Entry: **__ __ / __ __ / 200 __** **_____** **Initials**
D D M M Y

Second Entry: **__ __ / __ __ / 200__** **_____** **Initials**
D D M M Y

Notes and Queries:

SECTION ONE: BACKGROUND

Thank you very much for agreeing to participate again in the study. Most of the questions in this questionnaire are ones you have been asked previously. Please try and relax, and remember that there are no right or wrong answers. Remember that everything you tell me will be kept secret. Many of the questions will ask you about things which have happened since the first time we interviewed you for this study last year.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101	What is your date of birth?	[ ] [ ] [ ] [ ] 19[ ] [ ] D D M M Y Y	
103	Are you currently studying?	YES.....1 NO.....0	
104	Apart from your involvement in this project, are you a member of any clubs or groups or societies?	YES.....1 NO……0	→106
105	How many other clubs or groups or societies are you a member of?	[ ] [ ] number	
106	**Would you describe yourself as active in your church?**	YES……1 NO …….0	
107	Have you done anything to earn money since your first interview for this study, apart from the R20 we gave you for the last interview?	YES …….1 NO……...…….0	
107 a	Are you a migrant scholar?	YES …….1 NO……...…….0	

118 a	How many places have you lived in for a month or more in the last 5 years?	[ ] [ ] number	
118 b	Have you ever stayed in a town for a month or more?	Yes……..…1 No……..0	
119	Since the first interview, have either your mother or father died?	NEITHER.....1 FATHER……2 MOTHER……3 BOTH…….4	→151 →123
121	What did she die of? _____ (cause) IF WITCHCRAFT MENTIONED, PROBE IF PERSON WENT TO HOSPITAL AND WHAT THE DOCTOR SAID AND RECORD THIS	HIV/AIDS……...…1 TB……2 CANCER (BREAST /WOMB)……...……3 OTHER CANCER…….4 DIARRHOEA……5 PNEUMONIA…….6 ASTHMA……7 HEART PROBLEMS/ HIGH BLOOD PRESSURE/STROKE……8 DIABETES……9 OTHER ILLNESS……10 SUICIDE……11 ACCIDENT, POISON OR OTHER INJURY……12 KILLED BY PERSON OTHER THAN BOYFRIEND/HUSBAND.....13 KILLED BY BOYFRIEND/HUSBAND……14	IF ONLY MUM IS DEAD →151

123	What did he die of? _____ (cause) IF WITCHCRAFT MENTIONED, PROBE IF PERSON WENT TO HOSPITAL AND WHAT THE DOCTOR SAID AND RECORD THIS	HIV/AIDS……..…1 TB……2 CANCER (PROSTATE)……..……...……3 OTHER CANCER…….4 DIARRHOEA……5 PNEUMONIA…….6 ASTHMA…….7 HEART PROBLEMS/ HIGH BLOOD PRESSURE/STROKE……8 DIABETES……9 OTHER ILLNESS……10 SUICIDE……11 ACCIDENT, POISON OR OTHER INJURY……12 KILLED BY A PERSON.....13	
	I would like to ask you about Stepping Stones sessions that you may have attended.		
151	Did you attend a session where condoms were handed out?	Yes……1 No……..…0	
152	Did you attend a session that was all about HIV?	Yes……1 No…….0	
153	Did you attend a session which was all about woman abuse?	Yes……1 No……..…0	
154	Did you attend a session where you were shown different types of contraceptives?	Yes……1 No……..……0	
155	Did you attend a session which discussed how we communicate and whether we attack, avoid or manipulate?	Yes……1 No……..…0	
156	Did you attend a session that was all about cholera?	Yes……1 No…….0	

SECTION TWO: KNOWLEDGE OF REPRODUCTIVE HEALTH AND HIV AND ATTITUDES TOWARDS HIV , CONDOM USE AND GENDER RELATIONS

I would like to ask you a few questions about reproductive health and HIV. I am going to read out some statements and for each I would like to know if it is true, probably true, probably false or false.

		True 1	Probably true 2	Probably false 3	False 4	
201	The most common cause of infertility is a sexually transmitted disease	1	2	3	4	
202	A woman who is not using contraception and has sex during her period will probably get pregnant	1	2	3	4	
203	A woman can become sterile if she uses NurIsterate	1	2	3	4	
204	If a woman does not menstruate the dirt will build up in her body and make her ill	1	2	3	4	
205	Abortion is allowed by law up to 5 months of pregnancy	1	2	3	4	
206	If a person has a STD there will always be a sign	1	2	3	4	
207	A woman who takes contraceptive pills after she discovers she is pregnant will have an abortion	1	2	3	4	
208	A man who has sex with a menstruating woman will get ill	1	2	3	4	
209	Most women get pregnant right in the middle of their menstrual cycle	1	2	3	4	
210	If a woman has not got pregnant within 4 months after she stops contraception the couple are probably sterile	1	2	3	4	
211	A condom does not benefit the health of a person who already has HIV	1	2	3	4	

212	There are several ways a person can get i-drop (gonorrhoea)	1	2	3	4	

I am going to read out some statements about protection against HIV/AIDS. For each statement please tell me whether it is true, probably true, probably false or false:

People can protect themselves from HIV by:

213	Not mixing with people who look like they have HIV or do have HIV	True 1	Probably True 2	Probably False 3	False 4	
214	choosing their partners well	1	2	3	4	
215	using a condom until you trust or are comfortable with a partner	1	2	3	4	
216	choosing partners who look plump and healthy	1	2	3	4	
217	always using a condom	1	2	3	4	
218	not sharing razor blades or toothbrushes	1	2	3	4	
219	not eating food cooked by someone who looks as if they may have HIV or is known to have HIV	1	2	3	4	
220	wearing plastic gloves or bags on your hands when they help someone who is bleeding	1	2	3	4	
221	not dating someone who has been sick recently	1	2	3	4	
	Are the following statements true, probably true, probably false or false?	T	Pr. T	Pr. F	F	
222	I know someone personally who has HIV or died of AIDS	1	2	3	4	
223	I have had sex with someone who had a boyfriend who had HIV or died of AIDS	1	2	3	4	

224	I have had sex with someone who has HIV or AIDS	1	2	3	4	

IDEAS ABOUT CONDOM USE

Now I would like to ask you some questions about using condoms can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

225	Using a condom for sex would be embarrassing	SA 1	A 2	D 3	SD 4	
226	If I was going to have sex, I would not use a condom because I want it 'flesh to flesh'	1	2	3	4	
227	I know how to use a condom	1	2	3	4	
228	If you have been using condoms but miss them one or two times there is no point using them any more with that partner	1	2	3	4	
229	A condom may come off in a woman's vagina but it is impossible to lose one there	1	2	3	4	
230	If a man and woman trust each other they do not need to use a condom	1	2	3	4	
231	If a person wants to use a condom you know they probably have HIV	1	2	3	4	
232	If my partner suggested we used a condom I would think she was having sex with other people	1	2	3	4	
233	If I asked my partner to use a condom, she would think I am having sex with other people.	1	2	3	4	
234	I could definitely ask my current girlfriend to use a condom	1	2	3	4	

THE RESPONDENT AND HIS PEERS

Now I would like to read out some statements, can you tell me if you strongly agree, agree, disagree or strongly disagree:

235	I am left out if I do not have a girlfriend because all my friends have one	SA 1	A 2	D 3	SD 4	
236	I have to have sex because all my friends are doing it	1	2	3	4	
237	I am under pressure to have many partners because all my friends do	1	2	3	4	

I am going to read out a list of some aspects of our lives and for each I would like to know whether you have thought of doing them, whether you have decided you want to do them, whether you have actually done it recently or whether it's not a problem for you. Please remember there are no right or wrong answers here.

		Not a problem 1	Thought About it 2	Wants to change 3	Recent change 4	
240	Stop drinking alcohol before it gets me into trouble	1	2	3	4	
241	Always carry a condom	1	2	3	4	
242	Always use a condom	1	2	3	4	
243	Speak out about how you feel when your girlfriend upsets you	1	2	3	4	
244	Always use a condom with casual partners	1	2	3	4	
245	Reduce the number of people you have sex with	1	2	3	4	

246	Learning to understand that others are different from me	1	2	3	4	

IF I HAD HIV

I am now going to ask you some questions about what you would do if you discovered you had HIV. I am not going to ask you whether or not you have HIV. That is a private matter for you but most of us sometimes think about what we would do if we discovered we had HIV, this is what I want to ask you about. I will read out some statements and I would like to know if you would do the following. Please say if the answer is definitely ye, probably yes, probably no or definitely no.

		Definitely Yes 1	Probably Yes 2	Probably No 3	No 4	
247	I would keep it secret from my main partner	1	2	3	4	
248	I would tell all my recent sexual partners	1	2	3	4	
249	I would keep it secret from my family	1	2	3	4	
250	I would feel my life was over	1	2	3	4	
251	I would spread it to as many people as I could	1	2	3	4	
252	I would try to kill myself	1	2	3	4	
253	I would be frightened of the illnesses that I may get with AIDS	1	2	3	4	
254	I would always use condoms to protect other people	1	2	3	4	
255	I would educate others to help them protect themselves	1	2	3	4	
256	I would be open about my status to help others	1	2	3	4	

	know HIV is real					
257	I would have sex with a virgin to see if I could be cured	1	2	3	4	
258	Have you ever had an HIV test apart from the ones for this study?	YES ……1 NO……...……0				→260
259	Did you collect your result?	YES ……1 NO……...……0				

IDEAS ABOUT GENDER RELATIONS

Now I would like to ask your opinion on some statements on relations between men and women, can you tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:

260	A woman should listen to her husband	SA 1	A 2	D 3	SD 4	
261	A woman has to teach her man to respect her	1	2	3	4	
262	A woman should chose her own friends even if her boyfriend or husband disapproves	1	2	3	4	
263	Men should share the work around the home such as doing the dishes or cleaning or cooking	1	2	3	4	
264	Sometimes a man may have good reason to hit his girlfriend	1	2	3	4	
265	A woman can refuse to have sex with her husband if she does not want it for any reason	1	2	3	4	
266	If a wife does something wrong she should expect her husband to punish her	1	2	3	4	
267	A woman has to know how to look after herself as she cannot rely on her man to care for her	1	2	3	4	
268	A man cannot control himself when he gets sexually aroused	1	2	3	4	

269	A woman should expect to be taught how to behave by her boyfriend	1	2	3	4	
270	A woman should not expect the fathers of her children to give her money	1	2	3	4	
271	If a woman drinks alcohol and wears miniskirts she is asking for trouble	1	2	3	4	

SECTION THREE: MEN'S HEALTH AND CHILDREN

The next set of questions is about different aspects of your health and any children you may already have. I am particularly interested in what has happened since the first time you were interviewed for the study.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
302	**The first time you were interviewed had you had sex?**	YES ..... 1 NO…….0	→306
302 a	**Have you had started having sex since then?**	YES ..... 1 NO…….0	→319
303	When did you first have sexual intercourse with a woman or girl?	15 [ ] [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
304	Which of the following statements most closely describes your experiences the first time you had sexual intercourse? I was willing; I was persuaded; I was tricked; I was forced; I was raped.	I was willing.……1 I was persuaded……2 I was tricked ……3 I was forced ……4 I was raped ….……5	

305	Who was this with?	GIRLFRIEND……..1 FAMILY MEMBER……..……2 TEACHER…….3 GIRL FROM SCHOOL/AREA……4 WOMAN FROM AREA…….5 STRANGER/UNKNOWN PERSON…….6 FRIEND OF THE FAMILY……..7 OTHER……8	
306	**The first time you were interviewed, had you used a condom?**	YES ..... 1 NO…….0	→312
306 a	**Have you used a condom since then?**	YES ..... 1 NO…….0	→312
307	Can you remember the month and year when you first had sex with a condom?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
312	Since the first interview have you ever been told by a girlfriend that you made her pregnant?	YES ..... 1 NO……..0	→319
313	When was this?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
314	At the time this happened did you want her to become pregnant then, did you want to wait until later, or did you not want to have a child?	THEN……..1 LATER……2 NOT WANT ANY CHILDREN…….3	
314 a	Did you agree you were responsible for the pregnancy?	YES ..... 1 NO……..0	
319	Now I have some questions about the future. Would you like to have a child (or another child) or would you prefer not to have any (or any more) children?	HAVE CHILD IN FUTURE ……..1 NO MORE/NONE……2 UNDECIDED/DON'T KNOW……..3	→321a →321a

320	How long would you like to wait from now before the birth of your (next) child?	WITHIN TWO YEARS……..……. 1 TWO TO FIVE YEARS …… 2 MORE THAN FIVE YEARS……..3 UNTIL MARRIED……..4 OTHER_____ 5 (specified)	
321 a	Have you ever had a blood transfusion?	YES ..... 1 NO 0	
321 b	Since the first interview have you had an injection or had blood taken?	YES ..... 1 NO 0	
321 c	Since the first interview have you been cut with a razor by a Sangoma?	YES ..... 1 NO 0	
321 d	Since the first interview have you been involved in an accident or a fight when someone else's blood got on your wounds?	YES ..... 1 NO 0	
321 e	Since the first interviews have you been told by the clinic you have a sexually transmitted disease?	YES ..... 1 NO 0	
321	During the last three months have you been injured in any way?	YES ..... 1 NO……..0	→801
323	How did you get it?	FIGHT WITH A MAN…….……..1 FIGHT WITH A WOMAN……..2 ATTACKED BY A MAN…….3 WHEN DRIVING A VEHICLE ……..……..4 PASSENGER IN A VEHICLE……...…5 ACCIDENT AT HOME OR IN COMMUNITY ……..……6 HIT BY A VEHICLE WHEN WALKING……7 OTHER…….……..8	→801 →801 →801 →801 →801 →801

324	Did you hit the person you were fighting with first?	YES ..... 1 NO……..0	
	SUBSTANCE USE The next questions are about alcohol drinking		
801	How often do you have a drink containing alcohol?	NEVER ……1 MONTHLY OR LESS……...2 2-4 TIMES A MONTH……3 2-3 TIMES A WEEK……4 4 + TIMES A WEEK……5	 → 804 → 804 → 804 → 804
802	Have you ever drunk alcohol?	YES……..1 NO……..0	 → 815
803	Have you drunk alcohol in the past 12 months?	YES……..1 NO……..0	→806 → 812
804	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 OR 2……1 3 OR 4……2 5 OR 6……3 7 OR 9……4 10 OR MORE……5	
805	How often do you have six or more drinks on one occasion?	NEVER ……1 LESS THAN MONTHLY …….2 MONTHLY…….3 WEEKLY……4 DAILY OR ALMOST DAILY……..….5	
806	How often in the past year did you find you were not able to stop drinking once you started?	NEVER ……..……1 LESS THAN MONTHLY ……...2 MONTHLY……...3 WEEKLY……..….4 DAILY OR ALMOST DAILY…….5	

807	How often during the past year did you find you need a drink in the morning to get you going after a heavy drinking session?	NEVER ……1 LESS THAN MONTHLY ……..….2 MONTHLY…….…….3 WEEKLY…….4 DAILY OR ALMOST DAILY…….5	
808	How often in the past year have you failed to do what was normally expected from you because of drinking?	NEVER ……1 LESS THAN MONTHLY ……2 MONTHLY……...3 WEEKLY……..…….4 DAILY OR ALMOST DAILY…….5	
809	How often in the past year have you had a feeling of guilt or remorse after drinking?	NEVER ……1 LESS THAN MONTHLY ……...2 MONTHLY……..3 WEEKLY……..4 DAILY OR ALMOST DAILY…….5	
810	How often in the past year were you unable to remember what happened the night before because of your drinking?	NEVER ……1 LESS THAN MONTHLY ……2 MONTHLY……..…….3 WEEKLY…….4 DAILY OR ALMOST DAILY……..5	
811	How often in the past year did you have sex without a condom because of your drinking? Was it once, a few times or many times?	NEVER …….……1 ONCE……..…….. ……2 FEW TIMES…….…….3 MANY TIMES…….4	
812	Have you or someone else been injured as a result of your drinking?	NO……...1 YES, BUT NOT IN THE LAST YEAR…….2 YES, IN THE LAST YEAR …….3	
813	Has a friend or relative or doctor or health worker been concerned about your drinking and suggested that you cut down?	NO……...1 YES, BUT NOT IN THE LAST YEAR…….2 YES, IN THE LAST YEAR …….3	

814	Since the first interview, have you quarrelled with any of your girlfriends about your drinking?	YES ……1 NO ……..0	
815	Have you ever used … Dagga? Benzene? Mandrax? Drugs that you inject? Any other drug?	a) DAGGA..... YES =1 NO=0 b) BENZENE……ES=1 NO=0 c) MANDRAX ..... YES =1 NO=0 d) IDU ..... YES =1 NO=0 e) OTHER DRUG ..... YES =1 NO=0	
	CIRCUMCISION Now some last health questions		
326	Since the first interview, have you been circumcised?	YES ……1 NO ……..0	→401
327	In what month and year were you circumcised?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
328	Was it done by a traditional surgeon using traditional or modern methods or in hospital?	TRADITIONAL SURGEON OLD METHODS……..……1 TRADITIONAL SURGEON MODERN METHOD……..……2 HOSPITAL…… ...3	
329	At the time you were circumcised was it your choice to go, would you have liked to have gone earlier or later, or did you not want to go at all?	THEN……..……1 WANTED TO GO EARLIER.…….2 LATER…….3 DID NOT WANT TO GO AT ALL……. ...4	

330	Afterwards did you experience…. Delay in healing? Dehydration? Scarring? Infection? Anything else?	a) delayed healing……..YES=1 NO=0 b) dehydration..... YES =1 NO=0 c) scarring ..... YES =1 NO=0 d) infection..... YES =1 NO=0 e) other ..... YES =1 NO=0 Specify_____	
331	Did you have to attend hospital or the clinic because of problems after the circumcision?	YES ……1 NO ……..0	→401
332	Did you have to sleep a night or more in hospital because of problems after the circumcision?	YES ……1 NO ……..0	

SECTION FOUR: PARTNER

The next set of questions is about girlfriends.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401	Do you currently have a girlfriend or are you married or living with a woman or do you not have one now?	MARRIED ..... 1 LIVING WITH WOMAN ..... 2 GIRLFRIEND..... 3 NO GIRLFRIEND..... 4	→ chk5 → chk5 → chk5
402	Have you ever had a girlfriend?	YES..... 1 NO 0	 → chk3
403	When did your most recent relationship start?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
404	When did your most recent relationship end?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	→ CHK4

CHK3	IF HE HAS NEVER HAD A GIRLFRIEND SKIP TO QUESTION 577 (SEXUAL ABUSE AGAINST A NON-PARTNER)		
CHK4	IF RELATIONSHIP ENDED MORE THAN 12 MONTHS AGO SKIP TO Q. 535B (EVER STREAMLINED A GIRLFRIEND571 (SEXUAL ABUSE BY A NON-PARTNER))		
CHK 5	**I'd now like to ask you some questions about your current girlfriend and your relationship with her. If you have more than one I would like us to talk about the main one. It will help us talk about her if you can tell me her name or initials or a name we can use to talk about her even if it is one we make up for this purpose.** IF A PERSON DOES NOT HAVE A CURRENT 5-60 THEN ASK ABOUT THE MOST RECENT 5-60 – IF THERE HAS NEVER BEEN A 5-60 THEN ASK IF THEY CAN TALK ABOUT A RECENT CASUAL PARTNER.		
405	Is _____ also involved in this study?	NO……...0 YES..... 1 DON'T KNOW……...2	
405a	Was _____your main partner when you were first interviewed?	NO……...0 YES..... 1 DON'T REMEMBER……...2	
406	Which year was _____ born in?	30 06 [ ] [ ] [ ] [ ] Y Y Y Y DON'T KNOW	→408 →407
407	How old is she?	Years: [ ] [ ]	
408	Did _____ ever attend school?	NO……...0 YES..... 1 DON'T KNOW……...2	→411 →411

409	What is the highest level of education that _____achieved?	SUBA/GRADE 1 ……..……1 SUB B/GRADE 2……...2 STD 1/GRADE 3……3 STD 2/GRADE 4……4 STD 3/GRADE 5……5 STD 4/GRADE 6……6 STD 5/GRADE 7……..…7 STD 6/GRADE 8……..…8 STD 7/GRADE 9……..…9 STD 8/GRADE 10……10 STD 9/GRADE 11……11 STD 10/GRADE 12……12 INCOMPLETE DEGREE / QUALIFICATION.13 COMPLETED DEGREE / QUALIFICATION.14 DON'T KNOW……15	
410	**Is _____ currently studying?**	YES.....1 NO 0	
411	**Does _____ currently do anything to earn money?**	YES.....1 NO 0	
412	**Does _____ever drink alcohol? How often?**	EVERY DAY/NEARLY EVERY DAY ..1 ONLY AT WEEKENDS .....2 A FEW TIMES IN A MONTH .....3 LESS THAN ONCE A MONTH .....4 NEVER .....5 DON'T KNOW……...6	→ 415 → 415
413	**Have you ever quarrelled or had any other conflict over her drinking?**	YES……1 NO ……0	

415	**Do you and _____ ever discuss together you using contraception?**	YES……1 NO ……0	
416	**Do you and _____ ever discuss together methods to protect each other from HIV?**	YES……1 NO ……0	
417	**Do you and _____ ever discuss sex together?**	YES……1 NO ……0	
418	**Do you and _____ ever discuss having children together?**	YES……1 NO ……0	
419	In what month and year did your relationship with _____ start?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y DON'T KNOW MONTH = 06	
420	Have you had sex with _____?	YES……1 NO ……0	→422
421a	Do you ever have sex with her when she is menstruating?	YES……1 NO ……0	
422	How likely do you think it is that_____ is having sex with someone else? Would you say she definitely is, probably is, probably is not or definitely is not?	DEFINITELY IS ……1 PROBABLY IS……..…….2 PROBABLY NOT ……3 DEFINITELY NOT……...…….4	
423	Is _____ your 5-60/ main partner?	YES……1 NO ……0	
424	Are you her 5-60/ main partner?	NO……...0 YES.....1 DON'T KNOW……...2	

RELATIONSHIP CONTROL

I would now like to read out some statements and I would like you to think about your relationship with _____and for each statement to tell me if you strongly agree, agree, disagree or strongly disagree

428	I am quite comfortable when _____ greets men she knows	SA 1	A 2	D 3	SD 4
429	I like _____ to be at home when I come to check her, it bothers me if she is not there	1	2	3	4
430	I become jealous when _____ wears things that make her look too beautiful	1	2	3	4
431	I have more to say than _____ does about important decisions that affect us.	1	2	3	4
432	I never tell _____ who she can see or spend time with.	1	2	3	4
433	It might make me sad but _____ is free to leave our relationship any time she wants to	1	2	3	4
434	I like to do what I want, even if _____ doesn't want me to.	1	2	3	4
435	When _____and I disagree, I gets my way most of the time.	1	2	3	4
436	I like to know where _____ is most of the time	1	2	3	4
437	I expect _____ to do things for me like my ironing and cooking	1	2	3	4
438	Because I buy _____ things I expect her to please me	1	2	3	4
439	I let _____ know that she is not the only girlfriend I have or could have	1	2	3	4
440	When I want _____ to sleep over I expect her to agree	1	2	3	4

SECTION 5: RELATIONSHIPS AND VIOLENCE

The next questions are about your relationship with _____. We all have good and bad times in our relationships, these questions ask about some of these.

SOME OF THE QUESTIONS ASK ABOUT "ANY" PARTNER AND THESE ARE REFERRING TO ALL OF THE PARTNERS THE PERSON HAS HAD IN THEIR WHOLE LIFE.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP

501	In your relationship with _____ how often would you say that you have quarrelled? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
502	Would you say your relationship with _____ is it excellent, i-right, nje/just or ayiko right?	EXCELLENT…….1 IRIGHT……2 NJE/JUST……..…….3 AYEKO RIGHT…….4	
503	How often do you argue about money? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… …… 4	
504	Do you argue because she suspects that you are having an affair? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
505	Do you argue because you think she is having an affair? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	

506	Do you argue because she wants you to spend more time with her? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
507	Do you argue because she thinks you try to control her? Would you say never, rarely, sometimes or often?	NEVER……..1 RARELY ……. 2 SOMETIMES …….. 3 OFTEN …… 4	
	I want to read out some statements. Can you tell me if you strongly agree, agree, disagree, or strongly disagree with them?		
508	When I disagree with _____ I usually keep silent	STRONGLY AGREE……..……1 AGREE……..……2 DISAGREE……3 STRONGLY DISAGREE……...4	
509	When I disagree with _____ I try to talk the problem through with her	STRONGLY AGREE……..……1 AGREE……..……2 DISAGREE……3 STRONGLY DISAGREE……...4	
510	When I disagree with _____ we usually end up shouting	STRONGLY AGREE……..……1 AGREE……..……2 DISAGREE……3 STRONGLY DISAGREE……...4	
511	When I disagree with _____I try to say what I feel	STRONGLY AGREE……..……1 AGREE……..……2 DISAGREE……3 STRONGLY DISAGREE……...4	

512	I feel free to discuss my hopes, fears and future plans with _____	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……..4	
513	I would feel free to tell _____ if I had HIV	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……..4	
514	I would feel free to tell _____ if I had an STD	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……..4	
515	I would feel free to tell _____ if I wanted the relationship to end.	STRONGLY AGREE……1 AGREE……2 DISAGREE……3 STRONGLY DISAGREE……..4	
	EMOTIONAL ABUSE **In any relationship there are good times and bad times. I now want to ask you about some of the bad times we have in relationships and what has happened. Remember there are no right or wrong answers and anything you say will be kept confidential. I want to first ask you about what happened since the first interview.**		
516	Since the first interview did you insult _____ or any other girlfriend or made her feel bad about herself? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	
517	Since the first interview did you belittle or humiliate _____ or any other girlfriend front of other people? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW.....3 MANY.....4	

518	Since the first interview did you do things to scare or intimidate _____ or any other girlfriend on purpose for example by the way you looked at her, by yelling and smashing things? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
519	Since the first interview have you threatened to hurt _____ or any other girlfriend? Did you do this many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
520	Since the first interview have you stopped _____ or any other girlfriend from seeing any of her friends? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
CHK6	IF ANY EMOTIONAL ABUSE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 522		
521	Was _____ one of the girlfriends who you did these things to?	YES…….1 NO……..0	

PHYSICAL ABUSE

Men are often fighting with their girlfriends and often these fights get physical. I am going to ask some questions about this. I want you to speak freely and remember that everything you say will be confidential.

522	Since the first interview, did you slap _____ or any other girlfriend or throw something at her which could hurt her? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
523	Since the first interview, did you push or shove _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	

524	Since the first interview, did you hit _____ or any other girlfriend with a fist or with something else which could hurt her? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
525	Since the first interview, did you kick, drag, beat, choke or burn _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
526	Since the first interview, did you threaten to use or actually use a gun, knife or other weapon against _____ or any other girlfriend? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
CHK 7	IF ANY PHYSICAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 530		
527	When was the most recent time you had an argument with a girlfriend that got physical?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
528	Since the first interview on how many occasions in did you have an argument with any girlfriend that got physical?	[ ] [ ] NUMBER	
529	Since the first interview did you have an argument with _____ that got physical?	YES……1 NO……..0	
SEXUAL ABUSE			
530	Since the first interview did you physically force _____ or any other girlfriend to have sex with you when she did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	

531	Since the first interview do you think _____ or any other girlfriend had sex with you when she did not want to because she was afraid of what you might do? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
532	Since the first interview did you force _____ or any other girlfriend to have oral sex with you when she did not want? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
533	Since the first interview did you force _____ or any other girlfriend to have anal sex with you when she did not want to? Did this happen many times, a few times, once or did it not happen?	NEVER.....1 ONCE .....2 FEW .....3 MANY 4	
CHK 8	IF ANY SEXUAL VIOLENCE IS REPORTED PROCEED TO THE NEXT QUESTION OTHERWISE SKIP TO Q. 535a		
534	When was the most recent time you forced a girlfriend to have sex when she did not want it?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
535	Since the first interview did you force _____ to have sex when she did not want it?	YES……1 NO……..0	
535a	Since the first interview have you done streamlining with one of your girlfriends?	YES……1 NO……..0	
535b	Have you ever streamlined one of your girlfriends?	YES……1 NO……..0	
ALL MEN, EVEN THOSE WHO HAVE NEVER HAD A GIRLFRIEND, SHOULD BE ASKED THE FOLLOWING QUESTIONS			

SEXUAL VIOLENCE AGAINST NON-GIRLFRIENDS

We all know that boys in our communities are sometimes pressurized to do sexual things when they do not want to and sometimes make girls do sexual things they do not want to. I would now like to ask you some questions about this. The next set of questions is about situations you may have been in with women who were not girlfriends.

IF HE MENTIONS FORCING A GIRLFRIEND, CHECK THAT THIS WAS REPORTED IN RESPONSE TO Q.s 530 & 531. IF NOT, GO BACK TO Q.s 530 & 531 AND ASK THEM AGAIN. THEN RETURN TO Q.s 571 & 572 AGAIN AND PROBE BY SAYING "DID YOU DO THIS WITH ANYONE OTHER THAN YOUR GIRLFRIEND"

577	**Since the first interview, have you done streamlining?**	YES……1 NO ……0	
578	**Since the first interview, was there an occasion when you and other men had sex with a woman against her will or when she was too drunk to stop you?**	YES……1 NO ……0	**IF NO TO 577 & 578 → 571**

578a	Thinking about the last time you did streamlining or had sex with friends, which of the following statements describe how it came about: a) We had been drinking with the woman b) We asked her for sex and she agreed c) We pleaded with her until she agreed d) We forced her until she agreed e) She agreed to have sex with one of the group and then the others came and did it too f) We tricked her g) We got her drunk h) We drugged her i) Her boyfriend organised it j) We found her very drunk or unconscious	a)We had been drinking with the woman Yes…1 No…0 b)We asked her for sex and she agreed Yes…1 No…1 c)We pleaded with her until she agreed Yes…1 No…0 d)We forced her until she agreed Yes1 No.10 e)She agreed to have sex with one of the group and then the others came and did it too Yes…1 No…0 f)We tricked her Yes…1 No…0 g)We got her drunk Yes…1 No…0 h)We drugged her Yes…1 No…0 i) Her boyfriend organised it Yes…1 No…0 j) We found her very drunk or unconscious Yes…1 No…0	

578b	Which of the following statements best describe the reasons why you did it? a) We wanted to have some fun b) My friend wanted to punish her c) We thought it would be a nice thing d) We all wanted her e) It was a clash f) We were really bored g) It was just a game h) We were experimenting with sex i) I felt under pressure to join in j) We just wanted to see if we could do it k) We just wanted to have sex l) other	a) We wanted to have some fun Yes 1 No 0 b) My friend wanted to punish her Yes 1 No 0 c) We thought it would be a nice thing Yes 1 No 0 d) We all wanted her Yes...1 No 0 e) It was a clash Yes 1 No 0 f) We were really bored Yes 1 No 0 g) It was just a game Yes 1 No 0 h) We were experimenting with sex Yes 1 No…0 i) I felt under pressure to join in Yes 1 No 0 j) We just wanted to see if we could do it Yes…1 No…0 k) We just wanted to have sex Yes…1 No…0 l) other Yes…1 No…0	
578c	What did you think about after the streamlining? What of the following statements describe what you were thinking? a) I felt closer to my friends b) It was fine c) I felt bad afterwards d) I worried she would tell someone e) It made me feel really good f) I did not really think about it	a) I felt closer to my friends Yes…1 No…0 b) It was fine Yes…1 No…0 c) I felt bad Yes…1 No…0 d) I worried she would tell someone Yes…1 No…0 e) It made me feel really good Yes…1 No…0 f) I did not really think about it Yes…1 No…0	

571	**Since the first interview have you made a woman or girl, other than your girlfriend at the time, have sex with you when she did not want to?**	**YES..... 1** **NO..... 0**	
572	**Since the first interview have you made a woman or girl, other than your girlfriend at the time, have sex with you when she was too drunk to say whether she wanted it?**	**YES..... 1** **NO..... 0**	**IF NO TO 571 & 572 → CHK11b**
575	Did it happen once, a few times or many times?	ONCE ……1 FEW .....……..2 MANY……3	
576	When was the most recent time this happened?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	
578d	Thinking about the last time you made a woman or girl have sex when she did not want it or was very drunk, which of the following statements describe how it came about: a) I had been drinking with her b) I touched her and pleaded with her until she agreed c) I forced her until she agreed d) I tricked her e) I got her drunk f) I drugged her g) I found her very drunk or unconscious h) I was too strong for her i) She agreed but changed her mind	a)I had been drinking with her Yes…1 No…0 b)I touched her and pleaded with her until she agreed Yes…1 No…0 c) I forced her until she agreed Yes1 No.10 d)I tricked her Yes…1 No…0 e)I got her drunk Yes…1 No…0 f)I drugged her Yes…1 No…0 g) I found her very drunk or unconscious Yes…1 No…0 h) I was too strong for her Yes…1 No…0 i) She agreed but changed her mind Yes..1 No..0	

578e	Which of the following statements best describe the reasons why you did it? a) I was angry with her b) I wanted to punish her c) I thought it would be a nice thing d) I was in love with her e) I wanted her f) I was bored g) It was a game h) I wanted to see if I could do it i) I wanted to have sex j) Another woman had made me angry	a) I was angry with her Yes 1 No 0 b) I wanted to punish her Yes 1 No 0 c) I thought it would be a nice thing Yes 1 No 0 d) I was in love with her Yes..1 No 0 e) I wanted her Yes 1 No 0 f) I was bored Yes 1 No 0 g) It was a game Yes 1 No 0 h) I wanted to see if I could do it Yes…1 No…0 i) I wanted to have sex Yes…1 No…0 j) Another woman had made me angry Yes…1 No..0	
CHK 11b	**DID HE ANSWER YES TO Q. 571, 572, 577, OR 578? IF NO → Q. 579 OTHERWISE GO TO NEXT QUESTION.**		
570	**Since the first interview, how many women who were not your girlfriend have you made to have sex with you?**	**[ ] [ ] WRITE 0 0 IF NONE**	
579	**Since the first interview, was there a time when you tried to make a woman or girl, other than your girlfriend at the time, have sex with you when she did not want to but did not actually have sex with her?**	**YES.....1 NO.....0**	**→ 601**
581	Did it happen once a few times or many times?	ONCE……1 FEW ..... …….2 MANY……3	
582	When was the most recent time this happened?	15 [ ] [ ] [ ] [ ] [ ] [ ] M M Y Y Y Y	

CHK 12	***IF THE MAN HAS NEVER HAD SEX SKIP TO SECTION 7 – MENTAL HEALTH***

SECTION 6: SEXUAL BEHAVIOUR

The next questions are about your sexual relationships. Please remember that everything you say will be kept secret and your name will not appear anywhere on the questionnaire.

601	When was the last time you had sex?	[ ] [ ]DAYS (IF LESS THAN 14 DAYS) [ ] WEEKS (IF 2-8 WEEKS) [ ] [ ] MONTHS (IF OVER 8 WEEKS)	
602	The last time you had sex did you use a condom?	YES ..... 1 NO……..0	→ 606
603	Did you use a condom for every round?	YES ..... 1 NO……..0	
604	Who brought the condom, was it you or your partner?	SELF..... 1 PARTNER……..2 BOTH……..3	
605	Did you experience: m) condom breaking n) condom slipped off o) condom only put on half way p) condom was removed	a) CONDOM BROKE……..YES =1 NO=0 b) SLIPPED OFF ……..…YES=1 NO=0 c) ONLY PUT IT ON HALF WAY….YES =1 NO=0 d) CONDOM REMOVED WHEN LOVE MAKING CONTINUED…..YES =1 NO=0	
	We know that people have different types of affairs. We have our 5-60s or main partners, our Khwapheni and sometimes we have sex with a person who we never see again or never have sex with again, let's call these one-off partners		

606	The last time you had sex was it with a 5-60, or Khwapheni or one off partner or ex-partner?	MAIN PARTNER……..1 KWAPENI……..2 ONE OFF……..3 EX-PARTNER……..4	→ 607
CHK 13	CHECK Q. 420 HAS HE HAD SEX WITH HIS 5-60? YES → 607 NO→ 612		
607	Have you used condoms with your 5-60 since the first interview? Would you say you used them always, often or sometimes?	NO USE ..... 1 ALWAYS ..... 2 OFTEN..... 3 SOMETIMES…….4	→ 612 → 612 → 612
608	Have you suggested to your 5-60 that you use a condom to protect you from HIV since the first interview?	YES ..... 1 NO 0	→ 610
609	How did she respond? RECORD ALL MENTIONED	AGREE TO USE ONE…… YES =1 NO=0 BECAME ANGRY ……..YES =1 NO=0 SAID SHE DID NOT LIKE THEM… YES =1 NO=0 SHE WAS OFFENDED…… YES =1 NO=0 OTHER……YES =1 NO=0 SPECIFY_____	ALL TO → 612

610	What is the main reason why you have not suggested condom use? RECORD ALL MENTIONED	NEVER THOUGHT OF ASKING….YES =1 NO=0 TRUST EACH OTHER … ……..YES =1 NO=0 DOES NOT KNOW HOW TO ASK…YES =1 NO=0 FEAR SHE WOULD LEAVE……. YES =1 NO=0 HE DOES NOT LIKE THEM……. YES =1 NO=0 TRYING TO GET PREGNANT…… YES =1 NO=0 OTHER…… YES =1 NO=0 SPECIFY_____	
612	Would you say that getting a condom in this area is very easy, easy, quite difficult or very difficult?	VERY EASY……..1 EASY……2 QUITE DIFFICULT……..…3 VERY DIFFICULT……4	
612a	Havre you been on holiday since the first interview?	YES ..... 1 NO 0	
612b	Did you have a sexual partner when you were on holiday?	YES ..... 1 NO 0	
613	How many 5-60s have you had sex with since the first interview?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
614	How many Khwapheni have had sex with since the first interview?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
615	How many men have you had sex with just once since the first interview?	[ ] [ ] NUMBER (IF NONE ENTER 00)	
CHK 14	ANY KWAPHENI OR ONE OFF PARTNERS MENTIONED? IF YES go to Q. 616 OTHERWISE go to CHK 15		

616	Since the first interview have you used condoms with Khwapheni and one off partners? Would you say you used them always, often or sometimes?	NO USE ..... 1 ALWAYS ..... 2 OFTEN..... 3 SOMETIMES 4	ALL USE RS → 621
617	Have you suggested to Khwapheni or one off partner that you use a condom to protect you from HIV since the first interview?	YES ..... 1 NO 0	→ 620
618	How many times have you suggested condom use to Khwapheni or one off partners since the first interview?	[ ] [ ] NUMBER	
619	What responses did you get? RECORD ALL MENTIONED	AGREE TO USE ONE…… YES =1 NO=0 BECAME ANGRY ……..YES =1 NO=0 SAID SHE DID NOT LIKE THEM… YES =1 NO=0 SHE WAS OFFENDED…… YES =1 NO=0 OTHER……YES =1 NO=0 SPECIFY_____	ALL TO → CHK 15
620	What is the main reason why you have not suggested condom use? RECORD ALL MENTIONED	NEVER THOUGHT OF ASKING….YES =1 NO=0 TRUST EACH OTHER … ……..YES =1 NO=0 DOES NOT KNOW HOW TO ASK…YES =1 NO=0 FEAR SHE WOULD LEAVE……. YES =1 NO=0 HE DOES NOT LIKE THEM……. YES =1 NO=0 TRYING TO GET PREGNANT…… YES =1 NO=0 OTHER…… YES =1 NO=0 SPECIFY_____	
CHK 15	CHECK Q.s 607 AND 616 HAS HE USED CONDOMS IN THE PAST YEAR? YES → 621 NO → Q.100ai		

621	Since the first interview, how often have you experienced the condom breaking or slipping off or only put it on half way through or have you taken it off and continued love making?	EVERY TIME USED .....1 OFTEN .....2 SOMETIMES .....3 NEVER……4 NO USE……..5	
	I would like to ask you some questions about the partners you have had since the first interview. NOTE IF THERE ARE 9 OR FEWER (INCLUDING THE CURRENT ONE) START WITH ANY CURRENT PARTNERS AND THEN WORK BACKWARDS. IF THERE ARE MORE THAN 9 TAKE THE MAIN PARTNERS AND THEN THE MOST RECENT ROLL-ONS AND ONLY TAKE ONE OFFS AFTERWARDS. WE DO NOT NEED THESE COMPLETED FOR MORE THAN 8 PARTNERS. COPY THE TOTAL NUMBER OF PARTNERS FROM THE PREVIOUS PAGE Q.613 + Q.614+Q.615) HERE _____. Who was there apart from your main partner?		
No.	Write the initials →	_____	
100a 1	How old was this partner?	[ ][ ] years	
100b 2	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	

100c 3	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d 4	Did she live in the same village or place as you?	YES.....1 NO 0	
No.	Write the initials →	_____	
100a 5	How old was this partner?	[ ][ ] years	
100b 6	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c 7	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d 8	Did she live in the same village or place as you?	YES.....1 NO 0	
No.	Write the initials →	_____	
100a 9	How old was this partner?	[ ][ ] years	

100b 10	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c 11	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d 12	Did she live in the same village or place as you?	YES.....1 NO 0	
No.	Write the initials →	_____	
100a 13	How old was this partner?	[ ][ ] years	
100b 14	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c 15	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d 16	Did she live in the same village or place as you?	YES.....1 NO 0	

No.	Write the initials →	_____	
100a 17	How old was this partner?	[ ][ ] years	
100b 18	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c 19	When did you have sex for the last time time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d 20	Did she live in the same village or place as you?	YES.....1 NO 0	
No.	Write the initials →	_____	
100a 21	How old was this partner?	[ ][ ] years	
100b 22	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c 23	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	

100d 24	Did she live in the same village or place as you?	YES.....1 NO 0	
No.	Write the initials →	_____	
100a 25	How old was this partner?	[ ][ ] years	
100b 26	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100c 27	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d 28	Did she live in the same village or place as you?	YES.....1 NO 0	
No.	Write the initials →	_____	
100a 29	How old was this partner?	[ ][ ] years	
100b 30	When did you have sex for the first time?	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	

100c 31	When did you have sex for the last time? IF THEY ONLY HAD SEX ONCE ENTER THE SAME DATE HERE AS FOR THE FIRST TIME	[ ] [ ] [ ] [ ] 19 [ ] [ ] D D M M Y Y WRITE 15 IF DAY NOT KNOWN	
100d 32	**Did she live in the same village or place as you?**	YES.....1 NO 0	
Most of us like nice things. We as men often give presents to our girlfriends or give some money to women we have had sex with; sometimes we find we are given presents by women who desire us. Sometimes we know these relationships or the sex would not happen if we did not give or receive money or presents.			
625a	Since the first interview, have you been involved with a woman as a 5-60 because she provided you with or you expected that she would provide you with: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to stay? Cash?	FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES ..... YES =1 NO=0 PLACE TO STAY..... YES =1 NO=0 CASH ..... YES =1 NO=0 NEVER HAD SEX WITH 5-60 ☐	

626a	Since the last interview have you been involved with a griza because she provided you with or you expected that she would provide you with: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to sleep? Cash? Alcohol or a good time?	 FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 DRINK/ GOOD TIME..... YES =1 NO=0 ☐ NEVER HAD GRIZA	 → 628a
627a	Did you have sex with her?	YES……1 NO……0	
628a	Now I would like you to think about women you have had sex with only once since the first interview. Have you had sex with a such a woman because she gave you or you expected that she would give you: Food? Clothes? A lift, a ticket, or money for transport? A place to sleep for the night? Cash?	 FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 ☐ NEVER HAD ONCE OFF PARTNER	
CHK 16a	CHECK QUESTIONS 625a, 626a & 628a IF NO "YES" ANSWERS SKIP TO Q.625		

629a	When was the last time you had sex with a woman because she gave you or you expected that she would give you money or something else?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
625	Thinking about the 5-60s that you have had since the last interview. Do you think any of them may have become involved with you because they expected you to provide them with, or because you provided them with, any of the following: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to stay? Cash? Status? Cosmetics? Items for her children or family such as clothes, food, school fees?	FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES ..... YES =1 NO=0 PLACE TO STAY ..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 COSMETICS ..... YES =1 NO=0 CHILDREN / FAMILY .... YES =1 NO=0 ☐ NEVER HAD SEX WITH 5-60	

626	Thinking about the Khwapheni that you have had since the last interview. Do you think any of them may have ever become involved with you because they expected you to provide them with (or because you provided them with) any of the following: Food? Clothes? Transport, tickets or money for transport? (If school) Your own school fees or residence fees? Somewhere to sleep? Cash? Status? Cosmetics? Items for her children or family such as clothes, food? Drink/good time?	FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 SCHOOL FEES ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 COSMETICS ..... YES =1 NO=0 CHILDREN / FAMILY .... YES =1 NO=0 DRINK/ GOOD TIME..... YES =1 NO=0 NEVER HAD KWAPHENI ☐	→ 628
627	Did you have sex with this partner?	YES……1 NO……0	

628	Now I would like you to think about women you have had sex with only once since the first interview. Have you had sex with such a woman because you gave her or she expected that you would give her: Food? Clothes? A lift, a ticket, or money for transport? A place to sleep for the night? Cash? Status? Drink or a good time?	 FOOD ..... YES =1 NO=0 CLOTHES..... YES =1 NO=0 TRANSPORT ..... YES =1 NO=0 PLACE TO SLEEP ..... YES =1 NO=0 CASH ..... YES =1 NO=0 STATUS..... YES =1 NO=0 DRINK/GOOD TIME……YES =1 NO=0 ☐ NEVER HAD ONCE OFF PARTNER	
CHK 16	CHECK QUESTIONS 625, 626 & 628 IF NO "YES" ANSWERS SKIP TO Q.701		
629	When was the last time you had sex with a woman because you gave her or she expected that you would give her money or something else?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
630	In what month and year did you first have sex with a woman because you gave her or she expected that you would give you money or something else?	15 [ ] [ ] [ ][ ] [ ] [ ] M M Y Y Y Y	
631	How many women have you had sex with because you gave her or she expected that you would give you money or something else?	[ ] [ ] NUMBER ENTER 00 IF NONE	
632	How old was the oldest one?	[ ] [ ] YEARS	
633	How old was the youngest one?	[ ] [ ] YEARS	

SECTION 7: MENTAL HEALTH STATUS

Thank you very much for answering all these questions we are now getting towards the end of the questionnaire and I would like to ask you some questions about how you have been feeling in the past week. I am going to read out some statements and ask you to say how many days you have had particular feelings or ideas or whether you have not had them at all.

		Rarely or none of the time	Some or a little of time (1-2 days)	Moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
701	During the past week I was bothered by things that usually don't bother me	0	1	2	3
702	During the past week I did not feel like eating, my appetite was poor	0	1	2	3
703	During the past week I felt I could not cheer myself up even with the help of family and friends	0	1	2	3
704	During the past week I felt I was just as good as other people	0	1	2	3
705	During the past week I had trouble keeping my mind on what I was doing	0	1	2	3
706	During the past week I felt depressed	0	1	2	3
707	During the past week I felt that everything I did was an effort	0	1	2	3
708	During the past week I felt hopeful about the future	0	1	2	3
709	During the past week I thought my life had been a failure	0	1	2	3
710	During the past week I felt fearful	0	1	2	3

711	During the past week my sleep was restless	0	1	2	3
712	During the past week I was happy	0	1	2	3
713	During the past week I talked less than usual	0	1	2	3
714	During the past week I felt lonely	0	1	2	3
715	During the past week people were unfriendly	0	1	2	3
716	During the past week I enjoyed life	0	1	2	3
717	During the past week I had crying spells	0	1	2	3
718	During the past week I felt sick	0	1	2	3
719	During the past week I felt that people dislike me	0	1	2	3
720	During the past week I could not get 'going'	0	1	2	3
724	Now I want to ask you a question about the past **four weeks,** has the thought of ending your life been in your mind?	YES……1 NO……0			
	Can I just ask you the last of the questions about yourself; remember all the information will be confidential.				
733	**Since you were 15, have you been involved in a physical fight in the community?**	YES……1 NO ……0			
732	**Were you ever involved in a physical fight at high school?**	YES……1 NO ……0			
734	**Have you ever been involved in a fight with weapons (such as knives) in your community?**	YES……1 NO ……0			
729	**Have you ever been arrested for using violence?**	YES……1 NO ……0			
730	**Have you ever been arrested for having or using a weapon such as a knife or gun?**	YES……1 NO ……0			

731	**Since the first interview, have you been arrested for either of these?**	YES……1 NO ……..0	
725	**Since the first interview, have you been a member of a gang?**	YES……1 NO ……..0	
726	**Since the first interview, have you been in prison or held in a police cell overnight?**	YES……1 NO ……..0	
727	Since the first interview, have you had sex with another man?	YES……1 NO ……..0	
735	Have you ever worked as a taxi conductor or driver?	YES……1 NO ……..0	
736	Have you worked as a taxi conductor or driver since the first interview?	YES……1 NO ……..0	

SECTION NINE: YOU AND YOUR COMMUNITY

The last set of questions I want to ask are about your community. Thank you very much for your time, we are nearly finished now. I am going to ask these questions and for each I would like to know whether the answer is definitely yes, probably yes, probably no or no.

901	Do neighbours in this area tend to know each other well?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……..4
902	In this area do most people generally trust each other in matters of lending and borrowing?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……..4
903	If there was a fistfight in this area would people do something to stop it?	DEFINITELY YES……..1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……..4

904	If you were away from home for some time and on coming back you found that your home was broken in to, would you think it likely that your neighbour would give you some help with food or blankets or clothes?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……4
905	If you were going out on a trip and didn't have enough provision would you expect the other group members to share what they had with you?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……4
906	In this area, is it safe to walk around at night?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……4
907	In this area, do women fear being raped?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……4
908	In this area do men fear being robbed?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……4
909	Would people in this area say there is a lot of crime?	DEFINITELY YES……1 PROBABLY YES……2 PROBABLY NO……3 DEFINITELY NO……4

FINISH

I would like to thank you very much for helping us. We have talked about some very difficult things today. I appreciate the time you have taken. I realise that some of these questions may have been difficult for you to answer, but we have to ask them if we are to really understand men's lives. We really appreciate your participation in this study. By sharing this personal information with us you are helping us with our research and that will ultimately help many other people in the country.

End Time of Interview: _____ h _____

Appendix 1.3: Participants information and consent form

CONSENT TO PARTICIPATE IN RESEARCH EVALUATING *'STEPPING STONES'*

Introduction

HIV touches the lives of all of us in South Africa. The Government estimates that over three million people are infected with the virus. Unless we radically change our sexual practices, within ten years we will find that out of every four people, one will have the virus. HIV affects men and women of all ages, occupations and races living in all provinces. Many of us already have family members who have died from HIV, some of us may have it ourselves and most of the rest of us will soon find that somebody close to us is infected. Unless we take the necessary precautions we could all contract HIV.

The problem is great and can seem terrifying and overwhelming, and yet the greatest tragedy of HIV is that we know how to prevent the infection. Other countries in Africa, most notably Uganda, have been able to harness the energies of all sectors of their society to fight the epidemic and have managed to turn back the tide of the disease. This has been done by achieving substantial changes in sexual behaviour. This can be done in South Africa too, but if it is to happen we all need to play our part.

Why do we need to undertake research on HIV prevention?

Health workers have known for many years what behaviour changes are needed to prevent HIV infection, but we do not have a good understanding of how to persuade people to change their behaviour. We have found that just telling people the facts about AIDS is not enough; we have to develop better approaches which help people overcome the barriers to changing their behaviour. One such approach is called “Stepping Stones”.

What is “Stepping Stones”?

It is a participatory training programme which is designed to be educational and also fun, and a person does not have to be well educated to learn and take part. It is used with both men and women, but in separate groups. The programme is made up of 14 separate sessions which look at gender roles, what is love?, sexual problems, sexual health, HIV, safer sexual practices, gender violence, why we behave in the ways that we do, loss and dying and provides training in communication and relationship skills. There are also five broader meetings in the programme. Three of these are just for people who are participating in Stepping Stones training and enable the single sex peer groups to present their work to each other and communicate with each other. The other two are held at the start and end of the programme and are designed to involve the broader community. In the final meeting participants from Stepping Stones workshops make special requests to the broader community. These are requests concerning their own lives, HIV and gender violence, which they would like the broader community to accept in order to improve life in the community.

This long version of Stepping Stones has been used in South Africa for some years and people have been very enthusiastic about it. However we want to test for sure whether it can change sexual and reproductive health practices. If it is successful Stepping Stones could make a big difference to our communities and prevent many people from becoming infected with HIV and provide a much more supportive environment for people who have it. In order to see how good it is we have prepared a short version of Stepping Stones, let's call that 'Stepping Stones Short', which takes three hours and addresses HIV, sexually transmitted diseases and safer sexual practices. We want to compare the two versions of Stepping Stones.

The research

I am being asked to participate in a scientific study to see which of the two versions of Stepping Stones is better at preventing HIV infections and changing sexual practices. I understand that one group of people will receive the long version of Stepping Stones now and another group will receive the short version. I understand that the group which will get Stepping Stones Short now will be offered the long version after two years if they want it.

Which intervention group?

I understand that I will not find out whether I will get Stepping Stones long or short until after have agreed to participate in the study. I understand that the process will be at random or like tossing a coin and I agree to abide by this.

In addition to agreeing to participate in the health promotion programme, I agree to participate in the research by completing a questionnaire and giving a small sample of blood from my arm.

The questionnaire

I understand that the questionnaire will be completed by an interviewer. I understand that this will include questions about my home, my health, sexual and reproductive health matters, my attitudes towards condoms and relationships between men and women and some questions about my relationships. I understand that there will be some questions about things which are often thought of as secrets but which can often influence whether or not a person is at risk of HIV. I understand that everything which I tell the interviewer will be kept secret. I understand that even the person who is conducting the group will not know what I say. I understand that I have the right not to answer any questions that I do not wish to answer. I understand that the questionnaire will take about 30 minutes to complete.

Blood test

I agree to give a small amount of blood. I understand that this will be tested for HIV now. I understand that this will involve a small amount of discomfort. I understand that the nurse will know whether I have HIV within 10-20 minutes of doing the test.

Many people are very worried about HIV infection and are very keen to know whether they have it or not. I understand that before having the test I will receive counselling and if I opt to have the result I will receive counselling again afterwards. I understand that I may choose whether to get the result and will not be told it, even if it is positive if I opt not to hear it. I understand that the result will be kept secret. The information will only be communicated to a study leader in Pretoria and she will not know my name. The information will not be given to anyone else who may come to learn that we have it. I understand that if I am found to have HIV that it is a very serious illness which cannot be cured. I will not be excluded from the study.

I understand that after the blood test the blood specimen will be stored and I agree that it can be tested in future, but only for research purposes. I understand that it will not be sold or used for any commercial purposes. I understand that any results which arise from future testing will also be kept confidential.

If I agree to hear my HIV result

I understand that I will be told the result if I agree to this. I understand that if the result is negative it means that I most probably do not have HIV, although there is a small chance that I could have it and it not be revealed if I only recently caught it. I understand that if the result is positive, it will be likely that I have been infected with the virus but to be completely sure I will need another test. I understand that the study team will help me go to a clinic run by PHASO in Umtata for another test, counselling and basic care. They will pay for the costs of this.

How often will the questionnaire be completed and the blood test taken?

In agreeing to participate in this research, I agree to work with the study team over a period of two years. As well as completing a questionnaire and giving blood now, I agree to give an interview again in six months time. I understand that there will be no blood test then. I understand that I will be asked to complete the questionnaire again and give blood again in a year and then for the last time one year after that. I agree to the study team taking my photograph and making me and ID card for the study which I will bring every time I am interviewed. I understand that every time I give blood I will be asked whether I wish to hear my HIV results or not. I agree that if I move I will leave an address and that the study team may contact me at my new address.

What will be the benefits of participation?

Benefits for me

HIV/AIDS is a major problem in South Africa; it is believed that as many as one out of every ten people has the infection. The interventions will provide me with information; attitudes and skills which will help protect you against HIV. If I decide to hear my HIV test results I will also benefit from knowing my status. It has been explained to me that if I am negative this can help me make decisions to protect myself to make sure I remain negative. If I am positive it is important to know this so I can try and look after myself and make sure that I stay well for as long as possible and can plan for the future. It has been explained to me that I will be given R20 to compensate me for time spent completing the questionnaire and giving blood every time I am interviewed.

Benefits for society

It has been explained to me that overcoming HIV/AIDS is one of the most important challenges facing South Africa this century. In order to do this effectively it is necessary to know whether particular tools to have to use to do this are effective, before they are made them widely available. By participating in this study, I will be playing your part in the broader struggle against HIV and AIDS.

What are the risks?

I understand that there is no major medical risks involved with participating in this study. I understand that some of the questions may cause emotional distress when responding to them, but that the study staff will provide me with support to minimise these risks. I understand that there is a small risk that certain information could become known. The study staff has taken precautions to protect my information. They will identify me only by ID number, not by my name. Only the nurses and the study leader in Pretoria will know my HIV result. I understand that all the staff involved in this study has been give special training on the importance of confidentiality. I understand that there is a small risk that information I disclose in the intervention workshops could become known. I understand that I do not have to share information with a group that I do not want to and that all group members will also discuss the importance of confidentiality.

Can we change our mind about participating after we agree?

I understand that at any stage I can change my mind and no longer participate. I can then stop participating and I will not be punished in any way for this.

Having read and understood the above explanation,

I, _____ of _____, agree to participate in the *Stepping Stones* evaluation study.

Signed _____Date_____

Witness_____ Date _____

RCT EVALUATION OF STEPPING STONES: CONSENT FORM FOR HIV TEST RESULT

INITIAL TEST

I, _____Of _____,

Have agreed to participate in the research to evaluate Stepping Stones. I have agreed, after counselling, to give a specimen of blood which will be tested for HIV. I have been told that this will involve drawing blood from a vein in my arm with a needle. The blood will immediately be tested and the specimen of my blood will be kept and may be tested in future for research purposes only. I have been told that that HIV is a serious infectious disease and that there is no cure for HIV. The result will be confidential. It will not be communicated to any person, apart from the main researcher in Pretoria, in any way which could enable someone to know whether or not I have HIV. I understand that I can choose whether or not I wish to be told whether or not I have HIV. I understand that if I am found to have HIV and have chosen to get my result I will be referred for a further test, counselling and support in Umtata.

I hereby declare that:

- I would like to be told my test result i.e. whether or not I have HIV

- I do not wish to be told my test result whether it is negative or positive

I have circled my chosen option.

Signed _____Date_____

Witness_____ Date _____

RCT EVALUATION OF STEPPING STONES: CONSENT FORM FOR HIV TEST RESULT

END OF YEAR 1

I, _____Of _____,

have agreed to participate in the research to evaluate Stepping Stones. I have agreed, after counselling, to give a specimen of blood which will be tested for HIV. I have been told that this will involve collecting a drop of my blood from a prick on my finger. The blood will immediately be tested and no specimen of my blood will be kept for any purpose. I have been told that that HIV is a serious infectious disease and that there is no cure for HIV. The result will be confidential. It will not be communicated to any person, apart from the main researcher in Pretoria, in any way which could enable someone to know whether or not I have HIV. I understand that I can choose whether or not I wish to be told whether or not I have HIV. I understand that if I am found to have HIV and have chosen to get my result I will be referred for a further test, counselling and support in Umtata.

I hereby declare that:

- I would like to be told my test result i.e. whether or not I have HIV

- I do not wish to be told my test result whether it is negative or positive

A agree to have the blood test and I have circled my chosen option.

Signed _____Date_____

Witness_____ Date _____

RCT EVALUATION OF STEPPING STONES: CONSENT FORM FOR HIV TEST RESULT

END OF YEAR 2

I, _____Of _____,

Have agreed to participate in the research to evaluate Stepping Stones. I have agreed, after counselling, to give a specimen of blood which will be tested for HIV. I have been told that this will involve collecting a drop of my blood from a prick on my finger. The blood will immediately be tested and no specimen of my blood will be kept for any purpose. I have been told that that HIV is a serious infectious disease and that there is no cure for HIV. The result will be confidential. It will not be communicated to any person, apart from the main researcher in Pretoria, in any way which could enable someone to know whether or not I have HIV. I understand that I can choose whether or not I wish to be told whether or not I have HIV. I understand that if I am found to have HIV and have chosen to get my result I will be referred for a further test, counselling and support in Umtata.

I hereby declare that:

- I would like to be told my test result i.e. whether or not I have HIV

- I do not wish to be told my test result whether it is negative or positive

I have circled my chosen option.

Signed _____Date_____

Witness_____ Date _____

Appendix 2.1: Interview guide

Introduction: an informal conversation will be engaged in to break the ice and develop rapport with the participant so that they feel comfortable.

Experiences:

The interview will move on starting by acknowledging to the participant that everyone feels distressed at some point in time and encourage them to think of a recent episode and tell the story of what happened.

Could you explain what happened?

How did you feel?

Did it in any way change how you go about daily? In what ways?

Participants will be encouraged to speak about a time when they have been distressed even if it fell outside the past few weeks/months. The main objective of this question is to elicit information about signs and symptoms of distress. Participants can make reference to more than one instance.

Expressions: did you try to get any help for your experience specifically about how you felt.

If yes, where?

If no, why not? What influence your decision to seek help (or not)?

If you were extremely distressed where would you go for help with your distress?

Here participants are encouraged to share information about their sources of help/strength n the face of adversity. The researcher will explore whether they would go

to the clinic for counselling, traditional healer for help or spiritual healer for prayers. Also the possibility of speaking to a trusted person in the family, friends and a boy/girlfriend will be explored. In this section, the participant will be encouraged to not talk about where they should be going but about they do go if they seek any form of help

A 30 minutes break

Intimate relations: participants will be asked if they think that intimate relations with boy/girl friend are helpful in times of distress or if they (partners themselves) are a source of much distress. Also other types of sexual relations/sexual activity or other aspects of sexuality will be explored here.

Closure: The participant will be encouraged to share anything that wasn't asked that she or he considers relevant to mention. Also the participant will now be given a chance to ask any questions that they may have related to the interview.

Appendix 2.2: Participant's information sheet

Dear sir or madam

Re: Information about the study of 'distress and intimacy among young people'

My name is Ms Mzikazi Nduna I work at the University of Witwatersrand as a lecturer at the Department of Psychology. I am also a PhD. Candidate at the School of Public Health. Thank you so much for showing your interest in my study. This serves to give you more information about the study entitled "Distress and intimacy among young people in rural South Africa".

What is the purpose of the study?

This research project is conducted in order to add to the body of knowledge that helps us to understand young people's lives. This study is about how young people feel about things that bother them and where do they get support when they are bothered. There is a gap in the knowledge of how young Black people themselves live their lives especially in the face of emotional disturbance and in relationships in the modern world.

Who is taking part?

The research involves young people between the ages of 18 and 22 from this neighbourhood. Participants are recruited on voluntary basis and will be required to share information in response to an open informal interview following questions that should not last more than two hours. Anyone can volunteer to take part in these interviews. All the interviews will take place in privacy at a place and time agreed with the volunteer.

There is no compensation for participating in this research but R20.00 will be provided for lunch/refreshments. There will not be any personal benefits or foreseeable risks for participating in this research.

All the information collected through the interviews will be dealt with strict confidence, no one else apart from the researcher and her supervisor will have access to the raw transcribed data. After the research is completed, the results will be published in conferences, a journal or a book and as part of thesis copy that will be submitted to the University of Witwatersrand.

Should you have any concerns related to this research you are free to speak to me, Mzikazi Nduna at 011- 717 4178 or cell 0836312537.

Appendix 2.3: Participant's consent form

Dear sir or madam

Re: Invitation to participate

My name is Ms Mzikazi Nduna I work at the University of Witwatersrand as a lecturer at the Department of Psychology. I am also a PhD. Candidate at the School of Public health.

This serves as an invitation to you to participate in the study entitled "Distress and intimacy among young people in South Africa". This is a study of young people's lives, feelings and thoughts about things that sometimes bother them. I am conducting this study to learn more about young people's lives so as to gain an understanding of how they cope with feelings. Your participation in this study will contribute to grow the body of knowledge that informs us about how young people experience upsetting emotions.

I plan to interview young men and women from this neighbourhood. If you agree to take up this invitation and please remember that you are not forced to, please be aware that in this research the following will be involved:

1. I would like to have an interview more of an open discussion like a conversation with you for about an hour to two. For this we will be talking about what it is like to be you, how you feel, what difficulties you have in your life, your relationships with boys or girls and what sort of support you have. I would also like to ask you about your relationships with other important people in your life.
2. The interview will take about one hour.

I will do all the interviews with you in private at a place and time agreed with you. We will basically talk about what you want and feel comfortable with. You have a right to stop taking part at anytime and not answer any questions that you do not wish to answer.

There is no compensation for participating in this research but I will give you an equivalent of R20.00 for lunch refreshments. There will not be any advantages or foreseeable risks for participating in this research. However, I will be asking you questions about difficulties and issues that cause you distress in your life, if after talking to me you feel that you need some help with these issues in your life I would discuss with you what help is available.

I would like to tape the interviews on an MP3 Player, with your permission so as to record everything thoroughly. I will keep all the recorded material safely in my password protected computer with no access to anyone else. Once the study has been completed, which is envisaged to be in February, I will delete all the files for the recorded interviews. However if you do not wish the interview to be taped I can take notes instead.

All the information collected through the interviews will be dealt with strict confidence, no one else apart from the researcher will have access to the recording and only my supervisor may see the typed up version of the interview. No names will be used in the typed work and all information will, be collated together into a written piece. After the research is completed, the results will be shared in scientific work and written journal articles to fulfil requirements for award of a PhD. Degree. Should you have any concerns related to this research you are free to speak to me at 011- 717 4178 or cell 0836312537.

If you agree to participate in the research I cordially invite you to sign consent that I have fully explained the study to you and you are giving me your informed undue consent to participate:

I, (Name) _____ agree to be interviewed by Mzikazi for the research on Psychological distress, sexuality and young people.

I, (Name) _____ agree to have the interview audio-taped.

Audio-tape consent not granted.

I, (Name) _____ would like my interview to be recorded with pen and paper.

Signature: _____

Date: ___ / ___ / _____

I wish to thank you

Mzikazi Nduna

Cell: 083 631 2537 or Tel: 011- 717 4168

Prevalence and factors associated with depressive symptoms among young women and men in the Eastern Cape Province, South Africa

Paper II

Associations between depressive symptoms, sexual behaviour and relationship characteristics: a prospective cohort study of young women and men in the Eastern Cape, South Africa

Paper III

Disempowerment and psychological distress in the lives of young people in Eastern Cape, South Africa

Paper IV

Undisclosed Paternal Identity in Narratives of Distress Among Young People in Eastern Cape, South Africa