Comment number	Specific comment	How addressed or not	Where addressed
Front material			
(1)	Include ethics docs etc in the appendix	Moved to appendix	Appendix
(2) Abstract	Add in extra sentence about methods	Added: One-on-one narrative interviews were done on 19 girls with the aid of a interview schedule. A life history of their sexual encounters was documented. The interviews were taped, transcribed. Thematic analysis was performed.	Abstract page 5
(3) Nomenclature	Take out	deleted	
Chapter 1			
(4)	Determinates change to "determinants"	Changed throughout report	Changed throughout report
(5) pg 16	Inference of condom use, HIV and lack of understanding of STIs	For me this may be an indication that there may be a lack of understanding or knowledge of the consequence of STIs and the relationship between STIs and HIV	Pg 14
(6) pg 17 para 2	DoE "has" Some STIs may remain silent	Done Added in about some STIs remaining silent especially women	Pg 15
(7)1.2.1.2 treatment seeking	Financial cost of treatment seeking?	Look for literature on financial implications for adolescents	Pg 16
(8)pg 19	Reference made to books, magazines, newspapers as "available media". What about internet café's etc? Also make not about extrapolating data from continent to continent and even within continents	Eventhough internet facilities are available, this supposes that women have access to them financially or have the knowledge to use these. Noted	Pg 17

(9)pg 20	Where is Hlabisa district? Moving from SA to Ghana and tehn to Quebec – need to be careful with these different contexts	KZN What I was trying to show was that even in different settings, whether rich or poor and whether girls or sex workers, there is reluctance to seek treatment for STIs	Pg 18
(10)Pg 21. Nigeria – treatment seeking and gender differences	See if there is this kind of information for SA – if not, can pick this up as area for further study. Inference regarding clinic staff being non-judgemental and caring – reference it if available. NAFCI – make clear that it is SA study and see if can find more studies – 1 not enough to prove point.	From the previous readings cited, addressing the issues of negative attitudes from health care workers (HCW), embarrassment about talking about their condition to a HCW, preference to seeing female doctors (especially if they are unmarried women), confidentiality at the clinic, clinic efficiency, the perception of STIs not being a serious problem are aspects that would improve treatment-seeking for STIs at health care facilities.	Pg 19 and added to research gaps
(11) Pg 21, 1.2.2	10 essential public health services – elaborate and conceptualise	Reworded: According to the USA Centers for Disease and Prevention, the 10 essential public health services include assurances of a competent public and personal health care workforce which could inform and empower people about health issues (CDC, 1994). Although this is a US quality of care point, it should be something all countries would want to emulate. However, this is	Pg 20

		not always the case as evidenced here. A qualitative study done by Reddy et al (1998)	
(12) Pg 22 1.2.2.2	Include costs – direct and indirect.	DoH	Pg 21
(13)Pg 23	NAFCI South African and adolescent care?	Reworded: The National Adolescent Friendly Clinic Iniative (NAFCI) started planning adolescent-friendly clinics in South Africa from the early 2000s because a gap was identified in that adolescents, being at high risk for STI/HIV were not accessing the normal primary health care clinics for all the reasons mentioned previously (unfriendly clinic sisters, long queues, embarrassment to be assessed for STI etc). Adolescent friendly clinics are essential because adolescents require being treated differently to children and adults. Seeking treatment for STIs, especially if one is young and unmarried, is considerably different to seeking treatment for eg flu-like illness or ongoing diarrhoea. In 2006 Dickson reported that NAFCI clinics performed significantly better than the control clinics on criteria specific to the provision of adolescent-friendly services including knowledge of adolescent	Pg 21-22

		rights and non-judgmental attitudes of staff (Dickson et al, 2006).	
(14)1.2.2.3 - resources	Fiscal vs financial	Word changed	Pg 22
(15)1.2.3	Context	Reworded: A study by Jemmot et al (2010) done with adolescents in the Eastern Cape has shown that risk-behavior intervention studies are being engaged by adolescents. In this study a more intense HIV/STD risk reduction intervention was compared with routine health promotion.	Pg 23
(16)Pg 25 - summary	Life orientation skills not previously mentioned	Reworked to make mention of this in literature review.	Pg 10
Chapter 2			
(17) pg 27	Reference Bt20	Personal communication with Prof Shane Norris	Pg 26
(18) pg 28 2.2	Include brief discussion on age terms – acknowledge the vast differences that emerge in ages. Terms fairly unhelpful – reflect on arbitrary and unhelpful use of these terms	The terminology of adolescent, young people and youth is confusing where adolescents are those aged from 10 years old to 19 years old, young people from 10 years old to 24 years old and youth defined as 15 years old to 24 years old. The terminology is really not helpful because the age bands are so wide and the experiences of 10 and 24 year olds so vast. MacPhail and Campbell (2008) report on Aggleton (2007)'s criticism of the literature failing to take into account the wide	Pg 29

		variations of sexuality of young people. Partly this is due to the wide age range and different experiences within these age groups.	
(19)	Why are Rwanda and Nigeria an exception and where are the references?	referenced	Pg 29
Chapter 3			
(20)	Introduce Bt20 earlier. Move 3.1.1 and 3.12 to previous chapter and focus this chapter on methods	Moved to chapter 2.	Pg 27
(21)Terminology	Why was HPV and HIV excluded from this study?	HPV not screened for. I did not want to concentrate on HIV positive girls only. If the girls with STI happened to be HIV positive too they were not excluded.	Pg 32
(22)	Supporting references for the discussion around recruitment, interviewing, piloting, change in strategy		Pg 33
Chapters 4 and 5		These 2 sections have been combined to match results with discussion – makes it read better and eliminates duplication	
(23) Pg 37, para 1	Include table of description of participants in the text rather than as appendix. Clarify wording re	This section moved to methods as per Examiner 1 and queries discussed there. Table included in results.	Chapter 2 and 4 (pg 44)

	employment Who do they live with? How do they live?		
(24)	Condoms – taught at school. School education to be discussed previously	Discussed under LO skills	In literature review
(25) pg 38	Shocked they had STI, because assumed partner was loyal? Condomise – write "use a condom"	Yes Done	Pg 39 Pg 39
(26) pg 39	Life –orientation skills description	Discussed under LO skills	In literature review
(27) final paragraph	Can you write more about 1st sex of participants. Include Tables in the text	Added: All the respondents (except for the 2 who had been raped) stated that they had not been forced or coerced into sex with their first partners. They were in a relationship with their partners and had consensual sex. Table 2 taken out and tables renamed. Original table 2 discussed in the text.	Pg 42
(28) Pg 40. 4.2.1	Only 2 women had been raped – surprising? Majority of girls were 16 or older at first sex – surprising? Related to longer schooling or Bt20?	No – girls are still young. Stats say 40% women will be raped in their lifetime. No – fits in with DoH stats that 6% of girls in Gauteng have had sex by age 15 years.	Pg 44
(29) Pg 41	Judgemental statement	reworded	Pg 47
(30)	Peer pressure and	Recommend as research	Chapter 5

	gossip culture	gap	
(31) Pg 44-45	Condom blasted	Burst	Pg 52
(32) pg 45. 4.2.5	Rewrite pregnancy status	A large proportion, 15 of the 19 girls, have been pregnant, two have aborted. One girl was pregnant at the time of the interview, 9 girls had one child, 3 girls had had 2 pregnancies.	Pg 53
(33) 4.2.6 pg 46	Only one girl had a sugar daddy – add to this	Dunkle and Jewkes reported 21% of women in their having had transactional sex.	Pg 54
(34)	What treatment for Herpes – so common so why bother	Mostly asymptomatic so no treatment – the sister of Respondent 3 told her it was nothing to worry about and so Respondent 3 did not seek treatment	Pg 57
(35) Pg 51, para 2	"nurses did a wonderful job" – personal inference	Taken out	
(36)	Life orientation – poorly structured curriculum. Why do you say this?	Did not address needs of learners because newly implemented – better now since analysis of it was done	Pg 40
(37) Pg 53 para 1	Early age of sexual debut. Ex 2 finds it surprising that 40% of women are still with same partner	Early sexual debut (<15 years old). 3/19 (11%) of my study – higher than SA stats of 6% Guteng girls. Jewkes, Vundule et al showed also that half of their cohort were with same partner	Pg 46
(38) pg 54	Poor peer group network for support	Need further research – put this in research gaps	Pg 66
(39) Pg 55 para 1	"developed world" – don't generalise Family networks – did you have data on this?	reworded	Pg 50

(40) pregnancy and school leaving	Teenage pregnancies – high? Are all respondents African?	Reworded 18 African, 1 Coloured	Pg 53 Pg 27
(41)Pg 58 last line	Delete "fortunately"	deleted	
(42) Pg 59	Women don't get treated for STI – why would they?	Reworded	
(43) Pg 61	Nurse attitudes – rewrite or delete	deleted	Pg 60
Conclusions			
(44) Pg 62	Address research bias	Expanded	Limitations pg 69
(45)	Family involvement or absence – for future study	Added	Research gaps pg 66-67
(46)	Condom use to prevent STI/HIV	Reworded and added to research gaps	Research gaps pg 66-67
(47) pg 64 6.3	Discuss clinic costs	Done	
(48) pg 66 research gaps	These suggestions are already in the literature	Noted and removed	Research gaps pg 66-67
(49)	These may be real gaps	Noted and expanded	Research gaps pg 66-67