The Kids Are Alright

Self-perceived Health and SOC among South African Adolescents

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Abstract

This study was conducted in South Africa among a total of 86 South African adolescents. The aim of this study was to investigate self-perceived health among youths from two different socio-economic groups in South Africa, what they believe promote their health and what views they have on school health education. The study used a mixed method approach consisting of quantitative questionnaires and qualitative interviews. The study draws Aaron Antonovsky’s theory of health, the salutogenic perspective and the sense of coherence theory. In addition, Antonovsky’s 29-item orientation to life questionnaire formed the quantitative part of the study. The main findings of this study is that higher socio-economic status does not necessarily correlate with higher SOC. Family and supportive people had the greatest affect on the adolescents’ ability to cope with stressors and are therefore the main health promoting factors. Finally, health education and the subject Life Orientation, as well as the school as an institution, are health-promoting factors and have in different ways influenced the participants’ views on health.

Keywords: Sense of Coherence, SOC, youths, South Africa, socio-economic groups, Antonovsky, qualitative, quantitative
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1. Introduction

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1948:100)

Health is a debated and relevant research area today, but due to the difficulty of defining health it is also challenging to study. Researchers have studied and tried to measure adults’ self-perceived health by conducting quantitative approaches, using questionnaires, by asking questions such as ‘How is your health in general?’. According to OECD (2011), self-perceived health is a subjective assessment of a person’s own health including both physical and psychological aspects. Perceived health is an indicator of general health status and can be used to evaluate the general health needs, mortality and health inequalities in a country since it reflects peoples’ general perception of their own health (OECD, 2011). Self-perceived health is, however, mainly studied in relation to factors such as economy and sicknesses, but there is a gap in knowledge regarding young people and their perceptions of their health and what they believe promote their health.

Findings from the world happiness report show that subjective health is the most important factor in a child’s life (Helliwell, Lavard & Sachs, 2015), which makes this a significant area to investigate. Additionally, other findings from the same report show that factors such as physical health and nutrition, wealth and poverty and war and conflicts, affect peoples’ mental health, but also, more personal factors such as stability, support and stimuli play a major role when it comes to peoples’ health and well-being (the world happiness report, 2015:107).

South Africa is the wealthiest country in Africa and large parts of the population live by western standards, but due to the history with apartheid there are major differences between the social groups in the country and South Africa is still considered to be a developing country (Landguiden, 2013). A major number of the children in South Africa live in unsafe environments and are surrounded by criminality and lack supportive parents. Furthermore, even though the majority of the children in South Africa are registered in primary school, many of the schools cannot deliver quality education. Electricity, running water, toilets, sport fields, material or qualified teachers is non-existent at several of the schools in townships. These schools
have a high level of violence and abuse which also is a wide spread problem in South Africa (UNICEF, n.d).

The world happiness report also shows that a wide range of social organizations and various institutions, such as school, have effects on peoples’ health (The world happiness report, 2015:107), and there is an on-going international debate discussing school and the school subject Physical Education’s role in promoting public health. According to Sullivan (2004) legislature, school boards, principals and parents rely on the Physical Education subject and teachers to contribute to the students’ physical fitness and healthy lifestyles. In South African schools, the subject Life Orientation has the main responsibility to provide the youths with knowledge regarding health and health issues (Department of Education, 2003:10).

With this in mind, it is of research interest to conduct this study in South Africa and investigate whether youths can obtain a high level of self-perceived health despite the circumstances and examine if there are any differences between the youths from various socio-economic groups.

### 1.1 Aim and research question

The aim of this study is to investigate self-perceived health among youths from two different socio-economic groups in South African, what they believe promote their health and what views they have on school health education (Life Orientation). The study was, thus, guided by the following research questions:

- 1. What are South African youths’ perceptions of their health and how to promote health?
- 2. What differences can be identified between youths from different socio-economic backgrounds in South Africa?
- 3. How do South African youths believe school health education has influenced their views of health?
2. Background

This chapter will present background information related to the aim of the present study. The chapter is divided into five sub-headings, which will introduce the definition of health and well-being, present different perspectives of health and give a short explanation of South Africa and the school subject Life orientation.

2.1 Definition of Health

Health can be seen in a variety of ways and the views of health change over time. Perspectives of health are contextual and culturally connected, and it is therefore difficult to give it a definitive definition (Quennerstedt, 2006). Instead the term health has several and various definitions. The World Health Organisation (WHO) defines health as “[a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity]” (World Health Organization, 1948:100). Health is according to WHO (1948) not solely a state of absence of disease. In contrary, people’s everyday definition of health is, however, most often explained as a condition free of disease, and not as a state of well-being and how an individual feel in general (Quennerstedt, 2006). According to Quennerstedt, health is closely connected to sicknesses and diseases and being free from it, but also with well-being - how we feel (Quennerstedt, 2006). The present study will be based on WHO’s definition of health. Moreover, when speaking of health the term well-being is frequently used, including in this study, and is therefore defined below.

2.2 Definition of Well-being

Just like health is a difficult term to define, so is well-being. Well-being is a currently growing research area, and the definition is widely and constantly debated (Dodge et al., 2012). The term is complex and numerous definitions exist. According to the Oxford dictionary, well-being is ‘The state of being comfortable, healthy, or happy’ (Oxford dictionary). Moreover, well-being has also been defined as the state when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge. If the individuals experience more challenges than resource and vice versa, they will experience unbalance and their sense of well-being will decrease (Dodge et al., 2012).
2.3 Different Perspectives of Health

Aaron Antonovsky developed the salutogenic perspective of health out of the critique of the traditional pathogenic perspective of health (Quennerstedt, 2007). The pathogenic perspective of health can be explained as a dichotomy where an individual is considered either sick or healthy. In the pathogenic perspective the normal condition of a human being is defined as healthy or free from sickness and sick is considered as an abnormal state of condition. Therefore, the focus on health issues is on how to avoid sickness, how to prevent people from getting sick and how to cure sicknesses. In contrast to the pathogenic perspective, the salutogenic perspective views an individual’s health on a multidimensional continuum, in which an individual can move towards both ends of the continuum. The difference in these views of health is that from the salutogenic viewpoint every individual has health, good or bad, while from the pathogenic viewpoint people are either considered sick or healthy. The purpose with the salutogenic perspective is to promote health rather than prevent sickness, which is also one of the main differences between the two health perspectives (Quennerstedt, 2007). The present study will be based on and focus on the salutogenic perspective of health.

2.4 South Africa

As stated in the introduction South Africa is the wealthiest country in Africa and among the 20 richest countries in the world. Even though it is a wealthy country, a large proportion of the population live in poverty, whilst the other parts of the population live by western standards (Landguiden, 2013). Poverty is a major issue in South Africa as well as HIV and unemployment, with a fifth of the working force being unemployed. Even though South Africa has been a democracy for more than 20 years, there are still extreme inequalities between different groups in the country (UNICEF, n.d). Coovadia et al., (2009) state that even though the constitution says that the state is bound to work towards every inhabitant’s right to health, South Africa is still struggling with major health inequalities among its population. The black population is far more represented than the white population in different negative aspects of health, such as infant mortality, HIV/AIDS and they have significant lower life expectancy. There are also health inequalities among different provinces and even within the different provinces between different socio-economic groups. Additionally,
Charasse-Pouélé & Fournier (2006) claim that the white population have significantly better access to high quality health care within the private sector, whilst the African groups in bigger numbers use the cheaper, less qualitative public health care.

2.4.1 The Situation of Children in South Africa
Poverty is an immense problem in South Africa, even though poverty has decreased, 11.9 million children in South Africa still live in income poverty, which estimates 64% of all children in South Africa. The main reason for the poverty issue appears to be unemployment. Four out of ten children in South Africa live in households with no employed household members. Poverty also generates several other issues, such as hunger problems, sanitation problems, diseases and mortality. One out of three children in South Africa in 2009 experienced hunger or was reported to be at risk of hunger and this is one of the causes to the vast number (one out of ten) of underweighted children in South Africa (Unicef, 2009).

The housing condition is another problem in South Africa. 1.7 million children live in shacks in backyards or squatter settlements with poor or no access to piped water. 8% of all children live in households where streams or rivers are the main sources to drinking water. Although adequate sanitation including flushing toilets, sewage systems and pit latrines with ventilation has improved it is still a major problem. Only 50% of the poorest households in South Africa have access to adequate sanitation (Unicef, 2009).

Another main problem in South Africa is the HIV prevalence. 17% of the global number of HIV-infected people live in South Africa and one out of eight children of the total number of children in the world with HIV lives in South Africa (Unicef, 2009).

2.4.2 School and Education in South Africa
Education and school attendance is also an issue that is highly prioritised in South Africa. Even though school attendance among children has increased in South Africa the last 15 years, and 1 of 2 children in public schools receives free education, a number of children are still not attending school for different reasons. The main reason is lack of money. The children from the poorest households are the ones who have the lowest attendance, obtain the lowest achievements and are less likely to finish secondary school. The insufficient quality of education and safety the schools in South Africa provide could affect the children’s attendance and achievement levels. 27% of
high school students reported that they felt unsafe in school and 16% have been threatened with a weapon (Unicef, 2009). Violence against children is widespread in South Africa. In 2009, 56,500 children were reported to be victims for various kinds of violent crimes, such as sexual and physical abuse, and many more remain unreported (Unicef, 2009).

During the Apartheid, the South African educational system consisted of nineteen educational departments divided by race, geography and ideology. The different departments aimed to prepare the students in various ways for future expected social, economic and political roles and occupations in society. The curriculum played an important role in the diverse departments in supporting the inequalities between the different ‘groups’ and what, how and whether the children were taught depended on which future role they were expected to take in society (The Department of Education of South Africa, 2002). Immediately after the 1994 election in South Africa, a transformation of the curriculum began. Compared to the previous curriculum, the new curriculum meant to develop the maximal potential of each and every student as a citizen of a democratic South Africa (The Department of Education of South Africa, 2002). Along with the new curriculum a new subject called ‘Life Orientation’ was established.

2.5 Life Orientation

The ambition of the South African school subject ‘Life Orientation’ (LO) is to prepare each student for life and provide him or her with qualities useful in a rapidly changing society. LO enriches the students with skills, knowledge, values and attitudes, which are supposed to prepare them and help them make meaningful and successful decisions in life (The Department of Education of South Africa, 2002). LO’s intention is also to teach the students about their and others’ rights and responsibility. Additionally, it teaches the students about the values of diversity, health and well-being.

In the earlier stages of the students’ schooling (R-9) LO focuses on 5 prime outcomes, which are:

- **Health promotion:** The student is capable of making informed decisions regarding personal, communal and environmental health.
- **Social development:** The student is capable of showing an understanding to constitutional rights and responsibilities, and to demonstrate an understanding of various cultures and religions.

- **Personal development:** The student is capable of practicing learned skills to develop personal potential when facing challenges in his or her life.

- **Physical development:** The student is capable of showing an understanding of, and partaking in activities that promote movement and physical development.

- **Orientation to the world of work:** The student is capable of making knowledgeable decisions about future studies and career choices (The Department of Education of South Africa, 2002:26).

The main focus in LO for the higher grades lies on the study of the self in relation to others. The subject intends to prepare the students for life by concentrating on personal, intellectual, emotional and physical growth as well as addressing knowledge, values, attitudes and skills about the self and the environment. These dimensions will develop responsible, confident and democratic citizens, a productive economy and an improved quality of life for the entire population of South Africa (Department of Education, 2003).

The syllabus for grade 10-12 concentrates on 4 focus areas;

- **Personal well-being** - focuses on self-concept, emotional literacy, social competency and life skills. Moreover, it emphasises the importance of relationship and life affecting factors as well as peer pressure. This area prepares the students for different roles they might take in the future such as being an employee and employer, as well as parenthood. The personal well-being focus area also highlights the issues regarding avoidance of abuse, diseases and sexually transferred infections along with promotion of personal and environmental health.

- **Citizenship education** – focuses on social relationships and human rights and responsibilities. It emphasises the importance of political knowledge such as to know and understand democratic processes and addresses problems such as various kinds of discrimination and encourage acceptance of diversity.

- **Recreation and Physical activity** – focuses on the understanding of the relationship between health and physical activity and how knowledge of nutrition, recreation,
participation in games as well as sports and leisure time activities and the environment can improve the quality of life and well-being for all students.

- **Careers and Career choices** – prepares the students for further studies and labour. It provides the students with information regarding higher education such as universities and preparation for job applications and interviews. It also offers the students knowledge about laws, the job market and work ethics.

  (Department of Education, 2003:10).

This shows that the school health education’s purpose in South Africa is to teach the students about health with a salutogenic perspective as well as pathogenic. On the contrary, Quennerstedt (2006) argues that the pathogenic perspective is the dominant perspective in school health education around the world, where health is taught in order to prevent students from becoming sick. The health issues that are discussed in health education in school today most often revolve around being free from disease, and nutrition and physical activity is taught as preventive factors to avoid this. Different perspectives of health and the consequences of different health perspectives are seldom discussed. Quennerstedt (2007) suggests that Antonovsky’s salutogenic perspective of health offers alternative ways to discuss health in school and instead of focusing on the unhealthy parts and on physical status focus should lie on how to promote health and well-being. The pathogenic perspective views health on an individual level while the salutogenic perspective has a wider view of health, focusing on both the individual and the collective level. The salutogenic perspective can be explained as a sociocultural term where health is developed through a relation between an individual and its surroundings (Quennerstedt, 2007). The salutogenic perspective will be further introduced in the next chapter.
3. Theoretical Framework

This study is based on the Israeli American sociologist Aaron Antonovsky’s ‘Sense of Coherence’ (SOC) theory, which presents a salutogenic perspective of health. Aaron Antonovsky was a professor in medical sociology and found in one of his studies that even though human beings had suffered from horrible circumstances they could still retain good health conditions. He found this quite remarkable and it led him to investigate what he came to call the salutogenic perspective of health. Within a salutogenic perspective on health, an individual is not categorized as being healthy or sick. Health is rather seen as a continuum where people are somewhere between wellness and sickness. The salutogenic perspective focuses on the origin of health instead of the cause of disease (Antonovsky, 1991).

SOC is by Antonovsky defined as:

...a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic, feeling of confidence that one’s internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected ( Antonovsky, 1991:13).

Antonovsky (1991) found it important to study the patient in its entirety, and to find strategies to promote peoples’ ability of conquering diseases instead of solely focusing on the diseases. Antonovsky not only suggested that health should not be determined on the basis of being free from disease or being sick, but on how individuals evaluate their own health (Antonovsky, 1991). With this perspective he focused on the factors that kept people in good health despite adversities. Additionally, he did not focus on how to eliminate the stressors, but on how to learn to live with the stressors that exist. He implied that the interaction between an individual and environmental factors generate control, which leads to health. These factors were explained as money, ego strength, cultural stability, social support and other phenomena that enable a person to cope with an extensive variety of stressors. What all this factors have in common is that they all facilitated the understanding of the constant innumerable stressors that people have to encounter and to create a SOC (Antonovsky, 1991). This theory is suitable for the present study since it aims to investigate youths’, in South Africa, a developing country, self-perceived health where the health and socio-economic inequality are major issues and where parts of the population live within very poor
living conditions (UNICEF, 2015). Since the youths in the present study represent two
different socio-economic groups the theory will be used as a tool to investigate
weather there are any differences between the two groups in SOC. As Anotonovsky
states, the SOC is about an individual’s ability to cope with everyday stressors, and if
an individual possess the ability to do so the socio-economic status should not matter.

SOC is described in terms of three components: Comprehensibility, manageability and meaningfulness. These components have an effect on whether people have a strong SOC or a low SOC. They do not necessary work together; a person can receive high scores on one or two components, but obtain low scores on the third one and vice versa. Which component they receive high or low scores on determines their SOC (Antonovsky, 1991).

**Comprehensibility**
Comprehensibility is explained as the extent to which an individual perceives internal and external stimuli as making logical sense, as information being in order and structured and being consistent rather than being disordered and chaotic. Comprehensibility is strongly connected to predictability. A person with strong comprehensibility assumes upcoming stimuli to be predictable or at least to be understandable and explicable if they appear as a surprise (Antonovsky, 1991).

**Manageability**
Manageability is defined as the extent to which an individual perceives that the resources he or she has are sufficient to meet the demands required from the stimuli that people are bombarded with. The resources include both resources which are controlled by oneself and resources controlled by others, such as, parents, partners, friends, God, history, the president etcetera, a person which they feel that they can trust and depend on. A person with strong manageability will not feel victimized by circumstances or feel mistreated by life, instead they will be able to handle the miseries and not grieve forever (Antonovsky, 1991).

**Meaningfulness**
The third component is meaningfulness, which according to Antonovsky is the most important component. This component is defined as the extent to which life makes sense and to which extent an individual feel that life has an emotive meaning. Out of all the demands and problems people face during life at least some of them are worth
the investment of energy, engagement and devotion. A person with a high degree of meaningfulness welcomes challenges and confronts them rather than sees them as problems. These people are determined to seek meaning in the miseries and do the best to conquer them. Antonovsky also called this component the motivating component, since meaningfulness makes people act and do things that lead towards what motivates them (Antonovsky, 1991).

3.1 Verifying Sense of Coherence

After a review of 458 articles and 13 doctoral theses, Eriksson and Lindström (2006) state that the SOC is a valid instrument for measuring health. Eriksson and Lindström (2006) imply that Antonovsky’s salutogenic model works as a health promoting resource and that the orientation to life questionnaire measures how people view life and how they in stressful situations identify and use their resilience resources to maintain and develop health. The SOC theory has been used in over 32 different countries and in several different cultures, South Africa included. Therefore, they claim that the SOC theory works as a cross-cultural instrument for measuring health. According to Eriksson and Lindström, the SOC theory is a reliable and valid instrument for measuring health and can be used in different countries and cultures.

3.2 Critique towards the Sense of Coherence Theory

Flensborg-Madsen, Ventegodt and Merrick (2005) have studied the SOC theory and the orientation to life questionnaire, and imply that part of the theory does not measure what it is supposed to measure. Their critique towards the theory is that predictability in life does not necessarily affect the comprehensibility of an individual. They suggest that an unpredictable life could rather be a factor that improves comprehensibility than the opposite, since an individual’s ability to handle changes in life rather improves than lowers the sense of comprehensibility. Therefore, they also imply that a number of the questions in ‘the orientation to life’ questionnaire do not measure what they are supposed to measure because the questions regarding comprehensibility are built upon the belief that predictability is a factor for high comprehensibility. Flensborg-Madsen et al., (2005) also mention that in an earlier research they determined that there was no strong correlation between SOC and physical health, but that there were significant correlations between physiological well-being and SOC.
This study aims to investigate how adolescents in South Africa perceive their own health and which health promoting factors they believe to have an effect on their health. Therefore, the SOC theory and the salutogenic model are used as theoretical frameworks for this study. Even though Flensborg-Madsen et al., (2005) provide some critique towards the theory and imply that the orientation to life questionnaire is partly built upon the assumption that predictability is a factor for comprehensibility and that this is incorrect and that the SOC theory can not measure physical health, this theory is, by the researchers, believed to be suitable for the analysis of the empirical findings. Since Eriksson and Lindström provide evidence that supports the theory in ways of validity and reliability and present study do not have the intention to measure physical health, but adolescent’s perception of their own health, the SOC theory is a valid framework for this study.
4. Previous Research

This chapter is divided into two sections, which will present previous research related to the research questions of the study.

4.1 Self-perceived Health and SOC around the World

Living conditions and lifestyle behaviour have an effect on individuals’ self-perceived health and SOC (Chan et al., 2015; OECD, 2011; Volanen et al., 2004). Chan et al. (2015) investigated self-rated health and its relation to lifestyle factors among adults in Malaysia, using questionnaires. Result shows that one fifth of the participants reported poor levels of health. The lifestyle factors that showed to be connected with low self-rated health among the Malaysian adults were, underweight, physical inactivity, former smoking and former and current drinking. The result also show that chronic diseases such as asthma, arthritis and heart diseases where associated with poor self-rated health among the participants (Chan et al., 2015). OECD (2011) also states that unemployed, retired and inactive people tend to report poor or very poor health more frequently than others (OECD, 2011).

In addition to this Volanen’s et al., (2004) study shows that living conditions had an impact on the participants’ level of SOC. They found, in a quantitative study of Finnish men and women between the ages of 25 and 64, that family and social network such as relationships have a major association with SOC and that living in a weak relationship threatens the SOC. The result also shows that living conditions during childhood had a greater effect on SOC than living conditions in adulthood. Finally, the evidence of this study demonstrates that having a paid employment was among the factors that were positively related to SOC. They highlight the relation between strong SOC and social support. They contend that social support and satisfaction with the social support leads to strong SOC, but at the same time, strong SOC helps people to gain social support (Volanen et al., 2004).

Discrimination is another factor that is evident to have an impact on peoples’ self-perceived health (Alvarez-Galvez & Salvador-Carulla, 2010). Evidence from Alvarez-Galvez and Salvador-Carulla’s study shows that perceived discrimination influences individuals’ physical health as well as their mental health. Findings show that there is an association between perceived discrimination and physical health issues, but perceived discrimination can also have a negative effect on and cause
mental illnesses. Racial and ethnical discrimination factors are the most studied and emphasized discrimination factors in literature regarding the relation between discrimination and health. Perceived discrimination based on racial or ethnical aspects is more associated with mental illness than physical illness. In turn, mental illness have a negative effect on physical health, which indicates that racial and ethical discrimination in most cases have a direct effect on mental illness, and an indirect effect on physical illness. Additionally, the findings from the study suggest that factors such as income and education have an impact on an individual’s perception of discrimination. People with higher income and level of education are more likely to perceive a lower perception of discrimination. Consequently, education affects individuals’ perceptions of discrimination and inequalities and perceived discrimination lead to a lower level of perceived health among people, which in turn affects the public health in a country (Alvarez-Galvez & Salvador-Carulla, 2010). This issue is also highly relevant to the study due to the situation in South Africa with its great inequality among the population.

Other research which is of interest for the present study, is Wienberg and Cummin’s (2013) study regarding self-reported well-being in Australia among offspring of holocaust survivors (OHS) and non-holocaust survivors. In the result they found that the OHS reported lower positive mood than the non-OHS, and the respondents with two holocaust-surviving parents reported lower positive mood than the respondents with only one holocaust-surviving parent. The reason for this is assumed to be associated with the responsibility the OHS felt towards their parents and might explain why the OHS could not express feelings the same way the other respondents did. The study proves that the effects of the holocaust can be transferred to secondary generations and actually affect their subjective well-being.

4.1.1 Youths and Self-perceived Health and SOC
Youths’ self-perceived health is closely related to social capital and socio-economic status (Novak, Suzuki, Kawachi, 2015; Braun-Lewensohn & Sagy, 2010; Quon and McGrath, 2014; Nyholm, Nygren & Svedberg (2014). Novak et al., (2015) investigated the connection between social capital and self-rated health among high school students in Croatia, using a quantitative method. 3427 students aged 17-18 years answered a survey with questions regarding three sources of social capital, family, neighbourhood, and school, and what effect these sources had on the students’
self-rated health. The result shows that high levels of self-rated health had a significant association with high levels of family social capital, interaction in school and neighbourhood trust (Novak et al., 2015). Family and supportive family members showed to be the prime factor that affected the students’ health. School came on second place, where findings demonstrated the relation between level of collaboration and exchange between the students, and how they rated their health. Moreover, neighbourhood trust was ranked as third and proved that the students who lived in a high-trust area rated their health higher than the students who lived in low-trust areas. Lastly, the people in the adolescents’ surroundings and the environment they live in had an impact on their health. (Novak et al., 2015).

Lower subjective SES is associated with lower health outcomes. These were the findings from a quantitative study of adolescents in Canada. In addition they pointed out that to live in an environment where people have similar SES has a positive impact on their health and works as a protective factor. Big differences in SES within a society or community lead to worse health outcomes (Quon & McGrath, 2014).

Nyholm et al., (2014) have also studied health in relation to socio-economic status. In their study 948 students in Halmstad, Sweden, where asked to rate their own health by filling in a questionnaire. The students were divided into two groups by age, 11-13 year old and 14-16 years old. The result from the study showed that it was solely among the boys, in both groups, that low socio-economic status correlated with low self-rated health. However, their conclusion is that socio-economic status is not sufficient in ways of analysing self-rated health because other factors might have equal impact on adolescents’ health.

This section shows that there are several different factors that have an impact on adolescents’ health around the world, and that the main factors are social capital, environment and SES.

4.1.2 Self-Perceived Health in South Africa

Self-perceived health differs between different groups in South Africa, which depends on factors such as wealth, access to health care and living conditions (Phaswana-Mafuya, et al., 2015; Charasse-Pouélé & Fournier, 2006). Findings from a quantitative study carried out upon adults 50 years old and over in South Africa, conducted by
Phaswana-Mafuya, et al. (2015) demonstrate that more than three quarters of the participants in the study rated their health as reasonable or good. However, there was a difference in self-reported health between whites, blacks and Indians, where the Indians and Blacks reported poorer levels of health in comparison to Whites. Charasse-Pouélé and Fournier (2006) claim that the South African population suffers from inequality regarding health issues, which could be a reason for the different levels of self-perceived health between the groups. In their studies of a survey in which the South African population estimated their own health they found different factors that indicate that there are differences between the groups they refer to as the white and the African groups. For example the white population had significantly better access to high quality health care within the private sector, whilst the African groups in bigger numbers used the cheaper, less qualitative public healthcare.

Socio-economic welfare and living conditions are other variables that may have an impact on how the different groups rate their own health (Charasse-Pouélé & Fournier, 2006). Findings from Phaswana-Mafuya’s, et al., (2015) study, also suggest that wealth status was determinant for self-rated health among the adults, where the wealthier participants in the study reported higher levels of self-rated health (Phaswana-Mafuya, et al., 2015). Additionally, evidence from Charasse-Pouélé and Fournier’s study (2006) implies that it is not exclusively the differences in levels of income and living conditions that affect the health issue, discrimination still plays a major role in the inequality between races and their various levels of self-perceived health in South Africa, even though the apartheid system have been abolished for 20 years (Charasse-Pouélé & Fournier, 2006)

The result from Phaswana-Mafuya et al. (2015) also displays that education was a determinant in whether the participants reported poor or good health. Higher education showed to be decisive for higher self-rated health.

4.2 Schooling and Self-perceived Health and SOC

Previous research shows that there is a correlation between peoples’ self-reported health and years and level of education (Subramanian, Huijts, Avendano, 2010; Novak et al, 2015; Mayer & Boness, 2011). Findings from a study conducted in 2002 in 69 different countries across the world that investigated the association between self-rated health and years of schooling, confirm that higher level of education contributes to better self-reported health. The respondents in this study were adults aged 18 and older
who lived in private households. The collected data from this study show that education has a positive effect on self-rated health. There is a relation between years and level of education and self-rated health among the adults. Adults with lower levels of education were more likely to report poor health than adults with higher levels of education. This is however on an individual level, no correlation exists between years of schooling and self-rated health on a national level (Subramanian et al., 2010).

Not solely education seems to have a positive effect on peoples’ SOC and health, but also the school as an institution. In a review of literature regarding SOC, Mayer and Boness (2011) found that school is an institution that helps kids and adolescents to develop and maintain a SOC. They state that within the school system there are great opportunities to provide the kids with means that promote their SOC and that SOC is strongly developed during youth and childhood. Mayer and Boness (2011) also imply that education should focus on interventions and therapies that develop SOC in order to help the kids to cope better with upcoming life challenges such as school tests or changes in life. They also imply that SOC can be developed through social interactions between students and teachers as well as interactions between students.

4.2.1 Youths, Self-perceived Health and SOC in South Africa
Supportive people affect South African youths’ self-perceived health positively (Cluver & Gardner, 2007), and SOC is a valuable tool for them to use when coping with stressors (Mohangi, 2014). In a study by Cluver and Gardner (2007) findings from interviews with orphaned youths in Cape Town, demonstrate that the most important, or the most mentioned factor regarding well-being among the participants were caregiving and support from people in their surroundings. The interviewees spoke positively about terms such as attention, being loved and wanted, and to have boundaries, all of which relate to caregiving and to have caring people in their surroundings. The study did not merely investigate the protective factors; it studied risk factors as well. The risk factors that the kids stressed in the interviews were crime, violence and being called “the orphan” by their foster parents etcetera. Many of these factors are present in several youths’ lives in South Africa, especially diseases, criminality and violence (UNICEF, 2010).

In a qualitative research of orphan kids living in institutions in South Africa, Mohangi (2014) found that the kids’ coping strategies for dealing with their situation
could be related to Antonovsky’s SOC theory. The strategies were often associated with religious beliefs, imagination or fiction and denying that their parents were dead. Mohangi (2014) contend that these coping strategies help the children to feel meaningfulness, comprehensibility and manageability, in order to receive a SOC. Furthermore, they imply that their findings could be valuable for other institutions such as school, and work as guidelines for handling orphan kids and to help them cope with their situation.

4.2.2 Schooling and Self-perceived Health and SOC among South African Youths

School and education is proven to have a positive effect on South African youths’ health and well-being and can be considered as a health promoter in a few different ways. School is a place where people can create and maintain social relationship and receive social support, but also the education school provides has a positive effect on peoples’ health (Blauuw & Pretorius, 2012; Cluver & Gardner, 2007; Govender et al., 2013; Plüdderman et al., 2014). In a study by Blauuw & Pretorius (2012) data from the South African National Income Dynamics study (NIDS) was used to study changes in well-being among South African people over the years. The study investigated the change in well-being among old, young, poor and rich people over a few years. NIDS documents the changes in income, expenditures, resources, education, health, access to services and other dimensions of well-being of a selection of households in South Africa. The findings from their study indicate that the higher educated individuals experience higher levels of well-being. Every additional year in school increases a person’s well-being (Blauuw & Pretorius, 2012).

Blauuw & Pretorius discoveries can be compared to the findings in Cluver and Gardner’s (2007) study where the youths also discussed school as a positive factor regarding health and well being, both as an institution and as a place to build social relationships with friends. This shows the value of schooling and education. It is also evidenced that youths who do not have the feeling of connectedness in school are more likely to engage in risk behaviours compared to youths who have a strong feeling of connectedness to school. This is what Govender et al., (2013) imply after a quantitative study of students from two different schools in South Africa. They found that students with less feeling of connectedness to school suffered significantly higher risk of behaviours such as substance abuse, violent-related behaviour, sexual risk
behaviour and suicidal ideation. This shows that school is one factor that helps the youths to cope with different problems and stressors in life.

Lastly, Plüdderman et al. (2014) state that being absent from school increases the risk of getting mental problems among adolescents. They conclude this after a research of almost 21000 high school students within the Western Cape province in South Africa. 14.9 % of the participants were estimated to be in the high-risk group of obtaining mental problems and among them girls were overrepresented. In conclusion, school is an important factor in every adolescent’s life and can be a promoter of health.
5. Methodology

5.1 Research Participants

Gratton & Jones (2010) state that when making a sample for the research there are several different approaches to choose from. One of them is the convenience sample, which was used for this study. A convenience sample means that the sample is made out of convenience in terms of location and accessibility, etcetera. Since this study was conducted abroad it was necessary for the researchers to, before departure, be sure that there were youths in South Africa that could participate in this study. A contact person in field was, therefore, desirable. A group on Facebook for people in South Africa was recommended from a friend and two contacts that could provide the researchers with youths that suited the criteria were found. To fit the criteria the youths had to be students and between 15 and 18 years old. The participant issue was a question of accessibility to be able to carry through the study. According to Gratton and Jones (2010) a convenience sample should be avoided as far as possible since it might affect the results because of that the researchers might know or work with the individuals who they hand out the questionnaires to or conduct the interviews on. This was, however, no problem in this case since the researchers knew none of the participants.

The total number of 86 South African youths from different socio-economic groups are representative for the overall data collection of this study. Ten youths participated in the interviews, five from each socio-economic group, and 86 youths completed the questionnaires, 50 from the middle socio-economic group and 36 from the lower socio-economic group. The intention was to receive 50 questionnaires from each group, but do to the absence of youths at the help organisations the final digit was, therefore, for the lower socio-economic group 36.

The participants consisted of a mixture of males and females. Because of the challenging and problematic collection of data in the middle socio-economic group and since there was no box on the questionnaires to fill in to specify whether the participant was a man or a woman it is difficult to determine the number of females and males who completed the questionnaires. Nevertheless, seven female and three male participants partook in the interviews.

The participants were all between 15-18 years old. This age group was selected in order to be able to reach the youths from the lower socio economic groups as well.
as the ones from the middle and higher socio-economic groups. This would not have been possible if the participants had been older, since school in South Africa is only complimentary up to grade 12 and then they have to pay tuition fees, which only allows the youths with sufficient economy to attend the higher grades. The youths from the middle socio-economic group all studied at the same public high school in a nicer area in Cape Town, South Africa, and the youths from the lower socio-economic group studied at different schools in Cape Town, but were all part of the same help organisation, which provided after school activities for children in townships to prevent them from obtaining criminal activities.

5.2 Selection of Method

In this study a mixed method approach was used to collect data. Due to the selection of Antonovsky’s theory about SOC the quantitative part in the present study is based on Antonovsky’s ‘orientation to life’ questionnaire. Additionally, the researchers of this study chose to supplement the quantitative questionnaire with qualitative interviews to receive a deeper analysis and understanding of the South African youths’ perceptions of health. According to Denscombe (2009) a mixed method approach can deepen and expand the analysis. Also Gratton and Jones (2010) suggest that a combination of a qualitative and a quantitative research method can be positive for the study. They claim that statistics from quantitative methods do not explain and describe the meaning of the data whilst the qualitative data such as in-depth interviews is not representative for the sample. However, a combination of a qualitative and a quantitative method results in both a statistic and a describing product, which widens the picture of the result. Denscombe (2009) illustrates a method combination by making semi-structured interviews and questionnaires to strengthen the result and analysis. This is the combination that will be used for this study. He also suggests that every method has its advantages and disadvantages and there are disagreements in which method that is best suited for various studies. Therefore, it may be appropriate to use two different methods. By using two methods it opens up a possibility to compare the result from the different methods and thereby either confirm or question the results with each other (Denscombe, 2009). A combination was chosen for this study because of the selected theory and the lack of qualitative studies within this research area and to receive a wider result.
5.2.1 Questionnaires

The quantitative part was based on Antonovsky’s orientation to life questionnaire (see Appendix 1) regarding SOC. The questionnaire consisted of 29 questions, which were all based on the three components: Comprehensibility, Manageability and Meaningfulness. Ten questions were based on the comprehensibility component, ten questions were based on the Manageability component and nine questions were based on the Meaningfulness component.

On each question the participants graded their answer on a scale from 1-7. The number equals the point the participants will score on that question. However, some of the questions are reversed, which means that number 1 equals 7 points and number 7 equals 1 point. These numbers were reversed before calculating the result. The questionnaire worked as a tool to measure South African youths’, from different socio economic groups, SOC in relation to their self-perceived health.

Bryman (2008) claims that a quantitative method is to prefer when the study aims to investigate if there are any differences between the answers from different groups, which this study partly intends to do.

The questionnaire collection process was in the middle socio-economic group problematic. Since the principal denied entrance to school the researchers waited outside the school area for the students to finish their exams. When the students were on their way home from school they were asked if they would like to participate in the study. Since all the students finished and left the school at the same time the situation became hectic and the area were they were stopped and asked to fill in the questionnaires became crowded. The students lined up and squeezed in next to each other and completed the questionnaires using the wall of a building as a support. Pens were borrowed from the researchers and between the participants and papers were handed out and collected at the same time.

In the lower socio-economic group the questionnaire was sent to the contact person at the organisation who printed out 20 of the questionnaires and had the youths to fill them in whenever they had time. A few days after the contact had received the questionnaire and when the conduction of the interviews in the lower socio-economic group took place, the 20 completed questionnaires were collected. The remaining questionnaires were filled in by youths from the same organisation, but in a different township. The questionnaires were, this time, handed out and explained face to face to the youths who wanted to participate, by the researchers. Ones again there were no
access to a room and the youths had to fill in the questionnaires outside sitting next to each other. This time the researcher had, however, more control over the situation and could make sure that the questionnaires were filled in individually without any “help” from the persons next to them that could affect the result.

The Orientation to life questionnaire has been used several times in different studies all over the world and is according to Eriksson and Lindström (2006) a reliably and valid instrument for measuring health. Gratton and Jones (2010) claim that, to reach a high level of reliability the questionnaire must be tested several times and show the same result, which this questionnaire has. Therefore, the result from the quantitative part of this study is assumed to be reliable as well as valid. However, due to the small sample of participants in this study it is not possible to make any generalizations.

5.2.2 Interviews

For the qualitative part of the study interviews were conducted to collect data. Ten youths were interviewed, five from the middle socio-economic group and five from the lower socio-economic group. The interviewees from the middle socio-economic group were randomly asked when they passed the cafeteria next to the school to participate in the study, and the persons who voluntarily agreed to partake became a part of the sample. This resulted in a sample of two male and three female participants. In the lower socio-economic group the contact at the organisation had beforehand, out of the criteria, chosen five suitable participants, four females and one male, who had willingly agreed to participate in the study. The interviews lasted approximately 20-30 minutes.

According to Bryman (2011) a qualitative study aims to understand a phenomenon on a deeper level by interpreting responses from interviews, texts and communications. The goal with the qualitative study is to understand society or social groups in their specific context (Bryman, 2011). In our study the aim was to understand South African youths’ perceptions of their health and factors that the youths consider affect their health. By using a qualitative method the interviewer can receive more trustworthy responses and more depth in the material due to the flexibility. The interview questions allow the participants to answer and formulate the answers freely and spontaneously. Compared to questionnaires, the participants do not have to choose between specific alternatives in interviews (Bryman, 2008).
A semi-structured interview-guide (see Appendix 2) was carried out in this study in order to give the interviewees as much freedom as possible and so that the interview would have the characteristics of a conversation and not a hearing, to make it more comfortable for the youths. According to Bryman (2008) a semi-structured interview guide is a schedule of specific themes or pre-designed questions, which the interviewer will proceed from by asking additional or follow-up questions depending on the interviewee’s answer. This gives the interviewee a greater space and freedom for discussion (Bryman, 2008) and the interviewee will hopefully give the interviewer his or her actual opinion and thoughts and not the information he or she believes that the interviewer wants. When giving the interviewee more space and freedom it will hopefully result in more interesting and reliable answers.

Health can be a sensitive topic to discuss, especially when it involves self-perceived health. The interviews were therefore carried out individually instead of in pairs or in a group. The researchers also chose to conduct one on one interviews so that the interviewee would feel more comfortable. As Bryman (2008) suggests it is not necessarily positive to be two or more interviewers at the time and it does not certainly generate better result. Therefore, the researchers decided that one on one interviews would be more suitable, since it would be less time consuming and possibly more comfortable for the interviewees.

All the interviews were recorded in order to facilitate the analysis of data. Denscombe (2009) states that for the result to be reliable it is of great value to record the interviews since it provides a full and permanent documentation of the interview. This allows the interviewer to go back and replay the interview as many times as necessary to be certain that he or she has not missed anything and that they have interpreted and understood everything correct. Moreover, according to Bryman (2011), the recorder catches all the details in the interviewee’s answers such as valuable expressions and word choices that could be of interest for the study. Nevertheless, the researcher needs to have in mind when they organise the time schedule for the study, that the transcription is time consuming (Bryman, 2011).

Gratton and Jones (2010) suggest that when talking about reliability in qualitative research it is not the result but the method that needs to be explained in a way that enables other researchers to repeat the study. Therefore, the researchers must describe their study in order to make it possible for other researchers to repeat it, even though the result might differ. To make this study reliable the research process is
described in detail. Additionally, the researchers used an interview guide (see appendix 2), which specifies information about the questions that were asked during the interviews. In addition to this they research sample for the study as well as the methodology is presented and discussed in the methodology section, which provides the reader with sufficient information regarding the study. Furthermore, Gratton and Jones (2010) point out that another way to assess qualitative research is by its credibility. Credibility refers to in what way the study presents the respondents’ answers in a correct and reliable way (Gratton and Jones, 2010). To assure this the interviews were recorded, transcribed, printed out and reviewed several times to find similarities and categories within the material. All to make sure that the answers were correctly cited and presented in the result chapter of this study.

5.3 The Research Process

A few problems occurred during the research process, which delayed and aggravated the collection of data. The greatest problem and concern for this study was to find adolescents that agreed to participate in the study, especially from the middle socio-economic group. Since the summer holiday begins in the beginning of December in South Africa and the students have exam periods just before the holidays, the schools prohibited all conduction of research inside the school during this period and they could not help with participants. The contacts in field that were able to assist with adolescents to participate in the study were, instead, found through a page on Facebook. After a lot of effort and e-mail conversations one person finally answered that she would be able to help with the participant issue. The contact insisted that the middle-class school where her daughter studied would be happy to help us. However, this person proved to be wrong. Well at the school the principal denied any entrance with research purpose into the school. After the principal’s denial to enter the school the contact promised that her daughter and her friends would participate in the interviews, but every time something got in the way. Because of the limited time frame, no more time could be wasted on cancelled appointment and waiting, instead students who passed the cafeteria next to the school were asked to participate in the study. When a student voluntarily agreed to participate the interviewer and the interviewee sat down at a table in the cafeteria. The participants were initially informed about their rights during and after the interviews and the ethical aspects, which will be further presented in the last section of this chapter. They were also
asked if it was all right with them if the interviews were recorded, which all participants in both groups agreed to. When the participant was ready the interview proceeded. The interviewer started of by asking the participants easy and relaxed questions about him or her to make the interviewee comfortable and to receive some background information. These questions later led into more subject related questions. When one interview was finished the interviewer asked the next student who passed the cafeteria if he or she would like to participate. The students could easily be distinguished from the other people who did not study at the high school because of their school uniform.

The collection of data in the lower socio-economic group was more workable and organised than the collection of data in the middle socio-economic group. The contact at the organisation was the person in charge, which facilitated everything. Before departure, appointments were booked and the day after arrival the first meeting with the contact at the organisation was held. At the meeting the researchers presented their study in more detailed and a new appointment was set for the interviews. When it was time for the interviews she had picked out suitable participants who fit the criteria and were willing to participate. When the researchers arrived at the organisation, they had prepared so that each of the interviewers had access to a quiet room, where they sat down and waited for the participants. This enabled the interviewers to follow the ethical rules and conduct comfortable interviews for both the interviewee and the interviewer. The interviews in the lower socio-economic group were carried out in the same way as in the middle socio-economic group. When the participants entered the room the researchers introduced themselves and asked the participant to take a seat. The interviewers informed the participants about the procedure and the study and also about the interviewees’ rights as well as the ethical aspects. Lastly, before the interview proceeded, the participants were asked for permission of the interviewer to record the interview, which they all allowed. Similarly to the procedure in the middle socio-economic group the interviewer began with easy and relaxed questions and when the interviewer felt that the interviewee was comfortable and had gained trust in the interviewer he or she proceeded with more subject related questions. The contact person at the organisation sent this time, when an interview was finished, the next interviewee into the room.

After the completion of the questionnaire and interviews the researchers began the transcription of the recorded interviews. The transcription phase can according to
Bryman (2011) be time consuming and might lead to several days of work. In order to make this process less time consuming it was exclusively the essential and relevant parts of the interviews that were transcribed. Sighs, laughs and questions and answers that were not relevant for the study were erased. The transcriptions were later printed out to facilitate the organization of themes in the result. When analysing and organizing the themes in the result the research questions were in focus. For the quantitative part, the questionnaires were calculated according to Antonovsky’s calculation method, which was all completed manually. The scores from the two socio-economic groups were later compiled and compared to each other in charts.

Except the complications to find participants for the study a few other problems occurred during the process. Initially, the organisation’s Internet cable was stolen, which resulted in that they could not access their e-mail for two weeks to confirm appointments. Moreover, since the organisations were situated in townships it was not safe to walk outside of the gated organisation area, which meant that it was not possible for the researchers to arrive without an appointment. This also complicated the transportation to and from the place. No taxis were driving in these areas and without a phone it took some planning and organisation for the researcher to sort everything out before they could go to the townships.

5.4 Data Analysis

A descriptive method was used to clarify the result of the questionnaires. The mean score of SOC, the mean score of each component and the highest and lowest score from each group was measured and all results were compared between the two groups. Gratton and Jones (2010) suggest that a descriptive method can be of preference when the researcher wants to organise the result in terms of average scores or if they want to make comparisons or make conclusions out of the participants’ responses. However, Gratton and Jones (2010) contend that the research questions have to be taken into consideration when selecting the method for the organization of the data. The researcher has to make sure that the chosen method is suitable for the analysis of the result (Gratton & Jones, 2010). Since the purpose of the present study was to investigate if any differences could be identified between the two socio-economic groups, the descriptive method was appropriate for the organization of the data. According to Gratton and Jones (2010) the purpose of the descriptive statistics in not
to explain the result and answer the question why something is happening, but to report what is happening and how much it has happened.

The result from the interviews was organised in themes based on the responses and related to the research questions. The answers from both groups were clarified and analysed together and a comparison between the answers from both groups was made.

5.5 Ethical Aspects

The Swedish Research Council brings up four ethical principles, which a researcher should respect when he or she conducts a study, in order to protect the individual and not harm the participant. These rules are, the requirement of information, consent, and confidentiality and to stipulating how the data may be used (Vetenskapsrådet, 2002). These four aspects were taken into consideration when carrying out this study. Initially the youths were all well informed that their participation was strictly voluntary and that they had the right to at any time withdraw. They were also informed about the study and what the data would be used for. Furthermore, the respondents were assured that all the information would remain confidential and anonymous, and that their identities would under no circumstances be able to trace. Additionally, the respondents were asked for consent of the interviewer to record the interview. Denscombe (2009) contends that it is against the ethical research aspects to record interviews in secret or to conduct an interview without the respondent being aware of it being an interview and not just a normal conversation. These are some of the aspects that every investigator should respect when conducting a study, so that people feel safe in participating in various studies and for research to continue (Denscombe, 2009).

When conducting a study in a foreign country it is essential to be aware of the cultural situation to avoid any risk of offending anyone during the research process. Since there might be cultural differences between the countries where the research takes place and which the researchers are from it is possible that there are differences in taboos, behaviour and values, which the researcher should have in mind when conducting the study (Sida, 20150929). Since it is difficult for a foreign person to be familiar of all the customs and cultural differences the organisation leader from the lower socio-economic group read and approved the questionnaire as well as the interview guide before hand to avoid possible offending or misunderstanding.
6. Result and analysis

This chapter will present the findings from the questionnaires and the interviews. The first section deals with research question number 1: *What are South African youths’ perceptions of their health and how to promote health?* And 2: *What differences can be identified between youths from different socio-economic backgrounds in South Africa?* Using the answers from the questionnaires, followed by an analysis of the result. Research question 1 and 2 will be further discussed in section number two, and will also discuss the result in relation to research question number 3, this time on the basis of the result from the interview questions. Every part in the second section will be followed by an analysis of the result. The analyses are based on Antonovsky’s theory regarding SOC with a salutogenic view of health.

6.1 Comparison of the youths’ SOC and Self-perceived Health Based upon the Result from the Questionnaires from the Two Socio-economic Groups

In this section the second research question will be answered. The quantitative results from the two socio-economic groups, the middle socio-economic group (MSEG) and the lower socio-economic group (LSEG) will be presented and compared to each other. The results will be displayed in tables 1, 2 and 3 and will be complemented with text to explain the tables and the results in them.

**Mean scores of the three components**

Table 1 shows the youths’ mean score on the different components of SOC. The first column shows the mean score from the 10 questions regarding comprehensibility (C), the second column shows the mean score from the 10 questions regarding manageability (MA) and the third column shows the mean score from the 9 questions regarding meaningfulness (ME). The highest score possible for C and MA is 70 and 63 for ME, whilst the lowest score for C and MA is 10 and 9 for ME. The total score of each component was divided with the number of participants, which were 50 participants from the MSEG and 36 from the LSEG, in order to obtain the mean score.

<table>
<thead>
<tr>
<th>Groups</th>
<th>C</th>
<th>MA</th>
<th>ME</th>
</tr>
</thead>
<tbody>
<tr>
<td>LSEG (34)</td>
<td>41.7</td>
<td>45.3</td>
<td>36.7</td>
</tr>
</tbody>
</table>

Table 1
These result shows that the answers from both groups follow the same pattern and there is no significant difference between the two groups’ mean scores from the three components. The third column, meaningfulness, displays a somewhat lower score than the other two components. The reason might be that this component only included nine questions while the other two components included ten questions. The result shows that the MSEG scored higher on comprehensibility whilst LSEG scored higher on the other two components.

**Mean Scores of SOC**

Table number 2 shows the mean scores of both the MSEG as well as the LSEG. The highest possible score to obtain on the SOC scale is 203 and the lowest score possible is 29. The SOC score is the summation of all three components added together. The table shows the mean score of each group, which was received from adding all scores in the separated groups and then divide it with the number of participants in the individual group. Which resulted in following calculation: The LSEG; 4203 / 36 and the MSEG: 6227 / 50.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sense of Coherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>LSEG</td>
<td>123,6</td>
</tr>
<tr>
<td>MSEG</td>
<td>124,1</td>
</tr>
</tbody>
</table>

The level of SOC is considered to be high when the score is above 120. The result from both groups indicates a high level of SOC and shows barely any differences between the two groups when looking at the mean score of SOC. According to Antonovsky this indicates that the youths from both groups have the ability to obtain a high level of health on the health continuum and that the youths are capable of handling problems, stressors and stimuli they face in life. Antonosvky states that SOC is not completely developed until an individual is around 30 years of age, which means that these scores, according to Antonovsky, are underdeveloped.
**Highest and Lowest Individual Scores on Antonovsky’s Questionnaire**

Table 3 shows the lowest and highest individual scores on the orientation to life questionnaire within both groups. The lowest score obtainable is 29 and the highest obtainable score is 203.

**Table 3**

<table>
<thead>
<tr>
<th>Groups</th>
<th>Lowest</th>
<th>Highest</th>
</tr>
</thead>
<tbody>
<tr>
<td>LSEG</td>
<td>103</td>
<td>155</td>
</tr>
<tr>
<td>MSEG</td>
<td>91</td>
<td>155</td>
</tr>
</tbody>
</table>

The result shows that there is a larger gap between the lowest and highest score among the youths in the MSEG than in the LSEG. It shows that the lowest score obtained by the questionnaire was obtained within the MSEG and that there were no differences between the groups in regards of the highest score. These numbers indicate that there are differences within the two groups and that not all of the youths have obtained a high level of SOC. Since the mean score is just above 120 (LSEG: 123.6 and MSEG: 124.1) for both groups the findings in table 3 indicate that there are several participants that did not reach the high score line of 120 as well as there are youths who scored really high numbers on the SOC scale.

### 6.2 Analysis of the Identified Differences Between the Two Socio-economic Groups

This section will analyse the differences in the answers to the orientation to life questionnaire between the two socio-economic groups. The analysis will be based on Antonovsky’s theory of Sense of Coherence and will be divided in four topics; Comprehensibility, Manageability, Meaningfulness and Sense of Coherence.

**Comprehensibility**

Comprehensibility is according to Antonovsky (1991) an individual’s ability to handle different stimuli and to make the different stimuli make sense. Comprehensibility is also related to predictability and the individual’s ability to foresee the future as predictable or at least as understandable if it appears as a surprise. The result regarding this component shows almost no difference between the two groups and the average score indicates a fairly high amount of comprehensibility, especially due to the fact
that Anotonovsky (1991) considers that SOC is under development during these years of a human beings life. The result from present study indicates that the participants have the ability to see various stimuli as something that makes sense to them and that they perceive their ability to predict or handle the future well. This is remarkable since these youths are still in school and that life may take several different turns before it is settled. Comprehensibility does though include the ability to handle unpredictable future problems as well and this aspect may be a key into getting high scores on this component. This matter will be further analysed in the qualitative part.

Manageability
Manageability is the individual’s perceived idea regarding the resources he or she possesses in demand to cope with stimuli that he or she meets. These resources can either be individual resources that are controlled by the individual or other uncontrollable resources such as social life including family, government or friends, etcetera (Antonovsky, 1991). The answers of the manageability component showed no significant difference between the two groups even though this component takes into account several resources that might be different between the groups. For instance money is one resource that has influence on the manageability and access to this resource is something that is assumed to be different between the groups in this study. Since the score did not differ between the groups one assumption is that money or access to money does not have an immense effect on the manageability. Another assumption is that other factors such as social support, friends and family have more effect and is of higher value to the youths than the money. Further investigation on what factors or resources that the youths perceive to have an effect on their health and their ability to cope with problems will be presented in the qualitative part of the analysis.

Meaningfulness
Meaningfulness is according to Antonovsky (1991) the most important component and is defined as an individual’s ability to see life as making sense and that life seems to be emotionally meaningful. Therefore, a person with high level of meaningfulness welcomes problems and confronts them and feel that problems or issues which people meet in their everyday life is worth investing time and energy in. As for the first two components there is no major difference between the two groups when looking at the
meaningfulness component. The score of both groups are slightly lower than the score of comprehensibility and manageability, but since there are only nine questions on the questionnaire regarding meaningfulness, whilst there are ten for the comprehensibility as well as the manageability component, the total score is about the same as for the other categories. To find meaning in life and to find the things you do in life to make sense and to be meaningful is important for a youth’s health, and there might be several factors that have effect on the ability to feel meaningfulness. Environment, family situation or predictability may be factors that have an effect on an individual’s ability to feel meaningfulness in life, meaning that the youths make sense of life within the context they live in and with the people they live with. Since there were no differences between the groups in regards of meaningfulness you may say that the youth’s ability to create meaningfulness is unattached to socio-economic standards.

**Sense of Coherence**

As the result in the previous chapter showed, the SOC in the two groups did not differ significantly from each other and both groups scored fairly high on the SOC scale. This means that both groups have a good chance to cope with and handle different stressors and problems that occur in life. Antonovsky (1991) states that a person’s ability to cope with stressors develops when an individual interacts with environmental factors like money, cultural stability, social support and ego strength and that this is what leads to SOC. It’s interesting that the answers from the different groups are almost the same even though the different groups live in different environments and have different socio-economic backgrounds. One way to look at it is that the youths from both groups have learnt to cope with stressors that appear to them in their own life, even though the stressor might be different for a person in the MSEG than the stressors of a person in the LSEG.

Since social support and cultural stability are among the factors that contribute to a strong SOC it is interesting to discuss if the LSEG youths’ participation in the help programs in any way had an effect on their high SOC scores. It is possible that these programs have helped the youths in managing their situation and to cope with different factors they consider have positive or negative effect on their health, more on this in the qualitative section of the analysis. In addition to this the result shows a vast gap between the highest and lowest scores on the orientation to life questionnaire, which confirms Antonovsky’s (1991) idea that an individual’s SOC is not fully
developed until the individual is about 30 years old. The lowest total score was among the participants in the MSEG.

The quantitative part of this research was carried out to investigate the youths’ SOC and examine if there were any differences between the LSEG and the MSEG. The results did not show any significant differences between the groups, both groups scored a fairly high level of SOC. So, the result has so far explained the level of SOC that the youths had, but it has not explained why. The question why will be answered in the next section, where the interviews will be presented and analysed.

6.3 Result and Analysis of the Interviews
In this chapter the qualitative data from the interviews will be presented and analysed. The chapter is divided into five themes. The first four themes will answer research question number 1, and the last theme will answer research question number 3. In each section the results from the two different socio-economic groups will be compared to each other to see if any differences or similarities can be identified, which answer the second research question. The result is a combination of text and quotations from the interviewees. At the end of each theme the result is analysed in relation to Antonovsky’s theory. The participants’ answers are coded with a number from 1-5 for each group. The letters M and L represent the MSEG respectively the LSEG.

6.3.1 Exercise, Eating Healthy and Some Mental Aspects
In order to receive an idea of what the students valued and focused on when they perceived their own health they were asked questions regarding their views on health and what health was and meant to them.

MSEG
When the youths were asked about their views on health the answers were quite similar. All of them spoke of the importance of eating right and that being healthy was to be fit, to exercise and have an active lifestyle. For example one of the interviewees said that, “Being fit and eating healthy, eating salads and not fatty food” (M4). This summarizes the answers from all of the youths except one who stressed the importance of mental health.
I think health is more the lifestyle the person lives and also with a mental aspect to it. I don’t only think physical so… I think a person’s mental health is what comes to mind when thinking about health (M1).

When the youths thought about health in general they mainly thought about health regarding their physical status and how to be healthy in a physical way and not so much about other aspects of health. Furthermore, the adolescents were asked to describe a healthy person and then the opposite, an unhealthy person. On this question the youth’s answers differed from each other. They started to add other aspects to health than just the physical one. One adolescent for example answered that an unhealthy person is “[…] when you think negatively about yourself and about other people” (M2), which indicates that they were aware about mental aspects of health as well, even though this did not come to their minds in the first place when they thought of health in general. In addition, hygiene was also mentioned as a factor that was important for an individual’s health. One participant described an unhealthy person with following words: “Not eating properly, not exercising a lot and not showering” (M5).

Moreover, the participants were asked if they believed that they had the same view on health as the rest of the population in South Africa, and most of the participants answered no. For instance one of the youths claimed that South African people’s concern about health seems to disappear as soon as they graduate from high school.

I think most people in South Africa doesn’t care about their health. Basically when they are out of high school they stop exercising and they just eat freely. Because in high school it’s kind of like the big boys are… being fit is normal. And when they are out of high school they don’t really care. They just eat and they gain weight (M4).

This statement shows that he believes that the major difference between his view and other South African people’s views of health is that they just don’t care about health. This was something the other participants stated as well. Another student also claimed that there were differences in knowledge among the South African population and stated that she knew more about health than other people in South Africa.
[...] everyone has their own opinion so like that other people probably think that healthy is going for a run like once a week or not to eating sweets but not knowing that it has to be a balanced diet (M2).

When the participants were asked about different perspectives of health they mainly spoke of other people being ignorant or less educated in the matter, and not so much of the actual different views on health.

**LSEG**

The interviewees from the LSEG focused almost exclusively on the physical aspect of health. The answers mainly contained subjects such as exercising and eating healthy.

Like types of health.. yeah I think it’s when.. do you see our street? They are dirty and we have to clean them because of our health, and exercise I think exercise is part of health. Like we must eat healthy foods like fruit and veg so our bodies can stay healthy (L4)

When asked how they would describe a healthy and an unhealthy person some mental aspects of health did show. Sleep was mentioned as an important aspect of health as well as stress that was claimed to be unhealthy for a person.

Having a lot of problems when growing up, having heart attacks, having weight problems, obviously not eating healthy, having no physical activity, always sitting down, having a bit of stress and gaining too much weight for your body (L5).

Otherwise, as the quote above states, it was mainly the physical aspect that was expressed. When asked if their view on health differs from other South African people’s views on health their answers were a bit different. One of the participants stated that there is a difference between the black and the white population.

Sorry for being… you see like a 67 year old woman and compare to a black woman of 67 year of age, they are totally different because the white person knows when I get up in the morning I first go to the gym, when I come back from the gym I eat breakfast, take my tablets, eat healthy food, and a black person doesn’t go to gym. Wake up eat a lot of fats, I would say they take their medicine just because they are instructed from the clinic (L3).
In addition to this, several of the participants implied that people other than them are ignorant to health aspects such as eating healthy and exercising. “They just don’t care. Because they know how to get healthy because they get pamphlets every time they go to hospitals for health” (L1).

The result shows that the participants from both groups had a similar view on health, which mainly included physical aspects of health, even though some of the respondents mentioned mental health as well. There was no significant difference between the groups except that mental health was more prominent in the MSEG while the LSEG more than the MSEG almost exclusively focused on physical health. According to Antonovky (1991) the salutogenic perspective considers all health aspects when evaluating health and determines an individual’s health state. This was not noticeable in the participants’ answers. Even though a few different perspectives of health were mentioned in the answers no one of the participants mentioned all health perspectives in their answers, instead they focused on one perspective and sometimes two when they evaluated their own health. Antonovsky implies that the salutogenic perspective focuses on how to promote health rather than on how to stay away from sickness.

6.3.2 Self-perceived Health Among the Youths

MSEG

The youth’s self-perceived health in the MSEG group was overall good, the participants claimed that their health was not the best, but that they were feeling good and that they believed that their health was good. For example one of the students from the MSEG said that “I think that I’m relatively healthy, not the best, I’m not the healthiest person but I’m relatively healthy” (M2). Another example of a student’s answer was;

I wouldn’t say it is the best but I wouldn’t say I have unhealthy physical habits maybe. Yes I do spend my time inside but I don’t overeat I do exercise a bit and when I do go out it is usually to do something physically like hiking or play paintball or stuff like that (M1).

LSEG
The interviewees from the LSEG rated their health as being bad or in-between bad and good. Their ratings, however, seemed to be based exclusively on physical health factors, where they stated that they were not healthy because they ate a lot of junk food. One of the respondents answered as follow, “I think my own health is also bad, because I like to eat junk food, like pizza eating food from McDonalds and KFC I don’t like what my mum cooks”. (L4). Nevertheless, the responses also show that all of the participants did exercise quite a lot to stay fit and healthy. For example, one interviewee stated: “I wouldn’t say I’m healthy nor say I’m unhealthy because yes I always do physical things that keeps me healthy and all that, but I have days when I always eat junk food” (L5). The quotation below also shows that food seems to be the prime factor why they did not feel healthy.

I think my health is to bad because I don’t like vegetables very much. I use sweets sometimes fats, eating meat, I love meat. Eating oily stuff I love. I don’t eat fruit and vegetable very much, I eat only food. (L2)

When the interviewees spoke of what they did to be healthier the physical aspect was mentioned once again. They brought up exercise such as dance, going to the gym and sports. These quotes indicate that the students felt that their health was good even though they claim that their health is not the best. All students said that they felt that their health status is not linear.

Antonovsky (1991) suggests that health or being healthy includes several aspects. With the salutogenic perspective the focus lies on the factors that promote health and how to cope with different stressors in life and not how to eliminate them (Antonovsky, 1991). Whilst Antonovsky seemed to view health mainly from a mental and psychological perspective the participants in present study had a more physical view of health. The first things that came to the youths’ minds when they were asked about health were exercise and eating healthy and the foremost reasons to why they did not estimate their health to be the best was because they sometimes ate bad things like junk food or other unhealthy things. There was, however, one of the youths who perceived his health as not that good and the main reason, just like the rest of the participants’, was that he ate bad food. This could be interpreted as if the stressors in the participant's’ society and surroundings today are to be fit and look physically healthy, which perhaps directs their health focus mainly to physical health. Whilst
other perspectives such as mental health and stressors connected to the psychological health were more prominent in the society Antonovsky lived in.

Even though the participants focused more on physical health in their answers, whereas Antonovsky focused more on other parts of health, the participants’ responses can be interpreted as if the youths, just like Antonovsky, perceived their health on a continuum, but compared to Antonovsky they saw it through a more pathogenic lens. Just as Antonovsky contended that people are somewhere between wellness and sickness (Antonovsky, 1991), the participants stated that their health was sometimes good and sometimes bad and that they were in between good and bad.

Since the participants solely focused on one or two perspectives of health when they evaluated their own health, instead of considering all perspectives, their perception of their health might be misleading and it is assumed that their health perhaps is better or worse than they stated. Nevertheless, the answers indicate that even though the participants from the LSEG rated their physical health as bad or in between bad and good the responses also demonstrate that the participants from the LSEG as well as the MSEG felt good and were happy. This agrees with Antonovsky’s theory, which implies that even though people suffer from bad circumstances, such as living in poor and criminal environment, they can still obtain good health. According to Antonovsky, this depends on different factors, which will be further presented and analysed in the next section

6.3.3 Family, Environment, Eating healthy and Exercise; The Main Health Promoting Factors

When the participants were asked about factors they considered influenced their health positively and negatively, physical activity and food were recurring factors in both socio-economic groups, but also more environmental related factors were mentioned.

MSEG

Even though food and physical activity were mentioned several times as factors that influenced the youths’ health, the environment and the people in the youths’ surroundings seemed to be the prime factors that affected their health both negatively and positively.
Probably all of them and my surroundings with people who make me happy and If I don’t think that they make me happy I just leave them and don’t be friends with them anymore. Exercise and diet and stuff. (M2)

I would say if you don’t live in a wealthy enough community. You will probably not have the opportunity to have a good health….I would say if you live in an area where the whole area is unhealthy, like polluted water and polluted air (M5).

The quotation below suggests that the neighbourhood and the people in the their surroundings had an impact on the youths’ habits and motivated them to stay away from them.

My neighbourhood is really nice. And my friends are not the people who drinks and smokes that’s nice and my family as well, they like motivates me to stay away from those things (M4)

Other stressors and health promoting factors that were mentioned were schoolwork, to have things to do, to be active and to have knowledge about how to stay healthy. The pressure one participant felt in receiving high grades had a negative effect on her health, but it could also be positive for her health if she achieved high grade, because it made her proud and happy.

LSEG
Similarly to the participants in the MSEG the participants in the LSEG mentioned physical activity and food as health affecting factors as well as more environmental factors and social situation. “Dance, parents, the people that I work with here. Yeah, basically… friends, some friends not all of them and obviously my family, my siblings and aunts” (L5). However, some differences could be identified between the groups. All the participants from the LSEG lived in an area were they on a frequent basis experienced crime, violence, alcoholism, drug addictions as well as poor living standards such as shed-houses and a soiled neighbourhood. They mentioned that this affected both their mental and physical health. They claimed that growing up in a township was negative for their health since the environment is very dirty and as kids they would play in this dirt, which made them sick.
It wasn’t good. No because growing up in a township there’s a lot of things that are outside like dirt and all that so that we would always play there. So obviously we would get sick because we were playing in the dirt and the water you know. So from childhood time we weren’t healthy at all but now when I’m growing up it’s changing because I know what to do and what not to do (L5).

Nevertheless, according to the participants, the environment in the townships does not solely affect a person’s physical health, but also their mental health.

The bad things that happen around the area like gang fights and stuff like that. [...] Some of the times in the area you wouldn’t feel safe. There are people coming around and swinging at each other and those are the people who mug us, rob us. Just for their own living but they don’t think about us. How we are going to live and that affects us mentally and we tend to be like scared people. (L1)

Or as another respondent expressed it:

I never feel unsafe, but when I see some criminals robbing a person or in our days now there are gangs who stab each other by the streets, when that happens, it happens like every week, they are stabbing this young youth…and stabbing each other so when I see that happening I’m not safe like, I like where is my phone like I’m scared that they will rob me. (L4)

The participants were all part of an organisation and the answers indicate that the organisation and the people at the organisation worked as health promoters. The support the youths received from the staff and the environment at the organisation had a positive effect on their health, since it was safe and good. Moreover, the organisation also provided the youths with healthy dinners every day and offered them different sorts of engagements and fun activities, such as sports and art. Additionally, the organisation had regular check-ups, in the forms of questionnaires regarding health and emotions.

They (the organisation) are very supportive, cause every month they give us I would say a questionnaire with questions about how we live and in this environment are we happy or not (L3)
The environment was according to the youths one of the biggest factors that either promoted or had a negative effect on health. The results show great differences between the areas in which the participants of this study live in and more precise it shows that the youths from the LSEG live in areas where crime and physical abuse is common. Antonovsky (1991) states that there are several factors such as money, social support and cultural stability that help people to handle their daily life. Antonovsky (1991) focused on the factors that kept people in good health despite adversities. Additionally, he did not focus on how to eliminate the stressors, but on how to learn to live with the stressors that exist. This suggests that since there were no major differences between the groups in self-perceived health, both groups have learned to cope with the stressors in their environments. This contradicts what one of the respondents from the MSEG answered, who implied that it is probably not possible for people who live in less wealthy communities with poor living standards to obtain good health when our findings from the LSEG, on the contrary, show that the they were in between healthy and unhealthy. This can be compared to what Antonovsky (1991) found in his study and what led him to investigate it further, where he found that a person who has suffered from terrible circumstances could still feel at good health. According to Antonovsky, it all depended on the peoples’ way of handling the negative factors. Even though the environment affected their health negatively the participants still felt that they had a sufficient health despite their living standards and surroundings. Compared to Antonovsky’s (1991) theory, this also shows that people learn to cope and live with the different stressors, which will be further presented and analysed in the next heading.

6.3.4 Family, friends and Alternative Coping Resources
An individual’s ability to cope with daily stressors is associated with his or hers self-perceived health status (Antonovksy, 1991). The youths were therefore asked about their coping strategies and resources and their ability to handle as well as their ways of handling different stressors in life.

MSEG
The participants in the MSEG claimed that they were quite good at dealing with various kinds of stressors and challenges in life. One participant used different coping
strategies to calm down and others went to older people, such as their parents or teacher, to ask for advice.

I’d say that I probably think it through a lot and I’d go straight to, older persons especially, like my dad or a teacher at school and see what they say and then I take my opinion and see what feels better. (M4)

One participant on the other hand claimed that she sometimes suffered from panic attacks in stressful situations. Nevertheless, at the same time she stated that she was fairly good at handling stressful situations since she had learned to control her panic attacks. Moreover, the participants spoke of the value of having supportive people in their surroundings and to have someone who cheered them up when they were sad, and how these people had helped them to cope with different situations in life.

How the youths experience their abilities to cope with various stressors and situations in life might affect their view on the future, because of the uncertainty they face. Some of the youths felt quite comfortable in meeting the future, even though they had different thoughts about it. Some of them knew what they wanted to do and some of them did not, but the ones who did not know felt more confident than the youths who had a plan. “Yeah I am, but I’m just not sure what’s going to happen with work and school and stuff.” (M3) However, some of them felt uncomfortable in meeting the future because they were scared about what might happen. One girl knew what she wanted to become, but she was uncertain if it would turn out the way she wanted, and that made her scared.

No I’m quite scared. Scared to see what will happen and stuff. [...] Well I got a dream and stuff but I don’t know how well it’s going to work out because something might happen and that will change everything, like you can never know. (M2)

The youths felt they had quite different feelings about meeting the future and it seemed like the ones with bigger plans were more anxious, perhaps because they had more things that could go wrong than the ones who did not know what they wanted to happen.
All of the participants in LSEG felt that they had good coping abilities. Some of the participants claimed that they had strategies to deal with different situations and stated that the way a person copes with different stressors is decisive for the effect it will have on you “as long as you know how to control it, it does really not impact you a lot.” (L5)

Some of the participants also stated that they were relatively good at handling challenges, problems and difficulties because of the support and advices they received from people in their surroundings.

Yes I think that now I talk whenever I think of something and I talk it out so that is does not stay in my head and now I have actually discovered a person that I can actually talk to about things and ideas that I have so that I get some other opinions and all that. So I’m opening up a lot know. I’ve always been that person that bottles up a lot of things and not talking because maybe I didn’t know who to talk to and I was so afraid of being judged and all that. That also had an impact on my health. Now that has changed slowly. (L5)

This can be compared to another participant’s answer that also stressed the importance of having someone to talk to about her problems in order to stay healthy. “I speak to someone I know that is going to help me with my problems. Because keeping quiet and keeping it to yourself will affect my mental life and my social life”. (L1)

Most of the participants felt confident in meeting the future by stating that they were confident persons. They had an optimistic view on the future and believed that they could reach their goals and become whatever they wanted to. Furthermore, one participant answered that she did not feel comfortable in meeting the future, because it might not turn out the way she want it to. However, she also stated that she had a positive view on the future and whatever the future had in sight for her would contribute to her personal development. “No, I’m looking forward to the challenges that I will meet in the future. It is going to help me become a stronger person and how to deal with life’s problems” (L1). All of the participants from both groups perceived their ability to handle problems as good. Some of them expressed the need of someone to talk to whilst others managed to deal with the problems themselves by using different strategies. This can be related to the comprehensibility and manageability components from Antonovsky’s theory. The youths who dealt with problems by themselves showed a high level of comprehensibility, which means that they have the
ability to see stimuli and information as ordered and structured. To be able to see information as structured and in order gives the youths the ability to handle themselves in various situations and cope with problems or stressors. On the other hand some of the youths always used their social life such as family and friends to help them overcome problems or issues that occur in life. This is closely associated with what Antonovsky (1991) call manageability. Antonovsky states that manageability is an individual's ability to handle stimuli with the resources the individual has. Resources in this case are, according to Antonovsky, family and friends, etcetera.

Some of the participants were stressed and scared of the future because of the unawareness of what was going to happen. The concern about the future created stress inside them, which affected their health. With Antonovsky’s theory, which claims that the feeling of confidence that there is a high probability that things will work out as expected, these people might have a lower SOC than the participants who had a clear goal of what they wanted and were instead looking forward to the future.

6.3.5 School Health Education and LO's Influence on the Youths’ Self-perceived Health

MSEG

The school health education was among most participants a significant subject in terms of health being an important topic to discuss. Some participants, however, stated that the school health education was limited and not up to standard, while some contended that the school health education covered most topics that were vital for the youths and it had taught them to balance their diet, how to exercise, sex and drugs and also about hygiene.

I definitely do think that it is important because it’s helps you later on in life and it helps you manage your life. It helps you understand now so that you don’t have to make a mistake later (M1)

One answer indicates that the school in its entirety promoted health and not exclusively the school health education. The school was very large on sports and encouraged the students to try different sports. It was compulsory for the students to practice one summer sport and one winter sport to pass school. Additionally, the school and school health education had a major focus on stress and depressions and
had qualified psychologists at the school with whom the students could talk. They also had staff that helped people with addiction problems or any other health related problems.

LSEG

The participants from the LSEG group all claimed that health education in school was an important topic to discuss. They believed that it was important to learn about what to eat, how to exercise and how to treat your body.

Yes I would say it is important because if we didn’t discuss about our health people wouldn’t know how to live healthy or know whether they won’t know how to live good, and good health and bad health they wouldn’t know which is right. (L3)

In the answers the youths presented the different views on health that were presented within the school health education, which were several topics. All of the participants pointed out eating healthy and exercising as topics, which were recurring topics in all of the different questions regarding health throughout the interviews. Some of the youths did mention other topics as well such as STDs, diseases and other sexual related aspects. No participant mentioned any mental aspects of health when discussing what views on health that were covered in school health education. This differs between the two groups.

MSEG

LO showed to be an important subject in school for some of the participants. It had changed their view of health and helped them to stay away from unhealthy habits such as drinking and smoking by clarifying the effects of it. “Definitely, I used to be very unaware, and they’ve opened my eyes.” (M3) In contrary, the findings also show that some participants believed that LO was an unnecessary subject since it was all about general knowledge, knowledge that they already had and had learned outside of school.

No, because most of the things I’ve learned here have I learned outside of school before so. [...] it only teaches you about you things that you know already. The things you have learned through doing. (M1)
Nevertheless, their negative view on the subject LO seemed to be due to the quality and content of the subject and not health education itself, since they did state that health was an important subject to discuss in school.

Most of the participants mentioned that physical health was the main focus in health education, while one person stated that they discussed mental aspects and had not covered physical health at all. Additionally, another participant claimed that LO covered physical, sexual and emotional health as well as community related health, such as how the community accepts you and how to be social with family and friends. Thus, the dissimilar answers can be explained, since the health education covers different things depending on which grades the students are in.

LSEG

The interview answers were quite similar between the two groups on the matter on what types of views that were presented in LO. As for the school health education the participants mainly spoke of physical and body related health. “How to keep your body healthy and like your mind healthy. How to keep you mentally healthy and stuff like that.” (L1). One student on the other hand answered “Physical abuse and emotions” (L4), which indicates that they talk about mental health as well, even though, this youth stated that emotions and physical abuse had nothing to do with health.

When talking about the importance of LO as a subject in school all of the participants agreed that the subject indeed was important. The foremost reason to why it was an important subject was that the youths felt that they had learned about health and that they were able to use this knowledge in life to obtain good health.

I would say it has changed me because I started to study life orientation in primary at grade 4 and I have studied life orientation it has changed my life, after studying it I knew how to live healthy and live good (L3)

They seemed to value the knowledge more than some of the participants from the MSEG where some of the youths stated that they already knew everything that they were taught in LO. However, one of the participants pointed out that the subject should be broaden in general and deepen within the different subjects that they discuss.
They should not just teach us the diseases they should also give us more like, because with a heart attack you will get the heartache and all that, but what if it’s not a heart attack. They should not just give us one symptom they should give us like more to learn of and even broader and not only put it in one circle for example because it’s very broad and that confuses us a lot because when we go somewhere else they teach you about something else. (L5)

Overall, the LESG were satisfied with the health education and stated that it was very important to discuss various health topics in school. They also implied that the knowledge about health they received in school helped them to stay healthy. Several of the participants from both groups believed that LO was important and that the knowledge they obtained from LO was useful. Antonovsky (1991) suggests that an individual have resources that are used when coping with stressors and according to the participants answers one of these resources might be the knowledge they receive from LO in school. The answers also suggest that school is an important factor for their subjective health since school provides them with knowledge they otherwise would not obtain. Because of that, the youths believed that LO was important and that the knowledge they received was valuable, it implies that LO and the knowledge from LO is meaningful knowledge and that the subject is meaningful. Antonovsky (1991) states that the feeling of meaningfulness is the most important factor to obtain a high SOC and therefore also high subjective health. This means that the school as an institution and LO as a subject helps the youths to obtain a high level of subjective health and in some ways helps them to cope with different stressors.
8. Discussion

This section will discuss the result in relation to previous research, which will be divided into three subheadings, followed by a discussion of the research limitations and lastly, ideas for further research.

What are South African youths’ perceptions of their health and how to promote health and what differences can be identified between youths from different socio-economic backgrounds in South Africa?

Higher socio-economic status does not necessarily correlate with higher SOC. Family and supportive people have the greatest effect on the adolescents’ ability to cope with stressors and are therefore the main health promoting factors.

The findings show that the youths that participated in this study perceive their health as good, even though they claimed that their health was not the best. There was a slight difference between the groups, where the LSEG estimated their health as being poorer than the youths from the MSEG group, mainly because they sometimes ate bad food. The quantitative findings did not show any significant difference between the groups which indicates that their ability to cope and handle stressors should be almost the same for both groups and therefore, according to Antonovsky they should have the same possibilities to obtain high levels of self-perceived health, even though they live by different standards. According to previous research, socio-economic status, environment, discrimination, neighbourhood trust, and lifestyles etcetera have an effect on an individual's self-perceived health and SOC (Chan et al., 2015; OECD, 2011; Volanen et al., 2004; Novak et al., 2015; Quon & McGrath, 2014). The findings support this in some ways, since the youths from the LSEG perceived their health as slightly less good than the MSEG, but on the other hand there were no differences in SOC between the two groups, which contradicts the previous research on that matter.

The most important factors for obtaining a good health were family and relationships, exercise and eating healthy and finally the environment and living conditions in the area in which they live. Gluver and Gardner (2007) states from their research of adolescents in South Africa that social capital is important for the youths’ ability to handle stressors. In line with their study our findings support that social
capital, such as family and friends, are important for the youths’ health and their ability to handle stressors and everyday problems, and that might be the reason why there are no differences in SOC between the two groups. Another explanation might be that both groups live in areas where the people in their surroundings have almost the same socio-economic status. According to Quon and McGrath (2014) living in an area with people that have the same socio-economic status is protective for one’s health. Since the youths from LSEG lived in townships where the socio-economic status between people is homogenous it might be a factor that promotes health, or at least has a positive effect on their self-perceived health.

The lowest total SOC score was among the participants in the MSEG. This might have to do with the fact that these youths face different types of problems or stressors and that every person has to create their own ability to face and handle the different situations or problems that occur in life. It might also depend on the different factors mentioned earlier such as their social support. Compared to the participants in the MSEG, the youths from the LSEG participated in help programs, which they stated had a positive affect on their health. This complements their social capital. The youths in the MSEG social support on the other hand relied on family situation and friends. The help organisation program might be one factor that increases the SOC among the participants from the LSEG and their self-perceived health. It is assumed that the help organisation is a factor that affects and decreases the gap between the two groups. The gap had possibly been vaster between the two groups regarding their SOC and self-perceived health if the participants in the LSEG had not been involved in a help organisation or if the participants in the MSEG had been part of one. It is possible that this had affected the scores in each group and increased the lowest scores in the MSEG and possibly decreased the highest in the LSEG. The consensus is that the help organisation might compensate for other factors such as living conditions and environmental factors as safety, abuse and clean areas.
How do South African youths believe school health education has influenced their views of health?
Health education and the subject LO, as well as school, are health-promoting factors, and have in different ways influenced the participants’ views on health. The results of the study demonstrate that the participants in the LSEG found LO to be an important subject and indicated that it had influenced their view of health. They believed that they had learned more about health and were now able to utilize the knowledge they had received to live a healthier life. The result from the MSEG was dissimilar since not all of them valued LO. Some of the participants claimed that the knowledge they received from studying the subject LO was knowledge that they already possessed, and it was therefore not considered to be an important subject. This displays a difference in the answers. However, most of the participants from the MSEG believed that LO was vital and that they learned from attending the subject. All the participants pointed out that health was an important subject to discuss in school and worked as a health promoter. This agrees with previous research, which suggests that education is an important factor that promotes subjective well-being. Gluver and Gardner (2007) state that education has a positive effect on adolescent’s subjective health. Since the participants of the present study pointed out the importance and value of health education this indicates that the health education has an effect and that it has influenced the youths’ views of health in regards of knowledge about what to do and what to avoid to stay healthy and to promote health.

The answers from MSEG indicate that school itself was a health promoter, since it encouraged the students to try different sports and it was mandatory to play two different sports. Also the way the school provided the students with help programs and the focus the school had on stress and other health related factors were seen as health promoters and positive for their health. This can be compared to the findings from the LSEG. The answers from the LSEG indicated that the organisation was a positive and health-promoting place for them. These findings correlate with previous research by Blauuw and Pretorius, 2012; Cluver and Gardner, 2007; Govender et al., 2013; Plüdderman et al., (2014), who suggest that various institutions such as school are positive for youths’ health. They state that different institutions are places where people can create social relationships, which is positive for their health. Relationships to peers as well as to adults can have a positive effect on their health.
Even though some answers imply that the participants had not received any new knowledge from the school health education, it is assumed that the physical activity in LO and the school as a place has had effect on their self-perceived health, since they stated that their health was good and they felt happy and their friends and adults in their surroundings were among the factors which had a positive effect on the participants’ health. In addition to this, the answers also insinuate that as soon as students had graduated from high school they became ignorant of health issues. This indicates that school is a factor that keeps youths healthy and make them concerned about their own health, at least while they are still in school.

8.1 Research Limitations

The selected method is, by the researchers, still considered to be the most suitable method for the purpose of the study. However, due to some of the complications that occurred during the process it was not possible to implement the method as intended.

Since the researchers were not allowed to enter the school, and could not go through the school to get in contact with the students the researchers had to find an alternative way to get the students to participate in the study. Instead, the collection of data had to befall outside of the school area and after school hours. It is assumed that the problem that occurred while the middle socio-economic group filled in their questionnaires has affected the result, since the students were standing next to each other and could see each other’s answers. Furthermore, since the researchers did not have access to any room or isolated area the interviews were conducted at the cafeteria next to the school. The youths were very curious and happy to participate which simplified everything. Nevertheless, the context where the interviews were conducted was not an ideal environment, since there was a lot of noise and people passing by which might have affected the answers and the result of the study, but it was the only option the researcher had at the time. As Bryman (2011) states, interviews should preferably be conducted in a quiet room were the participants feel comfortable and do not have to worry that someone else can hear their answers. This was not possible for this study since the researchers did not have access to any quiet room or area.

The data collection from the LSEG went smoother, however, a few problem occurred which delayed everything. The main problem was that the organisation could not assist the researchers with a sufficient number of participants, so the researchers had to contact another place as well, but the same organisation, to complete the
questionnaires and interviews. The researcher did however still not receive the number of questionnaires that they were aiming for. However, except that this reduced the result from the quantitative part, it has probably not had any significant effect on the total result of the study.

8.2 Further Research

For further research it would be interesting to study self-perceived health among youths from LSEG who are not a part of any aid organisation. Since the organization probably helps and affects the youths and works as support for them, it can be misleading to compare youths who belong to an organisation to youths who are not provided with additional help from organisations. Moreover, another area of research could be to focus on just the organisations or the children in the organisations and investigate if and how the organisation in any way affects the youths’ self-perceived health.
9. Conclusion

The main findings of this study show that there are no greater difference in self-perceived health and SOC between the participants from the LSEG and the MSEG, even though there is a minor difference between the groups in self-perceived health. Evidence from this study indicates that social capital such as family and friends is the main health-promoting factor, followed by exercise, eating healthy and also environmental aspects. Even though the youths who participated in the research lived in different areas with different living conditions, they could still obtain the same level of SOC and almost the same level of self-perceived health. These findings suggest that the youths have learnt to cope with their living conditions and the environment that they live in, which is in line with Antonovkys theory of salutogenesis. In relation to previous research this contradicts the research stating that socio-economic factors have an effect on SOC, however, it also supports previous research that point out social capital and support as factors that affect self-perceived health and SOC.

The findings also show that school, as an institution, and health education influenced the youths’ views on health in different ways. Participants from both groups pointed out that health education and LO have had a positive affect on and increased their knowledge about health and they, especially the participants in the LSEG, stressed the importance of health education and the subject LO.
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Appendix 1 – Sense of Coherence – Orientations to Life questionnaire

Sense of Coherence – Orientation to Life Questionnaire – 29 items

C = comprehensibility  Ma = manageability  Me = meaning  
R = before calculating the total score this should be reversed.

1. When you talk to people, do you have the feeling that they don’t understand you? (C)
   R  1  2  3  4  5  6  7
   Never  Always have this feeling

2. In the past, when you had to do something which depended upon cooperation with others, did you have the feeling that it: (Ma)
   R  1  2  3  4  5  6  7
   Surely wouldn’t get done  Surely would get done

3. Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them? (C)
   R  1  2  3  4  5  6  7
   You feel that they’re strangers  You know them very well

4. Do you have the feeling that you don’t really care about what goes on around you? (Me)
   R  1  2  3  4  5  6  7
   Very seldom or never  Very often

5. Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well? (C)
   R  1  2  3  4  5  6  7
   Never happened  Always happened

6. Has it happened that people whom you counted on disappointed you? (Ma)
   R  1  2  3  4  5  6  7
   Never happened  Always happened

7. Life is: (Me)
   R  1  2  3  4  5  6  7
   Full of interest  Completely routine

8. Until now your life has had: (Me)
   R  1  2  3  4  5  6  7
   No clear goals or purpose at all  Very clear goals and purpose

9. Do you have the feeling that you’re being treated unfairly? (Ma)
   R  1  2  3  4  5  6  7
   Very often  Very seldom or never
10. In the past ten years your life has been: (C)
   1 2 3 4 5 6 7
   Full of changes without your knowing what will happen next
   Completely consistent and clear

11. Most of the things you do in the future will probably be: (Me)
   R 1 2 3 4 5 6 7
   Completely fascinating
   Deadly boring

12. Do you have the feeling that you are in an unfamiliar situation and don't know what to do? (C)
   1 2 3 4 5 6 7
   Very often
   Very seldom or never

13. What best describes how you see life: (Ma)
   R 1 2 3 4 5 6 7
   One can always find a solution to painful things in life
   There is no solution to painful things in life

14. When you think about your life, you very often: (Me)
   R 1 2 3 4 5 6 7
   Feel how good it is to be alive
   Ask yourself why you exist at all

15. When you face a difficult problem, the choice of a solution is: (C)
   1 2 3 4 5 6 7
   Always confusing and hard to find
   Always completely clear

16. Doing the things you do every day is: (Me)
   R 1 2 3 4 5 6 7
   A source of deep pleasure and satisfaction
   A source of pain and boredom

17. Your life in the future will probably be: (C)
   1 2 3 4 5 6 7
   Full of changes without knowing what will happen next
   Completely consistent and clear

18. When something unpleasant happened in the past your tendency was: (Ma)
   1 2 3 4 5 6 7
   "To eat yourself up" about it
   To say "ok that's that, I have to live with it" and go on

19. Do you have very mixed-up feelings and ideas? (C)
   1 2 3 4 5 6 7
   Very often
   Very seldom or never
20. When you do something that gives you a good feeling: (Ma)
   R  1  2  3  4  5  6  7
   It’s certain that you’ll go on feeling good
   It’s certain that something will happen to spoil the feeling

21. Does it happen that you have feelings inside you would rather not feel? (C)
   1  2  3  4  5  6  7
   Very often Very seldom or never

22. You anticipate that your personal life in the future will be: (Me)
   1  2  3  4  5  6  7
   Totally without meaning or purpose
   Full of meaning and purpose

23. Do you think that there will always be people whom you’ll be able to count on in the future? (Ma)
   1  2  3  4  5  6  7
   You’re certain there will be
   You doubt there will be

24. Does it happen that you have the feeling that you don’t know exactly what’s about to happen? (C)
   1  2  3  4  5  6  7
   Very often Very seldom or never

25. Many people – even those with a strong character – sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past? (Ma)
   1  2  3  4  5  6  7
   Never Very often

26. When something happened, have you generally found that: (C)
   1  2  3  4  5  6  7
   You overestimated or underestimated its importance
   You saw things in the right proportion

27. When you think of the difficulties you are likely to face in important aspects of your life, do you have the feeling that: (Ma)
   1  2  3  4  5  6  7
   You will always succeed in overcoming the difficulties
   You won’t succeed in overcoming the difficulties

28. How often do you have the feeling that there’s little meaning in the things you do in your daily life? (Me)
   1  2  3  4  5  6  7
   Very often Very seldom or never

29. How often do you have feelings that you’re not sure you can keep under control? (Ma)
   1  2  3  4  5  6  7
   Very often Very seldom or never
Appendix 2 – Interview Guide

When you think of health, what thoughts come to mind?

How would you describe having good health? / What is it to have good health?

How would you describe bad health?

What view do you think other people in South Africa have on health?

How would you describe your own health?

How would you describe your health during/throughout your childhood?

Factors
What factors do you consider have a positive effect on your health?

What factors do you consider have a negative effect on your health?

How do these factors affect you in your everyday life?

Are you doing anything actively to improve your health?

How do you experience your ability to deal with situations/stressors in your everyday life?

What is your view of your social situation? / What is your experience of your social situation?

How has your social network affected your health and ability to face obstacles in life? / How do you experience your social network’s impact on your health and your ability to face obstacles in life?

School

What is your experience of the school health education?

Is health an important topic to discuss in school? Why is it or is it not important?

Which school subjects discuss/cover health?

Does Life orientation discuss health?

Life orientation

What kinds of health issues are covered in Life Orientation?
Is there anything else that the subject should discuss regarding health according to you?
Has life orientation in school in anyway changed your view of health? in which way?

Do you think life orientation is an important subject in school? Why/why not? What could be done to make it more important?

Do you feel confident in meeting the future?