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“Not on the agenda”: A qualitative study of influences on health services use among poor young women who use drugs in Cape Town, South Africa

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Abstract

Background—Poor young women who use alcohol and other drugs (AODs) in Cape Town, South Africa, need access to health services to prevent HIV. Efforts to link young women to services are hampered by limited information on what influences service initiation. We explored perceptions of factors that influence poor AOD-using young women’s use of health services.

Methods—We conducted four focus groups with young women (aged 16 to 21) who used AODs and were recruited from two township communities in Cape Town. We also conducted 14 in-depth interviews with health and social welfare service planners and providers. Discussion topics included young women’s use of health services and perceived influences on service use. Qualitative data were analysed using a framework approach.

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Conflict of Interest

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Results—The findings highlighted structural, contextual, and systemic influences on the use of health services by young women who use AODs. First, young women were absent from the health agenda, which had an impact on the provision of women-specific services. Resource constraints and gender inequality were thought to contribute to this absence. Second, gender inequality and stigma toward young women who used AODs led to their social exclusion from education and employment opportunities and health care. Third, community poverty resulted in the emergence of perverse social capital and social disorder that limited social support for treatment. Fourth, the health care system was unresponsive to the multiple service needs of these young women.

Conclusion—To reach young women who use AODs, interventions need to take cognisance of young women's risk environment and health systems need to adapt to respond better to their needs. For these interventions to be effective, gender must be placed on the policy agenda.

Keywords

young women; HIV; risk environment; structural context; substance abuse treatment need; gender; health services

Introduction

Despite decades of investment in HIV prevention and treatment, South Africa has a persistently high rate of HIV incident infections (Shisana et al., 2014). Nearly a third of all new infections are among poor young women aged 15 to 24, who seroconvert earlier (Shisana et al., 2014) and have up to eight times greater HIV prevalence relative to their male peers (Dellar, Dlamini, & Abdool Karim, 2015). Consequently, preventing HIV infection in this vulnerable group is essential for achieving epidemic control.

Multiple efforts to prevent HIV among this population have been employed; however, these efforts have largely focused on individual behaviour change, such as increasing condom use. More recently, there has been growing acknowledgement that for HIV prevention efforts to succeed, it is critical to understand the physical and social space in which young women's HIV risk behaviour occurs and the opportunities that exist within this space for young women to reduce their risk, which taken together are referred to as the risk environment (Rhodes, 1997). In keeping with this risk environment approach, physical and social context (including social disorder, social networks, and social capital) are understood to interact to drive individual risk for HIV and the uptake of opportunities to reduce this risk (Rhodes, 2002; Rhodes, 2009; Tempalski & McQuie, 2009).

South African studies have demonstrated the connection between environment and social conditions and sexual risk behaviour among poor young women. For example, poverty and gender inequality have been identified as drivers of age-disparate and transactional sexual relationships in which young women find it difficult to negotiate condom use (Chapman et al., 2010; Gevers, Jewkes, Mathews, & Flisher, 2012; Jewkes, Dunkle, Nduna, & Shai, 2010). In addition, HIV-related stigma within social networks, limits young women's use of sexual and reproductive health services and has an impact on how young women are treated within these services (Lince-Deroche, Hargey, Holt, & Shochet., 2015; Fatti, Shaikh, Eley,

Jackson, & Grimwood, 2014). These dynamics discourage young women's use of health services and the adoption of HIV preventive behaviours (Holt et al., 2012).

While these studies provided insight into the social and structural drivers of HIV risk among poor young women in general, they did not acknowledge the heterogeneity in HIV prevalence found among young South African women. In particular, young women who use alcohol and other drugs (AODs) are missing from policy discussions about how best to reduce the drivers of HIV incidence among young South African women. This is a critical omission because young women who use AODs are likely to be more at risk for HIV infection than young women who do not (Delaney-Moretlwe et al., 2015).

In South Africa, the link between AOD use and risk for HIV infection has been well established (Parry & Pithey, 2006; Kalichman, Simbayi, Kaufman, Cain, & Jooste, 2007). AOD use among young women is associated with multiple, syndemic risks for HIV (Pitpitan et al., 2013). AOD use impairs judgment and decision-making and this has been shown to lead to higher rates of inconsistent condom use (Kalichman, Simbayi & Cain, 2010; Parry & Pithey, 2006; Wechsberg et al., 2010). Further, women who use AODs report trading sex in exchange for AODs or money to buy AODs, or they may use AODs to cope with sex trading (Parry et al., 2008, Wechsberg, Luseno, Lam, Parry, & Morojele, 2006; Wechsberg et al., 2010), which in itself increases risk of exposure to HIV (Dunkle et al., 2004; Parry et al., 2008). Young women who use AODs are also at increased risk for gender-based violence relative to young women who do not use AODs (Pitpitan et al., 2012; Rosenberg et al., 2015), which decreases the likelihood of condom use (Wechsberg et al., 2010).

These earlier findings suggest that efforts to reduce HIV incidence among young South African women are only likely to be effective if young women who use AODs are provided with comprehensive services—including access to sexual and reproductive health, mental health support, and AOD treatment services—that help them reduce these risks (Sawyer-Kurian, Browne, Carney, Petersen, & Wechsberg, 2011; Wechsberg et al., 2010). Even though South Africa has a relatively well-developed AOD treatment system, comprising both residential and community-based outpatient services that offer a mix of evidence-based behavioural treatment approaches, less than 10% of poor women with AOD use disorders ever seek treatment, despite a high proportion desiring treatment (Myers, Kline, Doherty, Carney, & Wechsberg, 2014). Additionally, young women who use AODs rarely engage with other health services (Flisher et al., 2012; Luseno, Wechsberg, Kline, & Ellerson, 2010). While individual barriers to the uptake of these services have been identified (e.g., Myers et al., 2014), there is little understanding of how the risk environment of this marginalised population influences health service utilisation. This lack of information may hamper efforts to link these young women to health services, which ultimately may undermine efforts to achieve an HIV-free generation in South Africa.

As a first step to addressing this gap, we use qualitative data to explore how the risk environment of poor young women who use AODs in Cape Town informs access to and use of health services. In this study, we included the perspectives of young women who use AODs as well as the perspectives of service providers. The overall aim is to identify

structural and contextual factors that should be targeted when developing interventions to improve linkage to health care for this most-at-risk population.

Methods

Study design and setting

As part of a larger study to adapt an evidence-based woman-focused HIV prevention intervention (Wechsberg et al., 2014) for a younger population, we conducted focus group discussions (FGDs) with young, AOD-using women from two peri-urban township communities in Cape Town, South Africa. More than 40% of residents in each of these communities are unemployed, with close to 70% having a monthly household income of less than ZAR 3000 (~USD 300) (Statistics South Africa, 2013). We also conducted in-depth interviews (IDIs) with health and social welfare service planners and providers.

Participants and recruitment procedures

We conducted two FGDs (each comprising 6 participants) with Black African women and two FGDs (comprising 4 and 7 participants, respectively) with Coloured (of mixed race ancestry) women. Outreach workers approached potential participants in settings frequented by young women and described the study before requesting verbal permission to screen them for study eligibility. To be eligible, young women had to be between 16 and 21 years old, live in one of the target communities, report dropping out of school for at least 6 months, report using at least two drugs (including alcohol) weekly over the past 3 months, and report unprotected sex in the past 3 months.

We conducted 14 IDIs with service planners and providers. We generated a list of relevant health and social welfare departments and purposively selected key informants (KIs) from these departments to interview, guided by recommendations from our Community Collaborative Board. To be eligible for inclusion, KIs had to be responsible for planning or delivering AOD, HIV, or other relevant services in our target communities. Project staff contacted these potential participants, described the study, and asked if they would be willing to be interviewed. If a KI was willing to participate, an appointment was made for an interview.

Procedures

All FGDs and IDIs were conducted between September and November 2014. Prior to the start of the FGDs, participants were rescreened to confirm eligibility and were asked to provide written informed consent. FGDs took place in a private room at our study site and followed a semi-structured guide comprising a series of open-ended questions (with probes) about the impact of AOD use on young women's lives and the influences on help-seeking for these problems. Each FGD was facilitated by the U.S. principal investigator and a South African co-investigator, both of whom are experienced in conducting FGDs and one of whom is a trained addiction clinician and psychologist experienced in adolescent group dynamics. All groups were conducted in English and digitally audio-recorded. Other field staff were present to take notes and assist with translations into local languages. The FGDs lasted between 90 and 120 minutes. Participants were provided with refreshments, transport,

and a grocery store voucher valued at ZAR 150 (~USD 15) for their participation. They were also offered referrals to services.

IDIs took place in a private office at the participant's place of work. Interviews were digitally audio-recorded and lasted between 60 and 90 minutes. Interviews followed a semi-structured guide with opening questions and follow-up probes to elicit KIs' perceptions about factors that influenced linkage to services for young women who use AODs. Interviews were facilitated by a South African and a U.S. co-investigator, both of whom are experienced in conducting IDIs. Participants were provided with a gift valued at ZAR 150 (~USD 15) for their participation.

All procedures were approved by the Institutional Review Boards of RTI International and the South African Medical Research Council.

Analysis

Qualitative data analysis was conducted using the framework approach (Ritchie & Spencer, 1994). This approach, which comprises six stages (familiarisation, identifying a thematic framework, indexing or coding, charting, mapping, and interpretation of the data), allows themes to be explored in relation to the research questions and for new themes to emerge from the data. Data analysis was informed by theories of risk environments.

All transcripts were coded by two project staff who met regularly to compare notes. Coding discrepancies were resolved by discussion. A third person was not needed to break coding ties. No new codes emerged after two-thirds of the transcripts were coded, suggesting that we attained content saturation. Inter-coder reliability checks were conducted, with a Kappa score of 0.83 being obtained between the two coders. We used NVivo 10.0 to aid data analysis. We merged the findings from the IDIs and FGDs to ensure that we produced comprehensive descriptions of influences on health care use.

Findings

Four broad themes emerged from the data that are in keeping with the risk environment approach. The first 'Young women who use AODs are not on the policy agenda' describes how societal gender inequality informs health service policy and service delivery. The second, 'Social exclusion and stigma limit opportunities for change' describes how this gender leads to young women who use drugs being stigmatised and socially ostracised from opportunities to change their risk environment through education, employment and social support. Another theme that related to the risk environment of these young women is 'perverse social capital.' This theme highlights how neighbourhood poverty and lack of positive social institutions allows for perverse social capital to emerge that entrenches violence and drug use within communities and hampers change. The final theme referred to how systems that should ameliorate the risk environment and create opportunities for change, are largely unresponsive to the needs of young women and consequently keep them trapped in a cycle of violence and drug use. These themes are described in more detail, below.

Sample characteristics

The FGDs included 23 participants: 12 (52%) were Black African and 11 (48%) were Coloured. The mean age of participants was 18.7 years ($SD = 1.2$). All participants were unmarried, unemployed, and had not completed high school. All reported using multiple substances several times a week, with the most commonly used substances being methamphetamine, cannabis, and alcohol (heavy episodic drinking).

A total of 14 KIs were interviewed, of which five were male and nine were female. Five KIs were from the health sector, four were from the social welfare sector, four were from the AOD treatment sector, and one was from law enforcement.

Young women who use AODs are not on the policy agenda

The findings reflect how poor young women who use AODs are forgotten about in health policy and planning, and how this has a negative impact on their opportunities to reduce HIV risk. At the broadest level, young women who use AODs are ‘not on the agenda’ of health policy and service planning. Even though KIs agreed that women who use AODs often have multiple health and social problems, they noted that there was very little acknowledgement of the importance of providing services for these young women.

This exclusion of young women who use AODs from the policy environment has contributed to the lack of women-specific AOD services, largely because these kinds of services were not seen as a policy or funding priority. All KIs reflected that there were few services that were sensitive to the needs of young women who use AODs, with most available services adopting a ‘one-size-fits-all approach’ that provided men and women with the same services:

‘We don’t have a lot of women-specific services....also for girls, younger girl adolescents are a major problem for us.’

[KI 2, male social welfare policy maker]

While all of the KIs agreed that the ‘money just isn’t going into gender’ services, they were split along gendered lines as to the primary reasons for the lack of investment in these services. Most of the male KIs cited financial and human resource constraints as the primary reason for the lack of women-specific services. They described how services were struggling to keep up with the ‘expanding demand’ for treatment. As one KI stated, ‘Our problem is not a shortage of customers’ [KI 3, male social welfare planner]. Male KIs were concerned that additional efforts to reach underserved women would create an additional demand for services that they ‘would not have the capacity to take on’ [KI 6, male AOD service planner].

While female KIs also expressed concern about limited resources and capacity to implement women-specific services, they felt that pervasive gender inequality in South African society was the primary reason for underinvestment in services for young women. They explained that women’s position in South African society was weak and therefore their needs were not considered by policy makers. This led to a lack of investment in women-specific services:

‘Women don’t have influence.... They see women as mothers or daughters—the whole relationship is defined in relationship to men or they come from political ideologies that say oh you have functional freedom and therefore everyone is free to pursue their own agenda without looking at the fact that it doesn’t work that way because of disadvantage.’

[KI 1, female health service planner]

Social exclusion and stigma limit opportunities for change

Within communities, gender inequality translates into gender norms that value young men over young women and provide young men with relatively more opportunities to change their social circumstances. Several FGD participants described how the education of young women received less priority than that of young men. Some young women spoke of having to leave school to take care of younger siblings or because there was not enough money for both them and their brothers to attend school. FGD participants also described how their lack of education made it hard for them to find work, which kept them trapped in poverty. Many of the young women spoke of how they used drugs to alleviate the boredom of not having anything meaningful to do. As there were limited opportunities for them to change their circumstances through further education or employment, young women felt they ‘no longer had dreams.’ As one participant reflected ‘Their lives is not right. Their future is scurriel [hustling], almost like to say their future is done’ [FGD 1, Coloured woman].

Gender role expectations about what it means to be a woman also result in young women who use AODs experiencing more stigma than young men. FGD participants described how AOD use among women is socially unacceptable; however, among men it is viewed as a rite of passage. As one FGD participant noted, ‘you are no longer seen as a [proper] woman’ [FGD 1, Black African woman]. They also gave examples of how they were mistreated by community members because they used AODs, and how the stigma they experienced made them hesitant to seek health services for fear of being exposed as a drug user. As one KI stated, ‘It’s around stigma...the biggest thing is around shame that someone will see them’ [KI 8, male AOD service planner].

Stigma was also evident in participants’ descriptions of interactions with service providers. In all of the FGDs, participants reported that providers were rude and that stigma was pervasive in the health care system. They gave examples of how they were denied health treatment because of their AOD use and how their rights to confidential care were not respected:

‘Nurses living with us spread our [HIV] status.’

[FGD 2, Black African woman]

While stigma emerged as an important theme in the FGDs, none of the KIs reported that women who use AODs were discriminated against in the health care system. However, two of the KIs acknowledged that there was a lack of person-centred care that, although not specific to people who use AODs, could have impacted on how AOD-using young women experienced services:

‘What people say to us, the feeling is that they are not treated in a person-centred approach. There is a lot of judgment, people are very judgmental putting their own values in there, and things like that inform how they treat the client.’

[KI 4, female health service planner]

According to FGD participants, these experiences of social exclusion and stigma diminished their motivation to seek services, largely because they could not envision their lives changing. As one participant said, ‘We don’t go there (health clinic) and then when it’s time for us to go there ...it is too late’ [FGD 1, Black African woman]. Young women described how they needed to feel that their lives had meaning and that they had something important to do before they would change their risk behaviours:

‘Smoking [drugs] is just something you do because you are not doing anything. If there was something else you were doing, you wouldn’t do it.’

[FGD 1, Black African woman]

Perverse social capital hampers health service use

The findings from the FGDs and IDIs reflect how place influences the uptake of opportunities to change young women’s risk for HIV. Participants described how poverty in their communities set up a system of perverse social capital in which community members accepted the presence of gangs and drug markets because these provided economic opportunities for young people. In all of the FGDs, participants noted that many young people got involved with gangs that organised the sale and distribution of drugs as a means of financial survival. They described how family members often ‘turned a blind eye’ to these illegal activities because they were ‘putting food on the table’ [FG1, Coloured woman]. As one participant noted:

‘Children sell drugs, get involved with gangs, and then the mother gets money.’

[FG2, Coloured woman]

According to the KIs this has led to the widespread availability of AODs in these communities. The presence of gangs and the accompanying rivalry over territory and drug markets has also led to high levels of gang-related violence. All of the FGD participants and many of the KIs spoke of how gangs were a driver of social disorder in these communities. Young women had personally witnessed incidents of gang-related violence. They described how gang violence was ‘breaking down our community’ [FG1, Coloured woman]. They also spoke of how gang-involved boyfriends were often physically and sexually violent toward them. Despite this violence, young women described desiring boyfriends who were involved in gangs because they had status, power, and money. For many of the FGD participants, having a relationship with a gang-involved boyfriend was perceived as a way out of abject poverty. However, once they were involved with gang members, they indicated that it was very difficult to make changes to their drug use or to leave the relationship. The FGD and the IDI participants explained how social institutions that should have assisted young women in leaving these relationships colluded with the gangs. Young women described how in their communities the police could not be trusted and were often on gang payrolls:

‘There are police who are gangsters...they will like warn the gang when the next search is...there are certain police who will steal their dockets and like will destroy it. There are even police that will sell drugs.’

[FG2, Coloured woman]

Consequently, when young women turned to the police for help with violent, gang-involved boyfriends, they often ‘just did not come to help’ and noted that ‘policemen say you cannot open a case against that man’ [FG2, Coloured woman]. A few KIs agreed that police collusion with gangsters perpetuated social disorder in these communities. They described how police traded firearms and rifles with gangs and were unwilling to arrest gang members:

‘They [gangs] are testing heavy weapons, automatic rifles that they either bought or stole from the police....elements of the South African police service are deeply implicated [in organised crime].’

[KI 14, male law enforcement]

Young women also spoke of how their families did not support their attempts to change or leave their gang-involved boyfriends. In some instances, parents actively encouraged their daughters’ relationships with gangsters, even though they supplied the young women with drugs and were often violent, because these boyfriends provided the family with financial support and were viewed as an economic lifeline:

“Sometimes the family is not with the girl, then they tell the boyfriend, the girl is in here, you can come and take her out. You can’t trust the family also. The family don’t support them [because] they get paid sometimes.”

[FGD 2, Coloured woman]

According to the FGD participants, these contextual factors diminished their desire to seek AOD treatment. These young women felt that it was difficult to change and pointless to seek treatment because they would come back to the same violent environment where AOD use was ‘everywhere’ and to social networks where there was little support for changing their AOD use.

Many KIs recognised that these high levels of social disorder undermined efforts to provide services to these communities, further isolating young women from opportunities to reduce their risks:

‘You can’t run services in communities when the bullets are flying. Your clinics are closed, your health services are closed, the schools close, teachers walk off site saying “we’re not coming back until the shooting stops.”’

[KI 14, male law enforcement]

KIs also recognised the role that poverty played in perpetuating this perverse social capital, noting that ‘gangs are not going to change unless there are other [employment] options’ [KI 12, female social welfare planner]. Despite this recognition, most of the KIs clung to the notion that young women were not ‘passive, had control over their lives, and could make different choices’ [KI 14, male law enforcement]. Several gave examples of individuals who had managed to ‘rise above their circumstances’ and leave their environment or successfully

change their AOD use. They seemed to blame young women for not being resilient or motivated enough to make a change:

‘I think they often aren’t even motivated to come, you know it’s all about the next fix and the next....’

[KI 13, female health care provider]

While the FGD participants recognised that they needed to be motivated to seek services, they also felt it was not enough to enable them to change their risk behaviours.

Systems are unresponsive to the needs of young women who use AODs

Even if young women who use AODs manage to access health services, the findings suggest that these services are often unresponsive to their needs. FGD participants described how, in addition to AOD services, they needed sexual and reproductive and mental health services. These needs were often unmet by health care providers. The structure of the health system appears to contribute to these unmet needs. The KIs described how sexual health services were provided at primary health care facilities, AOD services by stand-alone treatment facilities, and victim empowerment services by nongovernmental organisations. None of these services ‘look holistically at a person’s risky behaviours’ [KI 13, female health service planner]. Consequently, young women are required to navigate three separate systems of care to obtain comprehensive services. The KIs commented on how this increases the difficulty in accessing services, largely because of transport costs and other logistic barriers. Although the KIs suggested that case management could assist with system navigation, this rarely occurred:

‘The problem is they are not doing that [case management], what happens is they open a file, and they send the person away, and they forget about it.’

[KI 3, male social welfare planner]

National policies for health and AOD services appear to underpin this approach to health care. The KIs described how the Department of Health is responsible for sexual and reproductive health service delivery, whereas the Department of Social Development leads all AOD programmes. Having two different national departments responsible for these services, each with their own regulations and legislative requirements, seems to impede collaboration and the delivery of integrated health and AOD services:

‘So the outcome of that is you get a very restrictive approach around where substance abuse treatment services must be and where HIV testing and counselling must be, and the two are not in the same system.’

[KI 2, male social welfare policy maker]

Additionally, the FGD participants expressed concern about whether available services were appropriate to meet their needs. They remarked that existing AOD services ‘did not help you stop using’ [FGD, 1 Black African woman]. In all of the FGDs, the participants narrated how people went to drug treatment and were ‘better’ for some time, but were unable to maintain these changes. They speculated that this was because their environment remained unchanged. Although the KIs also had concerns about the effectiveness of drug treatment,

their focus was not on whether AOD treatment responded to the contextual drivers of AOD use, but rather on whether programmes provided evidence-based treatment targeting individual behaviour:

‘There are some cuckoo people out there tying people up in chains and praying for them...they are not necessarily implementing best practice.’

[KI 4, female health service planner]

The KIs thought that a shortage of skilled staff made it challenging to roll out evidence-based programmes and woman-focused services. According to the KIs, some AOD facilities were run by ‘low to moderate skilled staff,’ which has an impact on the quality of services and the responsiveness of programmes to the needs of young women. They said that current staff did not know what to do with or how to address the multiple service needs of young women:

‘So you got a lot of people that have a fairly low to moderate level of skills, and trying to get a more sophisticated programme going with people at that skill level can be difficult.’

[KI 3, male social welfare planner]

The KIs suggested that these staff would require training to be able to deliver treatment services responsive to the needs of young women:

‘I think also sensitising them, substance abuse service providers, around the need for a slightly different emphasis in the approach for women, I think will be valuable.’

[KI 11, female AOD service planner]

Despite these different perspectives, both the FGD and IDI participants agreed that young women’s perceptions that treatment is ineffective or not suited to meet their needs had a negative impact on their use of AOD treatment.

Discussion

Although studies in other settings (Blankenship, Reinhard, Sherman, & El-Bassell, 2015; Bobrova et al., 2006; Otiashvili et al., 2013; Strathdee et al., 2011) have shown that structural and contextual barriers have an impact on vulnerable women’s use of AOD and health services, little is known about the risk environment of poor, young South African women who use AODs and how this informs health service utilisation. This study has identified important structural and contextual factors that need to be considered when developing interventions to improve linkage to health services for poor, young, South African women who use AODs.

The findings show how poor young women in Cape Town who use AODs are multiply marginalised in South African society. Despite clear evidence of the value of women-specific AOD treatment for women’s treatment outcomes and the integration of AOD and HIV services for HIV prevention (Gilbert et al., 2015; Wechsberg et al., 2015), young women who use AODs are missing from health and AOD policy and service planning.

Consequently, there is a lack of appropriate services for young women who use AODs, which is a major deterrent to treatment-seeking. Male service planners were disinclined to consider adapting services to be more gender-sensitive, citing financial and human resource constraints as a major barrier to delivering women-specific AOD treatment services. These resources could be redistributed if women's needs were prioritised in health care planning; however, the findings suggest that women are not prioritised because of societal gender inequality. If pervasive gender inequalities in South African society are not redressed, it will be difficult to convince decision makers of the benefits of investing in targeted health services for vulnerable women.

Societal gender inequality also has had an impact on how young women who use AODs are treated in poor communities and the health care system. Our findings show that in impoverished South African communities, young women who use AODs are socially excluded from opportunities to reduce their HIV risks through education, employment, or access to health services by virtue of their gender and AOD use. Similar to other studies (Dellar et al., 2009), our findings suggest that young men's education is favoured over that of young women's, which has an impact on the ability of young women to find work, leads to boredom, and underpins their AOD use. Additionally, and in accord with other studies (Myers, Fakier, & Louw, 2009), young women who use AODs are stigmatised both by community members and within the health care system, largely because they defy gender role expectations. As our findings demonstrate, social exclusion entrenches risk behaviour and deters health service use; consequently, interventions to reach and link young women who use AODs to health services must consider how to reduce the social exclusion of young women. For example, interventions should consider creating opportunities for young women who use AODs to gain further education or develop income-generation skills so that they can envisage a brighter future and contribute meaningfully to their community. Also, community and health-system-wide mobilisation efforts are needed to address gender norms and role expectations that fuel the marginalisation of women in general and the stigmatisation of women who use AODs in particular.

These structural interventions are needed not only to reduce social exclusion but also to alleviate community poverty. Our findings show that community poverty fosters an environment where perverse social capital flourishes. Poverty has led to the emergence of gangs that run an underground economy and provide community members with a source of income. Despite high levels of social disorder that accompany the presence of gangs, young women seek out gang-involved boyfriends because they can provide financial support to them and their families. Through these relationships they became enmeshed in drug-using social networks and engaged in risk behaviours that do not support health service use. This is similar to findings from other contexts (McGloin, Sullivan, & Thomas, 2014). When young women attempted to leave these relationships, they found little social support for change within the community or their families because of financial dependency on the gangs. Social institutions such as the police and family actively colluded with gangs and could not be relied on to provide support or protection. Consequently, young women felt trapped in their circumstances and had little motivation to seek assistance. Studies from other settings also have demonstrated that the lack of community and family support for change has a negative impact on treatment use (Kennedy & Horton, 2011). These findings

suggest the potential value of community-level interventions (that focus on eradicating poverty, developing social capital, and strengthening prosocial institutions) for creating a community context where young women are supported in their attempts to reduce their risk behaviours and encouraged to use health services.

In addition to these contextual interventions, structural and systemic interventions are needed to ensure that the health system is responsive to the needs of young women who use AODs. The KIs described how young women needed to access separate systems of care, each with its own rules and regulations, to receive comprehensive care. Much like studies conducted in countries with similarly organised health care services (Otiashvili et al., 2013), this vertical structure made navigating the health system difficult for these young women and increased logistical barriers to accessing care. While the South African government has started reconfiguring the legislative and regulatory framework to improve the integration of health care services (Naledi, Barron, & Schneider, 2011), implementation of this new policy approach has been slow and will take years to achieve. In the meantime, interventions to enhance linkage to care for vulnerable young women could benefit from the inclusion of case management to help them navigate the current health system. Case management appears to enhance both service initiation and retention in care for vulnerable populations (Stokes et al., 2015).

Our findings demonstrate the need to enhance current services to respond more effectively to the needs of young women who use AODs. Interestingly, the young women and KIs in our study differed in how they thought AOD services should be reconfigured. Despite overwhelming evidence of the structural and contextual factors that drive young women's use of AODs, the KIs held fast to the idea that AOD services should target individual behaviour only. They thought that young women had personal agency and could overcome their circumstances and context if they were motivated enough. Consequently, their recommendations for improving the AOD treatment system focused on implementing individually focused, evidence-based treatment programmes and developing core competencies for providers. In contrast, the young women felt that available AOD treatment services were ineffective, not because of a lack of evidence-based programmes but because services did not address the structural and contextual drivers of their AOD use. While the provision of evidence-based programmes delivered by competent providers is essential for positive treatment outcomes, such programmes are unlikely to be successful in reducing young women's risk unless they are accompanied by interventions that target the risk environment.

Several limitations should be considered when interpreting these findings. First, although the FGD participants provided a detailed description of the influences on help-seeking among young women who use AODs in two township communities in Cape Town, these results may not be generalisable to other settings. However, the FGD findings were largely consistent with those from the IDIs conducted with regional service planners and providers. Second, we were unable to assess the strength of the relationship between these barriers and service utilisation. Consequently, future quantitative studies are needed to examine the relationship between these variables and service use.

In conclusion, to reach young women who use AODs and link them to health services, it is necessary to go beyond delivering interventions that build individual readiness for treatment. Our study indicates the importance of addressing the underlying structural and contextual drivers of AOD use that keep young women disengaged from health services. The findings suggest that interventions that reduce community-level poverty and social disorder (which allows for drug markets and gangs to flourish), facilitate inclusion in education and employment opportunities, address stigma, and build positive social capital (including social networks supportive of health service use) may yield important benefits. Systemic interventions that improve the fit between young women who use AODs and health services are also needed to facilitate health care utilisation amongst this multiply marginalised population. However, for lasting change to occur to young women's risk environments, gender inequality needs to be placed firmly on the AOD policy agenda.

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Highlights

- Young women who use AODs are absent from HIV and AOD policy which impacts on the provision of women-specific services.
- The risk environment of poor young women who use AODs influenced their uptake of health and AOD services.
- Gender inequality and stigma led to the exclusion of young women from opportunities to reduce their health risks.
- Community poverty resulted in the emergence of perverse social capital that limited social support for treatment.
- The health care system was unresponsive to the multiple service needs of young women.