AN ANALYSIS OF THE MANAGEMENT OF ADOLESCENTS' REPRODUCTIVE HEALTH SERVICES IN THE MAFIKENG AREA, NORTH WEST

A DISSERTATION SUBMITTED TO THE

FACULTY OF COMMERCE AND ADMINISTRATION

UNIVERSITY OF NORTH WEST

IN PARTIAL FULFILMENT OF THE REQUIREMENT

FOR THE DEGREE OF

MASTER OF BUSINESS ADMINISTRATION
MBA

BY

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FEBRUARY 2003

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ACKNOWLEDGEMENT

First and foremost I would like to thank God who made it possible for me to conduct this study. I also thank the Department of Health for having granted me permission to conduct this study.

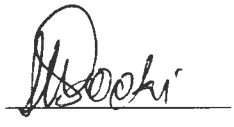
A big thank you goes to my husband, Kabelo, who motivated and supported me throughout my studies and particularly this research project, my two sons, Thabang and Mosimanegape who sacrificed and exercised patience during the compilation of this report when I had very little time to spend with them because the greater part of my time was dedicated to this report. I also would like to give a big thank you to my house manager, Tsitsi Mooki, who made it a point that my whole family, including myself, get the necessary care, clean and safe environment at all times.

The support and guidance I received from my supervisor, Dr MP Maaga, throughout the process of this study and compilation of this report is gratefully acknowledged. I must also thank peer educators for their co-operation during my study, Mohau, Puleng and PH, and most of all, the statistician, Jean Ditsebe at Statistics SA.

I am also thankful to all the respondents who participated in the study, and were the principal source of data. Without them I could not have made any progress in this venture.

DECLARATION

I, Mmmolaeng Laura Mooki, declare that this dissertation is my own, unaided work. It is being submitted in partial fulfilment of the requirements of the degree of Master of Business Administration (MBA) in the University of North West, Republic of South Africa. This work has not been submitted before any degree of examination at this or any university.

Signature: 

Date: 18 February 2003

ABSTRACT

The purpose of this study was to analyse management of adolescents` reproductive health services in the North West Province with specific focus on the Mafikeng area, by checking as to whether target group is being reached and to finally create an environment in the youth centre that would allow adolescents to make informed choices.

Stratified random sampling using a youth centre in Mafikeng as a stratum was used. Within the youth centre judgemental sampling was used whereby youth accessing the centre between ages of 10 and 24 was targeted.

From the study perceptions, experiences and attitudes of youth were explored in trying to find out why are there some adolescents who do not utilise the services.

The study also shown that most youth knew about the centre. Some of whom were satisfied about the services rendered; whilst on the other hand others were not satisfied about the service. Attitudes of service providers still need to be modified and changed to accommodate youth. Reproductive health rights of youth are still not taken into consideration. Parents are still not communicating with their children at an early age of their lives. The study also revealed that workshops have got no follow up.

It is recommended that:

- Parents should be involved in the services rendered at the youth centre so as to promote communication between them and their children.

- Service providers should be approachable and understand youth
- A nurse should always be available at the youth centre.
- The centre should be centrally located for easy access.
- More awareness about youth centre should be done and target group be reached.
- Youth educator especially that she is a teacher not a nurse, should work very close with the school health nurses.
- There should be a well established referral system from clinics to the youth centre, and from the youth centre to the clinics and the hospital.

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CHAPTER 1

1.1 BACKGROUND OF THE STUDY

Youth health programmes in the North West province warrant attention because there are no programmes specific for youth. Their services are incorporated in the Primary Health Care. The province is 60% rural and culture and tradition still dominate rural life (Statistics South Africa, 2000). There are cultural myths including those related to health issues in general and reproductive health in particular. In most if not all rural culture, topics related to reproductive health are still taboo. As a result young people in these rural settings do not receive sufficient health education (Planned Parenthood Association of South Africa, 1999).

It is also believed that talking about these issues is a simple way of introducing youth to promiscuity. North West Department of Health emphasised that it is very important to address these issues to youth at an early age of their lives. North West Department of Health decided that more education and information should be given to youth so as to make it easier for them to make informed choices regarding their reproductive health. This study therefore focuses on the management of adolescent reproductive health services.

Definition of an adolescent varies according to the source. Planned Parenthood Association of South Africa defines an adolescent as any male or female between the ages of 10 and 24 irrespective of colour, religion, sex, culture and education level, they target youth in school and out of school. In the South African context, (National Youth Commission report, 2000) an adolescent is a person between the ages of 14 and

35 years. However, (The White Paper on Social Welfare: 1997) defines an adolescent as a young person aged between 16 and 30 years. The Child Care Act of 1983 on the other hand defines an adolescent as anyone between the ages of 0 and 18 years. There is a need for harmonising across definitions on these matters. The number of young women and aged between 14 and 35 years is estimated at 16, 2 million, representing 39% of the South Africa population (UNFPA report, 1999).

Male attitudes, structures and procedures often undermine women, creating power relationships within which young women are often found vulnerable. In many occasions young women have less power over their own bodies than men, and they are often required to be more accountable for their actions than young men are, e. g teenage pregnancies (Women `s Health Report, 2001). Males can force their female counterparts or partners in to unsafe sex, females then surrender and fall pregnant after which they are to carry an unwanted pregnancy to term. This concept is vital because this study will focus on both males and females on issues of reproductive health, both will benefit from the knowledge delivered from the services.

For example, a Non Governmental Organisation, Planned Parenthood Association of South Africa, pilots adolescents' reproductive health services for two years. Adolescents' reproductive health services in South Africa have been rendered comprehensively with other services in the primary health care therefore reproductive health rights of women including youth have been violated and not taken into consideration. This is a new project of its kind in the North West Province. The purpose of this study was to find out relationship of the services and its outcomes,

change in behaviour of those who utilised the services (Department of Health North West Province).

The programme offered by Planned Parenthood Association of South Africa includes clinical services where the following are done: issuing of contraceptives, pregnancy tests, breasts examination and treatment of Sexually Transmitted Infections. It also offers education of a variety of topics including: teenage pregnancy, sexual decision making, STD's, self esteem, anatomy and physiology of male and female reproductive organs HIV/AIDS and counselling on teenage pregnancy, pre- and post counselling for termination of pregnancy, relationships, STIs and HIV/AIDS. It is important for the researcher to discuss the programme because it shows how important is the programme towards the adolescents.

It is important to offer education on adolescent' reproductive health because adolescents are future leaders and without full knowledge of their reproductive health, they can end up falling into the trap of contracting sexually transmitted diseases such as HIV/AIDS. Reproductive health services for adolescents are rendered in Mafikeng, Klerksdorp, Vryburg, Moretele, Winterveldt and Rustenburg in the North West Province.

For the purpose of this study focus will be on Mafikeng youth centre. Sports and recreation facilities also form part of the services so as to keep the youth busy. This study focuses on the youth in spite of the information and free services they get from clinics and youth centres, young girls fall pregnant without planning the pregnancies.

Some of these are terminated leaving young people frustrated, traumatised and with low self-esteem.

(Fogel, et. al. 1999: 30) states that research has established that most teenagers are sexually active. Therefore another study at the Institute of Medicine, United States, found out that although the attitudes of adolescents to school based clinics were positive, they still fell pregnant. The study also suggested that adolescent' reproductive health services such as those were still to be rendered at other more private institutions, because they created a more private environment for adolescents. On the other hand, adolescents still did not access those services as expected and the reason was that they were still shy to attend (Fogel, 1999:39)

An approach that is different from other adolescents' reproductive health services rendered in other countries is that parents are involved through parents meetings and information is therefore passed on to them, so that they can encourage their children to access such services without stigma attached to them. As a result the fact that parents be involved in adolescents' reproductive health services should be emphasised.

> Reproductive health services are an area where gains have been made in recent years, but with rising numbers of people in poor countries passing through their reproductive ages, the pressure is on to sustain and build upon this progress in the services provided, including offering choice of contraceptives, so as to meet the individual needs of women, men and adolescents. Expanding the

use of contraception clearly depends on access and information, but gender relations and power balances within couples are also important. Reproductive health depends on the extend to which men discipline their own sexual behaviour and support their partner s' rights and health.

Many adolescents lack formal education, work and beneficial recreation and many live in extreme poverty. Some are not sufficiently aware of the dangers they face since they are ill equipped to protect themselves and willing to take potentially life-threatening risks. (UNFPA field report, New York, 1999). Therefore it is vital to involve adolescents into adolescents' reproductive health services.

1.2 STATEMENT OF THE PROBLEM

In this study an analysis of the management of adolescent reproductive health services is examined. The fact that adolescents still fall pregnant and STDs are still treated in spite of the education given to them, needs examination. The rights of adolescents need to be respected, they are treated confidentially but despite all that, girls are still terminating unwanted pregnancies due to lack of knowledge and boys are still seen as abusive in their relationships. For this reason this research was based on the management of adolescents' reproductive health services.

1.3 PURPOSE OF THE STUDY

This study was undertaken for the following reasons:

- To analyse the management of adolescents reproductive health services in the North West Province with specific reference to the Mafikeng area.

- To see if the target group is being reached.
- To create an environment in youth centres that would allow adolescents to make informed choices through the guidance of outcome of the study.

1.4 SIGNIFICANCE OF THE STUDY

Information gained from this study will assist health care providers and parents in becoming more sensitive about the reproductive health needs of adolescents. It will also make health care providers aware of the rights of adolescents with regard to their reproductive health needs. It was important to conduct this research because factors that lead to adolescents not utilising reproductive health services be determined.

The challenges facing health care providers regarding reproductive health services will be outlined and related problems will be dealt with. Another significance underlying this study was it is a pilot project which may provide opportunities for problems to be identified and solved before the services are totally handed over to the North West Department of Health.

1.5 METHODOLOGY

RESEARCH DESIGN

This was an evaluation study aimed at evaluating the programme offered by Planned Parenthood Association of South Africa

1.6 SAMPLING METHOD

Stratified random sampling, using one youth centre as stratum was used. Within the youth centre judgemental sampling was used whereby youth accessing the centre between the ages of 10 and 24 were targeted.

1.7 DATA COLLECTION PROCEDURE

Data was collected through interviews and structured questionnaire.

1.8 DATA ANALYSIS PROCEDURE

Descriptive analysis was used for purposes of analysing data with a view to establishing patterns and trends in the youth centre. Data is presented in tables.

CHAPTER 2

2.1 LITERATURE REVIEW

The literature reviewed for this study focused on religious hospital mergers and access to reproductive health services, it stated that one of the most significant but least noticed changes in the current health care market is the increase in the size and influence of religious health systems and the impact of this growth on access to reproductive health services, (www.firstsearch.sabinet.co.za 12.07.2001). While a number of religious institutions, most significantly the Catholic Church, prohibit or discourage treatment for infertility, contraception, sterilization and abortion, advocates can use several innovative strategies to help prevent the elimination of legal and necessary reproductive health services, especially for adolescents (Fogel,et. al, 1999:30)

There are so many religions in the country and every one has its own principles and laws, therefore taking Catholic Church into consideration, this leads to different ideas regarding these issues because youth is vulnerable and prone to peer pressure. This may also lead to back street abortions due to fear of coming out and seeking for help (www.polity.org.za)

In the United States of America about half of all adolescents were found to be sexually experienced and active, about one-sixth reported having four or more lifetime sex partners. More than 15 million incident cases of sexually transmitted diseases occur annually in the US, with adolescents accounting for at least one quarter of these cases (Fogel, et. al: 1999:34). As a result focus should be on evaluating programme offered by Planned Parenthood of South Africa and to raise awareness

regarding the adolescent' reproductive health services in Mafikeng, this will also help identify gaps in the service rendering.

Even today the number of youth going to clinics with STD `s is still very high irrespective of services rendered to them. This is also seen form the statistics of HIV/AIDS. STD 's among adolescents are casually related to HIV infection as well as subsequent infertility, cervical cancer, spontaneous abortion and low birth weight infants (www.who.org, 03.09.2001). Further, ± 20% of all people diagnosed with AIDS probably were infected with HIV before the age of 20. Teen pregnancy in the US was also found to be problematic, (School Health Journal V.70 no1, 2000:22).

The situation is not too different in South Africa. For example teenage pregnancy is also still high in Mafikeng considering the rate at which teens terminate their pregnancies at Mafikeng Provincial Hospital, and those referred from other clinics. In September 2001, about 50 female youth were referred to the hospital outside Mafikeng for termination of pregnancy. This has been seen as youth utilising termination of pregnancy as a contraceptive method (Boikanyo, 2000).

(Speizer, 2001:48) believed that Sexually Transmitted Infections related services such as school-based clinical services should be readily accessible and available to prevent Sexually Transmitted Infections and to include family planning and Sexually Transmitted Infections-related services into comprehensive reproductive health services. Reproductive health services include testing and treatment for Sexually Transmitted Infections, family planning and counselling, including provision of

condoms and contraceptives, (Public health reports, 1996:75). School Health service is provided at all the schools in the North West Province, including Mafikeng, however the rate of teenage pregnancy is not reduced as expected.

School health nurses provide health education to school children allowing them to participate freely in the rendering of such a service. In most cases however, the youth is shy to go and seek help at the clinics for various reasons (Motswaledi, 2000). The study of adolescents' attitudes to school based clinics concluded that students overwhelmingly supported those clinics, particularly those who had enrolled in school based clinics. It was found out that ±95% were females attending those services (School Health Journal, 2000:29).

Females utilise such services but they are still victims of abuse and unwanted pregnancies. This shows that males are still practicing their dominance over females. Females irrespective of having knowledge and services at their disposal, they are seen surrending to their male counterparts

Providing health services in schools was consistent with social cognitive theory in that these services created a supportive environment for adolescents to discuss topics such as STI/HIV, unintended pregnancies, protective behaviour among adolescent students. Adolescents could not eek such services from their private doctors, hospitals, community health clinics and STD dedicated clinics (School Health Journal, 2000:37). Because youth is still shy and afraid to go to clinics for help, they are keeping their problems as secrets and go for help only when things are beyond their control, or when they have severe complications.

It was also found that in the US most adolescents did not consult medical practitioners because they did not have money so they had to use school based clinics. The study revealed that they wanted confidentiality at the clinics and their parents were not to be made aware of their access to such services. Adolescents whose parents disapproved of them having sex were unlikely to use the clinic (School Health Journal, 2000:46). As a result parents need to be involved in health care of their children so that there is continuity of service at home. Once a parent does not allow open discussion with her/his child, then that child will believe in what she or he learns from her peers. In most cases wrong information from peers is accompanied with dangerous experiments leading to unwanted pregnancies and Sexually Transmitted Infections.

One study established that female adolescents did not seek treatment for STIs as quickly as their male counterparts who were likely to access the services for such treatment. Females waited until they had symptoms such as pelvic inflammatory diseases which require emergency treatment and sometimes hospitalisation (HST report, 2001). Other students were shy to utilise the services in the school premises as they were convinced that their school mates diagnosed them before they could even be seen by professionals, i. e. they thought that school clinics were not private enough for them (UNFPA report, 2001).

A number of countries do recognise the specific needs of adolescents and are developing policies to respond to them In Nigeria where a target was formulated to provide suitable family planning education and information, family life education and to make all reproductive health services available to all adolescents (Fogel et.al,

1999). Special family planning clinics have been established in Finland and the US for adolescents. (Promoting individual reproductive rights, reproductive rights in practice (Anita, 1997: 62) In North West Province, there are youth centres in all five regions which provide suitable services to youth, mainly adolescents' reproductive health services. These centres need to be placed where the youth will feel comfortable to utilise them and where youth can reach them easily.

Restrictions regarding the rights of adolescents' reproductive health were found to be official government policy in Kenya, Nigeria, Bolivia, Mexico and Bangladesh. Kenya's policy requires spousal consent in the provision of all contraceptives. In Bolivia, Mexico, Bangladesh and Nigeria spousal consent is required in the case of sterilisation. In the Netherlands, Finland and Thailand provision of contraceptives is not officially restricted in such a way (Fogel, et.al, 1999:39).

Even though Nigeria was offering services, women were restricted to a certain number of children i.e. not to have more than four children the country's policy encourages men to limit their wives and children to a number they can support. Another restriction based on gender is the age of marriage; women are to get married at 18 years but men at 25 years.

In Mexico guidelines based on contraceptives addresses men's dissatisfaction with certain methods but does not address dissatisfaction of women about certain methods while women's dissatisfactions are ignored (Hardon, 1997:69).

2.2 ACCESS TO ABORTION SERVICES

In South Africa, unlike in some developing countries, abortion is legal. For example, in Bangladesh the penalty facing a person convicted of performing an abortion for non-therapeutic reasons is 3-10 years imprisonment. In Kenya and Nigeria a person performing an abortion is sentenced to 10-30 years imprisonment. In Bolivia, Mexico and Thailand condition under which abortions are performed is broader (www.polity.org, 13.10.2001).

2.3 MALE REPRODUCTIVE AND SEXUAL HEALTH

For most young men in late adolescence, the physical aspect of sexual maturation is nearing completion, with the appearance of adult genital configuration and hair distribution (www.malereproduction.com, 26.06.2001). Cognitively, mid to late adolescence sees a maturation from the concrete thinking of childhood to an ability to make abstract deductions and understand casual relationships (www.malereproduction .com, 11.06.2001).

However, this transition varies from person to person and may be affected by drug and alcohol use. Primitive men tend to have difficulty using effective methods consistently. Although a large majority of college students are sexually active, many have had only limited sexual experience, albeit perhaps more than their parents' generation at a similar age. Despite their sexual experience, adolescents are not as effective as they need to be in using birth control or in preventing the spread of STI 's; they have misinformation and misconceptions about gender-specific sexuality education (www.malerproduction.com, 12.06.02).

Youth centres are there to provide correct information and to do away with myths and misconceptions. Telling and trying to convince young people is easy, but very difficult to modify his or her behaviour. Behaviour modification should be dealt with as a matter of importance as this will be easily conveyed to the rest of the youth.

A broad definition of men 's reproductive and sexual health includes medical matters (patho-physiological) such as Sexually Transmitted Infections, developmental anomalies, malignancy, trauma and infertility. It also includes psychosocial concerns: sexuality, contraception, disease prophylaxis, developmental lifecycle issues, tobacco and drug use, sexual identity and orientation, and partnership issues (www.who.org, 27.02.2001).

College men, of whom a large majority are sexually active, have a range of male sexual and reproductive health needs, including some that are particular to their age and social environment. To reach men effectively requires approaches that are somewhat different from those used for women because they perceive reproductive health differently. (www.who.org, 18.11.2001). This is true because if one looks at the clinics in South Africa, only few men attend for other services, e.g. counselling, they only seek help in situations where they are in deep pain, for example STIs. It is also true that approach used in recruiting young men should be totally different from that used for young women. Some males tend to think that medical attention is for females only.

Clinicians in college health services are in an excellent position to help young men recognise the importance of reproductive health and sexual responsibility. Therefore

services for men should offer them screening, clinical diagnosis and treatment for MRSH conditions, information, education and counselling services, in a manner designed to meet their unique needs (www.who.org, 12.12.01).

Adolescents' reproductive health services are vital because males will be involved together with females in the rendering of such services. It will be of no use for females to utilise reproductive health services alone. Males should be taught whatever females are being taught so that they have common and same knowledge about such issues.

It remains unclear in Kenya whether males use contraceptives themselves or allowing their partners or spouses to use Family planning. Condoms and male contraceptives are widely available in Kenya.

(www.who.org, 15.09.2001).

However in the North West province there are no male contraceptives available at clinics and even at youth centres except for vasectomy at the hospital or private clinics. It is therefore necessary that males should be in the position to share knowledge about contraceptives with their female partners. This will make it possible for the positive results and outcome for proper use thereof.

Research done in the US revealed that it is very important to train the health care providers especially those rendering reproductive health services, (IPPF, UNFPA, United Nations Abortion Policy, 2001) because they will be in the position to can accommodate youth irrespective of the difficulty in dealing with them . The youth do

not always perceive things the same as their parents or other adults; they therefore need to be understood well.

Besides efforts being made to let adolescents get access to reproductive health services, there is still high numbers of teenage pregnancies, adolescents who have limited or no access to safe abortions and contraceptives resort to unsafe abortions and sometimes resulting in deaths (UNFPA report, 2001).

The study conducted by the department of health in Nigeria, found out that women who did not use wanted children and it was high in Kenya at 22.1%. In Bolivia and Mexico 15% were due to ill health. In Mexico 18.5% were due to lack of knowledge. In Thailand 1.1% was due to religious reasons. In Nigeria 12.2% partners opposed the use of methods. Other common reasons were the myths that dominated (Fogel, et. al, 1999:78). Community based service providers were hard to locate because the study in Nigeria found that youth actually used the methods for their private matters, so they thought interviewers were spies from the government.

Some services were rendered comprehensively and adolescents were sometimes not interviewed because they did not turn up. Service providers claimed that they could not have special days for reproductive health services for the reason that female service users were sometimes hiding when accessing such services and gave the impression that they came for other general problems (Harrison, et. al, 2001:9).

In South Africa it is common that contraceptives are not used for the purpose they are meant for. Oral contraceptives sometimes are used as fertilizers for plants while injectables are used as contraceptives for dogs. Service providers sell them instead of issuing them to youth.

Conclusion from this study is that it is better to have youth centres apart from other primary health care services because youth will have an opportunity to socialize and share ideas with their peers. They can be engaged in group discussions and workshops can be conducted for them in an environment which is conducive to their situation.

2.4 PROVIDERS TECHNICAL COMPETENCE

In 1996 in the United States most of the providers were having ±3 years experience, ±70 % had family planning training and majority had family planning course, respondents felt that it was not adequate because they lacked current knowledge (Harrison, et. al. 2001:11). Also most of the service delivery points and commercial outlets encouraged clients to decide for themselves on methods, but a study done in 2001 in the US found that commercial providers were more money-driven rather than motivating concern for welfare of clients. Most breastfeeding clients were encouraged to use combined pills, 46% were new users, and 28% had problems with the methods of contraceptives and probably wanted to discontinue (Harrison, et. al, 2001:16).

2.5 TEENAGE PREGNANCY

In South Africa unmarried, pregnant adolescents face a variety of difficult decisions. They must decide whether to give birth or to have an abortion and whether to raise a child they bear or to place the baby for adoption therefore proper management of adolescents' reproductive services will assist adolescents in such situations. Simultaneously, they must make the same critical decisions about school, work and relationships as other must make. In designing interventions to help young women to make the transition from adolescence to adulthood without unintended pregnancies, it is important to understand the life circumstances, motivations and events that lead some unmarried teenagers to become pregnant and the process involved in the decision to carry a non-marital teenage pregnancy to term.

If adolescents' reproductive health services are not rendered by providers who really have the welfare of youth at heart, the services will not have any positive results and the rate of pregnancies will increase, that will be seen when teenage pregnancy rate is increasing. The services should be well managed and reviewed from time to time.

Some researchers have investigated factors influencing the pregnancy options considered by young women in the United States who choose abortion. Others have explored pregnancy decision-making by comparing the characteristics of young women who opt for abortion, birth or adoption.

The events and communication patterns that lead pregnant teenagers to certain decisions, who helps them the most in making their decisions, the options women and their partners and parents consider and how decision-making differs according to

young women `s pregnancy intensions and background characteristics (www.who.org).

A study conducted in California, was designed to address the above issues for sample of unmarried pregnant 15-18 years olds who had decided to give birth. The researchers explored whether pregnancies had been planned and they compared the characteristics and motivations of adolescents who had intended their pregnancies with those of young women who had not intended to become pregnant or had not cared for whether they became pregnant. So they explored characteristics that distinguish aspirations, abuse and certain partner characteristics that will also distinguish young childbearing women who had intended to become pregnant from those who had not. In addition, the researcher looked at how race, ethnicity and nativity are associated with adolescents' pregnancy intentions (www.who.org). The results were that the latter were more frustrated at all.

One needs to consider the fact that decision about whether or not to terminate pregnancy strongly depends on the situation an adolescent finds herself in at the moment. If she is happy, then she would not want to terminate, but if she is stressed up perhaps due to her relationship with her partner, then she would want to terminate the pregnancy. If the relationship goes back to normal, then she will begin to regret and have guilty feelings and go to an extent of blaming herself.

In the same study cited above factors that were most important in the young women 'decision to carry their pregnancy to term, were investigated. This decision might have been affected by a variety of factors: the prior intention of the young woman and

her partner regarding becoming pregnant and having a child, the woman's relationship with her partner, her age, the structure of her family and her goals and expectations for the future. Other possible factors are familial or social support that affect a young woman's ability to bear and raise a child; the accessibility of abortion services; and the acceptability of abortion to the young woman, her family and her peers (www.who.org, 12.11.2001).

From the factors investigated in this study it can be decided that services for counselling and assisting adolescents are so that the youth can be helped with decision-making and complications associated with relationships identified and dealt with.

The study also anticipated that the findings would be useful for educators, program planners and others involved in designing interventions to help young women avoid unintended pregnancy and childbearing. The findings could also help in directing ongoing medical and educational services toward young people who might be at risk for unintended pregnancy (www.who.org, 12.12.2001).

2.6 THE PROVIDER PERSPECTIVE

> Almost everybody has preconceived notions of providers, from the cold and aloof physician to the dedicated, self-sacrificing nurse-midwife. Yet providers are each individuals with the full range of human characteristics. They have gender, age, race and social

> class. They have families, neighbours and communities (www.fhi.org, 16.11.2001).

Health providers are sometimes perceived as not human because clients and patients treat them that way. Society tends to forget that they have qualities that they also have. Ultimately instead of people accessing services, they would rather use home remedies. In most cases they do not have enough money for private doctors and general private hospitals. Youth would rather stay with their own problems and seek advice when they have complications and there is a lot to be done for their problems. This means that youth centres are needed to curb this problem. At the youth centre there will be enough confidentiality and privacy and the youth will be able to voice their problems confidentially to service providers.

(Speizer, 2001:45) states that youth have dreams and aspirations, they have needs, values, cultural orientations and political views. They have likes and dislikes, fears, biases, superstitions and much more.

> Still, certain characteristics lead to better provider performance, including altruism, a strong work ethic, technical competence, a proactive problem-solving mindset, self efficacy, organisational skills and the propensity to interact with clients on caring, connected human biases

A central question to ask is why people choose to be providers. For most, it cannot be because of the money since salaries are so low, especially in the government sector. Many providers augment their incomes in a variety of ways, such as by unofficially

charging for "free" services, by having private practices or by receiving compensation through travel and per diems.

> In all likelihood, the appreciation and satisfaction received from helping others are primary motivations for many providers

Another significant motivation for providers cited in the HST report is often the social status and respect that come with the positions. This social status has high value in itself, but may also enhance the legitimacy of the providers' extracurricular clinical practice.

> Moreover, many providers are women and the health service field may be one of the few opportunities available to them for a career or other out-of-the-house activity.

Thus, many women appear willing to act as volunteer community-based distribution agents or depot holders, with little or no monetary compensation. They seem motivated largely by the psychic rewards of altruism and the enhanced social status of their positions.

For more than 20 years, the family planning and reproductive health field has promoted the understanding of the "user perspective" and rightly so. They have learned that in order to have successful programs that serve clients well, they need a better understanding of the people they serve (UNFPA report: 1999). Although providers are obviously essential partners in service programmes, their perspectives

have received remarkably little attention. In the early 1990s, the International Parenthood Federation (IPPF) put forward its seminal work on the "needs of the provider" to complement its "rights to the client".

To improve programmes further, it is needed to see the world through the providers' eyes and understand them better. Providers' identity, their jobs and roles in their specific programmes should be well understood. Their needs and motivations, aspects of their work environments and human dimension of their overall lives should also be to those utilising adolescents' reproductive health services. (IPPF report: 2000).

The role of the provider in service delivery is crucial and far ranging. A wide variety of staff can be considered "providers" from the clerk who first greets clients in a clinic to the surgeon performing a vasectomy, from the peer educator promoting safe sex practices and providing contraceptives, to the shopkeeper selling condoms or antibiotics for sexually transmitted infections. For youth to have confidence in services rendered to them they should have service providers who really care and are prepared to influence and modify their life styles.

Not only do the providers` technical skills and knowledge affect service, but also their opinions, attitudes and advice strongly influence what services clients receive and their clients` subsequent behaviour. The providers` role as gatekeeper can profoundly affect how and when clients receive services or even whether clients receive services at all (HST report, 2001).

In the past there was a belief that providers are aggressive and rude. This is still experienced in many clinics and it brings this really brings to the point the fact that service providers at the health centres should be prepared to accommodate clients irrespective of their attitudes and behaviour. In recent years, nursing field has come to realize that training (health), which often focuses only on skills and knowledge, is often ineffective in improving provider performance, and thereby service delivery becomes poor also.

Women's Health Project report states that an alternative approach is performance improvement, which seeks to understand the myriad element that influence provider and organisational performance and considers the range of possible interventions to enhance service delivery. It stated that it seemed axiomatic that understanding providers better is the key to this approach.

The small amount of literature available on the perspective of health providers gives a glimpse of why such an understanding is important. For example, a study from Sitapur Diasterict in India provides poignant insight on the daunting constraints that confront auxiliary nurse midwives attempting to provide family planning and reproductive health services. These included problems with reimbursement, supplies and equipment, physical space, poor training and supervision, transportation, bureaucratic obstacles, time scheduling and even physical security (Avotri, 2001:197). From that study, one wonders how the auxiliary nurse midwives were able to deliver any substantial amount of service at all.

Another look into the provider's perspective comes from an anthropological study from Nepal showing that the views of health providers on their jobs often differed from the objectives the official programme. For example, many providers viewed the health of clients programme as a source of income rather than as means of improving skills (www.agi-usa.org, 18.10.2001).

A few studies have also specifically addressed providers' views of intra-uterine device and IUD insertion. In Morocco, oral contraceptives are the dominant method of birth control. IUDs are considered underutilized by some programme managers, and despite considerable efforts to promote IUDs, including substantial training activities, most health providers including physicians remain resistant to them. It appears that many physicians prefer oral contraceptives over IUDs partly because providing the pill entails less work (Speizer, 2001:78).

However considering the epidemic of HIV/AIDS the insertion of IUDs is no longer encouraged due to its side effects. Some youth still want an IUD as a contraceptive method, especially when taking into consideration its during prior to replacement. Youth in most cases want to utilise a method that will not need to be taken every day or injectables where one experiences pain every time one goes for check up. Studies from El Salvador and Kenya have established that certain characteristics of IUD service delivery make it less attractive to providers, including the time required for insertion, the variety of supplies and equipment needed for the procedure, the vicious cycle of infrequent insertion and low levels of self confidence that they can insert the device properly, misconceptions about the IUD and concerns about their own risk of infection (Leete, 2000:54).

2.7 REPRODUCTIVE HEALTH PROGRAMMES IMPLEMENTED AROUND THE WORLD AS OF SEPTEMBER 1, 2001

2.7.1 MEDICAL ABORTION AT HOME

A simplified medical abortion regimen is effective, safe and acceptable to women except in undeveloped countries. Women seeking termination of early pregnancy may be given 200mg of mifepristone, rather than the standard 600mg dose, and the option to administer misoprostol themselves at home (Women `s Health report, 2001).

In the study conducted in Kenya, of the 120 Vietnamese and 195 Tunisian women who participated in the study, 93% and 91%, respectively, had successful abortions. Nearly 90% of women chose home administration, because for them it was inconvenient to return to the clinic (Women `s Health Report, 2001).

Youth receiving contraceptives of any kind are less likely to discontinue the use if they receive ongoing counselling, according to a case-control study conducted among 350 adolescents in rural Mexico (Primary Health Network, 2000). Providers at family planning clinics in Yucatan counselled half of them about amenorrhoea and other possible side effects of contraceptives, emphasising that these side effects are not harmful to health. This information was reinforced every time the youth returned for their supplies, noting that many of them in the area believe that women' s blood collects in the uterus and poisons them if they do not menstruate. The researcher therefore emphasised that counselling should be continuous at each visit (Primary Health Network, 2000).

Nothing can beat counselling when considering side effects that youth are going through. If there is no continuous counselling then the results will be that youth will not use the contraceptives or services rendered to them.

2.7.2 GIRLS ARE WORTH THE INVESTMENT

The investment countries make in the welfare of girls and young women varies widely, leading to stark contrasts in the well-being of the young women themselves and that of their children (Avotri, 2001:34). Girls are an investment and need to be empowered with knowledge at an early age so that they can understand the facts of life and their reproductive health well.

In a report issued by Save the Children, 140 countries – 42 industrialised nations and 98 developing countries are ranked according to 12 measures of the health and education of girls, age at marriage and first birth and safe motherhood programmes and practices. Overall, Sweden and Finland share first place and Niger scored lowest. In the highest-scoring countries, about seven of every 1000 girls born die before their fifth birthday and primary and secondary school enrolment for girls and boys is roughly equivalent. One in every 6000 dies during childbirth (Save the Children Report, 2001).

2.7.3 THE UNITED NATIONS SESSION ON HIV AND AIDS

Calling prevention "the mainstay" of its global response to HIV /AIDS, the UN General Assembly issued a declaration stating its commitment to achieve targets for

prevention strategies and resources to address the epidemic. The Assembly adopted the declaration, which outlines more than 100 specific goals, at the conclusion of a three-day special session on HIV/AIDS in June **(www.unaids.org)**

In the document, the Assembly (www.un.org/News) stated its commitment to ensuring that at least 95% people aged 15-24 worldwide have access to information and education about HIV / AIDS by 2010. That year is also the target for achieving a 50% reduction in the number of infants infected with HIV, a goal to be reached by ensuring that at least 80% of pregnant women who receive prenatal care are provided with HIV prevention services and information about mother to child transmission.

In addition the declaration set explicit monetary goals, including and annual expenditure on HIV / AIDS of $7-10 billion in low and middle-income countries by 2005. The declaration urges developed countries to earmark 0.7% of their GNP for development assistance, including 0.15-0.2% of GNP for development assistance to the least developed countries. The document also states a commitment to cancel, "without further delay", all bilateral official debts of heavily indebted poor countries, especially those affected by HIV/AIDS (www.un.org, 12.12.2001).

More money is spent on HIV/AIDS programmes, but if there is no behaviour modification there will be a loss rather than a gain in this aspect. There is a lot of research done on HIV/AIDS but the death rate is still very high. It is better to implement programmes that target youth at a very early stage of their lives so that they can be able to make informed choices. Also it is important to educate a child

whilst still very young, rather than when she/he is old and has experienced life situations unprepared.

The UN General Assembly president Harri Holkeri, states that the special session provides hope. He also argues that the world has reached its turning point in the fight against AIDS, "either we will reach out to those who need this hope, or we will be held responsible for not acting when we had the chance".

In Kenya, president Moi has asked the citizens to abstain from sexual intercourse for at least two years in an effort to check the spread of HIV/AIDS, which has already infected 2.2 million people (2001). He made a plea shortly after announcing the government's plan to import 300 million condoms, an initiative opposed by the country's Christian and Muslim religious leaders (www.un.org, 12.12.2001).

According to the researcher, if Moi 's idea could be implemented in the whole country it would really have a positive impact in the whole country because abstinence is the only remedy to the spread of STI `s. Adolescents need to be taught to abstain and this can only be possible if there are appropriate services rendered to them.

Given that most adolescents do not want pregnancy, promotion of condom use should be a high prevalence and potential seriousness of teenage pregnancies and the reality that most priority for this population. Consistently and correctly used, condoms are an effective method of preventing the transmission of HIV/AIDS and other STI `s, as well as preventing unwanted pregnancy (Public Health Report, 1999).

During the first twelve months of use, the overall failure rate of condoms as a contraceptive method is 14% in typical use but the rate is higher in young women and those who are not married (Public Health report: 1999). Under perfect use conditions, the failure rate is only 3%. The effectiveness of condoms in reducing heterosexual transmission of HIV/AIDS and other STIs varies widely in different studies, but overall it has been estimated to be comparable to or slightly lower than condom effectiveness in prevention of pregnancy.

In the Republic of South Africa condom use among adolescents is gradually rising, but significant numbers of teenage and college men continue to engage in unprotected intercourse. The relationships between young men's condom use and other factors, such as race/ethnicity, age, and attitudes are complex factors and also contributory (Leete, 2000:79). Other important factors include positive relationship of condom use to discussion of HIV/AIDS with parents or other adult relatives. An inverse relationship to a compromise risk behaviour score that included measures of use of tobacco, marijuana, cocaine and alcohol, weapon carrying, and history of being in fights (Public Health Report, 2000).

If condoms are used in a proper manner they can be 100% effective. Adolescents are supposed to be taught about condoms as a second option if they fail to abstain. This complements the fact that adolescents should have youth centres that are multipurpose so that they can spend most of their time there. The report also indicates that monogamy and preference for other forms of birth control are frequently given as reasons for student's non-use of condoms. The perception that condoms are needed

when one is in a monogamous relationship is potentially hazardous in the context of short-term serial monogamy seen in college populations (Leete, 2000:56).

Condom use has generally been found to decline during the course of a relationship, whereas the likelihood of oral contraceptives use is increasing. Furthermore, condom use at first sexual intercourse in a relationship and at the most recent coitus tends to decline with a man `s age (Leete, 2000:57).

Leete states that establishing a "condom habit" from the outset is important because young people who use a condom at first intercourse are 20 times more likely to use condoms regularly than those who did not use a condom the first time. Consistency of young men `s condom use at one time has been correlated with their condom use two years later which supports the habitual nature of condom use (Leete, Richard:2000). Condom habit should be adopted in conjunction with proper knowledge of reproductive health. Youth and user-friendly services are supposed to be major focus to youth, unlike emphasising condom use without enough education.

Incorrect use of condoms can result in infections and pregnancies. Many studies of condom failure have found that inconsistent and incorrect use, unrelated to alcohol or drug use, is a more likely cause of condom failure than impaired judgement attributed to alcohol or drug use (Public Health report, 2001). For example, in a 1982-1984 US study, almost 60% of the pregnancies among condom users resulted from inconsistent use. A study of young men who had sex with men, more than 76% of whom were college students, found that relationships between unprotected intercourse and drug or alcohol use depended on the nature of the partner involved. If compared with

intercourse when sober, intercourse after drinking is more likely to be unprotected with non-steady sexual partners, but more likely to be protected with steady partners (Leete, 2000:69).

Other problems related to condom use are breakage, breaks or tears resulting from incorrect use such as rolling the condom before putting it on, trying to unroll it the wrong way, tearing the condom with fingernails or rings, reusing condoms, or using them with oil-based lubricants. This goes back to the fact that education especially from peer to peer and not only from providers is crucial. Incorrect practices also include unprotected genital contact before the condom is used or spillage of semen after ejaculation. Condom breakage is less likely for those with more condom experience and those who have recently had reproductive health education (Public Health report, 2001).

According to the report psychosocial factors strongly influence the use of condoms. Attitudes towards condoms, social norms, perceived social support for condom use and self-efficacy in their use have been shown to be significant determinants of young adults' intentions to use condoms. Partner and peer support are positively related to condom use, with partner support particularly important for men. Communication with a partner about condoms and safe sex has repeatedly emerged as an important factor in using condoms.

There should be a culture of parent involvement in reproductive health issues as this is a very sensitive aspect of life and yet very dangerous if not handled at an early age. In

most instances parents do not want to discuss these issues with their children, forgetting that one mistake can destroy a teenager or adolescent's future.

Family Adolescent Risk Behaviour and Communication Study (FARBCS) states that a 1993-1994 study of African American and Hispanic adolescents, in which the quality of communication with both their parents and their partners was found to influence condom use. The effect of discussions between teenagers and their partners and their mothers was found to be significant in increasing condom use only if the communicators were highly responsive-open to teenagers' feelings, skilled in communicating and knowledgeable in responding to questions and neither lecturing nor jumping to conclusions about the teenagers' behaviour (UNFPA report: 2001).

Communication plays a very important role in the lives of adolescents, without communication one cannot know if she/he has got the right concept especially regarding reproductive health issues.

The report further states that another finding from the FARBCS study was that although adolescents are more likely to have talked with their mothers than their fathers about a range of topics, there were gender differences. Male adolescents were more likely than female adolescents to have talked with their fathers about birth control, condoms, STIs prevention, physical/sexual development and masturbation.

Male adolescents were also more less likely than female adolescents to have talked with their mothers about when to start having sex and about pressures to have sex, as well as birth control, reproduction, physical and sexual development and STIs. These

gender differences in communication patterns of boys and girls with their fathers and mothers may reflect the social constructions of masculinities in both (UNFPA report, 2001). To avoid the culture of mothers being responsible for orientating teenagers and adolescents into their reproductive health environment, boys should be engaged in such discussions at a very young age so that as fathers they should be also orientate their teenagers into reproductive health. It should not be the responsibility of mothers alone who are responsible for the orientation of teenagers to reproductive health issues.

2.8 BARRIERS TO IDENTIFYING AND COPING WITH MEN s' NEEDS

The two aspects of men's health that first attracted attention on a gender-specific basis are related to men's biological and social roles. Men's specific reproductive and sexual health care needs were addressed with a focus on STIs. Traditional male roles as economic providers and military personnel made them a primary target for occupational health services to ensure a healthy workforce and adequate armed forces (Forrest, 2001:78). This, as a result, leads to the point of males being responsible for masculine factors only and neglecting their reproductive health. They shift the responsibility to their female counterparts.

Forrest states that other reproductive and sexual health needs were and to a large extent still are, addressed in a piecemeal fashion. He also states that for many years, inadequate resources have been directed toward men's unique sexual and reproductive health needs and to their contribution to reproductive health for both men and women.

Gender-related differences in health behaviour also have impeded the delivery of male reproductive and sexual health care as a result fewer males' access reproductive health services unlike their female counterparts.

Health care providers` discomfort with sexuality and gender-role stereotyping of men as strong and in control may also impede health professionals from enquiring into sexual matters of their male patients, unless the patient initiates the topic. For young men, asking for help about anything related to sexuality carries an implication of sexual naiveté and failure, which makes it difficult to ask for needed information (Forrest, 2001:79).

Gender differences, Forrest believes, are also noted in physician behaviour among primary care physicians, male practitioners are less likely than female practitioners to assess their patients` sexual risks, enquire about the patient 's use of contraception methods or condoms, the frequency of experiencing STIs and the nature of sexual partners and practices.

The researcher believes that identified barriers to providing male and female adolescents reproductive health services through family planning clinics include resources restrictions, negative staff attitudes and lack of staff training and experience in dealing with male patients. On the other hand Avotri believes that barriers indicated that family planning clinics are perceived as female organisations, that men are not familiar with the health care system or their medical needs, and that clinics lack adequate funding.

2.9 The National Survey of Adolescent Males (www.who.gov, 12.08.2001) showed that:

- Respondents who had discussed reproductive topics with a physician, family or friends have a lasting effect that may continue to prompt self-interest or concern years later;
- Early discussions may set a pattern of communication that persists in later life
- Some youth have innate characteristics that lead them to be more communicative or more worried through various phases of their lives.

Looking at this study it is evident that early discussions may set a pattern that persists in later life. The focus of this study is based on this assumption. If reproductive health services are reaching the target age then self-esteem will also be boosted in youth, both males and females. The adolescents will be able to face challenges of life especially pertaining to reproductive health.

2.10 CONFLICTING VIEWS

The Alan Guttmacher Institute report in the USA states that very broad parameters for sexuality and STD education were established; while most states mandate that some form of sexuality education be provided, they give local policymakers wide latitude in determining the content of the instruction. Abstinence promotion has taken hold as a matter of education policy in the US and it is reflected in classroom education **(www.agi-usa.org/pubs, 13.11.2001).**

If parents and teachers do not get involved in the adolescents' reproductive health programmes then there is a chance that youth centres can have little impact. What is

more important is to have service providers that have the skills and knowledge of adolescents' reproductive health. Policies can be developed and implemented but if there is no commitment from the youth themselves, then these policies will not have any effect or impact.

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2.11 THE ROLES OF ABSTINENCE, SEXUAL ACTIVITY AND CONTRACEPTIVE USE.

According to the Alan Guttmacher Institute declines in teenage pregnancies can be achieved through two mechanisms: changes in sexual behaviour and changes in contraceptive use. Some observers have claimed that the declines are the results of abstinence. Others credit both greater abstinence and increased contraceptive use, especially condom unuse, among teenagers, but have not quantified their specific contributions to the falling rates (www.agi-usa.org/pubs, 13.11.2001).

Broad societal factors underlie both mechanisms. Fear of contracting HIV, changing attitudes about sexuality and availability of new contraceptive technologies may affect sexual activity and change patterns of method use among those who do not have intercourse (Gender studies Journal, 2001.12.01). The strong economy, with its promise of improved career opportunities for young people, and welfare reform, with its constraints on the receipt of public assistance, may affect these behaviours, since greater educational and employment opportunity are linked to lower teenage pregnancy rates and birth rates (Women Health Project, 2001).

It is useful for the design of policies and interventions aimed at improving teenagers' sexual behaviour, contraceptive use and, ultimately, lowering teenage pregnancy

rates. Programmes and policies should aim at encouraging teenagers, particularly those at the youngest age, to postpone intercourse and at supporting sexually experienced youths who wish to refrain from further sexual activity. At the same time, most young people become sexually active during their teens, and sexuality education and information should also prepare them to adequately prevent pregnancy and sexually transmitted diseases.

Reproductive health services should be in an area that will help youth to behave responsibly, to ensure that they use contraceptives and to help them improve adequate education and information about sexual behaviour and its consequences. Confidential, affordable and accessible sources of contraceptive services and supplies, support for research and development of new contraceptive methods that young people will find acceptable and easy to use effectively should also be improved (Public Health report, 2001).

On the contrary, there are multiple pressures and demands that teenagers must face and manage. However at the same time, it is equally the responsibility of policymakers, educators, parents and society at large to prepare them to do so and to make the environment as conducive as possible to their being able to do so successfully.

2.12 CONCLUSION

This research focused on solutions to the problem of youth not accessing youth centres and ending up with unplanned pregnancies, unstable relationships and among others terminating their pregnancies. The research aimed also at making sure that

adolescents have education and information relevant to them and ultimately be able to make informed choices.

CHAPTER 3

3.1 FINDINGS AND DISCUSSION

From this study perceptions, experiences and attitudes of youth were explored in trying to find out why are there some adolescents who do not utilise the services.

3.2 PRESENTATION OF DATA

TARGET POPULATION

The target population was youth in the Mafikeng area who utilised the services in order to evaluate as to whether they were satisfied and reasons for their dissatisfaction.

3.3 SAMPLING SIZE

The sample size was a minimum of 150 youth, and it could have been more if it was not for the fact that youth centre moved to a new area where youth did not know about it. The centre is located at Fountain of Hope Cul 15, Unit 2 Mmabatho.

There were females and males whose ages ranged between 10 and 24 years. Their names and physical addresses were recorded at the youth centre 's registers. The study was judgemental as it targeted those who utilised the services and between 10 and 24 years only. All participants were given an option of participating or not to participate, i.e. it was not compulsory but voluntary participation.

The interviews began with the same question read verbatim from the interview schedule. Participants responded freely with probes where necessary.

3.4 DATA COLLECTION INSTRUMENT

Structured interviews with open-ended questions were used. Open-ended questions were used to allow free expression of participants. The questions were focused on evaluation of the management of the youth centre to ensure that the information received is relevant to the purpose of the study and also to meet the objectives set.

Structured interview is advantageous because it provides the researcher with systematic data collection; it also allows large number of respondents possible. Respondents have time to consider questions and the interviewer can explain questions to respondents and ask for more detail if necessary. (Langley, 1999)

3.5 DATA ANALYSIS AND INTERPRETATION OF RESULTS

Of the total number of youth who have utilised adolescents' reproductive health services in the Mafikeng area, the total of 200 female and male youth agreed to participate. During the study 50 of them refused to continue participating in the study. 150 youth agreed to answer all the questions even though some of them were not corporative during the survey. Those who refused stated that they have been engaged in surveys previously but they never had feed back. They claimed that it was useless for them because they did not benefit anything form such surveys; government is only doing such research for its gain and benefit. The fact that participation was voluntary, they were then left out.

3.5.1 TABLE 1: AGE DISTRIBUTION OF BOTH MALES AND FEMALES WHO ATTENDED THE YOUTH CENTRE (N=150)

AGE	TOTAL	PERCENTAGE
10 – 13	0	0%
14 – 17	67	45%
18 – 21	35	23%
22 -24	48	32%
TOTAL	150	100%

Table1 shows that 45% of youth attending at the youth centre falls within the age group of 14-17 and it is evident that age group 10-13 is not well represented. It might be that enough awareness is not to this age group as they are the ones that the researcher thinks they need more education on the subjects discussed at the youth centres. The researcher strongly believes that education is more effective when introduced at an early age to a child when he or she is not yet exposed to the myths around his environment.

3.5.2 TABLE 2

TABLE 2.1: PERCENTAGE BY AGE OF MALES THAT HAVE ATTENDED THE YOUTH CENTRE (N=50)

10 -13	0	0%
14 – 17	28	56%
18 – 21	11	22%
22 – 24	11	22%
TOTAL	50	100%

Table 2.1 shows that 56% of males within the age group of 14-17 are the ones utilising the services and they mostly attend for workshops not for clinical services, possible reason being that males are willing to attend workshops whereas they do not utilise the youth centre for clinical services.

TABLE 2.2: PERCENTAGE OF FEMALES WHO ATTENDED AT THE YOUTH CENTRE, BY AGE (N=100)

10 – 13	0	0
14 – 17	38	38%
18 – 21	22	22%
22 -24	40	40%
TOTAL	100	100%

Table 2.2 shows the females who used the centre. 40% of the female youth attending at the centre are between the ages of 22 and 24. This means that this age group difference defines the fact that they are not attending for the same reasons. They utilise the centre for clinical services, and were referred by other clinics. Possible reason for 38% of females under 17 attending the centre is that they have not yet started using contraceptives; most girls attend for clinical services not for workshops as compared to their male counterparts.

3.5.3 TABLE 3

TABLE 3.1: REASONS OF FEMALES FOR ACCESSING AND NOT ACCESSING THE YOUTH CENTRE (N=100)

YES		NO	
No stigma	4%	No privacy	4%
Came for workshop	23%	They know me	1%
Near my home	16%	People will think I am promiscuous	7%

Different from government clinics	16%	Centre too far	6%
Staff is kind	18%	Nurse is not friendly	5%

Table 3.1 compares the difference in reasons for utilising and not utilising the youth centre. Of those who accessed the youth centre, 4% said the centre had no stigma attached to it, 23% came for workshops and were recruited from schools, 16% said the centre was near their homes, 16% said it was different from government clinics, 18% said the staff was kind.

Of those who said they would not access the centre again, 4% felt that there was not enough privacy because the receptionist asked them confidential questions as if he was a nurse in front of other clients, 15% waited too long after travelling a long distance to the centre, 7% said people would think they are promiscuous and 10% said the centre was too far.

TABLE 3.2 PERCETANGE OF MALES WHO UTILISED THE SERVICES AND WHO WOULD NOT UTILISE THE SERVICE ANYMORE (N=50)

Attended workshops	60%	Nurse not friendly	2%
Requested condoms	6%	Too far	24%
Private	4%	Shy	4%

Table 3.2 shows that 60% of males who attended at the centre were recruited from their schools for workshops, 6% came for condoms and 4% came for treatment of STD and felt that it was privately situated. On the other hand 2% said that the nurse was not friendly, 24% said the centre was too far and 4% stated that they were shy.

TABLE 3.3: NUMBER OF YOUTH WHO FELT THAT OPERATING HOURS ARE CONVENIENT AND THOSE WHO FELT THEY ARE NOT. (N=150)

	YES	%		NO	%
Convenient	129	85%	Not convenient	23	15%

Table 3.3 shows that 85% of the youth felt that the hours were convenient for them, whereas only 15% said they were not citing their reasons that they wanted to spend more time at the centre and they only stayed for a short while after school and thereafter they had nowhere to go except for roaming around in the streets.

TABLE 3.4 WAITING HOURS REASONABLE (N=150)

YES		NO	
Recruited for workshops	60%	Waited too long for the nurse	40%

Table 3.4 above shows that 60% of the youth attended workshops and they said they did not have any problem regarding the waiting period because they went at the time for the workshop. 40% who were for clinical services, said that the centre was too far

and they had to wait for the nurse before they could be attended to. There is only one nurse and most of the time she was not at the centre.

TABLE 3.5: FREE TO ASK FOR INFORMATION (N=150)

	YES	%		NO	%
Yes only	23	15%	No only	3	2%
Friendly staff	50	33%	Referred to Department of Health	1	1%
It `s my right to ask	3	2%	Nurse (unapproachable)	15	19%
To teach others and improve my knowledge	42	28%			

Table 3.4 above shows that the youth had some fears of asking for information like at the primary health clinics, stating different reasons thereto. On the average they felt that health providers had a negative attitude towards them. 15% responded by saying yes only without giving any reasons. 33% said that the staff was friendly, 2% said it was their right to ask for information, and 28% said they wanted to teach their friends who did not know about the centre.

Of those who felt it was easy for them to ask for information, 2% responded by no only, one respondent said he was referred to the Department of Health for more information and 19% responded by saying the nurse was too serious, unapproachable and old, they needed a younger nurse who would be in the position to understand them.

3.5.4 TABLE 4: NUMBER OF YOUTH WHO FELT THAT THEIR RIGHTS WERE RESPECTED (N=150)

RIGHTS RESPECTED	YES	NO
Receptionist kept details confidential	90%	10%
Informed of treatment options	85%	15%
Participate in decision about their treatment	82%	18%

Table 4 above shows that on the average 86% of the total number of youth felt happy about their rights being respected. 90% responded by saying the receptionist, kept their records confidential because if one needed clinical services then the nurse opened the file not the receptionist. 85% responded by saying there were informed about treatment options because it was discussed, 82%c also felt that they could participate in the decision about their treatment.

Of those who did not feel their rights were respected, only 10% responded that the receptionist did not keep their rights. 33% felt that they were not involved in the decision about their treatment options.

3.5.5 TABLE 5: INFORMATION GIVEN TO YOUTH (N=150)

INFORMATION GIVEN	YES	%	NO	%
Posters and leaflets available	126	84%	24	16%
Information enough and clear	98	65%	52	35%
Staff knowledgeable	129	86%	21	14%

Table 5 above shows that on average 78, 3% were satisfied about the information given to them. 84% felt that there were enough posters and leaflets at the centre making it easier for them to understand some of the information regarding their problems, e.g posters on teenage pregnancy. 16% who were not satisfied their problems were not addressed, e.g termination of pregnancy and laws regulating it.

65% stated that information was clear and enough whereas the remaining 35% said they needed more clarity on subjects addressed at the centre. 86% said that staff was knowledgeable because they could answer their questions but 14% was not happy about the knowledge the centre staff had, especially when one had an STI and the nurse referred to the booklet on STIs.

3.5.6 TABLE 6: FOLLOW-UP OF YOUTH FOR NEXT VISITS (N=150)

FOLLOW-UP	YES	%	NO	%
Adequate instructions provided to meet their needs	125	83%	25	17%

Table 6 shows that most of the youth were satisfied with the information that was provided and felt that it was adequate because 83%, they also felt that they were given enough and clear instructions to meet their needs, e.g to bring their partners for treatment for those who had sexually transmitted infections and next dates for their contraceptive methods. The remaining 17% responded by saying that there was no proof to be given to their partners if they had to go for STI treatment (contact slips) so it was difficult for them to convince their partners to go for consultation.

3.6 SUGGESTIONS FROM YOUTH ABOUT THE CENTRE (N=150)

Youth had different suggestions regarding the centre and staff, 86% said that the centre would be most effective, e.g will help youth not to fall pregnant at an early age by having information at age of 10. Workshops should also target this age group (10-13) before they have false information from those who are ready to mislead them.

From Table 3.1 30% felt that the centre should be nearer the community, be centrally placed and the nurse should always be available because if they were not happy on several visits then they might just as well stay without contraceptives. They will however terminate pregnancies if it happened.

From Table 3.2 7% felt that the nurse should adopt an attitude of being friendly at all times because once they feel that she was not friendly, it would be difficult for them to discuss issues. From Table 3.2 40% said they waited too long for the nurse, there should be another nurse to render the service.

3.7 WHAT YOUTH LIKED MOST ABOUT THE CENTRE

What they liked most about their visits at the centre was the following: 60% said they liked workshops because they gained a lot of knowledge and 4% said the centre is privately situated (Table 3.4). Table 3.1 shows that 16% said the centre was different from other clinics, whereas 18% said the staff was friendly.

From Table 4, 90% said the receptionist kept information confidential, 85% were informed of their treatment options and 82% participated in the decision about their treatment. Table 3.3 shows that 85% said that hours were convenient and 60% said they liked the idea of being recruited from schools for workshops (Table 3.4). In table 3.5 28% said they liked the service because they could teach their friends and schoolmates and they could improve their knowledge.

Table 5 shows that 84% was happy because there were posters and leaflets available, 65% said information was clear and enough and 86% said staff is knowledgeable. 24% said there are no long queues with old and sick people, 35% said they were satisfied wit the service.

3.8 WHAT YOUTH DID NOT LIKE MOST ABOUT THE CENTRE

Table 3.2 shows that 24% felt that the centre was too far complemented by the fact that Table 3.4 reflects that 40% were not happy that they waited too long for the nurse after travelling long distances to the centre. Table 3.5 shows that 19% said the nurse in charge was unapproachable.

3.9 GENERAL IMPRESSIONS ABOUT THE CENTRE (N=150)

The general impression of the youth was that workshops that are conducted at the centre were worthwhile but the participants did not cover all age groups especially those that needed the service most (10-13 years old). The topics that were covered included: life styles in general, sex education, substance abuse, services offered by the centre, teenage pregnancy and relationships.

The set-up of the centre was considered good but it was too far and the nurse was not at the centre in most cases. This de-motivated them go so far only to find the nurse not available. Staff had certain favourites among youth accessing the centre. Youth that were favourites to staff members had difficulty discussing their problems especially when they had sexually transmitted diseases. They could not seek help because they were shy to discuss confidential matters from the staff who knew them as regular attendants at the centre; some were peer educators.

There centre should have young nurses and youth educators who will understand adolescents well and be down to their level of communication.

There is still a need for the centre to be well advertised, as most youth does not know about it.

There should be more centres in Mafikeng because one centre cannot cover all adolescents.

3.10 LIMITATIONS

3.10.1 The study did not include youth who did not access the services as planned because peer educators assisted the researcher with the collection of data. The youth who did not access services would have had an impact on the outcome of the study as they should be having their own reasons for not utilising these services; they were not target population for the study. Those who accessed the services were literate and knew some of the services rendered or might have heard about it from them from visiting nurses at their schools.

3.10.2 However those who needed the service are those not having an opportunity of getting the information at all. The study was limited to visits at the youth centre only. The question, however, arise as to what more can be done to raise awareness about the centre to make it a point that all potential users and those at risk can utilise it.

3.10.3 Another limitation was that the youth centre had moved to a new area and most of the participants felt it was too far. As a result most of them felt they would rather use nearby clinics in their next visits.

CHAPTER 4

4.1 DISCUSSION

The majority of youth in the North West Province still terminate pregnancies (Mafikeng Provincial hospital report: 2001). The report further stated that 104 choice on termination of pregnancy was conducted in 2001 November, these excluded septic abortions that were depicted in the outpatients department. In most instances the youth said they fell pregnant because they were afraid to go to clinics, and that they did not know about the centre. Others said that they fell pregnant because they went to the centre on the specific days the nurse was not present and because they did not want to go to another clinic they resorted to home remedies of preventing pregnancies which unfortunately failed.

Male youth who were treated for STIs reported that they had many partners and did not use condoms as they had other concepts about them. They said they preferred having sex without condoms as it was pleasurable for them. Both males and females were aware of education on relationships at the centre but they still engaged in unsafe sex because they wanted to proof other things. Female youth that were regular attendants at the centre and friends of the centre staff, had difficulties in approaching the nurse when they had STIs or if they wanted contraceptive methods. The reason was that they were told to abstain so they thought staff would think of them negative since they failed to keep their promises.

Most of the youth who used the centre were females and this rule out the fact of the American research that women are dominated by procedures and have less power over their bodies. In fact, the study revealed that female adolescents recognised their

rights, e.g female mutilation is something that is passing with generations. Considering the USA research – Merger Mania, 1999, adolescents had positive attitudes towards school-based clinics but they still fell pregnant because of their shyness. This brings one to the conclusion that males need to be more educated about balance of power with regards to sexual behaviour. Such services need to be more in Mafikeng and be well staffed with service providers who will have a listening ear to the adolescents.

When looking at the results of the study, one can infer that the centre does not cater for the age group of 10 –13 years. However, this is the stage where sexual behaviour can be modified before the youth are exposed to the prevailing myths around them and before they can be tempted to test other things or procedures and therefore land in high risk situations.

Many adolescents who lack formal education are exposed to extreme poverty and willing to take potentially life-threatening risks (UNFPA: 1999). Religion has shown not to have any impact, e.g some members of the Roman Catholic Church also terminate pregnancies and using contraceptives. Based on the female respondents at the centre, it can be inferred that they should be empowered at an early age so that they are not dominated and abused by their male counterparts who in most cases do not have enough information regarding the reproductive health issues.

Unlike the policy in Kenya that does not allow women to have information on reproductive health and not to use contraceptives without their spousal consent, in South Africa it should be easy as long as services are well managed.

It is vital to have well trained service providers, especially the youth educators, preferably nurses or health workers because in the situation of Mafikeng the educator is a teacher who struggles to have an in-depth knowledge of the subjects she teaches youth. This poses a problem in service delivery. Unlike in Kenya and Mexico, health providers were trained on reproductive health issues but at Mafikeng youth centre education is provided by an educator who has to research before she teaches the youth. It is therefore difficult for her to render appropriate service to the adolescents.

It is important to understand the life circumstances, motivations and events that lead to more unmarried teenagers to becoming pregnant and the process involved in the decision to carry an unwanted pregnancy to term (Avotri et al: 2001).

The researcher thinks that it is possible to create an environment at the youth centre that would allow adolescents to make informed choices, as long as the staff allows this to happen and the centre is located centrally where most of the youth can access the services easily and where it is privately situated. The youth like privacy and respect from adults too, it should not be a one-way practice whereby they should respect and not be respected.

After analysing the data, it shows that the youth is willing to access services at the youth centre, especially that they do not share the centre with old sick people. They travel long distances to the centre only to find the nurse not there, e. g. those who went for pregnancy tests were the were anxious not to find someone to help them because at that moment they needed to confirm whether or not they were pregnant.

Unlike the study conducted in California where 15-18 year olds decided to give birth instead of terminating their pregnancies, 14-17 year olds and 18-21 year olds in Mafikeng preferred to terminate because they claimed it was not their intention to fall pregnant. The researcher agrees with Planned Parenthood Association of South Africa to have established such services but according to the survey, to those who knew about it were not happy about other things. The researcher feels that the youth needs to be sensitised about the services and have an attitude of accepting and utilising the centre.

There is still high numbers of teenage pregnancies in Kenya, Bolivia and Mexico irrespective of reproductive health services they have, they still resort to unsafe and septic abortions and sometimes resulting in deaths (www.cpc.org). There are still some myths dominating the young generation and this leaves Department of Health with a mammoth task of looking into the approaches towards adolescents' reproductive health services because they seem useless to some areas.

The World Health Organisation addresses the issue of qualified service providers and the researcher believes that for this centre, service providers are qualified but the youth educator is not qualified for the job she is doing; the nurse is also not having a liking for the youth, she does not understand them.

If we also look at the survey, the receptionist who is also performing clerical job, is in most cases interfering in the questioning of clients who come in for the service and displayed an attitude of a nurse. This was not a good thing for the youth especially those who came for treatment of STIs and pregnancy tests. As much as WHO is for

the opinion that not only do the providers technical skills and knowledge affect the service, but their opinions, attitudes and advice strongly influence what service and their clients` subsequent behaviour. The researcher supports this statement by WHO and takes considers the fact that some of the youth were saying the attitude of the nurse was not good, the knowledge of youth educator in some instances was not enough, hence not returning on their return dates.

Arguments lie in the fact that if there is no continuous counselling for the youth then there is likelihood of discontinuity of the method and thus defaulting resulting in unwanted pregnancies especially if the youth come across mild to adverse side effects, this is supported by the study in rural Mexico (Harrison et.al: 2001)

Young people will continue to die of HIV/AIDS especially if one looks at the rate of teenage pregnancy. This leads back to the fact that youth centre is meant to cater, among other services, education on prevention of spreading of HIV/AIDS. The UN General Assembly (www.un.org) supports the statement of having access to information and education about HIV/AIDS by 2010 and achieving 50% reduction in the number of infants infected by HIV/AIDS.

4.2 RECOMMENDATIONS AND CONCLUSION

Based on the findings of this study, the researcher recommends that parents be involved from time to time at the centre so that they continue with the service at home and encourage their children to utilise the services. Emphasis should be on behaviour modification rather than emphasising the use of contraceptive methods and condoms.

The nurse, who is approachable and has a liking for youth, should always be available at the centre. The centre should be centrally located. The target group is not well covered, so awareness among the 10-13 year olds should be seriously done. Youth educator should work hand-in-hand with the school health nurses and their programmes be incorporated so that areas that cannot be covered by youth educators be given attention by the school nurses. Centre staff should not befriend youth, but be friendly to them and create an environment that is user friendly.

This is an excellent service aimed at the youth, target group is correct. The youth centre should be well marketed and staff must liaise with staff of all clinics so that there can be continuity of services. Clinics should know about the centre so that youth utilising the clinics can be referred to the youth centre.

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11 December 2002

Mrs M Mooki
North West Department of Health

Fax No: (018) 392 1046

Dear Mrs Mooki

RE: PERMISSION TO CONDUCT A RESEARCH STUDY THROUGH THE UNIVERSITY OF NORTH WEST.

The Departmental Research Committee reviewed your request to conduct a research entitled: ***Analysis of management of adolescents' reproductive health services in the central district, North West***, and wishes to inform you that permission has been granted for you to conduct your research project, subject to the following conditions:

i. That the North West Department of Health will not be responsible for any costs associated with the research project,
ii. That on completion of the research project, a copy of your research report will be submitted to the North West Health Department.

Any queries regarding your study should be addressed to Dr A Verburgh, tel (018) 387 5744

Regards,

Dr A Verburgh
CHAIRPERSON

Declaration by researcher: I agree with the conditions stipulated in this letter

Signature of researcher and date

QUESTIONNAIRE

SECTION A

PERSONAL DATA

1. Name of region _____

2. Demographic profile

What is your age group?

(Tick the appropriate box)

Age (years)	
10 – 13	
14 – 17	
18 - 21	
22 - 24	

3. Gender

Female	
Male	
Other (specify)	

SECTION B

YOUTH IN & OUT OF SCHOOL

SECTION B

ACCESS

1. Do you feel comfortable coming to the youth centre? Yes / No.

1.1 Give reasons.

.....

.....

2. Are the centre hours convenient? Yes / No.

.....

3. Did you feel comfortable asking for information about the clinic? Yes / No.

3.1 Give reasons.

.....

.....

4. Have you found waiting times reasonable? Yes / No, if "No" why?

.....

RIGHTS

5. Did the receptionist keep your name and reason for the visit confidential? Yes/No.

.....

6. Were you informed of your treatment options? Yes / No.

.....

7. Did you feel like you were able to participate in the decisions about your care?

7.1 Yes / No, give reasons

.....

INFORMATION

8. Did the youth centre have posters and leaflets on the services you needed?

Yes / No

.....

9. Were you provided with sufficient information to meet your needs? Yes / No.

9.1 If yes, what information did you get, if no, what more information do you need?

.....

10. Did you understand the information provided? Yes / No.

.....

11. Did you feel the staff that provided information / treatment were knowledgeable and competent?

FOLLOW-UP

12. Were you given adequate information to meet your needs? Yes / No.

.....

13. Did you understand the information you were provided with? Yes / No.

.....

14. Were you given adequate instructions to meet your needs? Yes / No.

.....

15. Were you given information regarding follow-up? Yes / No.

If yes, what information?

.....

16. Were you satisfied with the treatment that you received? Yes / No.

16.1 Give reasons.

.....

E. SUGGESTIONS

17. Do you have any suggestions for how we might improve your visit?

.....

.....

.....

18. Please tell me three things that you liked most about your visit.

.....

.....

19. Tell me three things that you did not like most about your visit here today?

.....

.....

.....

20. Give your general impression.

.....

.....

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