A SURVEY OF PRIMARY PREVENTION SERVICES FOR ADOLESCENTS' REPRODUCTIVE HEALTH NEEDS

by

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DEDICATION

I would like to dedicate this dissertation to all the adolescents in Shoshanguve who suffered the reproductive health problems due to lack of access to information or services in their community.
DECLARATION

I declare that A SURVEY OF PRIMARY PREVENTION SERVICES FOR ADOLESCENTS’ REPRODUCTIVE HEALTH NEEDS is my work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

MAMAKWA LETLHOKWA SANAH MATABOGE

DATE

15-05-03
ACKNOWLEDGEMENTS

I extend my sincere gratitude and honour to God the creator, the Protector and the Father for guiding my life up to date.

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- Mr. Mudau for finalizing the typing work
ABSTRACT

A SURVEY OF PRIMARY PREVENTION SERVICES FOR ADOLESCENTS REPRODUCTIVE HEALTH NEEDS.

The study comprehensively analysed the impact of primary prevention services for reproductive health in the environment within which the adolescents grow towards life skills acquisition and positive behavior patterning. The availability, accessibility and the effectiveness of adolescents' accompaniment in Soshanguve Township by certain caregivers were assessed. Unstructured observations, review of documents, questionnaire and semi-structured interviews were used for data collection.

The results revealed the least support by parents and churches to accompany the adolescents and the inaccessibility of specialised center to the disadvantaged. The continued lack of knowledge and life-skills perpetuated the onset of reproductive problems. The lack of programmes to equip care providers on how to improve communication during care provision was a major setback. There is a great need for the erection of special care centers for adolescents.
KEY TERMS

PRIMARY
PREVENTION
REPRODUCTIVE
HEALTH
NEEDS
PROBLEMS
ACCESSIBILITY
EFFECTIVENESS
ADOLESCENTS
POLICY GUIDELINES FOR ADOLESCENT AND YOUTH HEALTH
DEPARTMENT OF HEALTH
LIFESKILLS
PREVENTIVE
PROMOTIVE
BEHAVIOUR CHANGE/MODIFICATION
HIV/AIDS
TEENAGE PREGNANCY
COMPREHENSIVE
DECISION MAKING
ACCOMPANIMENT
**LIST OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of Pregnancy</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>HBM</td>
<td>Health Belief Model</td>
</tr>
<tr>
<td>MCWH</td>
<td>Mother, Child and Woman Health</td>
</tr>
<tr>
<td>NAFCI</td>
<td>National Adolescent Friendly Clinics Initiative</td>
</tr>
<tr>
<td>PPASA</td>
<td>Planned Parenthood Association for South Africa</td>
</tr>
<tr>
<td>DET</td>
<td>Department of Education</td>
</tr>
<tr>
<td>TTM</td>
<td>Trans theoretical model</td>
</tr>
<tr>
<td>NPMSS</td>
<td>Northern Pretoria Metropolitan Sub Structure</td>
</tr>
<tr>
<td>SABC</td>
<td>South African Broadcasting Co-Operation</td>
</tr>
<tr>
<td>Tv</td>
<td>Television</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme of Immunisation</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>RHRU</td>
<td>Reproductive Health Research Unit</td>
</tr>
<tr>
<td>HAM</td>
<td>Health Action Model</td>
</tr>
</tbody>
</table>
ORGANISATION AND STRUCTURE OF THE STUDY

Chapter one
Focuses on the overview of the problem, the research objectives and the research methods.

Chapter two
The conceptual framework was defined and developed. A schematic conceptual framework designed. The concepts discussed are Primary Prevention as the core for the discussions, and the reproductive health problems were:

- teenage pregnancy
- TOP
- Contraception
- Life skills

Chapter three
A detailed review of literature was undertaken to explore the accessibility and effectiveness of primary prevention services for reproductive health. The strategies implemented to curb the prevalence of the problems were explored nationally as provided within the legislative framework and internationally.

Chapter four
In this chapter research methodology and data gathering techniques were discussed.

Chapter five
Data analysis and interpretation was done and displayed in graphs, diagrams and tables.

Chapter six
The conclusions, recommendations, limitations and further research to be done were explained.
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CHAPTER ONE

AN OVERVIEW OF PRIMARY PREVENTION SERVICES FOR THE ADOLESCENTS' REPRODUCTIVE HEALTH NEEDS

1.1 INTRODUCTION

The incidence and prevalence of STI/HIV/AIDS among the adolescents are high, and they reflect the level of effectiveness of the primary prevention services for reproductive health problems. If the problem is unattended it may result to depletion of South Africa's resources in many spheres like health, economy and manpower. The adolescents comprise approximately 40% of the country's population, therefore their reproductive health needs are of significant importance to all health professionals and the country. Failure by the adolescents to complete their educational and career pathways, is partly due to the impact of the reproductive health problems. The emergence of the reproductive health problems among the adolescents is usually due to the lack of knowledge, life skills and support from the environment. This results to several problems that are related to the lack of knowledge and life skills listed as follows:

- STI/HIV/AIDS resulting to early deaths;
- Teenage pregnancy;
- Unwanted pregnancy resulting to school dropout, illiteracy and/or unemployment or

The adolescents' reproductive health problems are also exacerbated by the changing family structures and the type of work the parents do. The children are on many occasions left at home without parental care for fourteen hours or more, days
to weeks depending on their parents' work. This denies them of the positive guidance and the support they need, to enable them towards responsible decision making regarding their reproductive health needs.

The media in this situation becomes an alternative available role model, where different roles of the adult models are displayed, the adolescents may take wrong messages from these characters displayed by the media. This may reinforce wrong ideas and breed negative behaviour towards primary prevention of their reproductive health needs.

The National Health Ministry is also challenged by the circumstances the adolescents grow in. The HIV/AIDS statistics and the prevalence of STI's among the 15-19 years old raises great consent to the accessibility or the effectiveness of the primary prevention services. The ages between 15-19 years old females are more affected by STI's/HIV/AIDS, this challenges prevention strategies to identify females as a high risk group. The political will entrenches the guidelines to care for the risk groups, through the implementation of special programmes following the available policy guidelines (Department of Health 1999:14-15).

The study intended to survey the support the adolescents get from the environment they grow in, concerning positive care provision for their reproductive health needs. The reproductive health rights as enshrined within the constitution of the country, chapter 2, had great implications to the planning and the implementation of the health care (Act 108 of 1996)

Open discussions in gender and sexuality issues had to be established in all sectors, including the family and the church, to ensure information availability, and that further challenged the following:

- the existence of the education and counselling services for primary prevention;

2
their appropriateness;

- accessibility;

- effectiveness and

- efficiency in preventing probable problems related to reproductive health.

To ensure equal accessibility to all primary health services and exercising the right to choose, The choice of termination of pregnancy Act, 1996 (Act 92 of 1996)(TOP) was passed. The community as a whole was challenged by the formulation and the approval of the act. The cultural, religious and personal resistance regarding TOP was demonstrated and barriers to access to the service by the adolescents were eminent. The society passes its norms and values to the people, and the resistance demonstrated against the act may influence the adolescent's decision making with regard to TOP.

1.2 THE BACKGROUND OF THE PROBLEM

Soshanguve is a Township North of Pretoria. It is under the Northern Pretoria Metropolitan Municipality (NPMMS). This Township is characterized by the diverse and dynamic population growth, this is highly influenced by the emigration and immigration processes within and outside the country. There are about 17 high schools in the area with estimated pupil 13000. The estimation of the adolescents' population out of school is not available. The latter are regarded as the high risk group that need special attention to aid them avert the reproductive problems (Department of Health 2001: 17).

The increase of informal and formal settlement renders it difficult for health care delivery to be accessible to all. To ensure increased access, satellite clinics and mobile units are being made use of. The extended hours of service rendering is also implemented so as to address the health needs in different developing sections of the Township. The Soshanguve clinic 3 renders a 24hrs service, it is situated at the border of Gauteng and North West Provinces. Its situation renders it mostly
accessible to all train, bus, taxis commuters and pedestrians as it is within the Township, and most importantly alongside the mainroad.

The population is composed of the high income, middle and low or unemployed groups respectively. The unemployed or low income groups mostly live in the informal or formal settlement areas. They are 5-10km from the 24hour health center in block BB, and the adolescent care project in block F. The trip to the above services causes them R6.00-R12.00 return, which many households may not have.

The adolescents are involved in several group activities to keep them away from the streets, for example drama and dancing groups. While the skills are practiced, it may increase the risk to increased exposure to facilitated sexual relationships, with no life skills to handle the inherent challenges.

The clinics render comprehensive health service within which adolescents are also provided for. They are being referred for special services e.g. Social worker, STI'S management and antenatal care as the need specifies, and follow up care. There is a specialized centre for the adolescents care in Block f, where primary prevention through life skills development and youth support are provided for. The centre is existing for 6years and have not yet managed to exempt the adolescents from the various reproductive health problems. The reproductive health problems as reflected in the statistics for October to December 2001 are represented below.

Table 1.1 Pregnancy rate for the adolescents under 21years.

<table>
<thead>
<tr>
<th>Clients seen</th>
<th>Under 21 yrs</th>
<th>Total for the month</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2001</td>
<td>112</td>
<td>810</td>
<td>14%</td>
</tr>
<tr>
<td>November 2001</td>
<td>185</td>
<td>910</td>
<td>20%</td>
</tr>
<tr>
<td>December 2001</td>
<td>84</td>
<td>522</td>
<td>16%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>381</td>
<td>2242</td>
<td>17%</td>
</tr>
</tbody>
</table>
The incidence and prevalence rates raise questions regarding the accessibility and the effectiveness of the services for pregnancy prevention. The pregnancy rate during October month is 14%, and the least if compared to the other months. The reason may be due to the fact that the adolescents reported for ante natal clinic at about 16–20 weeks of pregnancy, and most of the conceptions are assumed to have occurred during the school holidays time. As reported by the staff that is allocated in the service, most deliveries take place around September, which is congruent to the observation that conception was around the festive season holidays. Preempted by the above circumstances in November approximately four months after the winter holidays the percentage increased to 20%. The risk to engage in unprotected sex is exacerbated by the lack of life and communication skills. The coupled risk to the pregnant adolescents being exposed to STI/HIV/AIDS cannot be given an oversight.

The implicated group of pregnant adolescents may not have a chance to complete their studies, no financial or social assistance to raise their children, suffer future unemployment with their children at higher risks for juvenile delinquency. These females are also at risk of poverty and pronounced surbordination to the patriarchial society due minimal access to the economic resources (Oakley et al 1995:158-162).

Below is the table to outline sexually transmitted infections among the youths in soshanguve three (3) clinic in block BB as one of the content studied.
Table 1.2 Sexually transmitted infections among the adolescents, under 21 years.

<table>
<thead>
<tr>
<th>Complaints</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Discharges</td>
<td>5</td>
<td>21</td>
<td>5</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>Ulcers</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Warts</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>PID</td>
<td>9</td>
<td>9</td>
<td>0</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Itchiness</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>37</td>
<td>8</td>
<td>37</td>
<td>6</td>
</tr>
<tr>
<td>Percentage</td>
<td>17%</td>
<td>83%</td>
<td>17%</td>
<td>83%</td>
<td>12%</td>
</tr>
</tbody>
</table>

The female adolescents presented with most symptoms than males, 83%-88%. The assumption may be that, the transmission of the infections was by the same male. Due to the inherent dominance of males in the society, the younger males also do have serial lovers. If the assumption above is true, the partners to the infected females are walking around with infections that are untreated, re-infections may complicate the above scenario. The complications of pelvic inflammatory diseases if reported late, or in case of repeated infections, may later overburden the health system that has to manage the infertility problems.

The possibility of HIV/AIDS presence in the above clients cannot be underestimated. The incidence rates of STI above also represent possible HIV/AIDS infections due to the unprotected sex. The highest risk factors to contract the HIV/AIDS, are ulcer incidence rate which is 15%, and the warts which is 5%.

1.3 STATEMENT OF THE PROBLEM

The White Paper for the transformation of the Health System in South Africa (Department of Health 1997) identified the youths as a risk group for health care
especially the reproductive health needs as specifically challenged by the HIV/AIDS among the adolescents. The pregnancy rate as reflected in table 1.1 challenges the comprehensive health delivery and its identification of services targeting the specific risk groups. The most concerns about the pregnancy rate is that they represent the incidence and prevalence rates of unprotected sex which exposes them to STI'S as reflected in table 1.2 and higher risk to HIV/AIDS for the clients suffering from ulcers and warts. The need for stringent primary prevention programmes need to be implemented

The health care provision is mostly secondary care orientated due personnel and patient ratio dynamics. School health services in this Township have not been offered on a continuous sustainable manner. Up to 2001 since after rationalization of the services, there have been scheduled visits to schools by the team of nurses from the Pretoria region. The type of service delivery did not ensure continuity and sustainability and effective communication. The type of service delivery may fail to bring about behavioural change as contact was scheduled and time for next visit was not in the nearest future. The service is nevertheless under reconstruction in order to address the identified gaps.

1.4 RESEARCH QUESTIONS

To explore the provision of primary health effectively, the researcher intended to concentrate on the following questions:

- What is the accessibility and the effectiveness of primary prevention services for adolescents' reproductive health needs?
- What is the support the providers of care get from the community?
- What problems are there in provision of care to adolescents?
1.5 THE PURPOSE OF THE STUDY

- To create awareness of the gaps within the programmes for adolescent reproductive health provision;
- To explore the and identify the strengths and weaknesses of the different care providers;
- To assist in the development of the most effective comprehensive programmes for adolescents reproductive health.

1.6 OBJECTIVES OF THE STUDY

1. To identify the health education and life skills the adolescents get from the community they live in.
2. To assess the accessibility of the centres that provide care to the adolescent within the community.
3. To identify the knowledge the providers of care have on adolescent reproductive health and health promotion models.
4. To identify the support the adolescents' care providers get from the community.

The primary level providers for adolescents' reproductive health needs, need health promotion skills, knowledge and attitudes necessary to initiate change and come up with recommendations to ensure effective accompaniment towards positive reproductive health.

1.7 THE SIGNIFICANCE OF THE PROBLEM

1.7.1 The compounding factors to care provision

Much research has been conducted on adolescents' reproductive health problems. However, it is fragmented and the problems seemed to be unique, each problem
belonging to a specific group of adolescents. The challenge is to view these problems comprehensively, and the adolescents as a community affected by these problems that are teenage pregnancy or unwanted pregnancy, STI, HIV/AIDS and school dropout collectively (Smith 1993: 41–43). Individualizing the problems denies the adolescents an established delivery of a comprehensive primary level preventive services. An incoherent approach to reproductive health put pressure to health services financially and human resource respectively, especially due to the present HIV/AIDS epidemic which is one major 21st century reproductive revolution problem.

In the report to evaluate the effects of the environment on the adolescents' health promotion, (SABC News 03.11.02) it was stated that the environment the adolescents are growing in has multiple factors, such as single parent, uninvolved parents, absence of positive role models and poor management to life challenges. This type of situation leaves the adolescents with limited options regarding modification of reproductive health promotion behaviours and for other needs.

The changing social structures also put pressure on adolescents and tend to confuse them too. Both urban and rural, low social class and high social class seems to be equally affected by the common reproductive health problems. Urbanization, peer pressure and expected social maturity as opposed to biological maturity compounds their reproductive health problems. The biological maturity is marked by menstruation and breast enlargement in females, penile enlargement and nocturnal emissions (wet dreams) for males. The developmental changes take place between 12 – 18 years. The social maturity is marked by academic qualification or assigning adult roles e.g. childbearing and working opportunities and is between 18-25 years. The adolescent is therefore dependent on adults' care for longer periods till into their late adolescent age, this increases the time of exposure to the risk factors, she is expected not to fall pregnant while still attending school (Foy and Dickson Tetteh 2001:24-25).
1.7.2 The current reproductive health problems

The increase in teenage pregnancy and HIV/AIDS infections lead to premature death of teenage mothers and increase in orphans numbers. Lack of information on primary prevention measures is a contributory factor of both teenage pregnancy and HIV/AIDS infections. The dilemma of confidentiality concerning HIV/AIDS infections also leads to the increase of HIV/AIDS infections and deaths. The effective primary prevention programmes need to be put in place to stop new infections and teenage pregnancy (DOH 2001:18).

The available primary prevention services for teenage pregnancy also discriminate among adolescents. SABC (Take Five 1998) screened an adolescent being denied morning after pill. This unwelcoming and the lack of professional behaviour with primary prevention skills leaves the adolescent helpless and vulnerable to teenage pregnancy and the consequential problems.

1.7.3 The Government initiatives

The concern by the government to roll out health awareness campaigns is commendable. A full and comprehensive health support strategy for primary prevention to adolescents by all health providers, public and private should be an achievable goal (DOH 1997).

Again the legislation of Termination of Pregnancy was in order to reduce death and complications brought about by teenage pregnancies or unwanted pregnancies. There are 40 000 women who now can access TOP legally whereas back street abortions still go on because of lack of access and knowledge about the existence of the service (City Press 2001:02:25).

The joined venture project between the Department of Health and Department of Education reinforces the commitment of the government to promote the health risks
for the adolescent age group, especially the reproductive health component (DOH and Department of Education 1997/8)

1.7.4 The expected outcome for a positive care provision

Taking responsible decision for sexual activities will undoubtedly reduce other problems like unwanted pregnancy or teenage pregnancy, STI's, HIV/AIDS, school dropout, delinquency, substance abuse and suicidal tendencies. Skill development and health promotion is essential and should be comprehensive (Johnson 1993: 80–96).

Effectiveness of approaches used to promote adolescents' sexual health need to be assessed constantly. This will determine reliability, effectiveness and might guarantee a change in behaviour and life skills acquisition. Positive self esteem development strategies and use of relevant health promotion models may help to sustain positive reproductive health (Oakley et al 1995: 152-162).

Some researchers argue that fragmented studies on adolescent reproductive health preventive strategies have been ineffective in curbing problems. Isolated studies among the adolescents community on STI's, the use of contraception and substance abuse were undertaken by several researchers, but the incidence of these problems are still alarming. The solution may be a comprehensive study to all diverse problems and their interrelatedness and perpetuating factors thereof to be addressed. The health belief model and the theoretical thought process model are the recommended approaches (Brock and Beazley 1995:124-128)

The adolescents' positive reproductive health depends on the support and guidance from the community towards knowledge acquisition and life skills development. For this reason primary prevention will be negatively influenced by the following factors:

- decline of adult authority,
- negative youth culture emergence,
and negative social changes.

The above listed factors compromise the reproductive health promotion and primary preventative strategy for promotion of adolescents’ reproductive health (e.tv. 3rd Degree 16.10.02).

1.8 DEFINITION OF CONCEPTS

To effectively study this problem, the following definitions were adopted:

1.8.1 Primary prevention

This refers to health education, advise, guidance, assistance or support given to the adolescents during their growing towards adulthood to help them to identify all health risks. It includes the promotion and maintainance of the behaviour that is preventing them to contract diseases, physically, socially or psychologically. It includes nutritional, environmental control, stress control, personal hygiene and life skills acquisition. Behaviour modification and adaptation is the key for achievement of positive health status. In this state there is no disease identified but strategies to prevent the onset of diseases are instituted and include immunization and protective clothing e.g. use of condoms (De Haan 1996: 12-13).

1.8.2 Adolescent period

1.8.2.1 Adolescence

According to the psychologists the period in adolescent’s development in which a person becomes physically and psychologically mature and acquires a personal identity, is known as adolescence. They are now ready to enter into adulthood. The ages differ according to cultures. It is divided into three stages namely:
- early adolescence: 12-13 years
- middle adolescence: 14-16 years

According to the health providers, adolescence is a time of discovery (age 12-20) of self, characterized by enormous pressures and multiple external and internal sources. They need at this age to adapt and achieve equilibrium between these pressures. Where equilibrium is not attained health related problems set in (Stanhope and Lancaster 1998:457).

It is a period of transition, adjustment and personal exploration. It ends when individuals demonstrates readiness to assume full adult responsibilities of financial, emotional and social independence (Edelman and Mandle 2002:401).

1.8.2.2 Adolescents

Adolescent are defined as persons from 12 to 19years, and youths as 20 to 24years. In this study both age groups will be used but only up to 21years old only. The concept adolescent will refer to all persons from 12 to 21years, the concepts youth, adolescent or teenager will always represent the same group of people under the study (DOH 2001:8).

Love life defines adolescents as according to World Health Organisation (WHO). They are persons between the ages of 10-19 years (Love life 2001:28).

1.8.3 Health

The term refers to the state of psychological, physical and social well being that enables the adolescents to pursue her academic career or fulfill her social responsibilities within the values, norms and beliefs of his/her community.
Health is a dynamic life experience of human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of ones’ resources to achieve maximum potential for daily living (Pearson, Vanghan & Fitzgerald 1998:90).

World health organization defines health as state of total well being physically, socially and psychologically and not merely the absence of disease or infirmity (De Haan 1996:21).

1.8.4 Reproductive health

This refers to physical, mental and social well-being and ability to enjoy sexual relationship with no fear of unwanted or teenage pregnancy. It refers to the ability to decide about how many children one want to have and when to have children. It aims at equipping individuals about strategies and information to prevent sexually transmitted infection HIV /AIDS, it is not gender bias and ensures availability and accessibility of services to all individuals and the groups at risk (Department of Health 1999: iii).

1.8.5 Facilitator or supporter

It refers to any person who is at a given period of time in contact with the adolescents and is enabling the adolescent to identify their reproductive health risk factors, and develop health promotion behaviors so as to uplift or maintain positive reproductive health status. They include adults, parents, guardians, teachers, priests, community workers, nurses, doctors, and church members.

1.8.6 Comprehensive

This programme is all-inclusive. It is not a fragmented or a speciality approach. It looks at a global need and the approach is such that it addresses multiple problems
during same time at one stop station. The implemented approach is a solution to several problems. No postponement of attendance is given to other problems in favour of others (DOH 1997).

Comprehensive health care is delivered in three levels, primary, secondary and tertiary. All the levels have the same components that are traditionally preventive and promotive. Among this mentioned levels primary prevention is the most cost effective and achievable level because it render individuals self reliant (DeHaan 1996:7) further defines it as stated below:

A comprehensive health provides people with maximum health benefits at a reasonable cost. It is an integrated and coordinated system of health care promotive, preventive and curative components. It is a system that sees an individual belonging to a family and community, and operating in a specific social and physical environment from which he is unseparable and profound to influence on his life.

A comprehensive programme is holistic in design and takes into account multifactoral factors to contribute significantly to disease causation and the control thereof.

Health care will refer to all the advise formal and informal, from all significant adults in the community. All such advises are aiming at assisting life skills acquisition. The term will be used throughout the study synonymous to service provision, accompaniment or care.

1.9 RESEARCH METHODOLOGY

1.9.1 Research design

A exploratory descriptive research design was used to ensure thorough understanding of human behaviour and attributes that influence the behaviour.
modification. Different reproductive problems have been researched, the need was to describe the contributory factors, and explore the relationship of the factors. In order to guide the development of a comprehensive programme to avert the repeated incidences. The situation where the adolescents live would be described in details, to reveal all factors of negative effect to their accompaniment, and explore all the huddles so as to effect positive behaviour for health promotion (Polit, Beck and Hungler 2001:186).

1.9.2 Research methods

Triangulation of research methods was used. The choice of the combination of the methods was influenced by the diversity of the problem under the study. The adolescents' reproductive health is shadowed by social, psychological, educational, personal and economic factors. The problems are largely behavioural in origin, they need in depth investigation to submerge problems and successes in care provision. Triangulation as defined by (Polit, Beck & Hungler 2001:472) is:

The use of multiple methods or perspectives to collect data and interpret data about a phenomenon, to converge on an accurate representation of reality.

1.9.2.1 Qualitative design

The qualitative design was characterized by interviews, and exploration of the documents. The two techniques aided in the demarcation of the area of the study and the questionnaire development. Due to its inductive approach it represented the daily experiences in the situation under the study. The findings may be applied to many situations of adolescents' health care with certain adjustments. They will again assist in understanding and forecasting the area of need for future research (Morse 1997:227).
Observation of the natural environment at the health clinics to identify attitudes, knowledge and other factors related to care provision was carried out simultaneously with both methods. No artificial situation for the study purposes was created. Observations were automatically carried out during the two methods of investigation as explained. The adolescents' uniqueness, behavior and experiences were extensively explored by the use of the different methods (Polit, Beck & Hungler 2001:280).

1.9.2.2 Quantitative design

A questionnaire was developed to quantify the information gathered from interviews. The quantitative method used the results of the qualitative investigations to complement or bridge the gaps inherent in the latter. The use of qualitative method as a precedent of the quantitative method is recommended for sequenced use because they are useful in advancing knowledge, and is the scientific way of investigating behavioural health problems.

1.9.3 Research setting

The area studied was Soshanguve Township in the Gauteng province north of Pretoria in the NPMMS. The community clinics serving the two different social classes area were selected, and included block BB clinic and Boikhutsong clinic. The adolescents' project center in block F was also included. Negotiations in written and verbal forms have been made to negotiate entry (appendix 1.1 and 1.2). There are about 17 high schools in the area with estimated pupil population of 15000. The estimation of the adolescents' population out of school is not available. The latter are regarded as the priority target group that need special attention to aid them avert the reproductive problems (DOH 2001:6). There is one special high school for the handicapped. The Philadelphia high school provides for visually handicapped, cerebral palsy physical and hearing impairment.
The Northern Gauteng Technikon is also situated in the neighbourhood of the high school, both have their own nursing personnel to provide for their health needs comprehensively.

The population is composed of the high income, middle and low or unemployed groups respectively. The unemployed or low income groups mostly live in the informal or formal settlement areas. They are 5-10km from the 24hour health center in block BB, and the adolescent care project in block F. The trip to the above services causes them R6.00-R12.00 return, some household do not have the money to reach this services.

1.9.4 Sampling

1.9.4.1 Population

The population to be researched is the adolescents using the health services in Soshanguve. The daily statistics was used to estimate the total population. The type of population did not have a fixed number and the weekly averages were used to determine the accessible population, this was equal to approximately 200 adolescents a week per service point. All the clients fitted the criteria of the adolescents for the study and they were included in the pool of subjects for the study (Polit et al 2001:235).

1.9.4.2 The sample size

The total population was equal to 200 adolescents, the sample, which is a subset or units of the population is made of, was decided upon. It was very important to ensure that the size is representative. Hundred (100) adolescents were included, about 70 was a sample for the quantitative design, the remaining was a sample for the qualitative data gathering techniques.
1.9.4.3 Sampling procedure

Samples were drawn from the two clinics and the adolescent care project center. Within the services probability sampling, specifically systemic sampling was used, this would ensure representation of different groups within the population. This study included three primary prevention services to enquire about their programmes towards health reproductive health promotion for adolescents.

Systemic sampling was used to access the adolescents in the visited clinics. All adolescents who attended the comprehensive service at Soshanguve clinics on the days of data collection had equal chance of being included in the sample. The pregnant adolescents were also included as the services survey referred to her experiences as well. A whole day was utilized to collect data to avoid one session only as bias information might spoil the whole results of the study, for example pupils came in the afternoon for birth control methods. From 7:30 in the morning until 16:00 adolescents who attended the clinic were randomly sampled, every 2nd client was included. The sampling went on for five days, (a week). The period was appropriate to avoid repeating clients, if done randomly. All sexes, attending school or not, pregnant or not were included if they suited the description used by the researcher. Convenience sampling was done for the qualitative design. For the sample to be representative and allow generalizations it should reflect most characteristics of the total population. The sample included fitted the characteristics of the population under the study (Polit et al 2001: 233-236).

1.9.4.4 Inclusion criteria

Most importantly representation had to consider the following variables: gender, age and educational standards. These variables had to be equally represented depending on the phenomena being investigated. To ensure that, for teenage pregnancy, males and female were included as males are also teenage fathers. All educational levels up to Standard 10 and tertiary education were included, and ages from 12 – 21 years.
of age were included (Polit & Hungler 1999:279).

The inclusion of adolescents of any religious group was to ensure that most religious affiliations were included to allow generalization of the findings to religious groups. The Soshanguve clinic 3 (Block BB) was used as a Health Center that caters for most part of the community and the clients are from Blocks BB, DD, AA and F whose residents are middle and some high income groups. Boikhutsong clinic clients' are from Blocks FF, GG and part of RR, these areas represent the unemployed or low socio economic group of the population in most instances. This social and economic dynamics would also allow the results of this study to be used in other similar situations. It would again reflect on the successes and challenges faced by Soshanguve community clinics towards meeting the needs of the adolescents' reproductive health as provided in the policy guidelines. The information gathered in this study would represent the lived experiences of adolescents, and the contribution of the different structures within the community towards health promotion (Polit et al 2001:309).

1.9.4.5 Exclusion criteria

People who were included in the pilot study were excluded as their first responses might highly influence the outcomes of the study, as they were familiar with the questionnaire or interview questions. The very ill, the TOP clients and those who were attending the clinics with trauma or emergency were excluded. Voluntary informed exclusion was allowed. The respondents took part in data gathering for one design only.

1.10 DATA COLLECTION TECHNIQUES

To ensure reliability and validity the combination of methods were used as traditionally known for the different research methods in the study. The process of data gathering entailed the following:
1.10.1 Qualitative data collection technique

To ensure a representative truth of lived experiences, the following strategies were used.

1.10.1.1 Review of the documents

The documents were reviewed to study the prevalences, incidences, daily turnovers, success and failures in the service delivery. All documents used for the adolescents' care, the pamphlets, activities recorded for awareness and visits to the schools were reviewed.

1.10.1.2 Semi-structured interviews

The semi-structured interviews were held with care providers and the adolescents. They were individually interviewed and the interview was directed by specific themes encoded within the objectives, the information from documents and literature review. The interview focused on accessibility, knowledge of caregivers and consumers, effectiveness and constraints for service delivery. Interviews were held behind close doors and ensured privacy and freedom of expression. The session allowed for respondents to narrate stories as lived experiences, in a formal setting. The interviewer never aimed at directing the interviewee to certain specific points, but towards certain themes as listed above. The semi-structuredness signaled the openness, and interactive potential, of the interview session (Morse & Field 2002: 76).

1.10.1.3 Observation method

Observations were carried out during data gathering sessions for the qualitative design. Participant observation methods were used. The health education session and interviews of new clients and old ones by the care providers were observed. Both the care givers and the adolescents were observed.
1.10.2 Trustworthiness

In order to evaluate the quality of the data and their findings, there are specific procedures for qualitative research. There are four criteria to be evaluated to establish trustworthiness. Trustworthiness refers to the truthfulness of the information gathered. The account and the extent to which it represents the social phenomenon to which it refers accurately, it is congruent to validity in quantitative research. The criteria to be investigated are credibility, dependability, confirmability (Polit et al 2001:314-316).

1.10.3 Quantitative data collection

A combination of close ended and open ended questions were developed. The process of questionnaire development was concluded after the implementation of observations and interviews. The questions to be included were identified as from literature review and completed after the interview. The area of demarcation for the study was determined by the findings of interview, observations and literature review. refer appendix 1.4.

1.10.4 Reliability

Reliability refers to repetition of the same results with the same study if repeated. The results are evaluated in numerical indexes. Reliability is very important to ensure the applicability of the study to other situation so as to improve health care. It has to take care of the following:

1.10.4.1 Random and chance error

As random and chance error might affect the reliability, and it is difficult to control, the anxiety was allayed by prior orientation to the study, and asking for voluntary inclusion. Ethical principles of trust, respect, and voluntary participation do allay
anxiety to an extent.

1.10.4.2 Internal consistency

Only subjects that fitted the characteristics in the sample will be included so that the internal consistency is ensured and the same characteristics are measured throughout (Polit et al 2001:305).

1.10.5 Validity

The extent to which the instruments measure what it is designed to measure is known as validity. The validity was ensured by including observable phenomenon, which were easy to measure. Those were questions included in the questionnaire. The accessibility, knowledge and skills of the providers and the consumers, effectiveness of the primary prevention services and the constraints for care delivery were the factors researched. The content validity and construct validity were therefore ensured.

1.10.5.1 Content validity

This determined the question to be included in the quantitative data collection instruments. The content had to be related to the phenomenon under the study. In these study the content focused on most attributes that might influence health promotion only (Talbot 1995:281).

1.10.5.2 Construct validity

In order to ensure construct validity, logical analysis and the testing of the relationships predicted on the basis of theoretical considerations might be done. The
constructs used in the study were intelligence or educational level, attitudes inherent in the environment and motivation and interest of different caregivers (Talbot 1995: 282).

1.11 DATA ANALYSIS

1.11.1 Qualitative data analysis

The semi-structured interviews were held and gave several chunks of information. Thorough meaning and commonness in the statements were derived at, after careful analytic reading of the notes. The information was segmented into meaningful units. The different categories were identified and analyzed. They led to several subcategories.

To validate the result themes variables had to be categorized so as instruments to control and correct them can be developed (LoBiondo-Wood & Haber 1994: 484). Validation of the finding is most important because generalization is not always possible unless where the population is best known. The adolescent population has common problems in both urban and rural areas, therefore the study will be valid because of existing commonness in the population studied. The process of validation for qualitative design is known as trustworthiness.

1.11.2 Quantitative data analysis

The operationalisation of the collected data is most important. Numbers were assigned to the items and responses. Nominal scales that classify responses or items into only one category were used. Items were included only in one category. These were used for age and gender, standard of education and family structures.
Interval scales will be used to measure intelligence and attributes that represent self-esteem as these characteristics may influence the successfulness of the implemented programme. Ratio scales will be used to calculate the percentages of items or response.

1.11.3 Observations analysis

The observed phenomenon will be discussed with findings in either qualitative analysis. Analysis and interpretation was also done to integrate the observations in the study.

1.12 ETHICAL CONSIDERATIONS

Act 108 of 1996 chapter two provides rights for every citizen unconditionally. The researcher as directed by the provisions within the act is compelled to observe the citizen's right by strictly observing the following. The research ethical principles also give the necessary guidelines of how to protect the respondents' rights (Burns and grove 1999:158). The principles to be followed are discussed below.

1.12.1 Permission

Basic respect principles will be implemented by first asking for permission to do this study from the authorities in charge of institutions to be used refer appendices1 and 2. The District Health Manager of Pretoria region Community Health services was written a letter and asked for a written permission to do the study in the health services.

1.12.2 Informed consent

The population that qualifies the criteria for the study was asked for verbal consent and the procedure of the study was explained to them. No participant was coerced
1.12.7 Confidentiality

All studied information will be published anonymously as the Soshanguve area study on primary prevention of adolescents' reproductive health services not identifying by name or residential address the subjects of study that were selected. Information to identify any respondent was not to be revealed during data collection, therefore it was not accessible to the researcher.

1.13 BRIEF OVERVIEW OF THE AREA OF SOSHANGUVE

Soshanguve lies to the North-west of Pretoria, the capital of South Africa. It forms borders on the north western site with Mabopane, which is a township in the North-West Province, the latter may after the completion of the local government restructuring be part of the NPMMS. Soshanguve is a relatively new area about 36 years old. The name "Soshanguve" is an acronym comprising the following elements:

So - Sotho (Sesotho)
Sha - Shangaan (Xitsonga)
Ngu - Nguni (IsiNguni)
Ve - Venda (TshiVenda)

For historical reasons, it is a product of the forced relocation and therefore is inhibited only by black South Africans. It is regarded as a suburban area. It is part of the Northern Pretoria Metropolitan Substructure (NPMSS) which is situated in the northern part of Gauteng Province. The population in the township is mixed with the aged, middle adults, young adults and teenagers, school age, toddlers and babies. There are about 17 high schools. About 50% of the residential areas are informal and formal settlements, characterized by single parents families, and below breadline income. The mentioned factors put the population at higher risks of the health problems, especially the reproductive health. The latest population census in the NPMSS, based on the 1996 findings, shows the following:
Even though Soshanguve is urban, it is also peri-urban in character, comprising informal settlements and back-yard squatters in unofficial areas. The residents in these areas are, in most cases, either in the lowest income category, unemployed or merely destitute.

As stated earlier the respondents will comprise of all residents from all areas and all social classes. The informal areas and formal areas represent the poor that the youth and adolescents policy aims to put first on the priority list for service delivery. The formal and informal areas offer minimal or no work opportunities. Some of these people are women and children, females and males who have moved to urban areas to be closer to their spouses, who themselves could only find jobs in an urban area. They are mostly of childbearing ages and there may be high risk factors for reproductive health problems for parents and teenage children.
The map in Appendix 5 also shows the other areas that are adjacent to Soshanguve. NPMSS consists of Akasia, Klipfontein, Kruisfontein and Soshanguve. The formal and informal settlements and squatters are called sections, but the settlements are classified in alphabetical order (block H, M, or DD, for example). There are thirty two (32) sections of which twelve (12) are formal settlements, while the remaining twenty (20) are informal settlements and so-called squatter areas.

There are four health clinics. One is a Community Health Care Center, which operates for twenty four hours a day. It also has a maternity ward and an operating theatre. The area is served with 72 schools from the preschool level to the high school level and tertiary. There is a transborder crossing for school, shopping, police services and other services that are more accessible in Soshanguve from Mabopane and Winterveldt residents. Trains, buses and taxis in the form of mini-buses and private sedans, are the main modes of transport. There is a police station with satellite stations in other sections. Two railway stations are located in the area. Soshanguve lies about 40-60 km from the city center of Pretoria.

1.14 SUMMARY

The phenomenon that emerged from the introduction was that the area for the study is large, and had multiple factors that might either promote or not promote the promotion of reproductive health provision to the high risk groups. The succeeding chapters will investigate the contribution of variables that were identified.
CHAPTER TWO

CONCEPTUAL FRAMEWORK

2.1 INTRODUCTION

To enhance communication and maximize the understanding of the study, it was important to give an outline framework of the concepts that will be used in the study. In this chapter a conceptual framework is explained and a schematic representation given as derived from the interrelatedness of the concepts.

2.2 DEFINITION OF THE CONCEPT

The conceptual framework explains aspects to be studied, and organizes the key factors and the interrelatedness of the variables or constructs. The variables among these aspects can also be presumed. It further derives boundaries or parameters of a problem, purpose and variables (Miles & Huberman, 1994:18).

The definition given by (Burns and Grove 1999:133) is as follows:

Conceptual models are similar to theories and sometimes referred to as theories. However, conceptual model broadly are even more abstract than theories. A conceptual model broadly explains phenomena of interest, express assumptions, and reflects a philosophical stance.

Polit & Hungler (1999:107) describe the conceptual framework as conceptual schema or models. These deal with abstractions that are assembled by virtue of their relevance to a common theme under the study. Conceptual framework uses building blocks just like theories. It provides loosely structured conceptual perspectives.
regarding the inter-relatedness of the phenomenon than theories. Thus represents a less formal and developed mechanism for organizing phenomenon than theories. Conceptual framework is not directly testable by researchers as theories are. They represent certain aspects only in the environment due to the way they are constructed. Constructs are represented by use of minimal words, and the symbolic representation help to express abstract ideas in a more understandable or precise way than the original conceptualization.

In confirming the statements in the paragraphs above (Burns & Grove, 1993: 186-187) explains conceptual framework as mapping the concepts and statements to ascertain their interrelatedness. The concepts that contribute or partially may cause an outcome are identified during this mapping and are grouped together. The presumptions among the variables or the relevance of concepts to the study can be assumed. The organized concepts can be represented in a map or schema, such representation assist in identifying gaps in the study. They also state that conceptual framework lead to theory development.

2.3 CONSTRUCTING CONCEPTUAL FRAMEWORK FOR THE STUDY

In chapter one the introduction, the significance of the problem and the background of the problem included the factors that may contribute to positive status of reproductive health of adolescents. The positive status of health is achievable through the provision of primary prevention services that are accessible and appropriate so as to ensure effectiveness. The common factors' contribution towards health promotion as researched previously were discussed.

In this chapter grouping of those common factors will be done in order to develop a conceptual framework for this study. All relevant factors contributing to primary prevention reproductive health problems will be organized to outline the interrelatedness of these factors to the topic of the study. Presumptions or cause and outcome can already de made with such conceptual framework, map or schema.
Data analysis will also make use of the conceptual framework as common factors will be discussed together to evaluate their contribution to health promotion. Furthermore, a body of knowledge may be developed from the framework as it might generate debates and new studies around the identified factors.

In this study the available programmes and providers for primary prevention for adolescents' reproductive health promotion will be analyzed. The analysis might establish if they are accessible and effective to address all challenges and needs of the adolescents' reproductive health needs.

To explain the conceptual framework for this study a list of the variables or constructs that the study is to explore is provided below. Common factors are grouped together to illustrate their interrelatedness and make presumptions related to the variables in the study.

2.4 EXPLANATION OF THE CONCEPTUAL FRAMEWORK

Primary prevention services as the core of the framework will include the health education and life skills development. The core of the framework determines all other factors that may contribute to it as socially, legally and educationally determined.

Persons who interact with the adolescent:
- parents;
- any adult;
- peer groups and
- health workers

Social structures/resources and the centers that offer the services like:
- churches/NGOs;
- clinics;
- youth clubs and
- media
The following reproductive health problems prevalences will be surveyed.

- Growing up
- Birth control
- Termination of pregnancy
- STI / HIV / AIDS
- Life skills
- Teenage pregnancy

The key influencing factors and framework that determine the provision of care are:

- the legislative framework,
- the environmental context the adolescents grow in, and
- the use of health promotion models.

These three groups of factors will be referred to through out the study to keep to the boundaries as determined by the conceptual framework. The primary prevention will be affected by these factors or variables positively or negatively, hence in schematic representation in figure 2.1 primary prevention is at the centre of all the three grouped factors. The conceptual frame work will refer to the following explanations or meaning of the terms.

- Environmental context

The effectiveness of primary prevention intervention mostly depend on the environmental context available to the adolescent. The environment in the conceptual framework will include all role models, parent figures, media, and peer group social contact. The relationships and messages that may be copied from the mentioned environment may promote the reproductive health of the individual adolescent negatively or positively. The psychological and educational circumstances challenging the adolescent will be considered.
Health Belief Model

The successfullness of most health promotion programmes depended on the models used to enhance life skills development for self reliance among the adolescents. Among the various models the study will use the following health promotion models, Health Action Model (HAM), Health Belief Mode (HBM)

Legislative framework

The guidelines for programme development and facilitation are stipulated in the different policies and acts of each country. The political will of a government greatly influences the implementation of the guidelines. The study will refer to the following acts and policies.

- The National Health Plan for South Africa,
- The White Paper on the Transformation of Health in South Africa,
- The National Health Bill 2001,
- The Policy Guidelines for Youth and Adolescent Health,
- Choice of Termination of Pregnancy act,1996(Act 92 of 1996),
- Child Care act 1983 (Act 74 of 1983) as amended Act Child Care act 1996(Act 96 of 1996,
- The Constitution of the Republic of South Africa1996 (Act 108 of 1996) and
- Life skills and HIV/AIDS Education Programme

The reproductive health needs of the adolescents are among others the acquisition of necessary knowledge towards the development of life skills to prevent the inherent problems as listed under 2.4. The interrelatedness of all three aspects are represented clearly by the overlapping portions of the circles in the schematic framework below.
2.5 SCHEMATIC PRESENTATION OF CONCEPTS

Primary preventative Care Facilities:
  - Parents
  - Health workers
  - Any adult
  - Peer group

Health promotion models

Primary preventative services:
  - Churches
  - Media
  - Clinics
  - Youth clubs

Environmental Context

Primary prevention

Legislative framework

Reproductive Health Needs Knowledge on:
  - Growing up
  - Teenage pregnancy
  - STD/HIV/AIDS
  - Life skills
  - Family planning
  - TOP

Figure 2.1 Conceptual framework
2.6 SUMMARY

The conceptual framework is necessary to determine the direction the investigations in the study follow. The use of primary prevention at a pivotal point will allow a comprehensive exploration of the circumstances the adolescents grow in. It was necessary for the researcher to determine the boundaries and the phenomenon included in the study, by referring to specific environment, legislative framework and health promotion models. This will allow a scientific investigation process to be followed while investigating the reproductive health problems, and may allow the generalization of the results to be realized.
CHAPTER THREE

LITERATURE REVIEW

3.1 INTRODUCTION

To ensure the delivery of a comprehensive primary prevention service for the reproductive health needs of the adolescents, an exhaustive survey for the present provision of service was a necessity to be undertaken. This chapter will deliberate on the literature reports on the strengths, challenges and weaknesses of the available accompaniment of the adolescents internationally and nationally.

There are numerous studies done on the adolescents' reproductive health needs, most of the studies used a selective approach for care provision. The problems were compartmentalized and individualized, and denied development of the proactive strategy to prevent the numerous other anticipated problems, that needed development of self reliant behaviour. The different recorded studies will be coalesced to enable derivation of an appropriate comprehensive primary prevention approach. 37

The Department of Health in the White paper for the Transformation of the Health System in South Africa, (DOH 1997) included the adolescents among the special groups. This age group have risks factors that need to be modified through primary intervention to can avert possible health problems. In order to achieve this, private sectors and public sectors have to join effort in achieving primary disease prevention especially for this age group. The services should be interrogated and comprehensive in approach. To maximize performance the government will sustain some non-governmental organizations by financial assistance and policy guidelines provision. There were challenges identified for initiating and sustaining multidisciplinary approach for disease prevention at primary level, as causes of diseases are multifactoral in origin. To ensure comprehensive accompaniment of the
adolescents, the following people are of great importance: parents, church leaders, community leaders, all multidisciplinary health team members and all adults in contact with the youths. They all have to ensure a significant contribution towards health promotion and disease prevention especially at primary level.

The legislative framework lays the ground rules for the delivery of services. The Department of Health provides the following legal framework for the delivery of the comprehensive reproductive health.

3.2 LEGISLATIVE FRAMEWORK FOR ADOLESCENTS' CARE

In order to effectively render the health care that is acceptable, appropriate and cost effective, the government of the country developed some guidelines. These are spelled out within the policies or acts that lay out the acceptable procedures to be followed by each sectoral directorate for health service delivery. Adolescent reproductive health is also provided for within the acts and policies as discussed below.

3.2.1 A National Health plan for South Africa

The National Health plan provides special attention to mother, child and woman health (MCWH) services, school health and adolescent care. The promotive and preventive programmes regarding high risk behavior and sexuality have to focus on effective life skill development. These skills will include safer sex practices as a top priority and all guidelines should be put into action (A National Health Plan for SA 1994:20,36,41-43).

A multisectoral programme for HIV/AIDS prevention should be developed to contain the spread of the epidemic. These should be an endeavour of all governmental sectors.
3.2.2 The White Paper for the Transformation of the Health System in South Africa

This document was developed in order to redress the inequalities of the past government especially regarding accessibility and appropriateness of health provision. In order to hasten appropriate risk and need identification, the following six principles are provided as guidelines to the country as whole:

- Mother, child and woman health (MCWH) services should be accessible to mothers, children, adolescents and women of all ages and focus be on rural and urban poor and farm workers;
- MCWH Services should be integrated;
- Clear objectives and targets should be set at National, Provincial, district and community levels in accordance with the goals of the RDP, the health sector and the United Nations Convention on The Rights of the of the child;
- Individuals, household and Communities should have adequate knowledge and skills to provide positive behavior related to maternal child and reproductive health;
- MCWH should be efficient, cost effective and of good quality;
- Men and women will be provided with services that will enable them to achieve optimal reproductive and sexual health.

These principles has to be observed throughout health care provision with adolescents being one of the risk groups and reproductive health, an area of need with specialized services. Most importantly the appropriate skills development should be towards the creation of a conducive environment for adolescents’ accompaniment is to be achieved by all facilitators. The HIV/AIDS epidemic challenges the implementation of these guidelines adequately (Department of Health, 2001: 12).
3.2.3 The National Health Bill 2001

in order to ensure availability of services the National government stipulates in the bill the provincial government responsibilities as follows:

- schedule (2) part A(1), states that the formulation and implementation of health policies, norms, standards and legislation will be done by the provinces.
- part B(1) the provinces are to ensure promotion of community participation in the planning, provision and evaluation of health services (National Health Bill, 2001:61).

The responsibilities of the province as enshrined in bill legitimise the community originated programmes like the youth clubs, church and other non profit organisations for health promotion. The community originated programmes will be better utilised as they are need originated and community owned. The reproductive health needs requires similar programmes that are coherent with cultures and beliefs of their developers to prevent health problems whilst promoting health.

3.2.4 The Policy Guidelines for Youth and Adolescent Health

The National Health Plan and The White Paper for the Transformation of the Health System in South Africa identified the adolescents as a risk group. They need special care so as to prevent health problems especially, the reproductive health problems. They become sexually active and need skill development and health education so as to manage their reproductive needs positively. In order to achieve the target for health delivery laid down by the country, the policy outlines the following principles for youth & adolescent health:

- adolescent development underlies the prevention of health problems;
- problems are interrelated;
- adolescence and youth are a time of opportunity and risk;
- the social environment influence behavior;
- not all young people are equally vulnerable;
- there are five general intervention strategies for adolescent and youth health;
promoting a safe and supportive environment, which include relationships with the families, social norms, cultural practices, mass media, accessibility of key opportunities and commodities and policies;
- providing information;
- building skills;
- counseling and
- access of health services.

These strategies can be applied in all situations where any adult interact with adolescents. This should be taking place at any given time in one of the following places:
- home;
- school;
- health facilities;
- workplace;
- community based organization and residential centers.

Each situation will need a special programme to address the needs but areas of priorities will always be among the following needs:

- sexual and reproductive health,
- drug abuse and
- violence (DOH 2001:5-6)

The health priorities include sexual and reproductive health, and this re-emphasize how adolescents are at higher risk to be affected by the neglect of this needs. The other problems such as drug abuse and violence are indirectly related to the sexual and reproductive health. The policy identifies the following areas where adolescent stay as areas of concern. These identified groups may not have the same access to the services and information centres, they do not have access to telephones, computers, radios or television. Those areas are:
youths outside schools,
- youths living in the streets and
- rural, the urban poor and farm workers groups of youths.

3.2.5 The National Contraceptives Policy Guidelines

The adolescents are provided unlimited access to birth control services. All people who are sexually active and visit the center, should go away with provision of a contraceptive method and the relevant information. The adolescent by virtue of being sexually active is also provided for and is entitled to receive a non discriminatory care. The following shortcomings should be addressed in the birth control service:

- dual protection;
- counseling and
- building life skills (DOH 2001:21,23and27).

3.2.6 Choice of Termination of Pregnancy act, 1996 (Act 92 of 1996)

The formulation of the act was influenced by the high mortality rate due to unsafe abortion among all ages of females of child bearing ages, the adolescent are also included. The act provides an alternative in the case of accidental and unwanted pregnancy. The adolescent has unlimited access to these service, with observation of her rights to make informed choice. During the provision of the service, confidentiality and privacy must be ensured. Under this act, any female of any age has the right to choose to terminate the pregnancy, if she does so under the circumstances within the provisions in section 2(1) of the act (Act 92 of 1996).


Section 39 (4) (b) provide for the 14years old permission to seek medical treatment without parental assistance or accompaniment. The health provider has to provide
information on how to deal with problems, including the promotion of abstinence or provision of contraceptives (Act 74 of 1983) as amended.


The basic human rights are enshrined in the country's constitution. Chapter two tables all rights of each individual, the adolescents are also provided for by virtue of being South Africans. The rights include among others:

- Right to access to services,
- The maintainance of bodily integrity,
- Making decision regarding the reproductive needs,
- Security and control over the body (Act 108 of 1996).

3.2.9 Life skills and HIV/AIDS Education Programme

To implement and heighten the attainment of all guidelines in the discussed legislative framework, the initiative between the Department of Education and the Department of Health was instituted. The teachers, non-governmental organizations (NGO) and some health promoters were taken for mentorship training. They were trained on approaches to use while accompanying adolescents to acquire life skills to aid in the protection against HIV/AIDS. The adolescent out of school can be reached within the programme provision.

The discussion to follow will examine how the provided guidelines are met and also the shortcomings thereof. Alternative approaches to meet the guidelines will also be discussed (DOH and DEH 1997/8).
Primary prevention is a preventive and promotive health care provision, it includes health promotion and specific protection. At this level an individual is not yet ill, efforts are towards averting the onset of diseases by modifying the identified risk factors inherent in the environment in which he grows. As stated earlier, the growth spurt and identity confusion are major risk factors challenging the youths reproductive health. The two are crisis situations and need strategies in place to ensure benefaction towards health promotion.

Adolescence last for nine years or more, from ages 12yrs-21yrs, or 10-19yrs. The period is nearly a decade and is long enough to can yield positive or negative status of health due to the time effects on reproductive health needs. Extensive comprehensive programmes are needed to ensure health promotion, and should include health education. Heath education demands from the educator the relevant knowledge of the subject, as also stated under policy guidelines for youth and adolescent health. This challenges the adolescent accompanier to be well informed about all the factors surrounding the adolescent reproductive health. Failure to address the risk factors will perpetually lead to failure in behaviour modification and health promotion. Health education has to equip them with information to identify situations that may lead to negative actions undermining positive reproductive health status. This has to include teenage pregnancy and STI/HIV/AIDS prevention.

To ensure disease prevention and health promotion, primary prevention includes specific protection. In this study, specific protection is the effective use of condoms and other birth control methods. The health centers do provide free condoms even if the statistics of STI/HIV/AIDS keep escalating. Provision of condoms alone without continuous support on how to effectively use the protective device may yield the negative results. Support and supervision of how protective devices are used in the industries led to the drop in contracting the specific diseases. This is difficult to adjust and apply in the reduction of the STI/HIV/AIDS incidences, because the
protective device (condom) is not used in the public situation, where supervisors are employed, as coitus is a secret act. Giving of the information and developing skills for responsible decision making are the two weapons to promote the condoms safe use. Sexually transmitted infections are difficult to prevent because they are behavioral problems, they challenge establishment of counseling and education services towards health promotion, and behaviour change through internalization of the information.

Once the health education and counseling are established, continuous contact with the youth is assured and positive behavioural patterns may emerge leading to the development of positive self esteem. Negative behaviour may be timely detected if continuous contact with the youth is ensured. Other specialized care disciplines need to be in place to support those who need specialized accompaniment so as to have prompt referral system (De Haan 1996:13).

The descriptions by Edelman and Mandle (2002:14) agree with De Haan in the explanation of primary prevention. They say prevention means averting the disease onset or development. At primary prevention there is benefaction, disease has not yet set in, and all steps are towards preventing the onset of diseases. The primary prevention services should always aim at averting the onset of diseases by early contact with the adolescent. The modification of the risks factors for disease causation must be timeously implemented. All the areas where the adolescent spend some time should have motivated positive providers. The reproductive health problems to be averted may be failure to take responsible decision concerning:

- the use of birth control methods and
- condom leading to:
  - teenage pregnancy;
  - STI/HIV/AIDS;
  - Lastly the lack of knowledge concerning ones reproductive rights, and
- regarding TOP.
The extended immunization programme (EPI) also included immunization for the adolescents. The rubella immunization has to be given to all females in their early adolescence. The prevention of the disease is one of the objectives, but most importantly, the prevention of deformities to the foetus if pregnancy may occur. The provision of immunization concludes the specific protection, above all knowledge and skills to prevent onset of problems is the multifaceted weapon needed by the adolescent (DOH 1995:17-18).

The National Health plan (1994: 41) defines health promotion to ensure a comprehensive approach as follows;

Health promotion combines diverse approaches such as legislation, fiscal measures such as taxation, controls on advertising, community action and development, intersectoral programmes environmental and monitoring education.

3.4 ENVIRONMENTAL CONTEXT FOR ADOLESCENTS' REPRODUCTIVE HEALTH

3.4.1 Physical development factors

The behavioral theorist views the adolescent stage as a stage of identity crisis. They seek identity and this lead to the emergence of youth culture in order to give support to each other due to peer group identity. The fact that they experience similar problems regarding the growth spurt and sexual changes opens similar topics for social discussions among themselves. This is the time of information sharing and adopting health promotive or non promotive behaviour depending on the support they get from adults they live with in the environment.
The behaviour the adolescent will adopt at this age depends on how task in the previous developmental stages were resolved. The adolescent that received support from parents and other significant adults earlier, they will use the guidelines given to him on how to resolve problems he encounters at this stage and the future developmental stages. Failure to supply the foundation for problem handling, may lead to identity confusion and self made identity characterized by formation of youth groups with negative behavioral patterns. These allow young people to create the coming society, and to effect the revolutionary change and combine the relevant past with the necessary future (Edelman and Mandle 2002: 460-465).

The adolescent stage is characterized by among others conflicts roles for identity and growth spurt. This manifest with reproductive organs major changes e.g. menstruation and breast development for females and penile enlargement, spontaneous erection and wet dreams for males. The changes need to be communicated before hand, this will prevent myths and create a situation of openness for discussions and consultation (Foy and Dickson Tetteh 2001:24-25).

3.4.2 Social factors

Challenges and expectations that confront the adolescents in the society on how they relate with parents, educators, health workers and policy makers. The adolescent has to make positive behavior change to avert the reproductive health problems for his own benefit. The adolescent sometimes become confused concerning the pressure put on him to conform to the guidance given. If no health benefits are stated for himself, and the social environment is not displaying positive role models all information given to him is interpreted as imposed facts. The challenge is on all adults to be positive role models to ensure that the positive behavior is sustained, and copied by the youths and the adolescents. The interrelatedness of problems at this age need development of a comprehensive programmes that stress the long term benefits of the positive behavior (Peens and Poggenpoel 1997:77-79).
The adolescents are not aware of the risk factors in the environment they grow in, this may negatively influence their reproductive health. (Petridon 1997:215-219) in his study, prove that drug abuse and failure to use contraceptives by the youths are risk factors that are ranked high, and the two are directly related. These risk behaviours lead to carelessness and increased risk to contract STI/HIV/AIDS and teenage pregnancy. The less privileged group is more affected by the effects of these risk behaviour, they may suffer school drop out, illiteracy and unemployment with resultant poverty. The South African health system is therefore challenged to ensure equitable distribution of the resources, and to intensify delivery in high risk areas including the rural communities and the disadvantaged areas like farm workers, and poor urban communities as identified by the White Paper for the Transformation of the Health System in South Africa within the mother, child and woman health care services (DOH 2001:4).

The behaviour modification that happens due to pressure from adults but not related to individual’s health benefit may not last lifetime. The youth who has been pressurized by the society he grows in to conform, may later practice unsafe sex because the society received what it needed from him. He did not internalize the reasons for him to change as related to HBM but only obeyed the parents. The support failed to emphasize the personal health benefits to him. Emphasis for health promotion must be on partnership but not pressure strategies, so as to encourage responsibility and ownership to the strategies developed by the adolescent (Peens and Poggenpoel 1997:77-89).

The adolescents reproductive health risks are to mention but a few, substance abuse, teenage pregnancy, STI’S/HIV/AIDS. The risks are observed differently across the adolescent ages and social classes. The risks are behaviour related and therefore need behavior patterning towards positive health. The circumstances around each age group and social class do differ, and may need a different approach in order to address behavior modeling by parents and significant adults in contact with the teenagers. The policy guidelines on youth and adolescents health also lay
out that each situation will need a different programme as the groups' vulnerability differs (Reif and Elster 1998:1-21).

The other challenge to the youths is the biological maturity versus social maturity. Traditionally youths were emancipated at approximately 18yrs or younger to join on adult responsibilities, this led to lesser reproductive health related problems, as early marriage and earlier child bearing were acceptable at that time. Presently social and academic demands lengthens the adolescent periods resulting into increase in sexually related problems due to continued postponement of social responsibilities and marriage. By the age of 18yrs most youths are entering the tertiary education and they may have to spend three to seven years in the academic institutions. During this period they are still dependant on parental support and guidance. This long dependency period also add to youth period that is approximately 9yrs to be 15yrs.

Before acquiring a profession a lot of youths are still dependant on parental support and not yet emancipated from youth age. In some instances the information on positive behavior for positive reproductive health is present, but the time spent in these age span seem to increase the risk exposure time to health problems as listed earlier.

The media seem to be exacerbating the situation by showing more of sex related promoting programmes. These lead to moral deprivation among the community especially the groups at risk including the teenagers. The country's Deputy President, Mr. Jacob Zuma raised this concern in the moral summit held in Gauteng on the 17th 04. 02. He further urged the media to create a positive moral inducing programmes (SABC News: 17.04.02).

The Oprah show stated that the social environment especially the television, show more of sex activities or sex evoking situation which are estimated to two million scenes by the time the child reaches the age of 12yrs. Such scenes represent sex
as an expected and awaited activity that teenagers are willing to experience soon (etv Ophrah show 08.04.02).

The zoophism behaviour up in the Limpopo Province screened on (SABC 1 documentary 2001), revealed the adolescents of a village in Messina, performing the harmful practices with an aim to prevent HIV/AIDS. A group of male adolescents were interviewed, and admitted having sex with goats because they feared that females in the village were infected with the HIV. They displayed the extent of lack of information on the acceptable human behaviour, and risks of contracting new infections from animals that may not be treatable as well. They also contaminated the animals that were reared for rituals ceremonies by the community.

The traditional initiation schools are urged to transform, as some expose the adolescent, especially the male rural to several risks. The main one being the infection leading to sepsis due to certain conditions under which the circumcisions are performed. The positive outcomes for sexual accompaniment offered during initiation period are not being overlooked. The delay of integrating this adored traditional practice into western medicine may further disadvantage the adolescents' reproductive health (SABC News June-July 2002).

3.4.3 Psychological factors

The risks for adolescents' reproductive health are re-emphasized by the American studies. The reproductive health problems are interrelated, but the most observed problems originate from psychological factors. The health providers need to have knowledge in handling the diverse needs especially those of psychological origin. These put pressure in the health sector to ensure provision of counselors and mental health experienced care providers. Once the environment fails to create the relevant situation for health promotion the teenager reproductive health is further disadvantaged (Allensworth and Bradley 1996:281-285).
3.5 STRATEGIES FOR PRIMARY PREVENTION

3.5.1 Health promotion through health education and life skills development

Health education is one of three categories of services within primary prevention aimed at health promotion and disease prevention. Other categories include health protection services (environmental health and safety control measures) and preventative health services (primary preventive services e.g. birth control, adolescent’s services and pregnancy prevention services). Health education and counseling are mutually supportive services, care givers use one to one and group session in accompaniment of adolescents to ensure health promotion, and the session may be direct contact or through the media or telecommunication or in more advanced areas through the use of the internet (Edelman and Mandle 2002:252).

Health education objectives are life skills development to enhance behaviour change or modification, and environmental adaptation for disease prevention. Strategies on how to develop positive health promotion behavior are taught, and the life skills practiced and sustainability ensured. The following deliberations give an outline of the methods used in health education and life skills development.

3.5.1.1 The use of Health Belief Model (HBM)

Health behaviour modification and life skills acquisition are the end result of health education. Health belief model uses beliefs, attitudes, values and information as motivation towards decision making for positive behaviour modification. Health behaviours are any activities that one engages in, in order to enhance positive health and prevent diseases.
The health workers, or all accompaniers of the adolescent, may use the health belief model to analyze factors that contribute to individuals' health status, and identify risk factors. The following should be considered:

- individual's perceptions or readiness to change;
- the value of health to the individual as compared to other aspects of life;
- perceived susceptibility to diseases and related complications and
- perceived complications and the debilitating results thereof that are disabling.

The modifying factors that determine if a person is about to adhere to positive behavior are:

- demographic variables (sex, age);
- Socioeconomic variables such as family and group characteristics and the level of education and
- Previous experience with diseases.

Motivating factors and environmental factors that have an impact in modifying behaviour are:

- exposure to advertising,
- advice from others,
- reminders from health professionals,
- perceived benefits to comply to treatment plan and
- previous success with behaviour change (Edelman and Mandle, 2020:253).

The above stated factors within the health belief model, challenges the design of the programme for adolescents' reproductive health needs. This age group still lack in most if not all of the stated factors to enhance behavior modification as one of the motivating factor in the model. There is a need for extensive sessions to introduce the adolescents to risks in the environment, and the use of relevant examples and referrals is of most importance. Continuous contact and most importantly, knowledge of the factors which are components of the health belief model by the facilitator, is
the only reason to can successfully effect the anticipated health behaviour change in these age group.

The risk factors for adolescents' reproductive health are among others physiological, social and emotional. The females are at higher risk to contract STI's/HIV/AIDS because of immature mucous lining of the genital tract that easily break or tears during coitus. Some are compelled by the social circumstances to engage in commercial sex earlier in life. For the others, it is due to the emotional status of identity and role confusion, their decision making undermines their health benefits in those situation, and they are controlled by pressure from peers (DOH 2001:39).

To refer to the risk factors identification, adolescent is not aware of susceptibility to diseases and related complications. The health educator has to ensure acquisition of the necessary information so as preventative steps towards reproductive problems are implemented. Lack of knowledge by the health educator and consequently the adolescent depicts the ineffectiveness of the programme. Continuous accompaniment in order to ensure advise and reminders provision is also a weapon to ensure success of the health education programme. Thorough reinforcement and repetition of the needed information for health promotion may heighten life skills acquisition.

3.5.1.2 The use of the Health Action Model of change (HAM)

Behavioral change or modification is a process that is characterized by steps. Adolescents go around the revolving door more than once before emerging to a permanently changed state. It is important to notice that some people may never get as far as entering the revolving doors. The crucial developmental stage the adolescent is in, need one to aid him in entering the revolving door so as to go around some circles several times towards permanent or sustainable behaviour change. The thought processes need to be involved in carrying out different tasks
to enable movement from one door to the other. The end results of the process should be positive behaviour change that depicts life skills acquisition. The stages for this model are similar to trans theoretical model for change (TTM) and are discussed below (Ewles & Simnet 1999:261-263).

3.5.1.2.1 Pre-contemplation stage

At this stage a person does not have any need for change, because he is not aware of a need for change due to the lack of knowledge. He is ignorant of her health deteriorating behaviour. He needs to be awakened and conscienced to identify the health risks that he is faced with, the risks need to be eliminated by adopting positive behaviour that is health promotive and disease preventive (Ewles & Simnet 1999:262).

3.5.1.2.2 Contemplation stage

This is the entry stage into the revolving door, adolescents need to be enabled to enter into this revolving door by engaging them in discussions, debates and open opinions engaging the thought processes. Once they are inside, the health care provider has to make sure that they are aware of their health risks and ready to undergo a process towards behavior patterning and positive self esteem building, as prerequisite for sustainable positive health status.

3.5.1.2.3 Commitment stage

This stage is characterized by decision making whereby adolescents take decisions to take charge of their health. They decide to detach from peer group pressure that undermines their health status by stopping drug abuse, taking responsible decision in their sexual relationships in order to prevent STI's/HIV/AIDS and teenage pregnancy. They become committed to behavioral change towards health promotion.
3.5.1.2.4 Action stage

This is characterized by actions that are positive towards health promotion and disease prevention. The statistics for different health problems decline and this shows the successfulness of the intervention this action or positive attitude needs to be sustained. Contact sessions are to be more frequent and positive motivation should be the rule of the game. Comprehension and synthesis of the knowledge are to be enhanced.

3.5.1.2.5 Maintenance stage

Here the coping strategies are developed to sustain the positive behaviours. The group effort, monitoring, use of external motivation and continuous monitoring and re-enforcement through regular contact with the group, forms a major character of this stage to prevent relapse. Reminders in form of pamphlets, stickers, concerts and peer group support are strategies used to ensure the success of this stage. There is internalization of the process up to so far, and arguments on different factors can be engaged in.

3.5.1.2.6 Relapse stage

Some adolescents will relapse and detach from group norms because of lack of coping and maintenance skills. The relapse is expected to occur to the average adolescents, the great concern is what health problems may arise during this relapse stage that have permanent health debilitating effects e.g. contracting HIV/AIDS or falling pregnant. This is not reversible and the chance to re-enter into the contemplating stage may be denied. Unlike with smokers, it is researched that three cycles of relapse lead to permanent quit of smoking (Ewles& Simnet1999:263) This stage need to be prevented and health providers should be able to observe this
before happening so as behavioral reinforcement is done and special care is given to those who are at risk of relapsing. They need to be engaged earlier in evaluating what negative outcomes are possible, to prevent the relapse.

3.5.1.2.7 Exit stage

This is the permanent settled stage where a positive behavior with relevant life skills is established, maintained and yield positive health results. The clients in this stage are self-empowered and can be used for raising awareness to other people in what benefits are there in behavior change. The adolescents who are used for peer group health promotion programmes are at this stage. If all or more than 50% of adolescents can reach and maintain this stage, primary prevention will be a positive vehicle and health promotion and disease prevention a character and normal phenomenon of adolescents' reproductive health (Ewles & Simnet 1999:263). The information is very much critical to all adolescents' supporters. They must be available throughout the long journey so as to ensure completion of these circles successfully by the adolescent, through extensive engagement of the thought processes.

3.5.3 Using the media for health education

The media may use several means of communication, radio, television, movies, magazines, newsletters, internet and computers. Limited few may enjoy unlimited access to all the modern means of enhancing communication. The majority of the population targeted as high risk groups may never be reached if media is the main means of reach out programmes. There is sustainable time spent by the adolescents watching television rather than studying or being at school (DOH 2001:26).

Use of media for health promotion is coupled with problems that may hinder skill development or behaviour modification. The lack of eye to eye contact may hinder thorough clarification of some aspects that the presenter omitted. Sometimes
telephonic discussions are scheduled, where questions are being asked is provided for, but one desperate listener may not go through while phoning and stay with unexplained concerns. The programmes are scheduled within specific time limits and may not go beyond the scheduled time, this also limit the time for discussions and questions. Some of the viewers may fear the public and hold back points of concern to avoid the public to listen to them. Other people do not have access to the media at all due to poverty and illiteracy. To therefore expect that media alone can bring about behaviour modification is doomed with disappointment. As health educator the success that the media may yield should be considered while developing a health promotion programmes.

For successful health promotion by media the topic has to be simple. And mostly it should be for health awareness. The topic should be of public interest to can create debates that are based on policies and health risks related to some common public behaviors. The adolescents' diverse needs are difficult to can effectively modify through the media only because they are behavioral in origin. Behaviour is a dynamic subjective phenomenon that differs from person to person. It needs continuous contact and observation to can pick on risk behavior and monitor for change (Ewles et al 1995:274-277).

A media series like Soul Buddyz and Soul City in SABC 1, demonstrates how the identified gaps in the use of media for health promotion can be bridged as it addresses areas of concern. The repeated episodes ensures modification of behavior through reinforcement. At the end of each episode (Soul Buddyz) the objective of the series are stated so as to emphasize the points of importance to the viewers. The approach used in this series may be adopted by youth facilitators in ensuring that important benefits for the topics discussed during each session are well prioritized and understood (SABC 1Soul Buddyz 2002.04).

The other way of use of the media is through pamphlets, advertisements, books and magazine articles on topics of interest e.g. HIV/AIDS, these are used by the reader
time and again and can lead to behavior change as the reader may consult the health promoter for other facts that may not be clear to him. In instances where contact numbers are given consultation is also possible to clear misconceptions, denial and rationalization on the topic are minimized and behavior modification may be effected as those eager to benefit will continuously refer to these resources.

The successful use of media has to ensure the use of relevant language and the topic chosen should reinforce positive life skills. Positive life images portrayed and the message delivered should consider different categories and experiences of adolescents. Message to avoid rhetoric and clichés (DOH 2001:27).

3.6 AVAILABILITY OF PROGRAMMES AND FACILITATION

3.6.1 International studies

3.6.1.1 Factors influencing programme development and facilitation

In Botswana the study on adolescents' health needs comprehensively looked into all health problems and needs, including reproductive health needs. It revealed that the impact of socio-cultural, economic and political settings bears a great influence into the prevalence and incidences of multiple reproductive problems observed among the adolescents. The adolescents need to be recognized as a group with special needs. Only then will the health care providers curriculum be sensitive to their needs and training of relevant competent health providers or programme developers for adolescents' health promotion (Seboni, 1997:110-114).

South Africa being a neighbour to Botswana and experiencing National restructuring in economic and political sectors cannot be differently viewed. There is a need to review adolescents' reproductive health needs comprehensively for appropriate development of programmes. The relevant qualified and experienced people are to
be trained, to effectively bring about positive behavior modification for health and school settings as part of socialization for the adolescents. Health programmes are to be change responsive and adapt to new challenges from political, economic and socio cultural activities. Continuation of the care needs to be communicated with parents to ensure sustainable care provision, use of parents meetings, fun days and letter up dates ensures communication with the parents concerning changes in the programmes and identification of risk behavior e.g. drug abuse. Finance may be a barrier for this type of a service as new programmes are developed to include changes becomes costly (Ferretti, Verhey and Isham 1996:35-52).

The effect the changing social milieu has on sexuality issues was surveyed in Mali. The survey was done among 15-19yrs old. The reason for their first sexual intercourse was surveyed. The results were as follows, about 50% urban males responded by saying that they regret that happened, it was necessary to have postponed that. The reasons were curiosity and peer pressure. Unlike 20% of their rural peers, there were no responses to indicate regret. The rural females said they engaged in sex because they were promised marriage. In general females gave reasons that were psychological in origin, this may deny them the self esteem development to ensure compliance in the use of contraceptives (Gueye, Castle &Konate2001:56-62).

The sexual behaviour risks identification among the adolescents was studied in the United States (US). The ages included were 15-17yrs old attending high school. The sexual active males reported using the condom. The positive efforts were contradicted by the rate at which those who are sexually active were acquiring new partners. They almost had one to three partners in the past three months. The females reported having two or more partners. They all had sexual intercourse in the
past three months. The response distribution was the same for all racial groups. The need for early intervention was eminent from the findings, the most important efforts towards averting the early sexual intercourse should be highlighted in the programme development (Santelli, Lindberg, Abna, McNeely & Resnick 2000:156-65).

3.6.1.2 Bridging the present gaps in programme development and facilitation

To have an effective programme the care provider must ensure confidential handling of all information. All clients have the right to confidential handling of their health problems. Observing this constitutional right will increase trust, and follow up and open discussions will be possible. The other way to ensure open discussions between providers and the adolescents is the use of health belief model (HBM). If all who provide care including the parents are given guidelines of how to talk with the adolescents, following the steps of the model, open communication and skills development will be attained. The adolescent will develop the foundation for negotiation skills that are necessary for the love relationship. They have to negotiate abstinence, the use of condom and other safer sex practices (Schuster 1996: 906-913), (Brok 1995:124-128) and (Lear 1995:1311-1323).

As much as cost determines the quality of the programme and the visual aids to be used, efforts implemented should be aiming towards having validated teaching aids materials. They have to have clear instructions for implementation. Different groups also have to be catered for, the deaf, blind and others with chronic diseases including cardiac problems, diabetes and epilepsy (Betschart 1996:374-378) and (Paulssen, Kok, Schaalma & Parcel 1995:227-243).

Parent child communication about sex and sexuality appears to be strong determinant of positive outcome for adolescents’ reproductive health. The promotion of abstinence was done through the implementation of a school based programme.
There were five assignments designed for parents and pupils to work through on sexuality issues. The control group received classroom instructions only excluding assignments. The results showed positive results for the pupils who worked through the assignments, they developed self efficacy and positive decision making strategies, they intended to postpone sexual intercourse until they finish school. For ethical principles not to be bridged the control group was later given the same assignments to complete. The need for communication between parents and their children cannot be underestimated, and its contribution to life skills development must not be underrated (Blake, Simkin, Ledsky, Perkins & Calabase 2001:52-61).

According to the study by (Felton, Lig, Parson and Gesani 1998:67-80) the findings in the study above confirmed that self image is the most salient predictor of health promoting behaviour. They had to make choices to enable weight loss which boosts their self esteem. The females under their study became equipped with problem solving strategies. They underwent behavior change towards health promotion, that brought about positive self image which became a multifaceted weapon towards sustainable positive health status. In his study he encouraged weight loss and implied health benefits and positive self image resulting into positive self esteem. This approach of consequences may as well be applied in reproductive health education for positive self esteem development.

The use of TransTheoretical Model of change was examined among the adolescents in the initiative to promote abstinence. A school based programme for the grade seven was implemented where stages of the model were observed and supported. There was a significant difference in decision making among the adolescents in the pre-contemplation, contemplation, preparation and action stage regarding abstinence. The need to use the model for adolescents accompaniment cannot be underestimated as it stimulate the thought processes to evaluate benefits of each situation (Hulton 2001:95-115).
The availability of programmes for teenage pregnancy prevention was investigated in the United States. There was still an escalation of the problem irrespective of the existence of certain preventative programmes. The results indicated a need for a comprehensive sex education and skills training programmes. The providers of care should undergo training based on social learning theory and skill training. The approach must be community based and be integrated into school programmes (Franklin & Corcoran 2000:40-52).

In Boston, a study was done across five high schools. The grade ten and eleven, ages 16-17yrs were included in the sample. The assumption of the study was that there were varying risks for teenage pregnancy. The aim was to prevent future pregnancies. The findings were as follows, 63% were sexually active, of which 72% were males and 54% females. Of all sexually active 35% were using contraceptives consistently and 65% were not constant users. There was a need for the following factors for pregnancy prevention to be in place.

- more talks on pregnancy and birth control;
- access to contraceptives to be increased;
- education on relationships to be given;
- parent child communication to be established and
- information about parenting to be given.

The results revealed information gaps in accompaniment of the adolescents that needed to be bridged (Hacker, Amare, Strunk & Horst 2000:279-288).

Almost a similar study was done in Nigeria. Knowledge of contraceptives and the use by the adolescents was examined. The results indicated that 44.2% of females did not know when during the menstruation cycle is high risk for conception. 63.6% had no knowledge at all on contraceptives. Those who had information got it from friends or health workers but not parents. The absence of knowledge and parent child communication clearly tailors the scope for curriculum development for effective care provision (Briggs & Blinkhorn 1999:57-58).
The other factor that may improve the present available programmes is the integration of the effects of teenage pregnancy to different social groups. Every group's risks are to be highlighted, and be included in health education settings. Social learning theory should be used, and each individual must be able to identify his own shortcomings. The results revealed that teenage pregnancy was mostly prevalent among the low socio economic and single parent families. There was a need for a special programme to be developed for the group. The study was carried in Texas and indicated urgency in planning to ensure equity and effectiveness of programmes (Blake & Bentov 2001: 33-39).

Immunization or specific protection is part of the programme for teenage reproductive health. The family or parents play a major role in ensuring coverage according to immunization schedule. Rubella, mumps and hepatitis B immunization should be given according to expanded programme of immunization. The fact that school health services are not available to all children may leave them with future reproductive problems of infertility from mumps infection or foetal abnormalities if rubella infection is contracted during pregnancy. Parents are to be informed about the benefits of the immunization so that they take their teenage sons and daughters for immunization (Soldano, and Marled 1997:292-293) and (Veron, Bryan. Hunt, Allensworth and Bradley 1997:252-255)

3.6.2 National studies (South African studies)

According to the findings by (Ehlers, Maya, Sellers, and Gololo 2000: 45-53) in the study based among Gauteng's teenagers, the utilization of the reproductive health services by teenagers was delayed due to the lack of knowledge. The contributing factors may be inaccessibility and inavailability of the services. They recommended that the adolescents' services for reproductive needs be on a weekend day, so as they do not have to meet with their parents or school teachers at the clinic during the
week days. Services like TOP need to ensure privacy as provided in the Act 92 of 1996 section 5(3) which state that termination of pregnancy may not be denied if the minor does not want to notify her parents or guardian.

Other findings were that the under 19yrs old teenagers underutilized the antenatal clinic, they either reported late or at the last trimester of pregnancy. This could lead to failure to detect problems related to pregnancy early and leading to early death and maternal death.

The National Adolescent- Friendly Clinic Initiative (NAFCI) by the Department of Health and Reproductive Health Research Unit (RHRU), has developed guidelines for the provision of the recommended service for the adolescents. There are ten standards to be met, and the human rights are also to be observed during the provision of care. The service has the key objectives listed as follows (DOH 2001:8):

- to make health care more accessible and acceptable
- to establish standards and criteria for adolescent health care in clinics throughout the country
- to build the capacity of health care providers to improve service performance for the delivery of adolescent-friendly services

The other study was done in Welkom and the findings were that youths are at high risk for STI'S/HIV/AIDS. To address these risks, a multifaceted youth center is needed with reproductive health being a focus point for life skill development and behavioural modification. Once reproductive needs are successfully managed, school teenage pregnancy leading to school drop out and the related problems will be halted. Other sexually related problems including STI/HIV/AIDS leading to premature death will also be reduced and prevented (Henis, Van Rensburg & Ngwenya 2000:54-62).
To confirm the shortcomings of the available programmes the study carried in Umtata among the pregnant youths to assess their knowledge on sexuality issues revealed that there is little or almost no information the youths receive from the nurses. The minimal information they have is from parents. The tendency was that of being involved in unsafe sex although condom use was promoted (Williams & Mavundla 1999:58-63).

The 19 yrs old females have 35% pregnancy incidence rate, 42% of all sexes are sexually active, 13% of them are sexually active as early as 12-13 years. The above statistics were presented by the psychologist on Felicia on e, an e-tv show, during the discussion of adolescents' pregnancy prevalence rate. The predisposing factors were mentioned as the lack of reproductive biology knowledge, the available programmes do not intensively or at all address the topic. Pregnant teenagers never disclosed the pregnancy to their parents, they were discovered between four and six months, when the pregnancy showed by enlarged abdomen. The reason were that it was difficult because there has been no talk on sexuality issues with parents at any time, having to report pregnancy was therefore very difficult. They were not suitable candidates for TOP because of advanced pregnancy. Some mentioned the religious and societal values as the constraint against choosing to go for TOP (e.tv Felicia on e 22.10.02).

The access to contraception has to be increased by dissemination of information to all adolescents. The availability of emergency pill should not be restricted to specific services, it should be available to all who need that. The reproductive biology to include conception and make the female adolescent aware of when in case of unprotected sex, should they seek for post coital contraception (Love life 2001:64).

The lack of knowledge continues into late adolescent age. This was proven by the study at the University of the North, the study included first year students with age average of 20 yrs. The aim was to establish the knowledge the adolescent have on condom use. It was found that 56% of the sample did not know when to put on a condom, 55% did not know when to take off the condom. Those who did not use the
condom did so because they believed that they did not have HIV/AIDS (Peltzer, 2001:53-57).

The lack of knowledge is influenced by the parent child communication within the family structures. Nqxabazi (1997:160) listed the following factors as having great influence among the mothers in Umtata to impart information to their teenagers:

- the knowledge they have;
- the guidelines they have to initiate communication and
- culture acted as a barrier of communication on sexuality issues

The lack of communication left the adolescents without any knowledge whatsoever on human sexuality. They received information from friends and classmates. The authenticity of the information is not known, but it nevertheless failed to protect them from pregnancy.

The other study done in South Africa revealed other dynamics of the programme provision and development. Diale & Ross (2000:136-141) found out that the facilitator in this case being a community health nurse, needed to attend extensive training regarding youth needs and care. They also needed to undergo interpersonal skill training for adolescent care. Selection for the nurses to undergo such training need to be done after research into qualities to aid in selecting the most suitable provider for youth care. The planning of the programme has to include local needs and youths have to be included in the development of the programme. Such a programme will ensure inclusion of all or most local risk factors. This means that every youth development centre will have different programmes to address the local needs. Myths and misconception will be addressed as observed in individual situation, and the programme will therefore be need and situation responsive and adaptive.

In order to develop skills among the adolescents and youths the department of health developed the programme for life skills and HIV/AIDS education. School teachers involved with guidance and life skills development were taken for a master training
course to come and teach other facilitators. The success of this programme need to be assessed as people from auxiliary services, developmental units, early learning centers and adult basic education were among people trained to come and do the peer training. The aim of their inclusion was to make sure that adolescents out of school and those within the industrial areas and other sectors of the community are cared for (Department of Health & Department of Education 1997/8:27).

The Love Life programme also aims at committing all South Africans' adolescent community to have the same vision to stop new HIV/AIDS infection. Only through working together with one vision and mission will make the nation combat HIV/AIDS. The group of youths is working under the organization formed by the initiatives of the fist lady Mrs. Zanele Mbeki, the RHRU, the Planned Parenthood Association of South Africa (PPASA), non-governmental organizations (NGO's) and DOH. The mission of this organization is to guide and support the youths to prevent teenage pregnancy and STI/HIV/AIDS through the development of life skills and information sharing. The programme aims at keeping youths from nightclubs and shebeens by involving them in games and discussions on how to develop life skills. There are school based programmes for sports and dramas and also camping for peer group motivation (SABC 2, Morning life 20.02.02).

3.7 SUMMARY

There is still a large number of problems for adolescents reproductive health needs reported. The guidelines for prevention are clearly tabled, the onus is with the programme developers and adolescents care providers. The problems in achieving the objectives of the National Health Plan may be accessibility and targeting the risk groups. There is still a need to train knowledgeable programme developers and facilitators to ensure and also give effective care provision a boost.
4.1 INTRODUCTION

This chapter deals with research methods used to survey the primary prevention services for adolescents reproductive health needs. The research was coined around primary prevention as the hard core of the investigations. The researcher intended to survey the comprehensiveness of accompaniment programmes for the adolescents as guided by the country's policies for health promotion. All questions were developed to relate intensively to the reproductive health morbidity, the behaviour patterning approaches and the necessary information that should be communicated to adolescents.

In order to ensure the achievement of the objectives of the study, the blending of qualitative and quantitative research designs was necessary to be implemented. The two approaches as used by modern researchers, would assist in giving answers to most health problems that originate in the community. They would ensure the bridging of gaps that the individual research approach inherently had, and might ensure the validity of the research results and allow for generalization (Polit et al 2001;218).

The following research aspects will be discussed after a description and short report on the pilot study.

- description of research design
- justification of the integration of the qualitative and quantitative research
- qualitative research
- quantitative research
- the research setting and negotiating entry
- sampling techniques
4.2 THE PILOT STUDY

4.2.1 The uses of the pilot study

The pilot study served numerous specified functions to the study. It particularly familiarized the researcher to the research setting, and led to some adjustment to the tool accordingly. It again served as a pre-test to eliminate or modify the identified problems in the research setting related to the sample and sampling procedures, questionnaire and interview procedures and all that the researcher will undertake in the study (Burns and Grove 1999:40).

According to (Burns & Grove 1999:40) the pilot study is a smaller version of a proposed study conducted to refine the methodology. It conducted with all proposed approaches for the main study. The following reasons are listed for the uses of a pilot study.

- determine the feasibility of the study;
- develop or refine a research instrument;
- determine the representativeness of the sample;
refine or develop data collection techniques, and
experience the situation and conditions under which research will be done

The information obtained from the study gave a go-ahead to proceed with most aspects as outlined in chapter one, but led to adjustment of certain areas in the research to improve the investigation process and the outcome of the study.

4.2.2 The pilot study setting

Different area as that of the study was chosen as assumed that the reproductive health needs for urban, rural and semi-rural areas do not differ. The principles that governed the pilot study were as follows:

- the sample was from a different area as the one for the main study but their needs were the same.
- the participants in the sub-sample had same characteristics as the participants in the main study i.e. age, sex, and health needs,
- the same tools for data collection and guidelines were used.

4.2.2.1 The pilot study sample

The pilot study was done among the high school females and males aged 16-19yrs who attended same school but from different social backgrounds. The aim for having chosen this group was their accessibility, and they were the convenience group although more urban based. Except for the fact of being urban dwellers, all other characteristics did match the population the study was done in.

4.2.2.2 The pilot study sampling

Only ten pupils were included in the pilot study, they were in grades 10, 11, and 12 respectively (appendix 1.4 for questionnaire). One youth care facilitator was included to test the facilitator portion of the study. The outcome led to subsequent adjustment
to the study and modification to reduce over representation of some facts and biasness.

4.2.2.3 Data collection

The group was divided into two, interview session was held, open statements were used for qualitative approach to allow narratives by the interviewee. The questionnaire was administered to a different group, this eliminated the influence the interview would have on answering the questionnaire. The pilot study was conducted six weeks before the main study. These helped in identification of information themes and information categories to be identified while analyzing the qualitative data. It assured that several truths emerged related to the aspects included in the study, but most importantly, it assured the researcher that the questionnaire was developed within the very information that was identified in interview session to be of most necessity in adolescents' accompaniment.

4.2.2.4 Findings of the pilot study

Analysis of the data collected revealed the following:

4.2.2.4.1 Qualitative data analysis

The respondents for the interview session expressed that the parents did orientate them into growing up issues but not much of relationship problems, how to handle sexual feelings.

It was difficult to talk with the parents on reproductive issues, as you would be labeled as sexually active already. The media seemed to have met most of their needs especially programmes like Take Five, Soul City and Soul Buddyz. The physical accessibility of the services was a major problem as others were ran by people who are employed and not always present, but the Love life was known to them all. There were ample talks on STI/HIV/AIDS and they could also talk about that at school as they do a lot of assignments on the topics.
The facilitator was concerned about the financial assistance, the perpetuated lack of involvement of the parents in the community for organized accompaniment programme implementation was another loophole. There was training for life skills but no mention of the health promotion models was reported.

4.2.2.4.2 Quantitative data analysis

All subjects answered all the questions, this might be due to their literacy levels. 80% received information on sexuality first time at 13yrs while in grade seven. 70% agreed that television gave information on all aspects in the study except for conception and TOP. Parents gave information only on STI/HIV/ADS according to 90% of the subjects' responses. 100% responded that health workers gave all listed information. Churches and youth clubs gave information only on love relationship and no other listed topics. None of the respondents was using contraceptives, and they would like the following topics to be discussed contraception, conception and love relationships.

All responded that the information they received is inadequate to equip them for day to day challenges. They had knowledge on STI/HIV/AIDS. They would prefer a parent to give them first hand information, and the services were rated not accessible by 40%.

4.2.2.4.3 Observations

There was general excitement and hope to have improved services when orientation was done. Curiosity on information concerning TOP, conception and contraception was aroused. There was a general belief that more open talk was needed.
4.3 DESCRIPTION OF RESEARCH DESIGN

4.3.1 Survey

A survey is a very broad design that explores and describes the health information and identify needs and gaps of the existing nursing care. It investigates and analyze the factors involved in health promotion, and help in deriving answers to the questions in the study. The definition given by (Polit et al 2001:186) is as follows:

A survey obtains information regarding the prevalence, distribution, and interrelatedness of variables within a population

In this study it was necessary to explore and investigate the phenomenon under health care that are present, but presently given an evasive approach when caring for the adolescents' reproductive health needs. Those phenomena represent the variables that influence the distribution of incidences and prevalences of reproductive health problems. The information gathered here will contribute in modifying approaches to areas of major priority, and in designing a programme for an improved comprehensive health care delivery at primary level (Wood & Haber 1994: 233).

The researcher used the survey design to search for accurate information about the characteristics of particular group i.e. the adolescents in this study. The use of interviews and observations followed by questionnaire was necessary, so that information gathered was accurate. The gathered information represented the identified interrelated factors within the natural environment the adolescents grow in. The responses were represented in narrative stories for the interview session, and filling of a questionnaire for structured questions. The sustained contact of the researcher and adolescents in their natural environment, generated body of knowledge through the description of factors influencing their reproductive health,
in the form of stories representing the lived experiences. The researcher was motivated by the following advantages to use survey design:

- great information can be obtained;
- the design is economical;
- population is usually large and representative;
- information can be surprisingly accurate;
- in case of representation, same relatively small number of respondents will provide accurate picture of the whole population;
- it is also flexible and had a broad scope;
- and undoubtedly would cover a large area of information and numerous topics.

The choice of the survey method was inspired by the fact that the study was not funded, and again it covered a broad aspect in health promotion and disease prevention. It ensured inclusion of several aspects for example policies, health promotion models and funding as influencing the accessibility and effectiveness of the programmes. Generalization and representation could be done with a small sample that was taken from health care services in Soshanguve, because an accurate picture could be derived from the information that is gathered. The approach could nevertheless exist without disadvantages. The following were not ignored:

- results tends to be superficial
- the breadth rather than the depth of information is emphasized

To overcome the above disadvantages, the questionnaire was designed after the use of interviews to determine the relevant hardcore aspects of health promotion and primary prevention. In order to ensure an in depth study of the services the qualitative and quantitative designs have been integrated. The two research approaches will be discussed in the following deliberations (LoBiondo-Wood & Haber 1994:278).
4.3.1.1 Rationale for integrated design (triangulation)

To explain the reasons for the combination of the designs, let the statement for rationale as presented by (Polit et al. 2001:217) be presented in order to give strong motivation for the choice of the integrated designs.

The dichotomy between quantitative and qualitative data represent the key epistemological and methodological distinction within social and behavioural science. Some argue that the paradigm that underpin qualitative and quantitative research are fundamentally incomplete. Others, however, believe that many areas of inquiry can be enriched through the judicious blending of qualitative and quantitative data collection an analysis –that is, by undertaking multi method research.

The following advantages are the motivation for integrating the designs:

- **complementary**
  The findings are represented in words and numbers, the two fundamental languages of human communication. It avoids and bridges the limitations of a single design research.

- **Incrementality**
  The use of each method is necessary to speedy up progress during research towards understanding.

- **Enhanced validity**
  It support the hypothesis or the model with multiple and complementary types of data. The researcher can be more confident with the validity of the results.
Creating new frontiers

Qualitative and quantitative data may be inconsistent, with each other, when this happens it leads to more enquiry. It can be used as a springboard for further exploration (Polit et al 2001:217-218).

4.3.2 Qualitative research design

Qualitative research design combines scientific and artistic natures of caring to enhance understanding of the human lived health experience. The authenticity of the experiences is ensured because all that is gathered in this type of approach is self reported, and narrated by the people according to their experiences in their natural environment. It is grounded by beliefs that humans are composite of many body systems that can be objectively measured one at a time, towards measuring a whole. In order to have an in depth understanding of the human experiences, their own perspectives must be accommodated. Human experiences are complex and the reduction of concepts into questionnaire may not thoroughly achieve to reveal its complex nature, therefore no beforehand limited concepts is needed with this approach, as it will channel people responses and reduce the open nature of the investigation process.

The researcher had to chose the design because the people experiences have to be narrated to enable the analysis of the effectiveness of the services. To overcome the limited nature of the qualitative approach, the quantitative approach was used to close that gap. It further provided a framework for questions so as to strengthen the representation and generalization of the results. The following advantages were also a motivation for choosing the design (Polit et al 2002:207).

- it uses inductive reasoning as the researcher proceeds from the specific observation to general ideas;
- it is an in-depth and contextual approach that aims at gaining insight into lived experiences of a small sample;
it encourages interaction with the subjects on their own turf to enable interpretations;
• there are no structured questions developed and allows narratives by the respondents as there are no rigid questions to choose the responses from

The following disadvantages were not overlooked so as modification of the investigation grounds could be done.

• numerous truths emerges and may be time consuming to order the information in related categories
• the subjective nature of observation and the researcher’s involvement may lead to behavior modeling to impress the observer

The researcher considered all the advantages and disadvantages and decided on questions that were open in nature and allowed for story telling. Story telling was used to report one’s experiences were rich in perceptions but highly represent the lived truth. The reproductive health needs needed the inputs from narrations that reflect the experiences of the adolescents. The stories they related, unveiled the practical accompaniment they receive in their environment.

It was very detrimental to the researcher to integrate sequentially the two approaches described above, in order to mend the shortcomings each approach has, so as to ensure greater success in the future implementation of the results and recommendations. The qualitative was used to determine the demarcated area the questionnaire had to cover. The quantitative approach was used to quantify the qualitative results, by display of numerical data, to show the modes and mean of phenomenon on day to day life. The modern research encourages the integrated approach so as to fully investigate all areas of the topic under the study (LoBiondo-Wood & Haber 1994:277).
4.3.3 The quantitative research design

This design involves systemic collection of more information, in order to ensure measuring of the characteristics of the aspects that are investigated. It aids in the depiction of a clear, context free picture of what is being studied. It allows elimination and control of information that will interfere with the subject under the study. Clear demarcated areas of the study by drawing of a structured questionnaire provide direction for the study. It again allows the researcher to fully investigate, analyze and criticize the factual information already existing on particular topic. Intensive investigation of the aspects studied allows for retrospective, present and future planning. It allows prediction and acknowledges the fact that the topic investigated has been thoroughly surveyed through literature survey and experience.

According to (LoBiondo-Wood & Haber 1994:255) the questionnaire that is being developed represent areas of the study in divided aspects that has grouped phenomenon into areas of commonalities. This was made possible by the use of interview preceding the questionnaire development These does not promote segmentation of the whole picture but creates building blocks for the whole. Wholeness or holistic approach is what the quantitative approach aims at achieving. The fact that human being has a social, psychological and biological characteristics is also acknowledged by this approach to ensure wholeness, and extend the field of study to all aspect with significant contribution in health. The approach uses the natural environment for studying or investigating the specific phenomenon, no artificial circumstances or manipulation of the subjects and the subject under the study is allowed. The following advantages of the approach will be considered in crediting the predictability status and application of the findings in other similar situation.

- It strives for generalization of the research findings because it uses quite a large sample which can be more likely representative of the population.
- The variables are defined conceptually and operationally (refer to chapters...
Objectivity more than subjectivity is ensured by using a valid structured data collection instrument. It is inexpensive to implement the questionnaires, as it can be self delivered or posted and this can be done on one sitting with control of external factors by the unbiased person who may necessarily not be the researcher. It primarily uses deductive analysis to allow statistical analysis, and it is easily interpreted and represent the truth of facts investigated (LoBiondo-Wood & Haber 1994:255-257).

The advantages as listed above led to the subsequent development of a questionnaire with coalescence of the certain factors to give a whole picture of the adolescents support. These aspects were evaluated to measure the support given to the adolescents. The policy enhancement and National programmes implementation will be measured as well.

- content /information received by the adolescents;
- age of first information on sexuality education;
- availability of services and care providers;
- sustainability of services;
- impact of the available services on reproductive health promotion.

The following disadvantages were not overlooked as no deliberate manipulation was applied in this study, there was high ethical and professional consideration displayed during this study.

- the possible narrowness of the field of study and
- the pre-conceived ideas about the variables under the study (Polit et al 2001).

To overcome the disadvantages, a thorough survey of the morbidity for reproductive health was done. To relate to the practical natural situation the statistics of teenage
pregnancy and STI's have been used without biasness. The questionnaire was derived after an intensive literature search on the subject, observations and interview, so as to widen the scope of this study. The factors to be investigated were not purely preconceived but were part of procedures available and standardized in programme facilitation and development. The preconceived ideas were excluded by putting ideas in a scientifically represented manner that is equivalent to all epidemiological studies.

4.4 THE RESEARCH SETTING AND NEGOTIATING ENTRY

Soshanguve is a Township North of Pretoria. It is under the Northern Pretoria Metropolitan Municipality (NPMMS). This Township is characterized by the diverse and dynamic population growth, this is highly influenced by the emigration and immigration processes within and outside the country. There are about 17 high schools in the area with estimated pupil population of 15000. The estimation of the adolescents' population out of school is not available. The latter are regarded as the priority target group as classified in a National Youth Health Action Plan. (DOH 2001:17).

There is one special high school for the handicapped. The Philadelphia high school provides for visually handicapped, cerebral palsy physical and hearing impairment. The Northern Gauteng Technicon is also situated in the neighbourhood of the high school, both have their own nursing personnel to provide for their health needs comprehensively.

The population is composed of the high income, middle and low or unemployed groups respectively. The unemployed or low income groups mostly live in the informal or formal settlement areas. They are 5-10km from the 24hour health center in block BB, and the adolescent care project in block F. The trip to the above services causes them R6.00-R12.00 return, some household do not have the money to reach this services.
The permission to enter the clinic was requested from the regional training department and granted by the Regional Deputy Director (refer appendices 1:1&1.2). Further negotiations with the facility managers to visit the service point on particular days were made. The proposal was also submitted to the managers to exclude any factors within the study that they feared might injure the clients.

To maximize representation a probability sampling was a sampling procedure of choice so as each subject had equal chance of being represented and no hand picking of respondents could be done. After entering into the township the strata to be included will be the identified two community health centers and the adolescent project centre (Polit et al 2001:235).

The researcher explained to both samples for each approach the purpose of the study, and ensure guaranteed confidentiality of all subjects names and residential areas as even the data collection tool never had a space for such information. The research proposal was submitted to the managers both regional and institutional to ensure adherence to all ethical principles governing the research. The subjects were be identified considering the attributes that suite the targeted population that is age only. The area of research is Soshanguve but the cross border phenomenon was taken good care of, but it will not lead to exclusion of the North West people who attend clinic in Soshanguve.

Ethical principles were observed and maintained throughout the investigation process, this impinged on issues of trust and respect. To observe both approaches data collection techniques a structured questionnaire with close ended and open ended questions will be administered for adolescents. The interview with use of statements as guided by the literature review and observations were the initial data gathering techniques used.
4.5 SAMPLING

4.5.1 The population

The population to be researched is the adolescents using the health services in Soshanguve. The daily statistics was used to estimate the total population. The type of population did not have a fixed number and the weekly averages were used to determine the accessible population, this was equal to approximately 200 adolescents a week per service point. All the clients that fitted the criteria of the adolescents for the study were included in the pool of subjects for the study and are known as a target population (Polit et al 2001:233).

4.5.2 Sample size

The sample is a representative group of the population that represent the population that is being studied. The sample size for qualitative and quantitative approaches depend on whether generalization and transferability can be done. The sample must not be too small or too large. A sample size of 100 was decided upon as the population was about 600. All adolescents who possessed the specific attributes suitable to the researched population were legible for inclusion (Polit et al 2001:234).

The sample, which is a representative group of the population in the study was taken from the following groups at the clinic, the pregnant teenagers, those attending minor ailments clinic and birth control services. All adolescents in school and out of school were included if their ages were 12-21yrs.

The following factors were considered under the sampling plan as being very critical:

- no telephonic invitation will be done;
- no self selection;
- equal representation of the subjects in each strata determined by stratified sampling technique;
The main characteristics of subjects determines the criterion for inclusion in the sample.

Predetermining the sample size was necessary to ensure inclusion of all subjects without biasness and that would increase the generalization of the results. The use of systemic sampling would ensure or reduce the possibility of over representation or under representation. Enough subjects of the population were included as systemic sampling ensured that by virtue of its design. A 10-20% representation was aimed at. The results of the study could be applied to similar situations because the sample size in this study was representative.

4.5.3 Sampling procedure

4.5.3.1 Probability sampling

The sampling procedure that was used to get the representative population to be included in the research is a probability sampling. A systemic approach was used because of its high inclusion possibility. The procedure implemented allowed all adolescent in the total population equal chances to be included. No hand picking or self selection is provided for when using the systemic sampling.

All adolescents included in the sample were having the characters of the population that was researched, that is age 12-21 years, male or female as described above. Age will be used as the main criteria for description of the targeted population. The inclusion was ensured by the use of a probability sampling procedure. The procedure included every second adolescent client, respondent number one was randomly selected. This gave all adolescents that were visiting the services on the day of data collection equal chances to be included in the sample.
4.5.3.2 Stratified sampling

The stratified sampling was used, three strata were used as research sites namely, the adolescent care project center and the two community health clinics. A stratum is a mutually exclusive segment of the population where people of common interests or needs meet. Such divisions or groups within the population are homogenous and aims at higher degree of representation. In this study the adolescent care center and the clinics to be studied were explained and further demarcated under the discussion of inclusion and exclusion criterions (Polit et al 2001:235).

4.5.4 Sampling rationale

In order to explain the rationale for sampling, Polit & Hungler (1999:278) remarks that for a scientific endeavour, scientists work with a sample but not the whole population for scientifically credited information gathering, and thereafter application to other similar situation is done.

Samples are used to study population's dynamics but not the whole population. The researcher used the sample because the population to be studied was very huge. A representative sample was appropriate to investigate and later use the results on the population. Even though Polit & Hungler (1999) reiterate that it is very much difficult to determine the estimated number of the subjects in the sample, representation is crucial.

Morse & Field (2002:65) point out to the need for a representative sample, it allows enough data collection and drawing of conclusions. The researcher has to strive to achieve these so that the results can be generalized to the rest of the population. The economic and the time factors allowed for the sampling procedures that were implemented. The time utilized to carry out the study was greatly dependant on the
researcher's availability and periods when she was allowed to take study days from her public work situation. There was no money special for the study therefore the researcher used the more convenient and cost effective ways to study the population.

4.5.5 Sampling bias

Sampling bias refers to the systemic over-representation or under-representation of some segments of the population. Such errors are nevertheless unintentional. The researcher did not intentionally without scientific grounds decide on how representation will be ensured, but she referred to scientifically adopted approaches of sampling to ensure representation as explained in the sampling procedures in the preceding section (Polit & Hungler, 1999:259).

4.5.6 Inclusion criteria

Having listed the guidelines for critiquing the sampling plan it is very necessary to categorically describe the inclusion or exclusion of all probable subjects in the sample. It is very important to determine beforehand who among the subject in the population will be included according to the criteria to exclude biasness. The objectives and the topic that is researched usually guide the criteria decided upon. Polit et al (2001:305&309) agree with the above and state that each topic or the phenomenon studied predetermine the subjects to be included, in this study the adolescent community had equal chances to be included, the criteria used were:

- visiting the clinics on the days of data collection;
- from all socio economic classes;
- age 12-21yrs old;
- all sexes;
- pregnant now or;
- post natal= teenage mother;
- in school or out of school;
all denomination or religious groups at the clinics as religion is not an
excluding factor in this strata and

employed or unemployed.

4.5.7 Exclusion criteria

The knowledge of cultural and other sociological factors that influence behaviour can
be studied under ethnography. To ensure that there is no overrepresentation of one
cultural group to influence the results to culturally based approaches of limited
groups the traditional or family based religious groups will be excluded. The
vulnerable groups of adolescents due to the following will also be excluded:

- very sick from HIV/AIDS or any other disease;
- abused and consulting presently;
- seeking TOP services and
- self determined exclusion.

4.6 DATA COLLECTION TECHNIQUES

4.6.1 Triangulation

The technique is used in modern social research as Polit et al(2001:472)
acknowledge the use of triangulation, and they define triangulation as represented
below:

The use of multiple methods or perspectives to collect
data and interpret data about a phenomenon, to
converge on an accurate representation of reality.

Triangulation is a combination of either the research approaches, data gathering
techniques or data analysis. It is necessary to use it because it uncovers a unique
variance that might be missed by the use of a single approach of investigation. The
use of two methods or more is also complementary, and submerges different dimensions of the phenomenon. The nature of the study warranted the use of the triangulation approach for the data collection because it surveyed factors around human behaviour. The use of a single approach would not reveal all factors as no one approach is able to detail all factors as discussed under disadvantages of the approaches in 4.3.2 and 4.3.3.

The approach is recommended in both quantitative and qualitative research to enhance the validity of the study. The following data collection methods were implemented:

- records and literature review (refer chapters 1&3);
- observations;
- interviews and
- questionnaire administration (refer appendix 1:4)

Triangulation was included in the pilot project to ensure that the research questions were subjected to scrutiny before they were released and tried on the sample of participants. The research project actually disclosed certain flaws that enabled the researcher to work on the research questions. It determined the sequence of the questions and eliminated leading questions. It lastly provided substitute questions in case the participant was reluctant to respond. The ambiguous statements that needed narrowing and rephrasing were altered without altering the objective of the study.

4.6.2 Qualitative data collection

Qualitative data collection is a subjective endeavour because it seeks to elucidate key informants' views that are expressed as descriptions or experiences. Proper communication skills and techniques to facilitate information to be dished out, is of vital importance. In chapter one and three the researcher already reviewed existing information on the subject under the study so as to obtain broader views of relative
perceptions. To ensure a representative truth of lived experiences, the following strategies were used.

- **Review of the documents**
  The documents were reviewed to study the prevalences, incidences of reproductive problems, daily turnovers, success and failures in the service delivery. All documents used for the adolescent’s care, the pamphlets, activities recorded for awareness and visits to the schools were taken note of.

- **The semi-structured interviews**
  The semi-structured interviews were held with care providers and the adolescents. The researcher’s knowledge on the topic assisted her to compile questions for the interview after the literature search. The answers were unpredictable and the respondents had enough time to respond. They were individually interviewed, the interview was directed by specific themes encoded within the objectives, the information from documents and literature review. The interview focused on accessibility, knowledge of care providers and consumers (Morse & Field 2002:76).

The interview was held face-to-face with the subjects so that both interview and observation were carried out concurrently. Subjects were allowed ample opportunity to express their experiences in story or narrations. The questions asked were open statements that allowed for wide inputs from the respondents. The examples of such statements that were used are:

- How is your reproductive health needs cared for within the community you live in?
- Discuss the various support in the community that assist you manage the challenges related to sexuality issues.
These statements were directed by the factors that were discovered in literature review. A tape recorder was used to capture the conversation during the interview. Other interview sessions were hand recorded immediately after each interview so that information was not lost. A room with a door to ensure privacy and confidentiality was used. If the narration was not deliberate, follow up statements to encourage more narration were posed. There was no stringent predetermined interview schedule. The advantages of using the interview schedule is that it tends to elicit the best results, those that are scientifically listed are as follows:

- an interview schedule allows the researcher to obtain a higher proportion of responses from respondents;
- it allows the researcher to successfully elicit information from a broader group of individuals because the respondents don't have to be able to read or write;
- there is no loss of subjects therefore the response rate is high;
- there is an opportunity to explain or repeat a question if the respondent did not hear the question well;
- therefore less prone to misinterpretation;
- and allows for conceptualization of research problem while informants narrate their experiences;
- researcher bias is controlled throughout the interview schedule;
- bracketing is ensured and researchers' manipulation of informants is excluded and,
- the sample is small and a lot of information is collected in a short time.

As for any approaches this cannot be implemented without acknowledging the next points. The researcher has to have good communication skills and probing skills and have a tape recorder to capture all the stories as narrated live (Polit& et al 2001:206-207).
4.6.3 Observations

Observations were used as part of qualitative data collection, the researcher used unspoken communication the form of action to collect real lived experiences in the provision of care. The following methods were used:

- **unstructured observational methods**
  Observations have been used as an initial motivation for the area of study. The method does not have researcher imposed constraints. Skillful unstructured observation permits the researcher to see the world as the study participants see it lead to development of rich understanding and appreciation of the phenomena of interest. Naturalistic observations are often made in field settings through a technique called participant observation (Polit et al 2001:280).

- **Observer participant role in participant observation**
  Throughout the study observation of fears, experiences, emotions and attitudes of the respondents were done during data gathering and when attending to their health needs. The unspoken words in a form of behaviour, gestures, change in tone when speaking were observed. The researcher aimed at gathering vast information from gesture communication. The fact that interviews were done face to face and individually it was impossible to get a holistic picture of the phenomenon that were observed. The positive facts of observations are that behavior is modeled without being aware of the observer's presence, subjects were not informed of her presence. The researcher had more freedom to carry out observations as she was not part of the work force. The greatest challenge to the observer was that she had to be aware of the interpretation of unspoken words to lessen misinterpretation and subjectiveness (Morse & Field 2002:87).
4.6.4 Quantitative data collection

The quantitative data gathering was done by administration of the questionnaire. The questionnaire was pre-determined, it used the information categories and subcategories from the interview as a framework. The sample of the tool is attached (appendix 1.4). The questionnaire investigated or explored the experiences and risks as spelled out in the policies and health promotion guidelines. The aim is not to limit the respondents as both open ended and close ended questions were included. To motivate the researcher’s choice of the questionnaire method are the following reasons:

- respondents remain anonymous;
- the researcher is not always present;
- objective information is gathered;
- a short time is necessary for the session and is cheap to administer;
- it is a flexible method and allows a lot of aspects to be included.

These advantages did not overshadow the inherent disadvantages of the method are the following:

- considerable time is needed to construct the tool;
- thorough knowledge of the subject is needed to be able to categorize common aspects and areas of the study and
- it exclude people who cannot read or write.

These shortcomings were bridged by the use of the interview session as discussed earlier. People who are not able to read and write were included in the interview sample. The researcher is familiar with the subject because she is a health worker and a reproductive health trainer, and engaged herself in extensive reading on the subject.
4.7 DATA ANALYSIS

Both designs, the qualitative and quantitative data was analysed. The collected data was transcribed first into meaningful statements and numerical values. Description of the data was then possible. Descriptive statistics is defined as follows by (Polit & Hungler 1999:439).

Descriptive statistics are used to describe synthesised data. Averages and percentages are examples of descriptive statistics. Actually when such indexed are calculated on data from a population, they are referred to as parameters. A descriptive index from a sample is called a statistics.

As triangulation was used with research approaches and data collection techniques, it was of paramount importance to conclude the process by using triangulation for data analysis too. Several resources were used to obtain data and different data representation were implemented. Numbers, statements and descriptions will be used to represent the quantitative, qualitative and observations respectively. The data analysis for each approach is discussed hereunder.

4.7.1 Qualitative data analysis

The process of data analysis requires astute questioning, active observation and accurate recall. It is a process of fitting data together and making the invisible visible, by linking the attributing consequences to antecedents is also included. It is a process of conjecture, verification, of correction and modification, of suggestion and defence (Morse & Field 2002:103).

The qualitative data analysis need to be reduced and organised so that it ultimately fit into three phases as suggested by Miles and Huberman (1994) as being:
The data display was carried out initially by the researcher as part of documentation not included in the report, the different statements were displayed, read and then common statements grouped together. The reduction of the statements into common truths facilitated the interpretation of the statements. The narratives as represented lived experiences, were reduced to common themes or units, this led into categories development. It was important to verify if the information representing the factors that are being investigated by establishing the trustworthiness of the data (Polit & Hungler 1999:427).

4.7.1.1 Trustworthiness

In order to evaluate the quality of the data and their findings, there are specific procedures for qualitative research. There are four criteria to be evaluated to establish trustworthiness. Trustworthiness refers to the truthfulness of the information gathered. The account and the extent to which it represents the social phenomenon to which it refers accurately, it is congruent to validity in quantitative research. The criteria to be investigated are credibility, dependability, confirmability and transferability (Polit et al 2001:314-316).

4.7.1.1.1 Credibility

To make sure credibility is assured, the researcher needs prolonged engagement with the informants. The researcher is health worker, a reproductive health trainer and a primary health care provider. She spent time in her work caring for the adolescents, a week was spent collecting data, and ensured continued contact. Triangulation is also used to strengthen the credibility. It referred to multiple sources
used to draw conclusions regarding the factors that predispose and cause the identified truth. The following are types of triangulation used in the study.

- **Data triangulation**
  Numerous sources of data collection were used to enable validation of the findings. Literature review, interview, listening to media debates and observations were used and the findings will be discussed in the next chapter.

- **Theory triangulation**
  The use of different theories for interpretation of the set of data was used. The health promotion theories, for self care and behaviour modification were used to discuss factors that undermines the reproductive health of the adolescents.

- **Method triangulation**
  Different methods to collect data were used to investigate the same phenomenon. The accessibility and effectiveness of the primary prevention services for the reproductive health needs of the adolescents was the core of the investigations. Qualitative and quantitative methods as stated above were used (Polit & Hungler 1999:428).

4.7.1.1.2 **Dependability**

The equivalence of reliability of quantitative research is observed in the dependability. It refers to the stability of the findings over different times and situations. To ensure the dependability, same constructs were measured throughout the three strata researched. Stringent observation of the ethical principles also barred any manipulation of the information or conditions (Polit & Hungler 1999:430).
4.7.1.3 Confirmability

The data have to be proved to be objective and neutral. The two independent people that have to evaluate the relevance of data, are my two supervisors in the study. Continuous supervision have been implemented to ensure these.

4.7.1.4 Transferability

The objective of the research was to make recommendation to the improvement of health care provision as determined by the findings. For the results to be transferable to other situations, the sample has to be representative, and all other research guidelines must be followed. The use of the method triangulation heightened the chances of the findings to be transferable to other situations. The use of the inclusion and exclusion criteria also allows the generalization of the findings (Polit & Hungler 1999:430).

4.7.1.2 Quantitative data analysis

The operationalisation of the collected data is most important. Numbers will be assigned to the items and responses. Frequencies of responses will be determined to decide on the distribution curves of some responses and what such distribution represent that is in this study comprehensive or not comprehensive accompaniment of the adolescents. Mode and mean of data will be displayed numerically and interpreted.

Nominal scales that classify responses or items into only one category will be used, that is exclusive and do not give wrong picture of the items. The data will be represented in tables.

Ratio scales will be used to calculate the percentages of items of responses from the frequency distributions. From the frequency or percentage calculations the graphical
representation may be designed to better communicate the findings to the public as statistical art (Burns and Grove 1999:42).

### 4.7.1.2.1 Validation process

Validation of the finding is most important because generalization is not always possible unless where the population is best known. The adolescents' population has common problems in both urban and rural areas, therefore the study can be generalized because of commonness in the population studied. The same constructs were measured in all situations where data was collected.

To validate the results themes or variables has to be categorized so as the instruments to control and correct them can be developed (LoBiondo-Wood & Haber 1994: 484).

### 4.7.1.2.2 Reliability

The investigations of the study are to ensure reliability. Reliable people do have predictable behaviour, one can rely on them because they behave in a consistent manner. Reliability as defined by LoBiondo-Wood and Haber (1994: 373) is explained as follows:

> Reliability of a research instrument likewise is defined as the extent to which the instrument yields the same results on repeated measures. Reliability is then concerned with consistency, accuracy, precision, stability, equivalence, and homogeneity. It refers to the proportion of accuracy or inaccuracy in measurement. The three main attributes of a reliable scale are stability, homogeneity, and equivalence.

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The researcher ensured that the attainment of the attributes was possible so as to be able to test its reliability on other situations. The pilot study was one of the ways used to test for reliability of the instrument. The three main attributes were assured. Content from other studies related to the study were used.

- **Stability**
  The instrument is thought to be stable or to exhibit stability when the same results are obtained on repeated administration of the instrument. It is an important attribute when the researcher intends to alter some variables in a situation. The pilot study was used to test the stability of the instrument. Pilot study let to necessary alterations in the questionnaire (Polit et al 2001:305).

- **Homogeneity**
  Homogeneity is similar to internal consistency. Both terms refer to the consistent or unaltered state at which the scale reflect or measure the same concept. It means that the items within the scale correlate or are complementary to each other. The instrument used in the study correlated the issues related to sexuality towards forming a holistic picture. It is therefore suitable for ensuring internal consistency. It was given to an independent statistician to measure and assess if it can be administered without any loopholes up to analysis (Polit et al 2001:306).

- **Equivalence**
  It refers to the agreement between two observers who uses the same tool or alternate forms of a tool. In this study the supervisors of the researcher will either agree to the results, and the results will again be compared to the previous other studies that used alternate tools.

Random and chance error affect the reliability and is difficult to control due to the anxiety of respondents, and it may not be observable during data gathering.
respondents were given orientation prior to the study. Ethical considerations included permission, trust, and respect so as to allay anxiety level (Polit et al 2001:307).

The respondents characteristics were correctly determined to reduce the systemic error. The respondents were from all social groups and educational levels to reduce the biasness and the systemic sampling was implemented (LoBiondo-Wood and Haber 1994: 367 – 373).

4.7.1.2.3 Validity

This refers to the degree to which the instrument measures what it is supposed to measure. The instrument was designed to measure the construct, which is the effectiveness of primary prevention strategies for adolescents' health needs (refer conceptual framework in chapter two). The variables to be used are problems influencing the reproductive health problems morbidity, prevalence and incidence will either confirm high or low effectiveness. This was determined and developed after thorough literature search was undertaken. Questionnaire was developed based on the researcher's observation and information from documentation as reflected in numerous scientific studies.

The interview provided a framework for the questionnaire, was also based on the constructs that the subjects referred to within their narrations, the effectiveness of the existing services. The consistency was assured by studying most of the centers that are in contact with the adolescent, health clinics and youth centers. Accuracy was ensured by the use of scales and rates to rank the health needs, knowledge and the available support. The same instrument was used in all centers included in the strata without any manipulation.

- Content validity
  The content validity determined the framework for questions used. All questions relate to the primary level preventative strategies. This included
among others content taught to the adolescents and health promotion strategies (Polit et al 2001;309).

External validity
The sampling procedure was probability sampling approach, systemic sampling procedure was used and ensured population representation. The external validity allowed generalization of the results outside Soshanguve area. It was assumed earlier in the literature study that the adolescents needs is the same among all groups, due to similar growth challenges that are not necessarily dependent on social classes or race. The population studied had a representative sample, because sampling biasness was eliminated and sampling rationale was unambiguous (Talbot 1995:281).

This study should therefore satisfy the predictive validity by predicting the future behaviour or approaches to be used in order to ensure reproductive health promotion for adolescents. The recommendations have to state achievable and scientific means of resolving the problems.

A pilot study was done by administration of a questionnaire to one high school, which was not included under the strata of services to be researched to test and ensure validity and reliability. The subjects included resided outside the area where the main study was to take place, this ensured none contamination of the research tool to ensure that it measured what it is designed to measure.

4.8 ETHICAL CONSIDERATIONS

During research, the researcher has a paramount responsibility to her informants. In all instances whether there is conflict of interest for example with the research setting, the informants must come first. It is very much important to be knowledgeable of one’s country’s laws and apply the peoples’ constitutional rights as entrenched within the ethical rights (Polit & Hungler 1999:133—139). The researcher has to
display an extensive body of knowledge to protect the informants physically, socially and psychologically. The ethical principles should be observed to provide for all citizens' rights, those are principle of respect for human dignity, principle of justice, and principle of beneficence.

4.8.1 Principle of Respect for Human Dignity

Permission
Basic respect principles were implemented by first asking for permission to do this study from the authorities in charge of institutions to be used. The District deputy director for community health services in the Pretoria region was asked for permission to carry out the study in Soshanguve. The other permission was asked from the facility managers and the youth care facilitators in Soshanguve. The last permission was asked from the participants themselves. No one was compelled to participate. This was achieved through explanation of intent as included in this study (refer appendix 1.3). Explanation of the questions was done in one's own language, as Soshanguve is a multicultural and multi-ethnic residential area. All subjects were included in the sample, on the basis that they gave informed consent after the explanation session (Polit & Hungler 1999:137).

Informed consent
Obtaining informed consent is a legal principle that directs explanation of intent and also to how explicit this was done. It governs the subjects' rejection or participation in the study as a sample's subset or not. The population that qualified according to the criteria for the study, were asked verbal consent and the procedure of the study was explained to them. No participant was forced or coerced to be part of this study. The aims of the study were tabled to them. No other activity except was included during orientation to get informed consent.
consent was included. All subjects had the right to withdraw if they felt uncomfortable to continue and no punishment or prejudice would be applied on any person (Polit & Hungler 1999:139)

- **Anonimity**

Their identity will remain anonymous and the information they gave will not be used against them. The only identification would be the area in which the study took place. Explicit explanation was done to all subjects irrespective of their educational or socio economic levels, no discrimination of respondents was done. To ensure this principle no any form of identity was included on the questionnaire or was asked for during the interview. This was to ensure that during data analysis no link of any information would be made to a particular subject.

- **Confidentiality**

All studied information will be published anonymously. The subjects of the study will not be identified by name or residential address.

**4.8.2 Principle of Justice**

- **Privacy**

Exclusion of sensitive and intruding questions is observed because such questions that intrude into personal feelings and secrets and start harming the respondent psychologically. Privacy and trust was maintained by holding closed door interviews and no disclosure of information to any other person except people involved in the study not as population for example, health authorities and during reporting and publication. No mention of other information except the area of study should be divulged to the public (Polit & Hungler 1999:139).
The right to fair treatment
Non-discriminatory, fair and equitable treatment has to apply to all subjects. Explanation of intent is aimed at achieving these, any subject may stop to participate in the study if he feels affected psychologically or socially, or physical pain is incurred. During data gathering explanation of information that was not well understood was also necessary. Debriefing of all subjects after data gathering was an inexpensive treatment to be given to all. Those who withdrew were treated fairly without punishment or threats (Polit & Hungler 1999:138)

4.9.3 Principle of Beneficence

Freedom from harm
Dignity and respect are to be maintained during the study to ensure that no harm is incurred psychologically, physically or socially. In these study there was no experimentation or treatment to be administered to any subject. The questions in the study were probing into no one's personal or sensitive information. There was nevertheless permission to withdraw if one feels uncomfortable to continue. Language used was the one the respondent was comfortable with. Translation of the questionnaire into preferred language was done excluding those languages the researcher is not conversant with (Polit & Hungler 1999:134).

Freedom from exploitation
Reassurance to maintenance of the respect and to have trust in the information they give in the study was reassured that no name and residential address shall be made use of. The information gathered will not be used for personal gain, as that will be exploitation of the informants' innocence. As research involved information gathering trust is a paramount necessity and it
is axiomatic that the rights, interests and sensitivity of those informants be safeguarded by ensure the principle of anonymity. A debriefing session is also necessary to eliminate grounds or doubts to be exploited.

4.9 SUMMARY

The researcher promises to carry out the study under all explained approaches, any situation that may arise and lead to any change will be given a scientific consideration, necessary changes will be done. It is the researcher's aspiration to observe all ethical provisions to ensure the success of the study. The envisaged research will take place in Soshanguve and triangulation of the research designs, data gathering techniques and data analysis will be implemented.
CHAPTER FIVE

DATA ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

It was of utmost importance for the researcher to communicate the findings to the health providers of all sectors used for data gathering and the respondents. This would complete the research process and highlight the risks factors inherent in the researched situation, complement and acknowledge all the positive findings. The combination of quantitative and qualitative data analysis was valuable to use, so as to provide different perspectives to care provision. While the former used statistics, the latter dealt with themes, categories, and subcategories to give a comprehensive meaning to the narrated statements. The analysis, interpretation and discussion of the research results are comprehensively deliberated upon in this chapter.

The questionnaire had closed ended and open ended questions, they were analysed individually, numerical display of data by means of tables and graphs was used. Qualitative data analysis methods were used for section two, and included comprehension, reduction and interpretation. Observed data was analysed and personal interpretations given to the observed behaviour. The trend of integrating both quantitative and qualitative data analysis is a technique used to reinforce the validity and reliability of the research findings because it is complementary. The triangulation of data gathering and analysis was the most appropriate way to ensure reliability and validity, it enabled widening of parameters of information collected that represented lived experiences.

The following discussions will represent the data analysis:
The age distribution as represented in the graph above included 58.8% in the ages 18-19 years. The ages in these ranges are the mode in the distribution. They represent the most ages that use the health services, especially the reproductive health services. The respondents mostly came for birth control methods, antenatal clinic and postnatal clinic. 24% of the respondents 18-19 years old and 3% were 17 years. Both groups were pregnant at the time of data gathering. 6% of the 19 years old were in the post natal clinic and another 6%, 19-21 years old had children in toddler ages. The findings highlight the age of 18-19 years as being characterized by high pregnancy incidence. The finding were congruent with findings by (Marot 1994 46-47), he concluded that 18 years old females had higher risk to falling pregnant.
The strongly disagree and the disagree responses were up to 45%, it was the highest among all questions. The non responses were also highest with 8% to 21%. The reflection might be that the topic was not communicated due to personal moral preservation. The observed conservative approach would decrease the access to the service as one of the reproductive rights.

5.2.8 Summary of care providers

The health workers, media and parents came out to be the highest rated care providers of information for most topics. The specific groups efforts needed to be acknowledged and supported financially, and with human resource to sustain their efforts. The bar graph below represents the general rating of each service provider. The existing youth clubs needed a community orientated monitoring to assess their activities and promote health related programmes within their activities.

Figure 5.2 Positive and Negative rating for all providers
The information gathered on age distribution and the problems, highlighted negative relationship to the effectiveness of the existing programmes for primary prevention of the reproductive health problems. Although the study was not surveying teenage pregnancy as an entity it does however, acknowledge that it is one of the problems to be used to measure the effectiveness of the services for the adolescents. The numbers reflected above are just but a tip of an iceberg, the problems may be of a wider scale, and need individual exploration on a broader area of study. Previous discussions highlighted the problems bred by teenage pregnancy as school drop out, economic dependency, illiteracy, juvenile delinquency and poverty, the same problems may be experienced by these adolescents.

5.2.2 Respondents' gender

Males and females had equal opportunity to be included in the sample, but the sample as represented by age distribution in the above table had only two males. This comprised only 3% of the sample, and raised concerns. As reflected in the findings, the males were not using health care services to sustain their reproductive health needs positively by seeking information and consulting for advises on their growing up experiences. The question is where do they get the necessary information from?

5.2.3 The family structure of the respondents

The tradition of staying in the extended family seemed to have disappeared due to the increasing, informal areas in the township of Soshanguve. The formal and informal areas are mostly inhabited by single working parents. Most of them left their homes to start their own families. The pie diagram table below represents the types of families the respondents came from. It was assumed that staying in the extended family benefited the adolescent because during the absence of the working parents, the grandparents were there to keep supervision and parenting roles, which in a way ensured sustained accompaniment of adolescents. The family structures the
adolescents came from is represented by the diagram below.

Figure 5.3 The family structure of the respondents (Frequency)

![Diagram showing family structure frequencies]

There was 71% of nuclear families, which implied that parental presence at home was minimal due to working, and the distance traveled to work daily. The residents of Soshanguve Township work in Pretoria city, which is 45-60 km distance from the township depending on the area one resides in. The preceding scenario results in parents leaving home at 6:00 and returning back at 18:00. The children are left for more or less 12 hours without parental supervision, that further deprive the adolescents of time to discuss growing up and other reproductive issues within the family. The relationship of the family structure and adolescents' accompaniment as discussed by Paulussen et al (1995 227-243) was considered to directly affect the adolescents' accompaniment. The results came from his study on the effects of the use of the health belief model by parents to ensure communication with the
adolescent. The results of parents giving information on growing up will be discussed later to affirm the above findings. 70% of the adolescents who were pregnant in this study came from nuclear families. The findings confirm the preempted lack of accompaniment within the nuclear family, especially if the parent is working long hours.

5.2.4 The educational standard

The standard of education was included and assessed, in order to verify if there was a positive relationship between identifying and understanding the risk factors and the educational standards. The researcher acknowledged the expected ages for each standard as according to the department of education policies. The table below represents the educational standards as distributed among ages.
Table 5.1  Age distribution according to the standard of education of the respondents

<table>
<thead>
<tr>
<th>Ages in yrs</th>
<th>13</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
<th>20</th>
<th>21</th>
<th>Not responded</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number per Each Standard</td>
<td>5=2</td>
<td>5=2</td>
<td>6=2</td>
<td>7=2</td>
<td>6=2</td>
<td>7=2</td>
<td>8=4</td>
<td>7=2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>16</td>
<td>22</td>
<td>6</td>
<td>2</td>
<td>12</td>
<td>68</td>
</tr>
<tr>
<td>Percentage</td>
<td>2.9</td>
<td>2.9</td>
<td>2.9</td>
<td>5.9</td>
<td>23.5</td>
<td>32.4</td>
<td>8.8</td>
<td>2.9</td>
<td>17.7</td>
<td>100</td>
</tr>
</tbody>
</table>
The total respondents who disclosed their educational standards were only 82% according to the table above. 12% of the respondents, of ages 18 years old were far behind with their educational progress, they were in standards 6, 7, 8, and 9 respectively, another 12% of ages 19 years old were in standards 7, 8 and 9. One 21 year old indicated that her educational level was in standard 7.

The above pattern depicts that the respondents may have slim chances to complete the academic and skill development pathways that presently exist in the country. The other concern is whether they have enough support to avert the inherent reproductive health problems. The pupils who were behind with school standards might also be excluded for life skills development guidance, the latter are taught according to class timetable, and there are specific topics for each standard.

The health workers who collaborated with schools for health promotion needed to access the pupils guided by their ages and not exclusively standard in school. The use of the standard only would make the services not accessible to all appropriate consumers. The respondents who were educationally behind the expectations, may be those who could not access the educational institutions at the recommended age.

5.2.5 The age at which information was given for the first time

82% of the respondents responded to the question. The youngest age was 12 years and the eldest 17 years. The average age of receiving information was 14 years, and the mode came out to be 13 yrs and 17 years. Those respondents who got information at 17 years of age were at higher risk due to lack of reproductive biology information and life skill especially negotiations skills to handle love relationships.

5.2.6 The number of children per family the respondents came from

The smallest family the respondent came from had one child and the biggest had nine children. The respondent from one child family received information at 17 years.
and the latter at 13 years. Even though the sources of information could have been outside the home, these pointed out that family size did not have direct relation with the first time one receives information on reproductive health promotion.

5.2.7 Information given by different adolescent care providers

The following were identified as the providers who had continuous contact with the adolescents. Such contact would enable open communication, create support, educate and counsel towards positive behaviour development for health promotion and disease prevention. The following information represented the responses as distributed on a likert scale. Each topic was discussed separately as in (appendix 1.4) the questionnaire.

5.2.7.1 Information on growing up

Table 5.2 Responses of information availability on growing up

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Media</th>
<th>Parents</th>
<th>Health Workers</th>
<th>Church</th>
<th>Youth Clubs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>22</td>
<td>32.4</td>
<td>34</td>
<td>50</td>
<td>20</td>
</tr>
<tr>
<td>Agree</td>
<td>22</td>
<td>32.4</td>
<td>16</td>
<td>23.5</td>
<td>16</td>
</tr>
<tr>
<td>Not sure</td>
<td>14</td>
<td>20.6</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>2.9</td>
<td>8</td>
<td>11.8</td>
<td>2</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>5.9</td>
<td>2</td>
</tr>
<tr>
<td>Not responded</td>
<td>6</td>
<td>8.8</td>
<td>6</td>
<td>8.8</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
</tr>
</tbody>
</table>
There was 18.9% respondents who omitted to answer the questions throughout the different providers. 53% of the respondents ranked the health workers as first and 50% the parents as second. The media and church were the least involved with the growing up topic with 32% and 30% respectively. There are numerous pamphlets available on growing up from the Department of Health. The reasons why the media is rated fourth may inversely reveal the reading involvement of the adolescents. The Read-Wright Organization also confirmed the less involvement in reading of the adolescents, it further made use of the following statement “if you want to hide information from the youths put it on paper.” The findings on the educational standards might also be a contributory factor, leading to the lack of full use of media especially by reading. 36% of the respondents were either behind in school standard or hid their schooling information by not responding to the question.

The lack of information on reproductive biology by the adolescents was found to have increased their risk to reproductive health problems by (Swenson 1995: 677-683). Menstruation, menarche, and other growing up topics should be the basis for all adolescents, this will form the foundation to better comprehend conception and contraception. The church came fifth and the reason may have been their involvement in abstinence promotion and therefore ignoring other topics. The challenge to the church is to put more programmes including this topic.
5.2.7.2 Information on life skills development.

Table 5.3 Responses on the availability of information on life skill development.

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Media</th>
<th>Parents</th>
<th>Health Workers</th>
<th>Church</th>
<th>Youth Clubs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>20</td>
<td>29.4</td>
<td>24</td>
<td>35.5</td>
<td>30</td>
</tr>
<tr>
<td>Agree</td>
<td>20</td>
<td>29.4</td>
<td>16</td>
<td>23.5</td>
<td>22</td>
</tr>
<tr>
<td>Not sure</td>
<td>18</td>
<td>26.5</td>
<td>12</td>
<td>17.6</td>
<td>6</td>
</tr>
<tr>
<td>Disagree</td>
<td>6</td>
<td>8.8</td>
<td>4</td>
<td>5.9</td>
<td>4</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>4</td>
<td>5.9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not responded</td>
<td>6</td>
<td>8.8</td>
<td>12</td>
<td>17.6</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
</tr>
</tbody>
</table>

The percent of those adolescents that did not respond to these enquiry ranges between 6-18%. The highest responses were given to the health workers as care providers, their efforts need to be applauded thus far. The total positive responses were 78%. The church was ranked second with 65% and the correlation of the responses to the promotion of abstinence could not have been underestimated. Sustaining abstinence requires life skills, so as to take responsible decisions to avert risks. The media was put under the spotlight when it came last in the ratings. As discussed earlier, in relation to the visual aids, it was found out that some television drama messages are confusing to the adolescents, and that could have influenced the responses.
5.2.7.3 Information on love relationships

The table below represents the communication between the service providers with adolescents on love relationships.

Table 5.4 Responses on the availability of information on love relationships

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Media</th>
<th></th>
<th>Parents</th>
<th></th>
<th>Health Workers</th>
<th></th>
<th>Church</th>
<th></th>
<th>Youth Clubs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>40</td>
<td>58.8</td>
<td>22</td>
<td>32.4</td>
<td>16</td>
<td>23.5</td>
<td>10</td>
<td>14.7</td>
<td>30</td>
</tr>
<tr>
<td>Agree</td>
<td>14</td>
<td>20.6</td>
<td>14</td>
<td>20.6</td>
<td>28</td>
<td>41.2</td>
<td>12</td>
<td>17.6</td>
<td>14</td>
</tr>
<tr>
<td>Not sure</td>
<td>6</td>
<td>8.8</td>
<td>5</td>
<td>14.7</td>
<td>8</td>
<td>11.8</td>
<td>16</td>
<td>23.5</td>
<td>4</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>2.9</td>
<td>5</td>
<td>14.7</td>
<td>6</td>
<td>8.8</td>
<td>16</td>
<td>23.5</td>
<td>8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>5.9</td>
<td>2</td>
<td>2.9</td>
<td>6</td>
<td>8.8</td>
<td>2</td>
</tr>
<tr>
<td>Not responded</td>
<td>6</td>
<td>8.8</td>
<td>8</td>
<td>11.8</td>
<td>12</td>
<td>17.6</td>
<td>8</td>
<td>11.8</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
</tr>
</tbody>
</table>

There was between 9-18% respondents who did not respond to the question. The media was ranked high with regard to information giving on love relationships. 79% of the respondents anonymously agreed to it as first service provider. Health workers were rated second with 64%. The high ranking of the media supports the discussions of media regarding lovemaking or sex related shows. Oprah show on e-tv (08.04.02) stated that media research revealed that by the age of 12years a child has already viewed 2million television shows or series with sex related behaviour. Such a rating challenged parents to supervise television viewing and to interpret the events and their probable risks and outcomes to children. Evaluation of educational series should be done and children be allowed to view only if there is message for health promotion and moral upliftment. The availability of the sex magazines on the shelves
of some cafés, and the selling of such magazines to adolescents without verifying the ages might be another source of information. The educational series that communicate dynamics of love relationship had been acknowledged and discussed in (chapter 3.4.1.3). The primary prevention approaches taught in Soul City and Take Five are of great influence for positive behaviour modification.

The challenge was put on the church to have more programmes about the topic of love relationships, it was given only 34% on the positive ranking. Only through coordinated efforts would the message be reinforced and behavior change be achieved. This was also confirmed by SABC 2 12.08.02 programme, “GOD’S ANSWER TO HIV/AIDS” wherein churches were motivated to include sexual issues in their teachings to redress the HIV/AIDS problem.

The other concern communicated to the adolescents was about contraception, all adolescents who were sexually active needed to effectively use a contraceptive method which would positively benefit them. They need skills to communicate the effective use of condoms as a dual protection method. These will ensure the protection from HIV/AIDS and pregnancy.

5.2.7.4 Information on contraceptives

The table that follows represents the information the respondents had on contraceptives.
Table 5.5  Responses on the availability of information on contraceptives

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Media</th>
<th>Parents</th>
<th>Health Workers</th>
<th>Church</th>
<th>Youth Clubs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>14</td>
<td>20.6</td>
<td>14</td>
<td>20.6</td>
<td>26</td>
</tr>
<tr>
<td>Agree</td>
<td>24</td>
<td>35.3</td>
<td>16</td>
<td>23.5</td>
<td>14</td>
</tr>
<tr>
<td>Not sure</td>
<td>10</td>
<td>14.7</td>
<td>6</td>
<td>8.8</td>
<td>12</td>
</tr>
<tr>
<td>Disagree</td>
<td>6</td>
<td>8.8</td>
<td>12</td>
<td>17.6</td>
<td>6</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6</td>
<td>8.8</td>
<td>10</td>
<td>14.7</td>
<td>2</td>
</tr>
<tr>
<td>Not responded</td>
<td>8</td>
<td>11.8</td>
<td>10</td>
<td>14.7</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
</tr>
</tbody>
</table>

Health workers were rated the highest with 59% by the respondents. This might be due to the fact that family planning is a free service to the public. The rating was a positive reflection of adequate accessibility of adolescents to the services.

The principles promoted within the religious perspectives were well represented by 20% positive response to the church involvement in giving information on contraceptives. The church rating was the lowest.Traditionally churches would promote abstinence as a positive vehicle in promoting positive behaviour for prevention of STI's and the moral upliftment. Prompt use of the contraceptives would prevent pregnancy and STI's, for example condom use.

The respondents’ responses to the question on the use of contraceptives was congruent to the implementation of the gained knowledge. The same percentage that agreed that health workers gave information on contraceptives used contraceptives. Methods used varied from injectables by 50%, condoms by 46% and pills by 4%. There was promotion of method mix as advocated within the National contraceptives...
policy guidelines, but the point of concern was that only 46% were using condoms, this assumed that more than 64% of the respondents were not using the condoms. The dual protection was either not known to them as the family planning initiative or they chose to ignore that. The fact that behaviour modification had to be achieved for all the adolescents to implement responsible decision to avert the reproductive health problems, is represented negatively by these findings.

78% of the respondents further agreed that condom promotion was done by almost all people in the community for pregnancy and HIV/AIDS prevention but only 20% of those who knew about its uses implemented the protective device. Those adolescents that used the condom were aware of the inherent risks of the situation they were in, and implemented preventative steps as implied in the health belief model. The statistics in table 1.1 and 1.2 in chapter one resulted due to lack of risk identification as explained above.

5.2.7.5 Information on conception

The knowledge the adolescents got from the services in the environment regarding conception is represented hereunder.
Table 5.6  Responses on the availability of information on conception

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Media</th>
<th>Parents</th>
<th>Health Workers</th>
<th>Church</th>
<th>Youth Clubs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>10</td>
<td>14.7</td>
<td>8</td>
<td>11.8</td>
<td>22</td>
</tr>
<tr>
<td>Agree</td>
<td>20</td>
<td>29.4</td>
<td>4</td>
<td>5.9</td>
<td>14</td>
</tr>
<tr>
<td>Not sure</td>
<td>20</td>
<td>29.4</td>
<td>14</td>
<td>20.6</td>
<td>20</td>
</tr>
<tr>
<td>Disagree</td>
<td>10</td>
<td>14.7</td>
<td>16</td>
<td>23.5</td>
<td>8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>2</td>
<td>2.9</td>
<td>10</td>
<td>14.7</td>
<td>2</td>
</tr>
<tr>
<td>Not responded</td>
<td>6</td>
<td>8.8</td>
<td>12</td>
<td>17.6</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
</tr>
</tbody>
</table>

There was 38% respondents who were pregnant, post natal and having babies in infancy ages respectively. These had direct relationship with the responses that were reflected the lack of knowledge of how conception takes place. The pregnancy rate at the clinics among teenagers directly reflected the ignorance rate and lack of use of the condom, with further exposure to the HIV/AIDS infection. The lack of information on conception was shown in (Felicia one, 22 October 2002), a teenager who fell pregnant after having sex only once, was amazed by that fact. She came out to make her age group aware that they must be aware of the fact that “you can fall pregnant at the very first time of having sexual intercourse”.

The percentage of those who did not respond was 3-18% ranges. It was constant with the other questions and ensured consistency in knowledge among the respondents. The topic of how conception occurs was rated positive by 53% as the maximum. The providers were again health workers. Parents were given 17% and were the lowest. This might be the way to reveal the need that the parents have to be taught basic reproductive biology to make them confident to talk to their children.
The responses confirmed the ignorance rate. The ignorance rate had a direct relation with the incidence and prevalence of teenage pregnancy and teenage mothers in the study sample.

The church was again rated second low by 20% on talking about conception, the abstinence policy is being promoted instead of the topic on conception. The challenge to the church would be that reality facts were represented in the HIV/AIDS and teenage pregnancy statistics, and these topics needed to be addressed within the church without defying the religious faith and principles. Openness by all adults in all social structures would reinforce the information to the adolescents towards positive behavior change.

5.2.7.6 Information on STI/HIV/AIDS

The table below represents the responses concerning information on one of the reproductive health problems, STI/HIV/AIDS.

Table 5.7 Responses on availability of information on STI/HIV/AIDS

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Media Freq</th>
<th>Media %</th>
<th>Parents Freq</th>
<th>Parents %</th>
<th>Health Workers Freq</th>
<th>Health Workers %</th>
<th>Church Freq</th>
<th>Church %</th>
<th>Youth Clubs Freq</th>
<th>Youth Clubs %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>32</td>
<td>47.1</td>
<td>18</td>
<td>26.5</td>
<td>38</td>
<td>55.8</td>
<td>26</td>
<td>38.2</td>
<td>26</td>
<td>38.2</td>
</tr>
<tr>
<td>Agree</td>
<td>16</td>
<td>23.5</td>
<td>22</td>
<td>32.4</td>
<td>12</td>
<td>17.6</td>
<td>14</td>
<td>20.6</td>
<td>18</td>
<td>26.5</td>
</tr>
<tr>
<td>Not sure</td>
<td>8</td>
<td>11.8</td>
<td>14</td>
<td>20.6</td>
<td>4</td>
<td>5.9</td>
<td>12</td>
<td>17.6</td>
<td>10</td>
<td>14.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>4</td>
<td>5.9</td>
<td>2</td>
<td>2.9</td>
<td>6</td>
<td>8.8</td>
<td>8</td>
<td>11.8</td>
<td>4</td>
<td>5.9</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2.9</td>
<td>2</td>
<td>2.9</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Not responded</td>
<td>8</td>
<td>5.9</td>
<td>10</td>
<td>14.5</td>
<td>6</td>
<td>8.8</td>
<td>8</td>
<td>11.8</td>
<td>8</td>
<td>11.8</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
</tr>
</tbody>
</table>
There was a general positive distribution of positive ratings among almost all care providers. These represented a widespread involvement on addressing the issue as a nationwide health problem. Health workers and the media were rated almost the same with 73% and 70% respectively. The acknowledged involvement needed to be applauded. The church also received positive rating, about 59% and that reflected a collaborative endeavour to combat new infections and give the support to those already infected and affected with HIV/AIDS. The support by non-governmental organizations includes churches as main providers.

Those who did not respond was 3% up to 15%, this was the lowest figure compare to other responses. The responses corresponded with the nationwide efforts taken by most providers to reduce the new infections. The health awareness in most health care centres did not observe HIV/AIDS awareness only in December. Throughout the year the programmes for HIV/AIDS are presented. The involvement in school health programmes also expanded their area of work and contact with the adolescents.

The media was involved in several programmes to raise awareness and educated the adolescents, the Love life organisation is having a roll out campaign where the pamphlets of Theta junction are freely available to all those who can read on sexuality issues and infections. The most important fact was to ensure sustainability of the contact and ensure reduction in incidences as positive results of the intervention. To continue the discussions on adolescents' accompaniment the termination of pregnancy is discussed next as one of information and service to be readily available to the adolescents to increase accessibility.
5.2.7.7 Available information on Termination of pregnancy

Table 5.8 Responses of the availability of information on TOP

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Media</th>
<th>Parents</th>
<th>Health Workers</th>
<th>Church</th>
<th>Youth Clubs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
<td>%</td>
<td>Freq</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>20</td>
<td>29.4</td>
<td>8</td>
<td>11.8</td>
<td>32</td>
</tr>
<tr>
<td>Agree</td>
<td>20</td>
<td>29.4</td>
<td>16</td>
<td>23.5</td>
<td>6</td>
</tr>
<tr>
<td>Not sure</td>
<td>2</td>
<td>2.9</td>
<td>8</td>
<td>11.8</td>
<td>8</td>
</tr>
<tr>
<td>Disagree</td>
<td>6</td>
<td>8.8</td>
<td>6</td>
<td>8.8</td>
<td>8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6</td>
<td>8.8</td>
<td>20</td>
<td>29.4</td>
<td>6</td>
</tr>
<tr>
<td>Not responded</td>
<td>14</td>
<td>20.6</td>
<td>10</td>
<td>14.7</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100</td>
<td>68</td>
<td>100</td>
<td>68</td>
</tr>
</tbody>
</table>

The legal abortion issue was introduced in the country in 1996, it became a moral issue debated by all the community health providers including the church organizations with great preservation of Christians' values. The reflection of the values was represented by the percentage distribution representing the information availability on the topic. 56% the respondents rated health workers first for giving information on TOP, even though it was an ethical dilemma. The question might be how many of those who wanted the procedure to be done got that successfully done? The answer might be sought through other studies. Parents and the church were both rated 16% and it was a clear reflection of the moral conservative approach they held as adolescents' companions. The church leaders came up strongly to oppose the implementation of the act during its proposal, and five years down the line they do not show any change.
5.2 QUANTITATIVE DATA ANALYSIS

A questionnaire consisting of twenty one close ended questions and five open ended questions was administered to seventy respondents, two (2) withdrew due to personal reasons and sixty eight (68) remained. The numerical data and discussions are aimed at analyzing the observed patterns, and their impact in reproductive health promotion.

5.2.1 Ages of the respondents

The study included a sample of adolescents between 12years and 21years, males and females, in school or out of school, pregnant and not pregnant. The following table represents the age distribution among the sample.

Figure 5.1 Age distribution of the respondents (Frequency)
The health providers need to be applauded once more for being highest on positive rating and last on negative. The church was rated fifth on the positive and first on the negative responses. The need for integration of adolescent health promotion programmes cannot be underestimated.

5.2.9 General impression of the availability of information

About 60% of the respondents agreed that the information they got in the community they lived in was adequate. 50% needed the following topics be talked about sex, stress, breaking up and rape. The use of family planning service by only 50% of the respondents may assume that the other 50% were abstaining. The 40% that did not acknowledge receiving enough information might be the one that were already pregnant. TOP was not used by any of the respondents although in the responses of the availability of information on TOP about 40%-60% of the respondents were given information by health workers and media respectively. The researcher assumed therefore that the health workers observed the rights of information giving and adolescents exercised their rights to choose whether to use the service or not.

5.2.10 Prevalence of STI among the respondents

9% had suffered sexually transmitted infections, 6% were per vaginal discharges and one whom was a male, suffered lower abdominal pains. The numbers represented the risks coupled with unprotected sex among those who did not use the condom as discussed earlier.

5.2.11 Feelings about HIV/AIDS as a reproductive health problem

76% did express fear to HIV/AIDS as a reproductive problem and gave various reasons as reflected and explained below.
Table 5.9  Responses on fears related to HIV/AIDS

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of HIV/AIDS</td>
<td>No Cure</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>People die from HIV/AIDS</td>
<td>27</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>It is sexually transmitted</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>There is escalating incidences</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>It is vicious cycle</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>People are not taking action to stop the disease</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

The greatest fear concerning the HIV/AIDS was expressed by 53% to be that people are dying from the disease. Both adults and babies are dying, and this was significant due to loss suffered by individuals and families, or fear by these respondents to die from the disease themselves. The second fear was the lack of cure by 12%, the assumption around these concern might be that if there was a cure it wouldn’t be a problem, or other infections like syphilis were not a problem because they have a cure.

18% of the respondents were worried that the disease incidences were increasing, and there were no actions taken to stop it, therefore the disease formed a vicious cycle. These respondents acknowledged the disease as a behavioural, organizational, departmental and national problem. They further reflected that there were actions to be implemented to stop the new infections by individuals, government and other organizations. They did not indicate loss of hope as reflected by the preceding respondents who feared death. They represented the people that would acknowledge that individual actions were to be taken towards stopping the diseases, Health Belief model for health promotion may yield positive results with the group. 24% of the respondents did not respond to the question and this may indicate their ignorance regarding the epidemic.
5.2.12 The visual aids used for health education

The assessment of the visual aids used during health education or information sessions were evaluated as not clear and message not understood by 34% of the respondents. The reasons given in writing as open ended questions for the individual responses were as follows:

Table 5.10 Responses on the quality of the visual aids

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual aids are not clear</td>
<td>No time to ask questions</td>
<td>8</td>
<td>34.6</td>
</tr>
<tr>
<td></td>
<td>Picture were not clear</td>
<td>7</td>
<td>31.6</td>
</tr>
<tr>
<td></td>
<td>Wrong and right not clearly indicated</td>
<td>8</td>
<td>34.6</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>

This supported the lack of supervision where adolescents might be viewing some drama series without supervision and they could not make the correct choices, sometimes they followed incorrect role models and copied self destructive behaviours. The Yizo Yizo 2 (SABC drama 25.07.01) showed a sodomy act, the scene aroused public debates up to the National parliament The intended outcome for educational purposes was not clear to the adults, even though they were expected to accompany the children and supervise television viewing. Such teaching aids needed to be communicated and censored for adolescents teaching. Some pamphlets were in black and white and did not give clear pictures e.g. the vaginal and penile discharges. The confusion on the lack of clear guidance, may delay the seeking of medical help.

Television and demonstrations were rated first by 17% for representing the real happenings, and portraying lived experiences respectively. Magazines and
pamphlets were highly useful by being available every time to read and refer to. One respondent said the visual aids were very useful also for the deaf people, this response was highly appreciated as it highlighted and acknowledged the needs of the deaf adolescents as being equal to those of other groups of adolescents.

5.2.13 Preferred care providers according to the adolescents’ choice

The adolescents preferred to receive information from the following people rated from the highest to the lowest.

- parents preferred by 18%
- teachers preferred by 10%
- health workers preferred by 10%

Other ratings came out very insignificant. The parents were preferred as first line care providers by 18%, the need was therefore to ensure that they were equipped with necessary knowledge to communicate to he adolescents to ensure positive behaviour development.

5.3 QUALITATIVE DATA ANALYSIS

5.3.1 Interviews

Interviews with adolescents and care facilitators were held to collect data, live experiences were narrated and those were reduced into common statements to represent the themes. The reduction was ongoing and led into categories and subcategories development. The interview assessed the accessibility and effectiveness of the services, the community support and identified problems regarding the running of the services. Different sample of about 25 was used for this section to avoid biasness. The following data analysis procedures were used as according to (Miles and Huberman 1994)
Data was transcribed so as to give a holistic interpretation. Observable trends and patterns emerged and their analysis led to themes identification. All these themes were reduced into categories using the key words of interview. Each category had several sub-categories, representing meaning and descriptions derived from the statements the respondents gave. The following data represent the interview sessions with the adolescents. The researcher used the semi-structured interview, this was possible because of the wealth of knowledge on the subject by the researcher.

5.3.1.1 Available information and providers for adolescents’ reproductive care

There were questions asked to direct the interview as the semi structured approach was used.

Question: What support and information did you get from the environment you stay in to assist you in handling your reproductive health needs?

Aim of the question: to identify the available supporters and the information they gave to adolescents.
Table 5.11 A report on available care givers and information by the adolescents

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available care givers and</td>
<td>Media give continuous information on HIV/AIDS</td>
</tr>
<tr>
<td>information for the</td>
<td>Parents are not talking on sexuality issues</td>
</tr>
<tr>
<td>reproductive health needs</td>
<td>Schools give information on life skills</td>
</tr>
<tr>
<td></td>
<td>Churches guided the development of life skills</td>
</tr>
<tr>
<td></td>
<td>Clinics promoted condom use</td>
</tr>
<tr>
<td></td>
<td>Some nurses seldom give information on sex issues</td>
</tr>
<tr>
<td></td>
<td>The information given by different supporters is not always the same, and confuses as to which one is right</td>
</tr>
</tbody>
</table>

The above statements represented the available support and information the adolescents got from the environment. The categories were congruent with the questionnaire outcomes, the fact that the media had the special programmes that specifically targeted the adolescents came out clear as being available, sustainable and even supported by the government for example Love life. The fact that there were respondents that commented about mixed messages raised a concern because this was a negative recipe for health promotion, explanation of all messages conveyed during any kind of contact with the adolescent should be of paramount importance to stop the confusion.

The above statement that is made of some nurses not giving information on sexual issues may exclude them, during data gathering these was not the researchers findings, the observations made would be discussed later in the report. The researcher accepted the statement as a true reflection of lived experience and these was supported by (Diale and Ross 2000: 136-141). They recommended that the adolescent care givers were to be screened before allocation in the service, as lack of skills and commitment would highly jeopardize the welfare of those under their care.
The responses regarding the lack of support by the parents was a public knowledge and needed to be addressed by implementation of special programmes. There is a need to give those parents who did not have the knowledge or time to discuss the sexual issues with their children, knowledge and opportunity to realize the need to do so. The high illiteracy level of the South Africans might exacerbate the situation.

5.3.1.2 Knowledge on contraceptives

Question. Why do you use the contraceptives? Explain by relating to the one you use.

Aim of the question: to get the knowledge and motivation the adolescent had concerning the use of contraceptives.

Table 5.12 Reasons for using contraceptives by the adolescents

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>The reasons for the use of</td>
<td>To stop menstruation so as to be able to do sport</td>
</tr>
<tr>
<td>contraceptives</td>
<td>So as to control the heavy menstruation</td>
</tr>
<tr>
<td></td>
<td>There is a man who threatens to rape me in the area where I live</td>
</tr>
<tr>
<td></td>
<td>My mother said I must come because I went to a party with a boyfriend at</td>
</tr>
<tr>
<td></td>
<td>night</td>
</tr>
<tr>
<td></td>
<td>The information given by different supporters is not always the same, and</td>
</tr>
<tr>
<td></td>
<td>confuses as to which one is right</td>
</tr>
</tbody>
</table>

The above responses excluded admitting to be sexually active. The prevention of problems like pregnancy and infections was given evasive answers. The responses represented the lack of openness in admitting ones sexual active status, such admittance would encourage taking the responsibility to prevent the risks of infections and pregnancy. Such disclosure might open way for discussions including advises and evaluation of the knowledge to identify the risks inherent in ones sexual
practices. The adolescents might miss an opportunity of risk identification and developing skills to handle those risks as according to the HBM.

One of the benefits of the injectables contraceptives as known is amenorrhoea, the statement of it being used for that benefit only might be overrepresented. Avoiding to disclose that they were sexually active at adolescent age, may be because they knew it was morally unacceptable in the society we live in. The other answer was protection against a possible rapist in the neighbourhood. This highlighted the risks present in the environment we live in. If ever when we consider the statistics of rape in the community, we than put all adolescents on contraceptives methods, we would not solve the problem. We need programmes for prevention of rape and how to defend oneself, and also how to manage rape victims to prevent sera-conversion in case of HIV infection. Such intervention would not only prevent pregnancy but infections and prolong life.

The others said their mothers told them to get an injection because they went to a party with boyfriends at night and they might fall pregnant. Pregnancy was still being feared more than HIV/AIDS. Contraceptives were used mainly to prevent pregnancy more than HIV/AIDS. The assumption here was supported by the findings in 5.5.6.4 on the use of dual protection. The condom was used by only 50% of the sexually active respondents even though 87% admitted that condoms were readily available in the clinics and other public places.

The last respondent wanted the injection because she wanted to control her menorrhagia. After examining the adolescent it was found that she had menometrorrhagia according to history she gave. The lack of knowledge of the adolescents about menstruation and the probable problems came to the highlight, implications of heavy bleeding and possible causes were not known. This was a life threatening situation as life could be lost due to heavy bleeding.
5.3.1.3 Accessibility and effectiveness of the services for reproductive health care

The following question was asked to the adolescents' care providers. How is the provision of services for adolescent care in your area? Aim of the question. To assess accessibility and appropriateness of the services as observed by the caregivers.

Table 5.13 Accessibility and effectiveness of services

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility and effectiveness</td>
<td>There is a clinic or a mobile point within 5 km of all residential areas.</td>
</tr>
<tr>
<td>of the services</td>
<td>Services are run 8 hrs a day 07:00-16:00 and are closed on weekends.</td>
</tr>
<tr>
<td></td>
<td>There are no toilets within the project center.</td>
</tr>
<tr>
<td></td>
<td>Community involvement is observed.</td>
</tr>
<tr>
<td></td>
<td>The effectiveness was not easy to measure as follow up is a problem.</td>
</tr>
<tr>
<td></td>
<td>The 24 hours crisis center is at one clinic.</td>
</tr>
</tbody>
</table>

The two health promoters were interviewed, they had matric as their highest standard of education and were both busy with the tertiary education. They both undergone training for the adolescent accompaniment sent by the church and regional training sector respectively. One was a 21 year old male peer group facilitator volunteer who also offered youth church care service within his church. This adolescent went through the revolving door several times and reached the exit stage which qualified him as peer supporter as in HAM (Ewles et al., 1995:183).

Both responded almost the same to all questions and the above statements represented their lived experiences. The health promoter was employed by Gauteng
Provincial Health and worked 40hrs a week which was the pattern of 07:00-16:00 a day. She only worked on Saturday if there was an organized activity. Such hours of duty were not user friendly to adolescents who might be performing sports and other extra mural activities at school until 16:00. The service was situated far from most formal settlement areas. The adolescents from those areas needed to use two taxis to reach the service, R6,00 - R12,00 return per trip. The money that most parents from those areas did not have because due to unemployment.

The crisis intervention was done by other health workers who might not be familiar with the adolescent's problems and the specific risk factors, that might lead to the delay in managing the problem holistically. This fact intended not to undermine the extensive work and the available care provided up to date, for example social worker in the clinic premises, collaboration with the child protection unit and abuse centres at the local police station. The effective referral system to the psychologist at Ga-Rankuwa hospital and for further medical care is also applauded.

The support from the community was present although not maximal. There was collaboration with schools in the region of Pretoria through the school health nurses. Out of the 72 schools only 13 would be visited for the year 2002. This was less than 50% of the schools and would restrict sustained contact because in 2003 programme other schools should be included. The accessibility of the service was therefore not maintained and behavior modification might not be enhanced through such contact. The activities that included adolescents projects for example celebration of youth day and health campaigns, suffered financial constraints for individual transport as there was no special budget for project activities but only for medical supplies and care.

Due to the wider areas served by the adolescent project service there was a problem of follow up. The adolescents ended up attending clinics next to their residential areas or defaulting because of the financial constraints related to traveling costs.
The success rate was minimal and the indigenous problems of reproductive health were still experienced by the adolescents. The incidence of STI, pregnancy and myths and illiteracy related to the use of contraceptives still prevailed.

Condom use was also a problem because some of the males said that females insisted on unprotected sex. This risk behavior might be the one exacerbating the problems as mentioned earlier. In some cases those who requested for TOP were not definite about their last normal menstrual period and they might be in the advanced pregnancy stage for manual vacuum evacuation procedure, all clients were referred for sonar and further management.

5.3.1.4 Observations analysis

The researcher spent five days in three services in the township where interviews, questionnaire administration and observations were carried out. Her experience as a health care provider assisted the researcher to be involved in history taking for new and old clients. She provided the service meanwhile observing the level of understanding the adolescents had by the time they were sexually active. The findings were as follows:

- 13 year old female was 100% illiterate, she could not read a word on the questionnaire,
- 18 year old female who came for repeat injection for contraception, was so shy to talk about sex and the risks inherent in sexual intercourse,
- those adolescents who have been on contraceptive method for one to three years did not know the mechanism of action of the method,
- the health care worker displayed patience and understanding for the needs of each client,
- and mostly promoted abstinence in their counseling, the initial visit was time consuming so as to get to the knowledge the adolescent had, but also observed the individual’s right to choose and make informed decisions.
The adolescents displayed fear and guilt when asked to talk about sexuality issues especially sexual intercourse.

Service factors
The service for contraception and TOP at clinic three is situated at the back of the building. Adolescents are hidden from the main queue from the main entrance where they may meet with significant adults. The privacy may promote follow up and confidentiality as one of the rights of clients receiving reproductive health care.

Promotion of abstinence was a positive way to encourage the youths to protect themselves from exposure to the risks related to sexual act. The counseling sessions were very relaxed and encouraged open discussions and expression of fears and experiences. A follow up appointment to report how individuals were coping was also secured and the health promoter also invited those who wanted to have telephonic discussions to do so.

Adolescents' factors
The above observations pointed out the prevalence of the ignorance due to lack of knowledge and the type of care that was available to the adolescent. Lack of basic schooling opportunity left one with fewer choices to make, because she did not have any information catalogue to refer to so as to make choices, such adolescents could not read magazines, interpret the television actions, or hear what was said in English as a commonly used language in the media. Perpetuation of the reproductive problems might be a way of life to the adolescents as they were not aware of alternatives for example the emergency contraception or TOP services. Lack of openness on talking about sexuality issues made one not to benefit from health education sessions, she might also become shy to ask questions to verify her concern, she was further exposed to abusive relationship as she would accept anything done on her by the boyfriend due to lack of knowledge of her rights.
5.4 SUMMARY

In conclusion the Soshanguve community still had a great work to do so as to ensure unrestricted access of adolescents services to the whole community. The more disadvantaged groups were to be put top on the priority list as they displayed greater percentages of risks factors. Adolescent user friendly services were to be available so as to mend the good efforts already in place from the Soshanguve community health center, clinic three, Boikhutsong clinic and the adolescent project. It came out clear that due to situations at the clinics, care given was mostly secondary prevention.
CHAPTER SIX

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

After analyzing the data and getting a whole picture of the comprehensive care given to the adolescents, it was necessary to draw conclusions and explain the implications of the findings towards comprehensive care provision for primary prevention, and lastly highlight the recommendations that would fulfill the reproductive health needs. The report will inform the health providers about needed future plans so as to fill the gaps and sustain all positive findings that were reported.

6.2 THE PURPOSE OF THE STUDY

As mentioned in chapter one, the study was necessary for the coalescence of all available care provision for reproductive health needs towards averting problems. The comprehensive reproductive health programme as a core component in health delivery for all adolescents is necessary to provide primary prevention of the present problems, and to create awareness of the gaps within the programmes for adolescent reproductive health provision. The following objectives were mentioned under the purpose of the study in chapter one:

- to identify the health education and life skills the adolescents get from the community they live in.
- to assess the accessibility of the centres that provide care to the adolescents within the community.
- to identify the knowledge the providers of care have on adolescents' reproductive health and health promotion models.
- to identify the support the adolescents' care providers get from the community
6.3 CONCLUSIONS

6.3.1 Age

The respondents were adolescents between the ages of 12 – 21 years, males and females, in school and out of school, pregnant and not pregnant. The sample was inclusive except for the very ill and those for trauma and emergency care. There was no 12 years old as the youngest respondent was 13 years old. All other ages and criterion for inclusion were included. The conclusions will be presented within the stated objectives.

6.3.2 The accessibility of the centres providing care to the adolescents.

6.3.2.1 Gender

There were only two males among the respondents, all respondents were taken from the different Soshanguve clinics. Only two males reported for health care or advise during the time of data gathering, the data was collected during school holidays. The expectation was that pupils would use the free time to consult for information on sexual issues. There may be problems in the service that are not user friendly to males to visit frequently and those reasons is an access barrier.

6.3.2.2 Situation of health care services

The situation of the clinics and the adolescent care project centre were accessible to some, because they were along main transport routes, and within 5km of each residential area. The areas with low income families are situated further from the adolescent center, an amount of R6.00-R12.00 is needed for one to access the centre. The negative finding was that the services were not available over the weekend and after 16:00.
6.3.2.3 The availability of the crisis center

There was a positive response to the availability of the center either as a Love Life telephone line, child protection unit and the community health center, clinic (3) three which offered a 24-hour service. The access of the centre is dependant on similar factors as stated in 6.3.2.2.

6.3.2.4 Visual aids

There were positive and negative ratings for the type of visual aids used. Media was said to be clear. It was always available as a referral source if the need arose, and again as giving unclear messages without clearly demarcating the wrong and the right.

6.3.3. The health education and life skills the adolescents get from the community

6.3.3.1. The available health education towards life skills development.

There was few research on the male adolescent reproductive problems among reports in the literature reviewed. The most researched problems are for females, teenage pregnancy and the lack of knowledge on contraceptives and reproductive biology.

The media was positively identified as giving continuous information on reproductive issues. The information is accessible especially to the literate and those having access to radio and television but not the illiterate and poor.

The contact the adolescents have with the care providers especially the health workers who are rated the highest care providers, is dependant on mostly the need for services such as family planning, ante-natal care and post-natal care. The contact
may not ensure life skill development as required within HBM and HAM for health promotion. In these models continuous contact has to be ensured.

6.3.3.2 The family structure and the number of children in the family

The two types of families were the nuclear and the extended family, these might have either single parent or both. 71% of the respondents were from the nuclear families and no direct relationship of the type of the family to adolescents' accompaniment was indicated from this distribution. The family was rated third for giving information on reproductive issues. The absence of significant difference in accompaniment of the adolescent between the two families, may directly relate to the lack of openness to talk about reproductive issues in the families which result to limited access to information. The family sizes varied from child one to nine children families. The size of the family did not also indicate direct relationship with adolescents’ accompaniment.

6.3.3.3 The age at which information was given for the first time

The youngest age for receiving the information was 13 years and the eldest 17 years. The average age was 14 years, which tended to be late into puberty as 13% of the adolescents of ages 12-14 yrs are sexually active (e-tv Felicia on e show 2002). They are put at higher risk by the late timing. The late timing for initial reproductive health education exposes the individuals to risky behaviour and limited access to information.

6.3.3.4 The standard of education of the respondents

There were 18% respondents who were grossly behind with their schooling progress, they were assessed according to the age of starting school as reflected in the National Education Policy guidelines, and 3% who were totally not schooled. The standard attended at school may be used for determining the need to implement

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sexuality programmes at schools. Adolescents that are behind with their schooling may be denied access to health education and skill development earlier in their life.

6.3.4 The care providers knowledge on reproductive health and health promotion models

6.3.4.1 The care provider ratings according to the responses

According to the strongly agree rating and the agree rating on the likert scale for care provision by the respondents, the following rating emerged from the highest rated provider to the lowest provider:

1. health workers,
2. media,
3. youth clubs,
4. parents
5. churches.

The topics according to the ratings have STI/HIV/AIDS as highly talked about and conception and TOP as the least. The care providers may be trained on the topics as the priority problems during the training they as stated in page 129. The health promotion models are not implemented as reflected in the service availability and lack of ensured follow up, there is tendency to change service points.

Parents and church had limited involvement according to the responses, the lack of support and information may have led to the limited involvement.

6.3.4.2 Contraceptives use and condom promotion

The providers did observe the guidelines in the National Contraceptive Policy Guidelines (DOH:2001) of method expansion. The respondents used the injectable,
a pill and condom respectively. The dual protection method was not 100% promoted
according to the responses, as condoms were not issued with all other methods.
88% of the respondents agreed to the sustained promotion of condoms but only 50%
of the sexually active respondents used the condom. The absence of the
implementation of health promotion models may have led to the behaviour by
adolescents. Pregnancy rate was up to 20% in the clinic statistics for October to
December 2001. 33% were pregnant and 12% were post delivery and mothers. This
indicate the incidences of unprotected sex. These further indicate the lack of life
skills due to the type of care provided.

6.3.4.3 Knowledge on Termination of pregnancy

Up to 56% of adolescents agreed that they knew about the service, none of the
pregnant and those already having children indicated to have attempted to use. The
choices the adolescent will make will greatly depend on the life skills acquired. The
lack to use the services may be due to lack of self reliant and positive self esteem.

6.3.4.4 HIV/AIDS as a reproductive health problem

The disease raised fear in 76% of the respondents as a major reproductive problem
because it is a killer disease and also there is no cure for the disease. Other reason
given was lack of implementation of measures to stop the disease. The responses
indicated the knowledge given by the knowledgeable care giver as positive.

6.3.5 The support the care givers get from the community

The health care workers at the adolescents' project centre indicated that they have
financial problems as the funding they get from the government mostly covers only
health equipments and expandables. The community is not involved in supporting the
project.
6.4 IMPLICATIONS

6.4.1 Age and the standard of education

According to health promoter, Life skills in the schools were given according to the standard attended by the pupil, this might disadvantage the pupils who were behind according to school progress especially that the planning would be done according to each standard's time table. The possibility would be that these pupils would get information later in life. The late giving of first information increases the risk factors to teenage pregnancy and STI/HIV/AIDS.

6.4.2 Gender

Only two males were included in the sample even though this was school holiday time. Although the health workers were rated first for information giving, the implications might be that most males were missing to benefit from the service. The source of information they used might need to be investigated and how it contributed to the way they handled their reproductive issues. They might continue with lack of information and perpetuate incidences and prevalences of reproductive health problems because they lack knowledge for risk identification and life skills development.

6.4.3 Condom use

78% of the respondents agreed that condom promotion was done by all care providers. This was used by 50% of the sexually active respondents, other 50% who did not use the condom were possible risks to the adolescents' community. The escalation of the incidences for teenage pregnancy and STI/HIV/AIDS is directly related to the non-use of the condom. The results might perpetuate the following problems:

- school drop out
6.4.4 Visual aids

The messages and pictures were unclear and confusing sometimes, this was the response by 34% of the respondents. Such experiences could hamper the positive development of the life skills. The results would be the negative health promotion with incidences of problems increasing. The lack of relevant education might also hamper one's interpretation of the meaning of the visual aids. The responses also included positive observations to those respondents that could read pamphlets as very useful and always available for reference, those who are illiterate are not benefitting from visual aids and had increased risks for exposure to the problems.

6.4.5 Knowledge on contraceptives

The adolescents' pregnancy rate is directly related to the lack of information on contraceptives. The lack of compliance leading to defaults is the results of minimal or absence of reproductive biology knowledge. The other reason that indicate the lack of knowledge is the non use of emergency contraceptives.

6.4.6 Knowledge and the use of TOP

The choice to continue with unplanned pregnancy is also related to lack of access or knowledge on the availability if the TOP service. The late reporting of pregnancy for TOP let the adolescent to carry on with unwanted pregnancy. Their future may be negatively affected due to school drop out and limited financial resources, especially the ones from a single and unemployed parents families.
6.4.7 HIV/AIDS

The adolescents who did not respond to the question on HIV/AIDS may have done so to avoid paper confrontation, because they knew one with the disease or due to the ignorance. The lack of knowledge may affect them, by increased risk exposure to contract the disease.

6.4.8 The STI

The presence of the infections is a risk to contract HIV/AIDS and falling pregnant due to unprotected sex. There is an indication of lack of negotiation skills and positive self esteem to protect oneself from the infections.

6.4.9 Crisis center

The lack of special crisis centre may delay the implementation of special support for the diverse problems the adolescents are experiencing. The lack of specialized care for each problem may lead to worsening of the problems.

6.5 RECOMMENDATIONS

The study revealed that there were problems with the type of accompaniment for the adolescents to ensure positive reproductive health status attainment. The main recommendations were that there is a need for the following:

- mentoring of parents for adolescents' reproductive health needs;
- education and training for all care givers;
- special church based programmes for life skills development;
- community participation;
- user friendly services for the adolescents;
- media censoring;
increasing the accessibility of the services especially:
- contraception;
- TOP;
- Life skills development;
- and STI/ HIV/AIDS prevention;
- strengthening of the reproductive biology knowledge availability;
- and targeting males as partners to change the landscape of the problems

6.5.1 Mentoring of the parents

Parents were rated fourth for information giving, socially the family or parents are considered to be the primary care providers. In the instances that they did not talk to their children about sexual issues, it might indicate lack of knowledge in their part. Most adolescents in the study were from the informal settlement area and their parents might not be enabled to talk with them due to the following reasons:

- Being illiterate and not knowing how to explain the physiological changes during puberty.
- The old culture of sex being a taboo to talk about might also be an influencing factor for the low rating.
- The fact that their children are in higher standards at school than what they achieved, might make them to think that they have more knowledge than they have.
- Lack of knowledge on how open discussion about sexuality might benefit the life of their children.

Considering all the factors that led to high illiteracy level, the need is for health and academic adult base education and training (ABET) programmes to bridge the existing information gaps. The advertisement by our previous president Nelson Mandela on SABC1 could be fulfilled and sex would than be an open topic for the
parents. To talk about sex, basic reproductive biology knowledge is a pre-requisite, it is necessary for the parents to have the knowledge.

6.5.2 Education and training for all care givers

Television drama writers and presenters had to be trained to present adolescent programmes, they have to be able to answer all questions relevantly when needed to do so. Clearly stated objectives for all health education programmes must be known to all viewers like is happening with Soul Buddyz series. More younger health providers need to be trained as adolescents’ providers, and the basic curriculum must include adolescents’ reproductive needs and health promotion as a module. It is necessary to equip all who qualifies for health care provision to identify the adolescents as a risk group with special needs. All topics related to reproductive health should be included. Including the following:

- growing up for females:
  - physical growth;
  - reproductive biology;
  - menstruation;
  - personal hygiene;
- growing up for males:
  - physical growth;
  - penile erections;
  - nocturnal emissions (wet dreams);
- life skills
- communication skills;
- negotiation skills;
- setting of objectives;
- developing positive self esteem;
- risks identification;
- love relationships;
- contraception;
6.5.3 Special programmes for the churches

All churches must be mandated to have the programmes for addressing the problems that had reached crisis levels in the community. Teenage pregnancy and HIV/AIDS should be included in church teachings. Adolescents should be recognized as a group with special needs by the church and develop special programmes for them so as to reinforce the positive behaviour development from the church and religious perspectives. This would ensure community participation as adults would have been made aware of the existence of such a programme, and could start supervising their children behaviour according to the religious values which are positive for promoting abstinence.

Religious institution should collaborate with other institutions like the school, so as to continue the life skills education in the church. The same curriculum can be used with observation of the religious values. Such an approach will reinforce education and may ensure positive self esteem and life skills acquisition.

6.5.4 Community participation

There were financial constraints to run non health related activities by the adolescent project at Soshanguve, the project needed the support from the community so as ownership of the project could be created. Fund raising and donations from businessmen in the community might help sustain extra programmes to encourage behaviour modification. All community members were to contribute towards the
sustainability of the project. The most important point is to make the community aware of the projects' objectives. A special committee should be selected to run the project must consist of the community members and the adolescents.

6.5.5 User friendly services for the adolescents

The services rendered were from 07:00 to 16:00 and closed on weekends. Adolescents were forced to ask for permission not to attend extra mural activities or afternoon studies to come for family planning and other primary prevention services at the clinic and project. They feared to meet with their parents or familiar adults who attended the same service, and therefore some defaulted. A service delivered during weekends would encourage increased attendance and prevent some of the mentioned problems in the preceding discussions. Males were to be encouraged to attend the services for information even if they were not sick. Services are to be male friendly.

6.5.6 Media censoring

The deputy president Mr. Jacob Zuma, made a comment about the effect of media for moral upliftment as being negative. The observations and feelings were presented in the moral summit on the 17th August 2002. This public statement might call for the programme censoring team to ensure positive moral development especially in order to ensure HIV/AIDS prevention. The promotion of negative behaviour by the media can spread like fire if not censored. Public opinion may be used for licensing some of the dramas or programmes.

The visual aids should be clear and precise, no double message to be given in order to avoid confusion. Negative message or role models are to be avoided as the adolescent may copy the wrong behaviour. The rural poor are to be provided with access to media by at least having a set of radio to listen to.
6.5.7 Increasing the accessibility of reproductive services for provision of:

- **contraception**

  The school curriculum is challenged to look into introducing human biology from the primary school grades. The compliance to contraception may improve with knowledge acquisition early on how the body systems functions. The human biology must be a compulsory subject taught from primary school grades. This will ensure development of positive self esteem and life skills as a primary requisite for every individual.

  The services should be accessible, considering the educational needs and social resources. If possible, let no one incur traveling costs to get the contraceptives. The option of school based contraceptives clinics may be piloted to assess the related costs, and for possible implementation. The other option is to implement the proposed adolescent friendly services (Love life 2002). The providers should be specially selected and undergo special training to be able to handle the dynamic adolescents' needs. Special groups must be catered for, the diabetic, epileptic and cardiac clients to get special attention due to high risks of drug interactions with the hormonal methods. The disabled and mentally retarded to be provided as according to (DOH 2001). The urban poor and rural are to be high risk groups targeted by all programmes for health provision.

- **Termination of Pregnancy**

  Access to the TOP service should be increased by giving out information on the necessity of timeous reporting of pregnancy. The training of more doctors and registered nurses is of great need. The limited access may be due to lack of trained personnel as provided for in the Act. In the Pretoria region access to termination after 12 weeks has been not available due to the lack of trained personnel. Such a provision of care denies clients to exercise their rights fully.
Life skills development

The multifaceted weapon among all is the acquisition of relevant life skills. The skills to communicate, negotiate and to set clear achievable objectives for oneself, is needed by all adolescents. Promotion of abstinence among all, males and females is necessary. Programmes promoting female virginity should be implemented parallel with male abstinence programmes. Such programmes should not be gender biased. Or inflict injury to adolescents. The ability to postpone the time of first sexual intercourse will safe the adolescent from the problems related to the early sexual intercourse. Proper use of condoms with all sexual intercourse, compliance to hormonal contraceptives, are the life skills needed by those who are sexually active and cannot revert to abstinence.

STI/HIV/AIDS prevention

Promotion of abstinence will ensure exclusions of all the risks to contract the diseases. Churches and adolescents care centers are therefore encouraged to continue promotion of abstinence. Alternatives for the sexually active adolescent should be geared towards promotion of morals to stick to one partner, and being faithful. The use of condom should not be restricted to certain condition e.g. when treating STI's only, but must be sustained throughout sexual intercourse to ensure dual protection. Free condom supply with relevant skills acquisition should be ensured. Females to get free female condoms or purchase them at the lowest price, the alternative should be used in case males resist to wear the male condom, most importantly skills to negotiate protection to contract the diseases should form the base of all love relationships.
6.5.8 Strengthening the availability of information on reproductive biology

The early introduction of biology within the school curriculum will advantage all who attend school, and those who are threatened by social factors to be early school dropouts. Mentoring of parents to ensure the orientation into accompanying the adolescents should include basic reproductive biology. Health belief model, Health Action Model and trans theoretical model (TTM) are to be used to ensure the achievement of the recommendations. More colourful and clear visual aids must be used with all health education sessions. Pamphlets in different languages must be available to all care providers with financial assistance from the Government. The adolescent friendly clinics must be implemented and access to the services and information assisting with skills development must be available.

6.5.9 Targeting males as partners to change the landscape of the problems

The males are to be equally involved in the primary prevention programmes. The reproductive biology must be taught to males, they must better understand the developmental and reproductive processes of both sexes, so as to be able to avoid harmful practices due to myths and stereotypes presently communicated in the community they live in. The society should first accept that males do not have a right to be promiscuous, accept the risks within the promiscuous relationship, and only then will the males be orientated into safer sex practices. Males must come for condom use demonstration themselves, in some cases females are given male condom for use, without prior acquisition of the necessary negotiation skills to persuade the males to use the barrier device.

The wrong use of condom may be preempted by the lack of skills to use the device by the males. Reproductive health services must have continuous provision of information on all aspects on daily sustained programmes, health education can be given in groups and individually. The introduction of such service will awaken the males to take preventive actions in curbing the reproductive health problems.
Practical methods for health education should be implemented, the use of HBM, HAM and TTM are recommended. For individual or group work case studies can be used to encourage debates and ensure internalization of the information.

6.6 LIMITATIONS

The size of the sample was small to allow generalization of the findings to the whole community. Generalisation can be made to all those who use the services only. There was no special funding to could have increased the sample to a larger size to generalize to the whole community. There was difficulty in understanding the terms used in the questionnaire by some respondents because of the low educational standards. The explanation of the terms was done in one’s own language as the questionnaires were self administered without manipulation of facts. Parents were not included for interview as providers due to the limited contribution shown in the statistics by them to avoid emergence of new variables that may confuse the study aims. Teachers were also not included as their contribution for life skills development may require an independent study.

6.7 FURTHER RESEARCH

- The provincial or regional health programme developers may do a larger scale study to get needs for adolescents' reproductive health in Soshanguve.
- The health providers could integrate the adolescents' reproductive care as a comprehensive module forming a separate module during personnel training,
- Parental involvement towards behaviour modification and skills development has to be piloted for creation of the effective model.
- Evaluation of the life skills and HIV/AIDS education can be assessed as it is four years of its implementation.
6.8 SUMMARY

The results yielded pointed out the need for structures that are coordinated to aid in curbing the escalating incidences of the reproductive health. The pronounced community involvement will enable every care provider to recognize the alarming rates of pregnancy and STI/HIV/AIDS in the communities. The joint effort may also make the adolescents aware of every parent's involvement in the health promotion programme initiative, they may be motivated to behave positively.

The Department of Health needs to set the period by which the full implementation of policy guidelines should be done. Without such deadline, implementation may be delayed for longer periods, breeding negative results for health promotion.
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SABC News 17.04.02.
SABC News 03.11.02
SABC 1 Soul Buddyz April 2002.
SABC I Take Five.1998.


APPENDIX 1.1

P.O.BOX 9112268
ROSSLYN

The Regional Training Manager
Pretoria Region C
Karel Schoeman Building
Pretoria
0001

RE: APPLICATION FOR PERMISSION TO DO A RESEARCH FOR MA(CUR)
AT SOSHANGUVE HEALTH SERVICES/CLINIS.

I herin enclose the application for the above above. my research topic is A SURVEY OF PRIMARY PREVENTION SERVICES FOR THE ADOLESCENTS REPRODUCTIVE HEALTH NEEDS.

Find enclosed a detailed proposal and tools for data gathering.

Thank you for the anticipated positive response.

M.S.MATABOGE
29 November 2001

Ms M A Mataboge
P O Box 9112268
ROSSLYN
2000

RE: APPLICATION FOR PERMISSION FOR RESEARCH PROJECT BY UNISA STUDENT: MS MATABOGE

You are hereby given permission to do research on primary preventive Services for adolescents reproductive health needs.

Permission is subjected to the following conditions:

(i) That you obtain permission from the clients you want to interview.
(ii) That you obtain permission from the staff.

I wish you well with your research.

Thank you

MRS OL VOLKWIN
Director, Metro
APPENDIX 1.3

LETTER TO PARTICIPANTS
VOLUNTARY REQUEST TO PARTICIPATE IN THE STUDY

Any information specific to you need not be written on the questionnaire. This is in order to ensure confidentiality and not to reveal your identity as a person. The service surveyed e.g. clinic or adolescents' project centre will be used in order to classify information from the different strata but not disclosing the name of the respondent.

You are not compelled to participate, but your voluntary participation will greatly help in the improvement of the adolescent's reproductive health services to prevent the related problems.

May you please fill in the questionnaires and return them within 10 days of submission.

Thank you

M. S. Mataboge (Mcur student)
APPENDIX 1.4

QUESTIONNAIRE FOR THE ADOLESCENTS

SECTION 1

Respond by marking with an X in blocks provided

DEMOGRAPHIC DATA

1. AGE

2. FAMILY STRUCTURE
   Nuclear
   Extended
   Other

3. Number of children

4. Educational standard

5. SEX
   Female
   Male

6. Age at which you received guidance/information on reproductive health for the first time
THE FOLLOWING REPRODUCTIVE ISSUES ARE BEING OFFERED OR COVERED ADEQUATELY BY THE SERVICES LISTED BELOW. MARK WITH AN X IN APPROPRIATE BLOCK THAT REPRESENT YOUR EXPERIENCE.

7. Service provider: media e.g. television, radios, newspapers, magazines etc.

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<thead>
<tr>
<th>Topics</th>
<th>Strongly agree</th>
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8. Service provider: e.g. Parents, grandparents, aunts, uncles etc.

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<th>Topics</th>
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9. Service provider: e.g. nurses, health workers, doctors, psychologists, motivational speakers etc.

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<th>Topics</th>
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10. Service provider: e.g. Churches, i.e. priest, youth leaders, church elderlies etc.

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<th>Topics</th>
<th>Strongly agree</th>
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11. Service provider: e.g. Youth clubs, social clubs, cultural clubs etc.

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12. Do you think the information given by the above people or services assist you in handling your daily reproductive challenges positively?

Yes [ ] No [ ]

Explain
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

13. Are you using any contraceptive method(s)?

Yes [ ] No [ ]

14. List the method(s) you use:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
15. Have you ever used termination of pregnancy services
   Yes [ ]  No [ ]

16. If yes at what age
   ________________________________

17. Have you suffered any sexually transmitted diseases?
   Yes [ ]  No [ ]

18. If yes specify
   ______________________________________________________
   ______________________________________________________

19. Is HIV/AIDS a major reproductive health problem?
   Yes [ ]  No [ ]

   Explain
   ______________________________________________________
   ______________________________________________________
SECTION 2

TOPICS COVERED BY DIFFERENT HEALTH PROMOTERS

2.1 Do you think the time spent with you discussing sexuality/reproductive issues is enough for you to can question all issues discussed. Mark with an X in appropriate block to represent your experiences.

<table>
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<th></th>
<th>Greatly adequate</th>
<th>Adequate</th>
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<th>Not inadequate</th>
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2.2 Do you think there are some issues on sexuality/reproductive issues that are not talked about in the mentioned services.

Yes [ ] No [ ]

Explain

2.3 Who will you prefer to give you information on reproductive issues especially on first sessions.

Mark with 1 up to 7 to indicate your 1st, 2nd up to 7th choice.

<table>
<thead>
<tr>
<th></th>
<th>Private practitioner</th>
<th>Parents</th>
<th>Teachers</th>
<th>Health workers</th>
<th>Peer groups</th>
<th>Church members</th>
<th>Others (specify)</th>
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</table>
ACCESSIBILITY AND AVAILABILITY OF REPRODUCTIVE HEALTH SERVICES PROVIDED

2.4 Are you able to talk or contact any person rendering the service at any time you have a need to do so.
   Yes [ ] No [ ]

2.5 The service providers have relevant applicable information on all topics as listed and are free to talk to about.

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<thead>
<tr>
<th>Topic</th>
<th>Yes</th>
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2.6 List the topics you feel need to be covered to promote your reproductive health that this survey did not cover:

__________________________________________________________________________
__________________________________________________________________________

2.7 The teaching material used e.g. visual aids, videos or poster are adequate to give information.
   Yes [ ] No [ ]

Explain to support your response:
__________________________________________________________________________
__________________________________________________________________________
2.8 Condom use is promoted by all service providers

Yes [ ] No [ ]

Explain to support your response

________________________________________________________________________________

________________________________________________________________________________
October 16, 2001

Mrs. MS Mataboge

STUDY LEAVE

Herewith 50/50 study leave is granted for 2001 on the following conditions:

1. Availability when you are needed for College activities.
2. Your allocated College responsibilities amongst others may not be neglected.
3. Planning regarding your studies must be discussed in advance with your HOD and team members as well as the time periods that you plan to take 50/50 study leave.
4. Record keeping regarding your class attendance and 50/50 study leave must be submitted to your HOD.
5. See also the operational policy: Personal & Profession Development

Good luck with your studies.

For Co-ordinating Committee
APPLICATION FOR LEAVE OF ABSENCE FOR PROFESSIONAL AND PERSONAL DEVELOPMENT

I, Mataboge Sarah, hereby apply for approval for the following period 2002-01 - 2003-04: I am in possession, and well-informed, of the operational policy and procedure with regard to absences for personal and professional development. I hereby undertake to function inside the operational policy and procedure and not to let my study commitment/absence from duty affect my duties.

Field of Study/Symposium/Course: MatCovJ

Year of study: 2002 - 2003

Educational institution/Venue: UNISA

Way of study:

<table>
<thead>
<tr>
<th>Own-time</th>
<th>Special Leave</th>
<th>Part-time</th>
<th>Financial support for symposia, workshops etc.</th>
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<tbody>
<tr>
<td>X</td>
<td>50/50</td>
<td>16/8</td>
<td>Special Leave</td>
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<td>Full-time</td>
<td>Bursaries</td>
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</table>

- Own time = weekdays after 16:00 and weekends

Examination month/s: none

Motivation: The study will give impetus into student's accomplishment and clinical work/interest.

Signature Date

[Signature] [2002 08 28]