THE EVALUATION OF THE NATIONAL ADOLESCENT-FRIENDLY CLINIC INITIATIVE (NAFCI) PROGRAMME IN GREATER TZANEEN SUB-DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA

by

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submitted in partial fulfilment of the requirements

for the degree of

MASTER OF ARTS

in

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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NOVEMBER 2006

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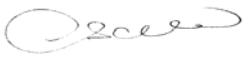
DECLARATION

I declare that THE EVALUATION OF THE NATIONAL ADOLESCENT-FRIENDLY CLINIC INITIATIVE (NAFCI) PROGRAMME IN GREATER TZANEEN SUB-DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



SIGNATURE DATE: 08/01/2007

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ABSTRACT

A case study design was used to evaluate the National Adolescent-Friendly Clinic Initiative (NAFCI) programme in Greater Tzaneen Sub-District of the Limpopo Province, South Africa. An interview guide was used to collect data from adolescents who visited the health centre at Nkowankowa in Limpopo Province and from professional nurses who provided the services at the health centre. Records were also reviewed to check clinic attendance of adolescents for sexually transmitted infections (STIs), voluntary counselling and testing (VCT), teenage pregnancy and contraceptive services.

According to the study, even though most adolescents made use of the NAFCI services especially those providing for contraception, pregnancy and STIs, the numbers of adolescents falling pregnant and contracting STIs did not decrease. Findings also indicated that VCT services were still not adequately used as indicated by the numbers in the registers. It is recommended that VCT, STI and pregnancy services be monitored and evaluated on a quarterly basis.

KEY CONCEPTS

Reproductive health, sex, sexuality, sexuality education, sex information.

ACKNOWLEDGEMENTS

I am grateful to God Almighty for giving me the strength and wisdom to persevere in this study. Blessed be his holy name.

I also wish to thank the following persons for their invaluable support and encouragement:

- Professor SM Mogotlane, my supervisor, for all she taught me and her endless support
- Donald, my husband, for his loving support and encouragement throughout the study
- Bongani, Base, Mafumisi and Don, my children, for their understanding and support
- The Limpopo Department of Health and Welfare, for permission to conduct the study at the clinic
- Nkowankowa Health Centre staff and management, for participating in the study and sharing their time and valuable input into the study
- Those adolescents who participated and without whom the study would have not been possible
- My relatives and friends, for supporting and assisting me in many ways
- Ms IM Cooper, for editing the manuscript

Dedication

This study is dedicated to:

Donald, my husband, for his unconditional support, and
My children, Bongani, Base, Mafumisi and Don,
for their understanding and support.

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AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CTOP	Choice on Termination of Pregnancy
ECP	Emergency Contraceptive Pill
HCP	Health Care Providers
HIV	Human Immune Virus
HST	Health Systems Trust
IEC	Information Education and Communication
NAFCI	National Adolescent Friendly Clinic Initiative
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
RH	Reproductive Health
RHRU	Reproductive Health Research Unit
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TOP	Termination of Pregnancy
UNFPA	United Nations Population Fund
Unisa	University of South Africa
USA	United States of America
VCT	Voluntary Counselling and Testing

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Chapter 1

Orientation

1.1 INTRODUCTION

Sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs and values about identity, relationships and intimacy. It encompasses sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image and gender roles. Furthermore, sexuality education guides the individual in becoming a responsible adult and is always accompanied by values and norms. Education and moulding of the individual are the primary aims to ensure a productive life (Department of Health 1999:69).

According to the National Department of Health (1999:70), the aims of sexuality education for adolescents are to

- make young people like and respect themselves and enhance their self-esteem and self-awareness
- help adolescents to see sexuality as a natural and positive part of life
- teach the skills needed for informed and responsible decisions, including decisions regarding sexual relationships
- explore different values and attitudes to enable each adolescent to develop his/her own moral framework
- teach adolescents how to protect themselves from exploitation and how not to exploit others
- teach adolescents how to communicate and express their needs and feelings
- teach adolescents how to use health services and find the information they need

The above aims are also contained in a programme called PRIDE (Department of Health 1999:70).

The acronym PRIDE is derived from:

- P Preparation of the individual for the physical changes of adolescence, and protection against guilt and exploitation by providing the necessary information and skills.
- R Remounting fears and misconceptions regarding sexuality.
- I Informing and providing insight into one's sexuality, attitudes, beliefs and values.
- D Developing positive self-esteem.
- E Education about responsible sexual relationships, sexual decisions and choices made (Department of Health 1999:70).

1.2 BACKGROUND TO THE STUDY

According to Dickson-Tetteh, Ashton, Pleaner, Moleko and Mangochi (2000:2), for the majority of young South Africans, sexual activity starts in the mid-teens and approximately eleven million episodes of sexually transmitted infections (STIs) occur each year in South Africa, with over half of these occurring among adolescents and young adults. Furthermore, adolescents' knowledge on reproductive function and sexuality is generally poor. Andrews and Boyle (1995:165) found that most teenagers look to other teenagers for information on sex. The authors have also reported that adolescents are physiologically vulnerable, susceptible to peer pressure; have a tendency to engage in risk-taking behaviour; are less able to negotiate safer sex practices, and have difficulty accessing reproductive health information and services. Despite the effort at public education about the risk of Human Immune Virus and Acquired Immune Deficiency Syndrome (HIV and AIDS), high risk sexual behaviour remains a norm (Stadler, Morrison & McGregor 2000:2).

According to LoveLife (2000:14), 60% of sexually active youth believe that having sex is a way of proving one's love to the other person, 3% indicated that they had their first sexual experience before their sixteenth birthday, 45% indicated that they first had sex between the ages of 16 and 18; 19% first had sex between the ages of 12 and 15, and 11% had sex at the age of 19 (Youth in Brief 2000:9-10). Table 1.1 depicts the age at first sexual intercourse.

Table 1.1 First sexual intercourse

Age at first sexual encounter (n = yrs)	Percentage (%)
12-15	19
16-18	45
19	11

Adapted from: Youth in Brief (2000:9-10)

To support the above information Andrews and Boyle (1995:165) in their study found that 20% of teenagers are sexually active by the age of 14, while 5% were found to be sexually active by 19 years and 35% of sexually active female teenagers became pregnant. The above information is an indication of the problem of sexual activity and pregnancy among adolescents.

Ehlers and Khoza (2001:2) found that adolescent mothers engaged in sex for the first time because they were coerced by their peers, while Abrahams and Hajiyiannis (2001:39) found that boys are more likely to have multiple sexual partners as well as engage in more risky sex than girls.

This study presents a programme (the NAFCI programme) that is designed to provide services to adolescents such that earlier and multiple sexual partner intercourse are kept to a minimum.

THE NATIONAL ADOLESCENT FRIENDLY CLINIC INITIATIVE (NAFCI) PROGRAMME

The Limpopo Province, South Africa, has introduced a programme, the National Adolescent Friendly Clinic Initiative (NAFCI) programme, to address issues related to sexuality among adolescents between the ages of 10 and 19. The overall goal of the programme is to effect positive behaviour change among adolescents as indicated in the following objectives of the programme, which according to Dickson-Tetteh and Foy (2001:11) are to

- make reproductive health care services accessible within community health clinics and acceptable to adolescents
- establish national standards and criteria for adolescent health care in clinics

- build capacity in health care providers to improve service delivery for adolescents

The NAFCI programme outlines ten standards by which adolescent-friendly services in clinics are to be judged (Dickson-Tetteh & Foy 2001:11). The standards are based on the general principles of good client care and characteristics of adolescent-friendly services identified by adolescents themselves, to ensure that

- management systems are in place to support the effective provision of adolescent-friendly health services
- the clinic has policies and processes that support the rights of adolescents
- appropriate adolescent health services are available and accessible
- the clinic has a physical environment conducive to the provision of adolescent-friendly health services
- the clinic has drugs, supplies and equipment necessary to provide the essential service package for adolescent-friendly health care
- information, education, and communication (IEC) consistent with the essential service package is provided
- systems are in place to train staff to provide effective adolescent-friendly health services
- adolescents receive an appropriate psychosocial and physical assessment
- adolescents receive individualised care based on standard case management guidelines/protocol
- the clinic provides continuity of care for adolescents

To this effect the NAFCI programme provides the following essential services:

- Information, education, and counselling on reproductive health.
- Contraceptive information, including counselling on emergency contraceptives, (oral and injectables).
- Pregnancy testing and counselling.
- Antenatal and postnatal care for teenagers.
- STI information, including diagnosis and syndromic management of STIs and partner notification.
- HIV and AIDS information, pre- and post-test counselling.

According to Dickson-Tetteh and Foy (2001:8), the NAFCI programme has inherent guiding principles that recognise that:

- Every adolescent is unique and has different needs for health information and services in accordance with age, race, gender, culture, life experiences, and social situation, physical and mental well-being.
- Adolescents have sexual and reproductive rights, including the right to a full range of services. Participation in the planning, development and evaluation of services and programmes that address their needs is also their right.

1.3 PROBLEM STATEMENT

The provision of adolescent friendly services was identified as a priority in the Limpopo Province, South Africa. The NAFCI programme was introduced in August 2001 to realise this priority. The Greater Tzaneen sub-district in the Limpopo Province was selected as a pilot site for this programme with Nkowankowa Health Centre as the service point.

The criterion used to select the pilot site was the high rate of STIs and teenage pregnancy in the sub-district. According to statistics at the Nkowankowa Health Centre, 255 cases of STIs were seen in 2000 and of these 155 were adolescents. The high incidence of STIs could be an indication of teenage involvement in unprotected sexual intercourse which activity can culminate to teenage pregnancy and HIV infection as well.

Since its inception in 2001, the programme has not been evaluated to establish its impact on service provision. Periodic evaluation of the programme is necessary because the province has invested human and financial resources to initiate the activities that are inherent in the programme. This study wished to evaluate the NAFCI programme in Greater Tzaneen sub-district of the Limpopo Province in South Africa, so that the programme can be reinforced or reviewed accordingly.

1.4 SIGNIFICANCE OF THE STUDY

Adolescent reproductive health is a key area of service provision in Limpopo Province and, as such, it is given priority. Adolescent sexuality education inherent in adolescent reproductive health will also contribute in controlling the spread of HIV and AIDS and STIs as well as in the reduction of teenage pregnancy.

The programme was introduced to provide adolescents with skills that would improve their health and build a society with a sound moral fibre, allowing adolescents to progress to adulthood healthy physically, socially and emotionally. The programme is also intended to identify problems in relation to sex and sexuality education as well as the provision of reproductive health services.

The study will also provide information necessary for planning for health provision in the province, identifying areas for research and policy development for the Department of Health in the province.

1.5 SUPPORTING LITERATURE

Relevant literature was reviewed. According to Wood, Maepa and Jewkes (1997:5), adolescent pregnancy ranks among the most important health and development problems in South Africa. LoveLife (2003:8) reported South Africa as having the highest teenage pregnancy rate in the world. The national teenage pregnancy rate is estimated at 330/1000 women less than 19 years of age (Wood et al 1997:5). Similarly, STIs, including HIV and AIDS, are a result of risk behaviour that adolescents often engage in (Department of Health 2001a:39).

According to the *White Paper on Population Policy* (South Africa (Republic) 1998:43), the objectives of sexuality education are to promote responsible and healthy reproductive and sexual behaviour among adolescents, reduce the incidence of high-risk teenage pregnancy, abortion and STIs including HIV and AIDS through the provision of life skills and user-friendly health services.

Vergani and Frank (1998:8) cited in Department of Health (1999:70) indicate that it is important to realise that knowledge on reproductive functioning is generally poor among adolescents. Although every adolescent has some beliefs, ideas and information about sex and sexuality, the information is not received from formal lessons or talks about sex and sexuality or from adults or parents, nurses and teachers. It is therefore often inaccurate and misleading. Adolescents often have contradictory views of sexuality, and can be misinformed about factual issues relating to sex and sexuality, such as birth control and most importantly HIV and AIDS. In the study conducted by Vergani and Frank (1998:8) cited in Department of Health (1999:70) a substantial number of adolescents also indicated that they needed information on matters such as pregnancy, STIs including HIV and AIDS, contraception and termination of pregnancy (TOP).

Dickson-Tetteh and Foy (2001:22) emphasised that a sound knowledge of anatomy and physiology of the male and female reproductive systems and common physiological experiences that occur during adolescence are essential for adolescents to know how their bodies function.

Greathead, Devenish and Funnell (1998:3) maintain that the lengthy period of transition from childhood to adulthood indicates a need for support. Knowledge about the physical and emotional changes during adolescence is essential as it lays the foundation for further sexuality education.

Furthermore, Greathead et al (1998:29) indicated that teenage years are filled with challenges. Pursuit of autonomy and independence include a struggle for peer group acceptance, acceptance of self and friction with the family, school and influential others. At this stage of development, relationships are important for support, comfort, acceptance, approval, and companionship. The key elements of a positive relationship include communication, mutual respect, empathy, genuineness, common values, attitudes, positive self-esteem and unconditional acceptance of the other person. In summary important relationships therefore include family and peer relationships (Dickson-Tetteh & Foy 2001:34).

The question of whether to have sex or not, usually starts at puberty. According to Dickson-Tetteh and Foy (2001:35)**,** the process is more difficult during adolescence

because of increased hormonal production, lack of decision-making skills, risk-taking behaviour and peer group pressure.

Literature provides evidence that there is a need to improve reproductive health of people particularly adolescents.

1.6 PURPOSE OF THE STUDY

The purpose of the study was

- to evaluate the NAFCI programme in the Greater Tzaneen sub-district, Limpopo Province, South Africa

1.7 OBJECTIVES OF THE STUDY

The objectives of the study were to evaluate the NAFCI programme in terms of:

- Adolescents' clinic utilisation as confirmed by adolescents as service consumers, professional nurses as service providers and as reflected in the clinic records.
- Service related statistics such as number of STIs diagnosed and treated in the clinic, contraception provided, and pregnancies attended to.
- Identifying factors that negatively or positively influence the implementation of the NAFCI programme.

1.8 RESEARCH QUESTION

The study wished to answer the following research question:

- What is the impact of the NAFCI programme on the reproductive health of adolescents in Greater Tzaneen sub-district, Limpopo province, South Africa?

1.9 OPERATIONAL DEFINITIONS

For the purpose of this study, the following terms are used as defined below.

- **Adolescent**

The *White Paper on Population Policy* defines adolescent as "youth between 10-19 years" (South Africa (Republic) 1998:38). *Mosby's Medical and Nursing Dictionary* (1986:29) defines adolescent as "of, pertaining to, or characteristic of adolescence; one in the state or process of adolescence; a teenager" and adolescence is defined as "the period of development between the onset of puberty and adulthood". It usually begins between 11 and 13 years of age, with the appearance of secondary sex characteristics, and spans the teen years, terminating at 18 to 20 years of age with the acquisition of completely developed adult form. During this period the individual undergoes extensive physical, psychological, emotional, and personality changes.

Collins English Dictionary (1991:20) defines adolescence as "the period in human development that occurs between the beginning of puberty and adulthood". Adolescence, then, is the period of physical, psychological, and social transition from childhood to adulthood, between the ages of 10 to 19.

- **Chill room**

A chill room is a place where adolescents go in for information on reproductive health and collection of condoms. Chill room statistics is collected based on the number of adolescents who collect condoms and received information.

- **Education**

Van Rooyen and Louw (1994:25) define education as "a means of assisting a child to become mature and moulded to display the image of adulthood with a sense of responsibility as well as developing socially acceptable attitudes in relation to sexual matters".

- **National Adolescent Friendly Clinic Initiative (NAFCI)**

Dickson-Tetteh and Foy (2001:8) describe NAFCI as “a programme designed to improve the quality of adolescent sexual and reproductive health services at primary health care level”. The NAFCI programme was developed by the reproductive health research unit (RHRU) in partnership with LoveLife in 2000. It was the first programme to be implemented in South Africa and Nkowankowa Health Centre was the pilot site in 2001.

- **Reproductive health**

According to the Department of Health (2003:102), reproductive health is within the framework of WHO’s definition of health as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, function and system at all stages of life.

- **Reproductive health services**

The Department of Health (2001b:38) refers to reproductive health services as “the constellation of services aimed at fostering sexual and reproductive health. The services include preventive and promotive services, such as information, education, communication, counselling and management in relation to sexual activities including STIs, HIV and AIDS, infertility, abortion, contraception, antenatal care, safe childbirth and postnatal care.”

- **Sex**

The Department of Health (2001b:39) defines sex as “the biological status of male or female. It is also used to mean sexual intercourse”.

- **Sexuality**

According to Van Rooyen and Louw (1994:23), sexuality is “an integration of physical, social, and intellectual aspects of an individual that express masculinity or femininity”.

The Department of Health (1999:69) define sexuality education as a lifelong process of acquiring information and forming of attitudes, beliefs and values about identity, relationships and intimacy.

- **Sexuality education**

According to the Department of Health (1999:70), sexuality education is a lifelong process of acquiring information and forming of attitudes, beliefs and values about identity, relationships and intimacy.

- **Sex information**

Sex information is the provision of information, including anatomy and physiology of sex organs as well as sexual development (physical and emotionally) and intercourse (Department of Health 2001b:38; Van Rooyen & Louw 1994:25).

- **Tick register**

A tick register is a register where health care providers enter the patients particulars including the name, file numbers, physical address and the patients complaints so that the patients can be directed to a specific service area as indicated by the presenting complaints. At the end of consultation the patient must return to the admission area for the medical diagnosis and treatment to be entered into the tick register. The register therefore contains the full details of the patient.

1.10 RESEARCH DESIGN AND METHODOLOGY

A exploratory survey was used to provide a quantitative and qualitative description of the NAFCI programme in Limpopo Province, South Africa (see chapter 3).

1.11 CONCLUSION

This chapter introduced the study and described the problem, purpose and objectives of the study, the NAFCI programme and defined key operational terms.

Chapter 2 discusses the literature review conducted on the topic under investigation.

Chapter 3 deals with the research design and methodology.

Chapter 4 presents the data analysis and interpretation.

Chapter 5 discusses the findings and makes recommendations for practice and further research.

Chapter 2

Literature review

2.1 INTRODUCTION

The NAFCI programme is about adolescent reproductive health service provision. This chapter therefore presents a review of literature on sexuality education for adolescents as well as aspects that expose adolescents to preventable reproductive health problems.

According to Dickson-Tetteh and Foy (2001:2), South Africa has 18 million people under the age of 20 years and these accounts for approximately 44% of the total population. The authors further stated that health and behaviour problems such as STIs, teenage pregnancy, HIV and AIDS, unsafe sex, and substance abuse occur together.

Secondary sexual growth occurs around puberty and results in changes in hormonal secretions, emotional, cognitive and psychosocial development. This, in turn, results in awareness of sexuality in male and female adolescents, sexual curiosity including experimentation with unprotected sexual intercourse that could lead to the transmission of STIs including HIV, unwanted teenage pregnancies, backstreet abortion, and death thereof (Oronsaye & Anukam 2000:30). Spradley and Allender (1996:411) reinforce that increasing sexual activity among adolescents predisposes adolescents to teenage pregnancy, STIs and HIV and AIDS.

2.2 SEXUALITY EDUCATION

Van Rooyen and Louw (1994:19) describe sexuality education as part of basic education that directs the learner towards a purpose and what ought to be. Basic education should uplift and refine the child. Sexuality education programmes should aim at promoting a positive attitude that would help adolescents to make informed decisions on their own in a responsible manner and take a stand with regard to personal life in a dynamic society. Sexuality education should inculcate self-awareness, respect and dignity.

Greathead et al (1998:6) emphasised that sexuality education cannot and should not be seen in isolation, but rather regarded as an essential part of life skills training as it is taking place continuously in each person's life through verbal and non-verbal messages from everyone around adolescents, including family, friends and the media.

LoveLife (2001:12) indicated that 51% of adolescents first learn about sexuality from nurses or nongovernmental organisations who visit schools or from teachers, 72% learn from television, 65% learn from friends and 45% from parents. This is an indication that adolescents learn about sex and sexuality from different sources which can be reliable and unreliable.

Calderwood (1983) cited in Greathead et al (1998:6) states that sexuality education within the NAFCI programme provides for growth. The NAFCI programme as depicted in figure 2.1 below indicates that the programme encourages professional nurses in the NAFCI clinic to provide accurate information to all adolescents going to the clinic for reproductive health services enabling them to make informed decisions.

Furthermore, through this programme the adolescents will develop communication skills to be able to face challenges like peer pressure and will be able to say "no", and build attitudes and values to be able to protect themselves against HIV and AIDS, teenage pregnancy and STIs thus contributing to the reduction thereof.

Figure 2.1 graphically illustrates the programme, which supports the notion of providing accurate information to guide decisions on sexuality. Furthermore, the diagram schematically anchors the NAFCI programme in the centre of all other programmes.

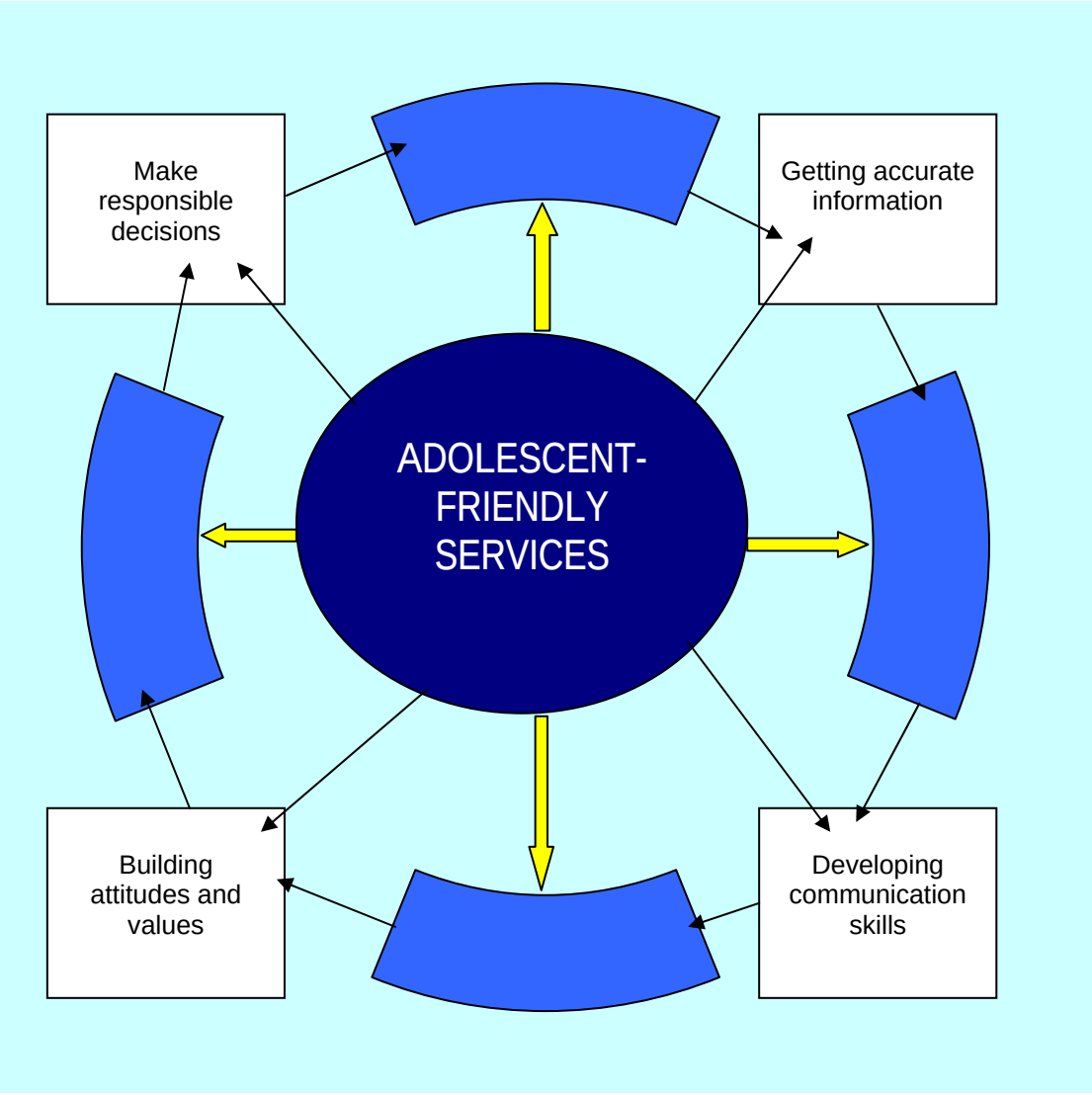

Figure 2.1

The impact of the NAFCI programme on the reproductive health of adolescents

Adapted from Greathead et al (1998:6)

2.3 TEENAGE PREGNANCY

According to LoveLife (2003:8), South Africa has one of the highest teenage pregnancy rates in the world. More than one-third of all babies born in South Africa have mothers younger than 19 years of age.

According to Mercer (1995:225), 13% of all live births were to adolescent mothers. In 1995 the teenage pregnancy rate was estimated to be 330 per 1 000 women under the age of 19, and 40% of all pregnancies were estimated to be to teenage girls (Department of Health 2001a:38).

2.3.1 Factors contributing to the increase in teenage pregnancy

Dickson-Tetteh and Foy (2001:112) identify the following as the factors that contribute to teenage pregnancy:

- Early sexual debut associated with the increasing loss of traditional social norms for both adolescents and adults.
- Risk behaviours, such as alcohol and substance abuse, which are particularly associated with unprotected sexual activity.
- Poverty and vulnerability that expose young people to sexual coercion, rape, and sexual exploitation.
- Lack of knowledge of self-protective methods.
- Declining age of menarche.
- Lack of access to adolescent-friendly sexual and reproductive health information and services, including inaccessible services for safe termination of pregnancy.

2.3.2 Consequences of teenage pregnancy

- **Socio-economic**

Mcwhirter, Mcwhirter, Mcwhirter and Mcwhirter (1998:140) states that a teenage girl who decides to keep her baby is likely to suffer negative consequences in the form of substandard housing, poor education, and unemployment or under-employment, and financial dependency. Young mothers with limited education do not have the skills, resources and experience necessary to overcome poverty and the pervasive sense of powerlessness that usually accompanies it. Most teenagers who carry their pregnancy to term also decide to keep their babies, increasing the potential for poverty.

- **Educational**

According to Mcwhirter et al (1998:140), teenage pregnancy is associated with low achievement scores at school and low vocational aspirations. Youth at risk of becoming parents are also at risk of dropping out of school and more likely to be unemployed or under-employed throughout much of their lives. Teenage mothers are three times more

likely to drop out of school than mothers who delayed childbearing until they were in their late 20s.

- **Health-related**

Mcwhirter et al (1998:141) state that pregnant adolescents commonly experience poor nutrition, poor health and limited access to and use of medical and health services. Prenatal and postnatal problems are more common among teen mothers and more of their babies are likely to die, because they seek prenatal care late in their pregnancy. The younger the mother, the higher the incidence of anaemia, toxaemia of pregnancy, urinary tract infection, STIs, HIV and AIDS, cephalopelvic disproportion and complications of labour and birth. Children of teenage mothers have serious health problems, like low birth weight, hypothermia and hypoglycaemia.

- **Family-related**

According to Mcwhirter et al (1998:141), few teenagers who fall pregnant actually get married. Of those girls who do marry, nearly a third gets divorced within five years, compared to 15% among couples who marry later. Most children born to teenage mothers will spend at least part of their lives in single parent homes, a factor that has a negative influence on the upbringing of the children.

Teenage mothers are at a great disadvantage when they try to create a healthy and stimulating environment for their children. They are often forced to work long hours and may have little time to spend with their babies. These problems may be compounded by neglect, as teenage mothers often know little about what babies need to thrive. Teenage mothers experience a great deal of stress and the potential for child abuse is significant.

2.3.3 Prevention of teenage pregnancy

Adolescent pregnancy has serious consequences for teenagers, their families and society, and it is essential to encourage responsible sexual behaviour.

Prevention is based on three approaches:

- Family life planning and sex education.
- Increased accessibility of contraceptives to teenagers.
- Increased life options for teenagers who are at risk for unprotected sexual activity and pregnancy.

2.3.3.1 Family life planning and sexuality education

For proper development, all children including adolescents need appropriate family education and support for responsible sexual behaviour, and access to information about human sexuality, reproduction and birth control (Mcwhirter et al 1998:144).

Information and knowledge about sexuality must be combined with other approaches and strategies to improve relationships, boost self-esteem and improve behavioural skill. For sexuality education to be effective, Mcwhirter et al (1998:144) as well as Smith and Maurer (2000:661) focus on three programmes: abstinence-only, contraception and abstinence, and comprehensive reproductive health education programmes.

(1) Abstinence-only programmes

According to Smith and Maurer (2000:661), abstinence-only programmes advocate family planning without the use of contraceptives. These programmes appear to affect attitudes regarding premarital intercourse.

(2) Contraception and abstinence programmes

These programmes address both behaviour and attitudinal change of adolescents whereupon some adolescents demonstrate positive changes in behaviour in relation to abstinence, while others demonstrate a positive change in attitudes towards contraceptives (Smith & Maurer 2000:661).

(3) Comprehensive reproductive health education programmes

Comprehensive reproductive health service education programmes include information about clinical services, abstinence, and contraceptives. These programmes appear to delay the initiation of intercourse, reduce the number of sexual partners, and increase the use of contraceptives, making the programmes the most crucial in sexuality education (Smith & Maurer 2000:661).

2.3.3.2 Increased accessibility of contraceptives to teenagers

Sexually active adolescents need to access contraceptive methods (Mcwhirter et al 1998:145). Information must be made available and while contraceptives cannot be forced on youngsters, they should be afforded a choice. Access can best be provided through community and school-based clinics that provide comprehensive, easily accessible, and high quality health services for adolescents.

2.3.3.3 Increased life options for teenagers at risk for unprotected sexual activity and pregnancy

Young people need skills to avoid pregnancy, skills in decision making, assertiveness and building self-esteem (Mcwhirter et al 1998:145). Young people at risk for pregnancy need to be encouraged to make correct decisions in relation to sexual activities. Adolescents need to understand the reasons for engaging in sexual intercourse and why they should use contraceptive methods that prevent pregnancy as well as diseases like HIV and AIDS and STIs. Adults who work with young people at risk for pregnancy need to understand the reasoning of adolescents to be in a position to help the young people make better decisions.

According to Smith and Maurer (2000:663), programmes that offer skills in life options provide a variety of structures and strategies, including one-on-one mentoring and role modelling with successful adults, community service participation, tutoring services, and remedial education.

2.4 ROLE OF THE NURSE IN REPRODUCTIVE HEALTH EDUCATION

Community health nurses can provide factual Reproductive Health education for teenagers as they provide other services (Smith & Maurer 2000:662). Nurses are effective Reproductive Health educators because they are equipped with the knowledge in anatomy and physiology of the reproductive system and how this impacts on sexuality. Community health nurses are in a privileged position to encourage clinic attendance and promote access to contraceptive services when counselling an adolescent.

It is imperative for the nurse to emphasise the importance of contraceptive use by all sexually active adolescents. At a time when STIs, including HIV, are rampant, the nurse is charged with the responsibility to provide adolescents with relevant information so that they are able to make informed choices.

2.5 CONTRACEPTIVES AND ADOLESCENTS AS CLIENTS

Greathead et al (1998:228) found that more teenagers in the United States of America (USA) are sexually active but few use contraceptive protection, resulting in rising numbers of pregnancies. In these situations contraceptive use is as low as 25% while teenage pregnancy represent a third of all births.

According to the Department of Health (2003:9), the onset of sexual activity in South Africa ranges from 13 to 18 years. Moreover, the majority of adolescents do not have access to sexual and reproductive health information and services, hence their poor knowledge on reproductive matters.

2.5.1 Factors influencing contraceptive use among adolescents

- **Knowledge of contraception**

There is a perception that almost all women in South Africa know of at least one contraceptive method. The Department of Health (2003:9) found that knowledge of reproductive functions is generally poor among adolescents and there is considerable confusion over contraceptives and family planning programmes.

- **Attitude of health care providers on contraceptive issues**

According to the Department of Health (2001b:12), health care providers' attitude is judgemental of adolescents who use contraceptives. For maximum positive results, it is recommended that health care providers need to be knowledgeable about the rights of adolescents, more understanding and more available to explain and counsel teenagers during the provision of sexual and reproductive health services to ensure that adolescents get relevant information to be able to make informed decisions.

Recommendations on the improvement of services include extension of consulting hours, reduction of waiting times and increased privacy for consultation. Contraceptive services should be integrated with other health services and, where possible, those related to adolescent should be rendered separate from other services. This would probably assist in reducing poor utilisation and lead to accessibility and increased contraceptive use among adolescents (Dickson-Tetteh & Foy 2001:27).

- **Socio-economic factors**

Low contraceptive use is also associated with poor socio-economic status where female adolescents engage in sex for money and do not use protection against pregnancy and STIs (Department of Health 2001b:10).

- **Urban-rural residence**

Urbanisation has been cited as a factor in sexual activity of adolescents and the use of contraceptives. Adolescents from urban areas have been found to be acculturated and more knowledgeable about contraceptives methods than adolescents from rural areas because of their early involvement in sexual intercourse and also because of availability of services in their schools and communities.

- **Women's education and status in society**

Department of Health (2001b:12) indicated that in South Africa, 7% of women aged 15 to 19 years have no formal education and, can therefore not access reading material where issues about sex and contraception are discussed. The inferior status of women

in the community and dependency in the family impact on the ability of women to make choices. Improving women's education and economic opportunities can have a significant influence on the use of contraception and control of sexual and reproductive health.

2.5.2 Recommended contraceptive methods for adolescents

- **Abstinence**

Abstinence or avoidance of sexual intercourse is the best method for avoiding pregnancy or STI including HIV and AIDS. Health care providers should, in their counselling, encourage adolescents to abstain. The gains of abstinence are manifold. Not only is health and no pregnancy a benefit, education is also sustained, ensuring a bright future for the adolescent.

- **Condoms**

Condoms have been found to be very effective as a contraceptive method provided they are correctly used. Dickson-Tetteh and Foy (2001:56) define a condom as a physical barrier to the passage of sperm, microbes and viruses between the genital tracts of sexual partners. Male and Female condoms are particularly appropriate for young people. They are usually accessible without prescription, immediately effective, user-controlled and only need to be used when required. When used correctly and consistently, they are effective in preventing pregnancy and infections like STIs including HIV and AIDS. Condoms can be used alone or in combination with other methods of contraception.

The United Nations Population Fund (UNFPA) recommends reducing the spread of STI and HIV through the use of condoms. UNFPA (2000:16) confirms that STI can increase the risk of HIV infection tenfold, while treating STI effectively can reduce HIV transmission. Salmon (2002:12) states that condom use has been found to reduce the transmission of STIs and HIV from infected men to non-infected women by 90%.

- **Emergency contraception**

Emergency contraception is not recommended as a regular method, and does not protect against transmission of STIs/HIV. Emergency contraception is recommended after sporadic, unplanned, and often unprotected sexual intercourse. Emergency contraception is also useful after contraceptive accidents, such as breakage of a condom or a missed pill. The Department of Health (2003:71) has emergency contraception protocol in place to guide the process in providing contraceptive methods in the first few hours or days following an episode of unprotected sexual intercourse, including

- the "morning after" pill
- hormonal, emergency contraceptive pills (ECPs) taken within five days of unprotected intercourse
- copper-bearing IUD, inserted within five days after unprotected intercourse

Table 2.1 Recommended emergency contraceptive pill (ECP) regimen

CONTRACEPTIVE PILL	1ST DOSE WITHIN 72 HOURS	2ND DOSE 12 HOURS LATER
Ovral	2 pills	2 pills
Nordette	4 pills	4 pills
Microval	25 pills	25 pills

Table 2.1 indicates the dosages to be given or prescribed to clients coming for ECP. The NAFCI programme recommends that all consultation rooms should have these guidelines and health care providers should be trained in the different types of contraceptive methods to ensure that clients including adolescents receive quality emergency contraceptive services.

2.6 SEXUALLY-TRANSMITTED INFECTIONS (STIs)

Other issues that adolescents are exposed to are STIs. The control of STIs is a public health priority in South Africa (Health Systems Trust 1999:84). STIs are a significant cause of ill health as they are associated with the transmission of HIV. According to Spradley and Allender (1996:418), an estimated 11 million cases of STIs are treated annually in South Africa and 2,5 million of these are amongst adolescents. The infecting organisms are chlamydia, gonorrhoea, and herpes.

Nationally, 15 to 19-year-olds have the highest rates of STIs, with female adolescents being more infected than males (Department of Health 1998:14). Adolescents are vulnerable to STIs because of inadequate knowledge of STIs, a tendency to engage in risk-taking behaviour and inaccessibility of health facilities. Adolescents from poor socio-economic backgrounds become involved in commercial sex work with little or no protection, exposing themselves to preventable diseases (Dickson-Tetteh & Foy 2001:80).

2.6.1 Behavioural and psychological factors associated with STI risk

- **Socio- economic factors**

Stanberry and Bernstein (2000:127) note that the rates of most STIs are greater in sexually active adolescents than adults. Ngesi (2001:19) points out that some factors that contribute to the spread of STI are that people who are poor may not be able to afford transport costs to health services and therefore may remain untreated for a long time. Sometimes in communities where housing and poverty are an issue women are made to have sex with men as payment for accommodation, protection and other favours.

- **Low status of women in society**

According to Ngesi (2001:19), many women are brought up to accept a subservient relationship with men and therefore find it difficult to enforce the use of condoms during sexual intercourse. Engagement in unprotected sex may expose the woman to unwanted infections.

- **Poor and inaccessible health services**

In many parts of the country, adolescents do not have adequate access to health facilities, and have difficulty in getting attended to in the regular services as a result of school hours in some instances. Busy, overworked nurses sometimes do not have the time to do a proper examination (Department of Health 1997:19 cited in Ngesi 2001:20).

- **Incorrect beliefs and ineffective treatment**

Ngesi (2001:20) found that people often delay seeking appropriate treatment because of incorrect beliefs about the causes of STIs. Those who believe in witchcraft may seek help from traditional healers rather than clinics or medical doctors thus delaying the diagnosis and advancing complications.

- **Societal factors**

Stanberry and Bernstein (2000:129) found that South African society has difficulty discussing sexuality openly. In some religions, sexuality is viewed from a moralistic perspective and STI is considered a result of promiscuity. Patients with this belief may find it difficult to approach a professional for assistance thus delaying consultation.

Parents are a primary source of information on sexuality, yet communication between parents and teenagers may not take place at all regarding sexuality. Given parental discomfort or lack of knowledge or skills on the topic of sexuality, there is a possibility that some teenagers may become sexually active with no guidance or provision of information.

- **Partner notification and follow-up**

According to Stanberry and Bernstein (2000:131), partner notification is a critical part of an STI prevention and control programme. Partner notification is important not only to prevent the spread of infection to others, but to prevent re-infection. The most common method of partner notification is self-referral and provision of notification referral slip.

2.6.2 Complications of STIs

The complications of STIs include:

- **Infertility in women and men**

One of the common causes of infertility in this country is the damage caused by infection due to STIs. In women, pelvic inflammatory disease causes scarring of the

fallopian tubes and blockage so that fertilisation is not possible. In men, epidydimo-orchitis can occasionally cause scarring and blockage of the vas deference and other structures so that sperm production and movement is impaired

- **Ectopic pregnancy**

Because of blocked fallopian tubes, pregnancy may occur in the pelvic cavity as ectopic pregnancy.

2.7 PREVENTION APPROACHES

Stanberry and Bernstein (2000:132) emphasise that all efforts to promote STI and HIV risk reduction should be based on sound principles of behaviour change, accessible and culture-sensitive health care provision. HIV and STI prevention begins with providing clear messages regarding sexuality before an individual becomes sexually active hence the NAFCI programme ensures that adolescents receive relevant information to protect themselves against STIs before they are sexually active.

Spradley and Allender (1996:513) add further that specialised training for clinicians providing sexual and reproductive health services for adolescents as important. This training should assist nurses in providing effective health promotion approaches in the community and should include HIV/STI prevention in the curricula of middle and secondary schools. The number of clinics offering STI/HIV screening, diagnosis, treatment, counselling and referral should increase substantially to improve access to comprehensive STI and voluntary counselling and testing (VCT) services.

Behaviour change will require diverse and multidisciplinary interventions over an extended period. These interventions must integrate the efforts of parents, families, schools, religious organisations, health departments, community agencies and the media (Spradley & Allender 1996: 513; Stanberry & Bernstein 2000:132). Parent-child conversation about sexual matters has been associated with delays in initiation of sexual intercourse and increased use of contraceptives by adolescents who engage in sexual intercourse.

- **Education for prevention**

The UNFPA (2000:14) states that young people with higher self-esteem are better able to avoid risky behaviour involving alcohol, drugs, and unprotected sex.

Through education, young people learn to negotiate and develop decision-making skills that they can apply to prevent unwanted sexual relationships, protect themselves from sexual exploitation and violence, and negotiate condom use when sexually active.

- **Peer educators**

Peer education is important as young people easily identify with peers. Young performers can get their message across through dramatic plays and songs or by acting correctly (UNFPA 2000:16). According to Salmon (2002:13), sex education in schools could enable adolescents to adopt or switch to safe sex practice much easier than they would if instructed at home.

Peer group education in schools is often more effective than education developed and delivered by external agencies. This education should be culturally relevant to target the underlying cultural issues in society relating to sexuality (Salmon 2002:13).

2.8 SUBSTANCE ABUSE

According to the Department of Health (2001a:47), children are beginning to use alcohol and other drugs at a much younger age. A national survey indicates that 34% of Grade 6 student experience peer pressure to use dagga and 51% experience pressure to drink alcohol.

The Department of Health (2001a:47) further states that the earlier the young person starts using drugs, the more likely he/she is to experience dependency and go on to other drugs. The friends are the culprits in offering most adolescents drugs for the first time. In a study of 1000 young people, the majority stated that all drugs (from alcohol to crack cocaine) are readily available to anyone who wants them (Department of Health 2001a:47). Alcohol is the substance most frequently abused by adolescents or young

South Africans and in the study 80% of Black youth aged 10 to 21 reported that they had used alcohol at some time or other.

- **Predisposing factors**

Dickson-Tetteh and Foy (2001:157) identify the following factors that predispose adolescents to substance abuse:

- Peer pressure
- Adult drunken behaviour that is portrayed as cool
- Adolescents' own low expectations of achieving valued life goals
- Emotional feelings of distress, such as depression, anxiety, and vulnerability
- Easy availability of abusive substances in the community

- **Impact of substance abuse on adolescents**

According to the Department of Health (2001a:47), adolescents are particularly vulnerable to the adverse effect of alcohol and illicit drugs because of the relatively smaller body size that reduces the tolerance thereof. Adverse outcomes include over dosage that may lead to unacceptable behaviour, poor school performance or drop- out and death. In addition, in the early stages of drug dependency, inhibition may be lowered, increasing the likelihood of participation in unsafe sex with the risk of unwanted pregnancy and STIs, including HIV.

- **Prevention of substance abuse**

Dickson-Tetteh and Foy (2001:160) outline the following preventative strategies:

- Inform and educate adolescents about alcohol, tobacco and other drugs.
- Emphasise the likely consequences on their bodies, minds, health, development and life.
- Help adolescents to develop a healthy self-image.
- Be involved with them, their life and interests to enhance self-regard.
- Help adolescents to develop a strong set of values so that they are more able to make decisions based on facts rather than peer pressure.

- Encourage the family not to abuse drugs as this may provide an environment that is not conducive for a child to grow in.
- Work to form close parent-adolescent relationships.
- Teach adolescents how to deal with peer pressure and to be able to say “NO”.
- Provide recreational activities, to reduce the need for substance use. Campaign against glamorous advertisements of cigarette and alcohol (Dickson-Tetteh & Foy 2001:160).

In addition, the Department of Health (2001a:48) lists the following intervention strategies:

- Improve the availability of substance-related counselling services at schools, health facilities, prisons and in the streets.
- Increase the availability of telephone hotline services, like LoveLife, and encourage adolescents to use them for counselling.
- Improve health personnel training in the detection, diagnosis and management of adolescents suffering from substance abuse.
- Provide free needles or arrange needle exchange programmes for young people addicted to intravenous drugs to prevent HIV transmission.
- Provide a support service for those addicted in an effort to wean them of the habit.

2.9 CONCLUSION

This chapter discussed the literature reviewed for the study. Premature, irresponsible sexual activity, teen pregnancy and HIV and AIDS are growing health problems in all communities worldwide requiring responsive action to help young people improve their feelings of self-worth as well as recognise their own strength and potential. Comprehensive programmes should be developed to expand educational and occupational opportunities for young people to realise their capabilities.

Chapter 3 describes the research design and methodology.

Chapter 3

Research design and methodology

3.1 INTRODUCTION

This chapter describes the research design and methodology, including the setting, data collection and ethical considerations.

3.2 RESEARCH METHODOLOGY

3.2.1 Setting

The study was conducted in Nkowankowa Health Centre in the Greater Tzaneen sub district in the Mopani district, Limpopo Province. Nkowankowa Health Centre is located 7 km from Letaba Regional Hospital and 26 kilometres from Dr CN Phatudi District Hospital, both of which serve as referral points. The Health Centre serves a population of 50 684, of whom 7 064 are adolescents. Sixteen professional nurses work on shifts seven days a week. Nkowankowa Health Centre provides the following NAFCI services for adolescents:

- Information, education and counselling on sexual and reproductive health.
- Information, counselling and appropriate referral for violence/abuse and mental health problems.
- Contraceptive information, counselling and provision of contraceptive methods including, emergency contraception
- Pregnancy testing and counselling, antenatal and postnatal care.
- STI information, including prevention, diagnosis, syndromic management and partner notification.
- HIV information, pre- and post-test counselling, including referrals for voluntary counselling and testing.
- Information on pre- and post-termination of pregnancy counselling and referral
- Minor ailments like coughs, sores, and wounds (Health Systems Trust 1999:1).

3.2.2 Research design

A exploratory survey was used to provide a qualitative as well as a quantitative description of the NAFCI programme. The information was used to evaluate the NAFCI programme, which had been in operation for four years (from 2001 to 2005) at the time of the study in the Greater Tzaneen sub district. According to Yin (1994:4), a case study is used to evaluate a phenomenon within its real-life context with the aim of reviewing key aspects of that phenomenon. The case is described as an event, process, programme, institution or social group and is usually described by activity and time. The selection of a case is based on the importance and benefits it has for the community, government or significant others (Yin 1994:4).

In this study the case was the NAFCI programme. The NAFCI programme fulfils the criteria of being a case in that (a) the Department of Health in Limpopo Province has placed priority on adolescent services and has invested resources in the services to be provided and (b) the programme provides an important service for adolescents in the community. The unit of analysis is the service/s that the programme provides, for example, reproductive services.

3.2.3 Sample and sampling technique of study participants

To provide the information required about the programme, service providers and service consumers/clients were identified. Three professional nurses in Nkowankowa Health Centre who were involved in the implementation of the programme were purposively identified as key informants while 24 adolescents were also purposively identified as consumers. The three professional nurses served as key informants as they provided information on the aims of the programme, how the programme was implemented and progress thereof. These three professional nurses were in a better position to evaluate the NAFCI programme because they were involved in the implementation of the programme and service provision thereof. The service consumers were adolescents between the ages of 14 and 19 and were purposively selected based on the knowledge they had about the programme and their willingness to share information about how they perceived the programme. The adolescents were approached individually in the clinic, informed about the study and asked to participate in the study. On agreeing to participate, they were each requested to sign an informed consent form after the

purpose of the study was clearly explained. Both the adolescents, as consumers, and professional nurses, as service providers, provided information at different levels.

3.2.4 Ethical considerations

Based on the approval of the study by the Research and Ethics Committee, Department of Health Studies, University of South Africa (Unisa) (see annexure E), permission to conduct the study was obtained from the Provincial Department of Health and Welfare, Limpopo Province, South Africa (see annexure A). Informed consent was obtained from the participants (this included both the service providers and service consumers) (see annexure D). The names of the participants did not appear anywhere in the documents provided. The participants were informed that their participation was voluntary and that their responses will not influence their relationship with the clinic or service provision. They were also informed that they could withdraw from the study at any time without risk of penalty. Permission to use a tape recorder to collect data as well as make notes during the discussion was also obtained from the participants.

3.2.5 Data collection

According to Yin (1994:4), in a case study a variety of methods are used to collect data. In this study interview protocols that served as guidelines were used to conduct interviews with the three professional nurses (see annexure C) and the 24 adolescents (see annexure B). Face-to-face interviews were conducted with both professional nurses and adolescents. The researcher was the only person who collected data. A tape recorder was used as an assistive device to collect data and notes were made for reference. Interview sessions were conducted over a period of six weeks. The interview questions were open-ended and conducted in a language understood by the adolescents, which is Xitsonga and English was used to interview professional nurses. Appointments were made with all the participants for individual interviews. For the adolescents the first appointments coincided with their clinic visits. Subsequent appointments were then negotiated.

Records on clinic attendance by adolescents from August 2001 to August 2005 were reviewed. These included records for antenatal care attendance, STI clinic attendance and management thereof, and contraceptive and VCT service provision. Other records

which were reviewed included strategic planning notes outlined by the Department of Health and Welfare, agendas and minutes of meetings held in relation to the NAFCI programme and statistical records of diseases attended to under the programme.

3.2.6 Data analysis

Tape recorded data was transcribed. This was read over and over again in order for the researcher to be familiar with the content thereof. Aspects like the tone of voice of the participants and urgency of the matter were also factored into the transcribed notes and often the researcher made more notes. Data from the interview guidelines was analysed such that common responses and narratives were identified and reported on. Field notes were referred to in order to verify transcriptions and interview information. Relevant information from the records was also analysed for clinic attendance, type of services rendered and type of diseases attended to. The recording of all essential information according to the guidelines was noted and analysed (Yin 1994:67).

3.2.7 Generalisability

The results of the study were not generalised to the entire adolescent population of the Greater Tzaneen sub district because the study focused on a small population group, but the study could be replicated in other areas of the province or district (Polit & Hungler 1995:230).

3.3 CONCLUSION

This chapter discussed the research design and methodology of the study.

Chapter 4

Data analysis and interpretation

4.1 INTRODUCTION

This chapter discusses the data analysis and interpretation. To collect data, face-to-face interviews were conducted by the researcher with the adolescents as service consumers and professional nurses as service providers. Fields notes were written and records reviewed. The following is the analysis and interpretation of this data.

4.2 ADOLESCENT RESPONSES

There were three main questions that were asked i.e. clinic utilisation by adolescents and how they would describe service provision since the inception of the NAFCI programme. The third question explored features that impact on the implementation of the programme (see annexure B). These questions elicited a lot of information ranging from duration, frequency, services that are helpful, and how these were rendered and issues related to the programme itself. The responses were presented mainly in a narrative form and in the language of the adolescents, which is Xitsonga. A translated version is presented for the benefit of non-Xitsonga speaking persons.

4.2.1 Utilisation of the clinic

The duration of using the clinic varied. Two respondents were not sure about the duration, while another two indicated that they had only started using the services one and half years ago and five had been using the clinic for three years. The rest (15) indicated that they started using the services in 2001 soon after the introduction of the NAFCI programme. All respondents (100%) mentioned that they came to the clinic for "consultation" at least once a month. The common response was:

> *Vukorhekeri bya Klinic leyi bya pfuna swinene, dzita laha Kliniki hikwalaho ka mavabyi yo hambana-hambana yo fana na mukhuhlwana, na kulumiwa endzeni ka khwiri, na loko ndzii lava vutivi hi ta rihanyu.*

Ndzi ta e Kliniki nkarhi wunwana na wunwana, nkarhi wunwana ndzi hundza hi kona loko ndzi vuya e xikolweni.

(Translation into English: I find the clinic very helpful; I therefore come for consultation for everything like cough, dysmenorrhoea and health information. I do not have to stick to days and times. I can come via on my way home from school).

These responses were an indication that adolescents were aware of the NAFCI programme and its services and were patronising the clinic accordingly.

4.2.2 Knowledge of the programme

All the respondents (100%) indicated that they knew about the programme because it was introduced to them in 2001 and announcements were made in the Village about the programme. A large number (83,3%) of adolescents were involved in the activities like youth day, World AIDS day, immunisation campaigns, substance abuse campaigns which took place in the clinic. They considered the clinic as a place where adolescents could come for information. They also indicated that the programme informed adolescents about their sexual and reproductive health like HIV and AIDS/STIs and teenage pregnancy.

One response was:

Nongonoko lowu wu dyondzisa no lemukisa hi ta vutomi, tshikilelo wo huma eka vatswa kulobye na ngozi yo tirhisa swidzidziharisi.

(English version: The programme provides information on life skills like how to handle peer pressure and avoid substance abuse).

4.2.3 Services that were helpful in the clinic

In response to the services that were helpful in the clinic, the respondents indicated that they found the provision of contraceptive services helpful, especially because these

were now moved from family planning services that served older women who in some instances were their mothers.

To this effect one teenage girl had this to say:

> *Vu korhekeri bya kunguhato lebyi hi byi kumaka laha Kliniki bya amukeleke hikuva a hi foli layini na vanhu lavakulu.*
>
> (English version: The family planning that we now receive is less embarrassing because we don't queue with adults).

Eleven (45, 8%) adolescents indicated that they were given information and counselling on contraceptive methods and were allowed to make informed choices. One adolescent indicated that she received a long talk on contraceptive services in the clinic and different methods were explained and in the end she made an informed choice. The adolescents indicated further that they received information provided by health care providers in the form of health education in the consultation rooms and from pamphlets in the clinic waiting area. These helped them to know more about how to live positively and prevent teenage pregnancy, HIV and AIDS and STIs. From the discussions, the contraceptive services at Nkowankowa Health Centre were provided in a friendly manner. Five (20,8%) adolescents had received services for pregnancy test and counselling on STIs/HIV and AIDS without being referred to hospital.

One of the adolescent commented that:

> *Hi pfuka ku sungula nongonoko lowu wa NAFCI hi kuma vutivi hi tinxaka to hambana ta nkunguhato, hi tlhela hi pfumeleriwa ku hlawula kunguhato lowu hi wu tsakelaka, hi nyikiwa na swiphephana swa swihungwa-hungwana leswaku hi ya swi hlaya hi thlela hi dyondzisa vanwana ni vatswari va hina e makaya.*
>
> (English version: Ever since the NAFCI programme, we receive information on contraceptives and are allowed to make own choices and are given pamphlets to read or share with peers and sometimes our parents).

She went on to say:

> *Vaongori va hi pfuna kahle vanga jahanga va hi nyika vutivi hi ta rihanyo hambi hi nga va vutisanga, va ti nyika nkarhi wa hina.*
>
> (English version: The nurses are not in a hurry. They give information about health even if one has not asked for it. They really have time for us).

Another commented that:

> *Ni khomeka kahle ku ta laha Kliniki hikuva niti kuma ninga tshamanga na vanhu lava kulu.*
>
> (English version: I feel comfortable being attended in this clinic as I am not embarrassed by being with the old folk).

All (100%) respondents interviewed stated that emphasis is placed on adolescent reproductive health. Even if one is consulting for minor ailments information on STIs/HIV and AIDS and teenage pregnancy is provided.

One respondent stated that:

> *Exikolweni xa mina va dyondzisi va vulavurisana na hina hi timhaka ta xitsongwa-tsongwana xa HIV na AIDS, na nkoka wo hamabana na ti mhaka to biha emirin munhu a hari mutswa.*
>
> (Englsih version: at my school the teachers make time to talk to us about HIV and AIDS and not falling pregnant.)

The provision of service for adolescents away from adults seemed to be positively mentioned especially after indicating that before this programme was introduced the issue of common regular services was a concern for adolescents.

4.2.4 Voluntary counselling and testing

Very few adolescent come forward for voluntary counselling and testing (VCT) service. In the total of 24 interviewees, only two had come for VCT.

One response was:

> *Mina ni tile laha Kliniki ni tata endla vukamberi bya xitsongwa-tsongwana xa HIV, muongori loyi anga ndzi pfuna andzi yingisela atlhela andzi pfunela exihundleni.*
>
> (English Version, I came to the clinic for VCT test and the professional nurse who provided this service to me was well-informed and I was helped in an area where privacy was ensured).

4.2.5 Condom supply

All (100%) respondents reported condoms to be readily available without having to ask the provider. All (100%) adolescents interviewed stated further that health education about condoms is conducted more than once in the waiting area. Seven (29%) had received individualised information on condom use and benefits thereof.

A comment made was:

> *Loko hi ta laha Kliniki hi lava tikhodomu ha ti kuma hinkwako e swihambukelweni, e tikamareni ta vutshunguri , laha vavabyi va fikelaka kona na le ghedeni, ha ti kuma nkarhi hinkwawo loko hi ti lava.*
>
> (English version: Condoms are available in the toilets, the consulting rooms, the waiting area and at the gate, so we find them in the clinic any time we need them).

4.2.6 Openness of the services

Most of the adolescents (67%) stated that they now feel welcome in the clinic. A comment made was:

> *E kiliniki vaongori va burisana na hina va tshunxekile hi nghozi yo endla timhaka ta masangu, Leswi swa hi pfuna swinene hikuva hi ndhavuko wa hina vanhu lavakulu ava fanelanga ku vulavurisan na vatswa hi ti mhaka ta masangu swa yila.*
>
> (English version: in the clinic nurses talk to us freely about sex and sexual activity. This is helpful because at home and according to our culture adults do not talk to children about sex).
>
> *Ku pfuleka ka va-ongori naku va va tshama va burisana na hina hi ti mhaka ta masangu na rimbewu swi endla leswaku hi tshama hi ehleketa hi timhaka ta xitsongwa-tsongwan xa HIV na AIDS*.
>
> (English version: The openness and insistence about sex talk by the nurses make us conscious that having sex with men is not a good thing. It also keeps us thinking about HIV and AIDS).

4.2.7 Factors that impact on the adolescents' participation in the programme

Adolescents indicated that different families reacted differently to the programme. Nine (37,5%) of the respondents indicated that their parents felt that the programme was teaching them about sex; therefore the family did not want them to participate in the programme. Some of the adolescents felt that parents required them to be brought up the way they (parents) were brought up, and adolescents felt that parents were not open to discuss issues related to sex and sexuality with them.

Four (16,6%) reported that some churches were too strict and did not talk to adolescents about sex and sexuality including condoms. They stated that churches made rigid and stereotype rules and regulations that did not address the problems faced by adolescents like HIV and AIDS/STIs and teenage pregnancy. One respondent indicated that the church focuses on girls and neglects boys and further indicated that

the church does not want adolescents to participate in the NAFCI programme. This type of information could be the reason for the increasing number in teenage pregnancy. This above statement support the literature by Stanberry and Bernstein (2000:129) which found that South African society has difficulty discussing sexuality openly. In some religions, sexuality is viewed from a moralistic perspective and STI is considered a result of promiscuity. Patients with this belief may find it difficult to approach a professional for assistance thus delaying consultation.

4.3 PROFESSIONAL NURSES' RESPONSES

Three professional nurses were asked to give their views and perceptions about the NAFCI programme since their individual involvement (see annexure C). The questions resulted in the professional nurses giving a lot of information about the NAFCI programme, which information is also collated in the records reviewed.

4.3.1 Profile of professional nurses (key informants)

Table 4.1 represents the profile of the professional nurses who were interviewed as key informants. These professional nurses had worked with the programme since its inception in 2001. They were suitable to give relevant feedback on the impact of the programme.

Table 4.1 Profile of professional nurses

Age	Qualifications	Year qualified	Duration of programme
Professional nurse 1: 53 years old	Registered nurse Registered midwife Primary health care Community nurse BA Cur	1980 1981 1984 1993 1997	Three years
Professional nurse 2: 50 years old	Registered nurse Registered midwife Primary health care Community nurse BA Cur BA Cur Honours	1979 1981 1983 1988 1992 1998	Three years
Professional nurse 3: 42 years old	Registered nurse Registered midwife Primary health care Diploma in community health Diploma in administration	1984 1985 1990 1996 2000	Four years

The three professional nurses indicated that the NAFCI programme was targeted at young people between the ages of 10 and 19. The programme addressed sexual and reproductive health problems like HIV/AIDS, STIs and teenage pregnancy. The professional nurses indicated further that the programme promoted dissemination of information to adolescents so that they could make informed choices on sexual and reproductive health services.

4.3.2 Services provided by the NAFCI programme

The professional nurses indicated the services provided by the programme as follows:

- Management and treatment of STIs including information on prevention of STIs and partner notification.
- Provision of VCT services including information on HIV and AIDS, distribution and use of condoms.
- Antenatal, childbirth and postnatal services for teenagers.
- Management of minor ailments.
- Contraceptives services.

The significance of the professional nurses knowing about the services was to ensure that they are able to link the services provided to the monthly adolescents statistics based on the types of services provided as indicated above, and that they are able to analyse the statistics so that they can be able to identify the increase and decrease in the utilisation of the above services. It was also essential to ensure that professional nurses are able to develop a plan to address the gap/gaps identified or to respond through outreach activities like school visits to provide reproductive health education and marketing of the services so that they can always review the programme in line with the expected services to be provided. All three service providers found the programme relevant in addressing adolescents' needs.

According to the service providers, adolescents were increasingly attending the clinic. The professional nurse who had been with the programme since its inception reported that:

The programme was initiated because of the high number of teenage pregnancies and sexually transmitted infections that were unacceptable in the area, hence the main focus is on sexual and reproductive health. Before then teenagers were not getting any information on sex and reproductive health. Up until 2000, it was difficult to identify adolescents that were attending the clinic. The records were mixed up with those of other patients and apart from the number of teenagers that delivered babies in the maternity ward we were not able to say exactly how many adolescents attended the antenatal clinic. After 2001 we have dedicated registers for adolescents and we are able to identify attendance. Our records are very helpful in keeping statistics. The three of us ran the programme and we are able to also see with our own eyes the increasing attendance. We have also noticed that they come even after school on their way home.

The researcher asked what the common problems amongst adolescents are? The response was:

The most common problems amongst adolescents are STIs, teenage pregnancy and we have more adolescents coming for contraceptive services. According to the records teenage pregnancy has not decreased, instead the antenatal clinic is very busy. Another problem that we have is non-availability of pregnancy test kit. Because the kits are not always available, some teenagers are not identified earlier and therefore attend the ANC late. We also found adolescents not readily willing to come for VCT. Here the local people still regard HIV and AIDS as a disease related to promiscuity and as such it carries a stigma. This may be the reason for the lower usage of VCT services. What we do is that we give them group information on the prevention of STIs, teenage pregnancy and HIV and AIDS. We also give health education on the different types of contraceptive methods including condoms and Individual information during consultation.

4.4 RECORD REVIEW

The researcher analysed data from the clinic records on contraceptive use, pregnancy, VCT and STI services, as well as minutes of meetings held in relation to the NAFCI programme. The information in the records was compared with that given by professional nurses and the adolescents.

4.4.1 Clinic utilisation according to records

According to the records reviewed at the clinic, the number of clinic attendance could be seen to increase. Whereas the average attendance per month in 2003 was 414, this had doubled to 824 in 2004, with the last quarter of 2004 seeing a huge increase to 5 696 services provided. The figures represent various services provided where one adolescent could have registered for more than one service per visit e.g. the adolescent could have requested contraceptive service as well as VCT services. Figure 4.1 depicts clinic utilisation per quarter in 2003 and 2004 in terms of services provided.

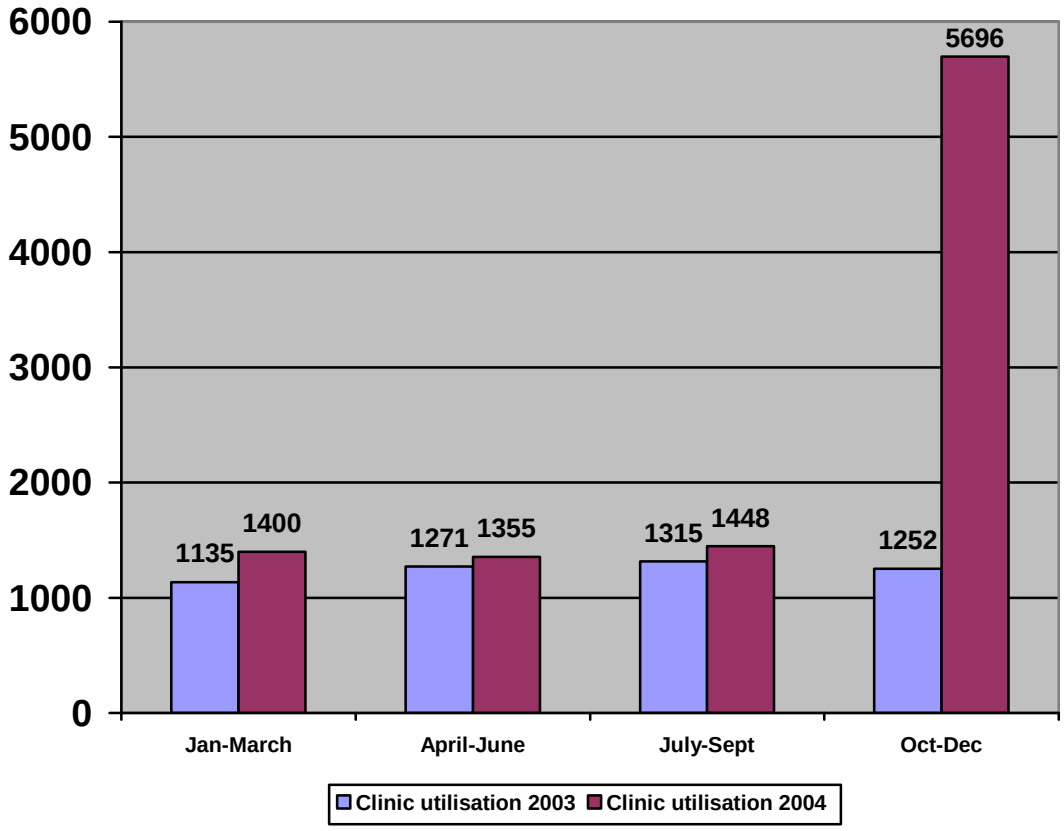

Figure 4.1

Utilisation of clinic in terms of service provided

4.4.2 Contraceptive use

4.4.2.1 Patients' records on contraception

According to the tick register the major presenting problems were teenage pregnancy and STIs. Even though an average of 4 000 condoms were distributed per month in 2004 adolescents still called for emergency contraceptive pills (ECPs) as indicated by the number of adolescents who reported for the ECP service which was 26 in 2003 and the number increased to 61 in 2004. This may be indicative of a high level of risky sexual behaviour with unprotected sex. This could also indicate the increased utilisation of the ECP service.

According to the 2003 and 2004 records, there was an increase in the use of contraceptives as indicated in figure 4.2

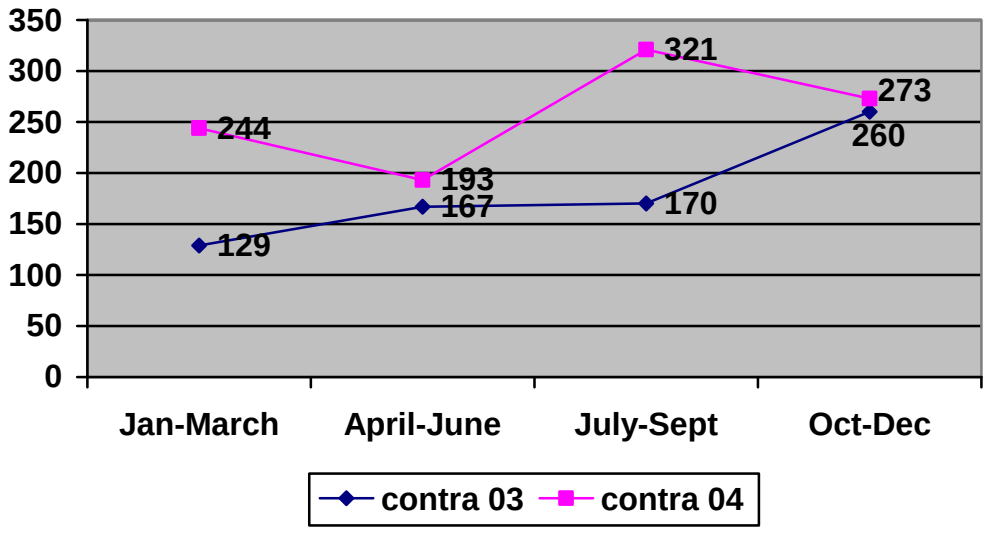

Figure 4.2

Adolescents' contraceptive use 2003 and 2004

Figure 4.2 indicates a quarterly record of contraceptive use. In 2003 alone, contraceptive use increased from 129 in the first quarter to 260 in the last quarter of the year. Similarly in 2004 contraceptive service increased from 244 in the first quarter to 321 in the third quarter and 273 in the fourth quarter. Another observation made was the increase in the use of chemical contraceptives. Increased chemical contraceptive use is associated with exposure to supportive information in the clinic, but this could also be

an indication that more adolescents engage in unprotected sexual intercourse (not using condoms) exposing themselves to STIs and HIV/AIDS, while preventing pregnancy through chemical contraceptives.

There was also observable change in the use of various methods of contraception, like injectables versus oral (see figure 4.3).

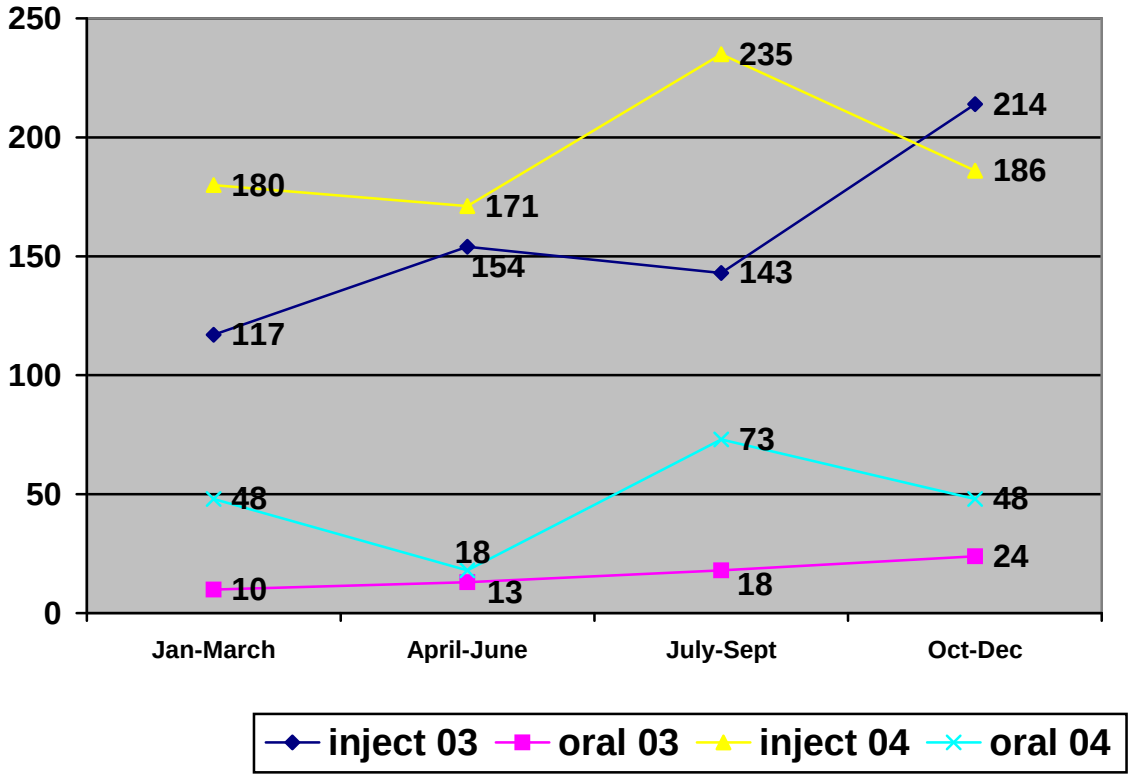

Figure 4.3

Comparison between the usage of injectables versus oral contraceptives in 2003 and 2004

According to this graph adolescent preferred injectables to oral contraceptives. Injectables are also recommended by service providers as these are reliable and defaulters can easily be identified. There is also an increase in both injectable and oral contraceptive utilisation which might be indicative of exposure to reproductive health information as it was indicated by the professional nurse's response on page 42.

In one of the written reports it was indicated:

> There was also an increased number of adolescents who preferred to use an injectable contraceptive method than oral contraceptives.

On the whole there was an increase in the utilisation of both injectables and oral contraceptives in 2004 and 2003.

4.4.3 Antenatal and postnatal clinic attendance

According to statistics, antenatal services have always been better patronised than are postnatal services. Figure 4.4 depicts poor attendance of postnatal services, with almost zero attendance in the last quarter of 2004.

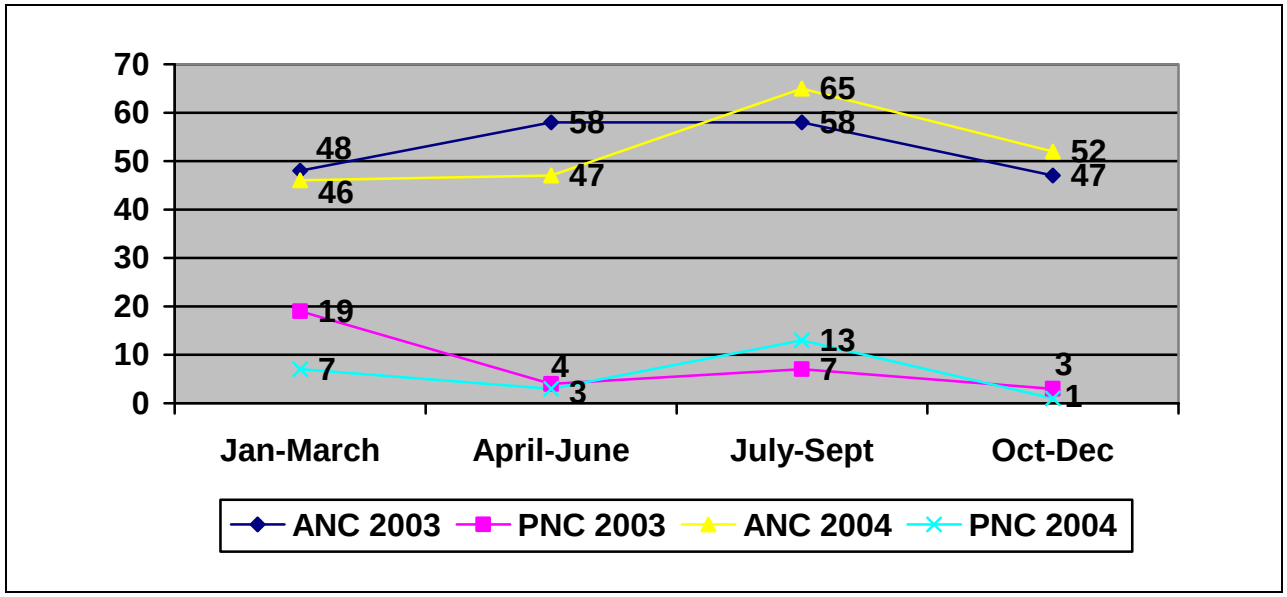

Figure 4.4

Antenatal and postnatal clinic attendance by adolescents, 2003 and 2004

Despite the increase in contraceptive service utilisation as indicated in figure 4.2 the rate of teenage pregnancy remains high as indicated in the antenatal attendance in figure 4.4.

4.4.4 Tick registers

Furthermore the clinic tick registers provided information on the disease profile and the provision of services like ANC, STIs, contraceptives, and VCT. The chill room statistic was also reviewed for the number of condoms made available to adolescents. In 2004 there was an average of 4000 condoms distributed per month.

The tick registers from 2001 to 2005 were randomly selected whereupon ten tick registers were reviewed. In these registers it was found that

- in most instances history taking was incomplete
- the family history was not included
- nursing diagnoses were not recorded in the registers
- STI treatment was not according to the guidelines and in several cases no STI contact slips were issued
- there was no evidence of health education given in the tick registers

4.4.5 Patients' records

Twenty adolescents files were randomly selected using the patients file number recorded in the tick register. The findings were as follows:

- Continuation sheets did not have a name and file number.
- STI treatment was not according to syndromic management.
- Duration and strength of treatment prescribed for the client was not indicated.
- No review date was given.
- Social history was not documented and behaviour risk assessment was not done.
- History taking was not documented and the duration of illness was not recorded.
- Nursing diagnoses were not recorded.
- There was no record of contact slip issued for STIs.

The above findings indicated poor documentation and the records were therefore not helpful in this regard, as they did not confirm some of the responses from the three professional nurses and adolescents.

4.4.6 VCT services

The records that were reviewed showed a poor VCT uptake at Nkowankowa Health Centre in 2003. In 2004, there was a great increase in the second and third quarters of the year and a big drop in the last quarter. Seemingly the VCT service utilisation fluctuates and the reason for this could not be found. The large number in the second and third quarters of 2004 did not correspond with the responses from the adolescents where only two reported to have come forward for VCT.

In view of the HIV and AIDS pandemic in South Africa the VCT service is still poor when compared to the number of ANC bookings as indicated by figure 4.4. The reason why VCT services are compared with the ANC or pregnancy services is that pregnant mothers that test positive for HIV are encouraged to join the PMTCT programme as an HIV and AIDS prevention strategy for both the mother and the baby. The reluctance of adolescents to come forward may be due to the stigma that the local people still attach to the HIV and AIDS as indicated by one professional nurse in page 42.

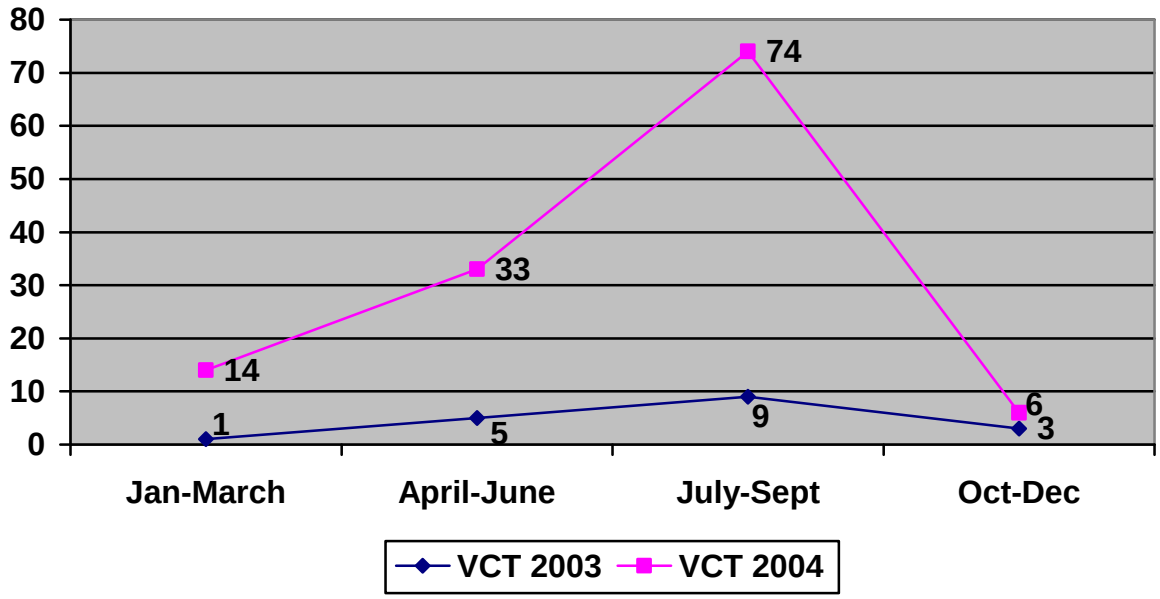

Figure 4.5

VCT service provision, 2003 and 2004

4.4.7 STI services

According to the records, there were more cases of STIs in 2003 than in 2004. Figure 4.6 depicts the male and female adolescents that were treated with STIs in the clinic in 2003 and 2004. The graph depicts a gradual increase of male adolescent's clients utilising the STI service in 2004 than 2003, and a decrease of female adolescents clients utilising the STI service in 2004 than 2003, this is supported by the literature that indicated that boys are more likely to have multiple partners as well as engage in more risky sex behaviour than girls (Abarhams & Hajiyiannis 2001:39). This was a disturbing finding as it may mean an increase in unprotected sex, thus increasing the risk of HIV infection and teenage pregnancy. The high rate of STI's among adolescents could also be associated with inadequate knowledge of STIs and a tendency to engage in risk taking behaviour as indicated in the literature by Dickson-Tetteh and Foy (2001:80).

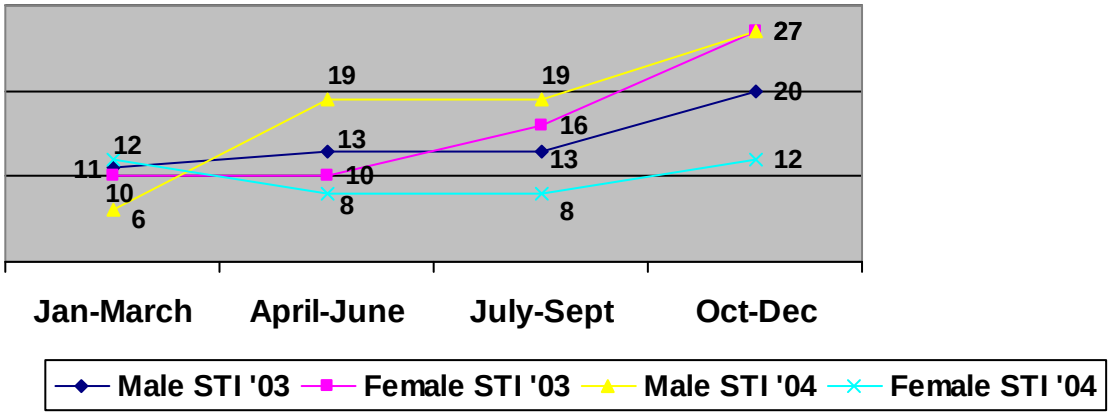

Figure 4.6

STI cases by gender in 2003 and 2004

4.4.8 Information from minutes of meetings

According to the documents reviewed from 2001 to 2005, the minutes affirmed discussions relating to problems identified and how these were addressed. At first the meetings were held bi-weekly, later these were held quarterly. During these meetings the clinic staff drew up action plans on the gaps/weaknesses identified. The issues

recorded most frequently at the meetings were high rate of teenage pregnancy, STIs/HIV and AIDS, lack of educational materials on sexual and reproductive health information.

Statistics reflected here above were analysed and discussed in some of the meetings.

4.5 CONCLUSION

This chapter discussed the data analysis. Both the adolescents interviewed and key informants provided valuable information to evaluate the NAFCI programme so that the programme can be reviewed, supporting those services that are successful.

Chapter 5

Findings, limitations and recommendations

5.1 INTRODUCTION

The main objective of the study was to evaluate the NAFCI programme in Greater Tzaneen sub district of Limpopo Province, South Africa. Clinic utilisation and perception of services that were provided under the programme were analysed as aspects that would determine the objective of the study. According to data collected and analysed the programme provided adolescent-friendly essential reproductive health services in Greater Tzaneen sub-district, Limpopo Province, South Africa. Fifteen (62,5%) of the adolescents reported to have been using the clinic consistently since 2001 to access services provided. There was also a positive report from 5 (20, 8%) other adolescents who had been using the clinic for three years. When this number is added to those who had been using the clinic consistently from inception, a total of 20 (83,3%) is realised. This then indicates that the clinic is well utilised by adolescents. Their participation in activities that take place in the clinic, like Youth Days, HIV and AIDS Day, prevention campaigns on immunisation and substance abuse is an indication of acceptance of the programme as the adolescents would like to see this programme succeed. From the narratives there is a sense of ownership. All (100%) interviewed adolescents knew about the NAFCI programme and the services it provided because when it was introduced it was well advertised. Services provided ranged from health education about STIs including HIV and AIDS, general information about peers and substance abuse to antenatal and postnatal care, minor ailments, diagnosis, treatment and referrals for STIs and counselling and testing for HIV/AIDS. A comment about the contraceptive services being helpful is supported by the increased utilisation as indicated in figure 4.2. Adolescents provided a framework by which adolescent-friendly services in clinics are to be judged (Dickson-Tetteh & Foy 2001:11) as depicted in their narratives.

According to respondents i.e., service providers and service consumers, the NAFCI programme has been pivotal in providing essential reproductive health services. This included education and counselling on reproductive health; provision of contraceptives including condoms; pregnancy testing; antenatal and postnatal care for teenagers; STI

information, including prevention of STIs and HIV/AIDS; diagnosis and syndromic management of STIs, partner notification, and HIV /AIDS information including Voluntary counselling and testing.

5.2 CONCERNS ABOUT FINDINGS

Aspects that do not compare favourable are, the increased supply of condoms and contraceptive use including emergency contraceptive pill as highlighted in the adolescents' responses with the high pregnancy statistics as indicated in figure 4.4. According to the statistics, pregnancy figures are increasing regardless of pregnancy prevention measures that are in place. It is important therefore that researchers find the reasons for the gap in these services. Another aspect of concern according to the report is the VCT services that turned to be very high at one time like in figure 4.5 in the third quarter and very low in the fourth quarter of 2004. This will also need attention, especially when put against the adolescents' responses where only two reported to have come for VCT. One would expect the VCT services to peak in the fourth quarter with the world AIDS day awareness on December 1st of every year.

For sexually transmitted infections the rate of infection seems to be increasing despite the availability of information and improvement in service provision as purported by service providers.

The review of clinic records identified similar problems, namely STIs, teenage pregnancy and a demand on contraceptives services. The record review also identified poor documentation of activities. Due to the poor documentation some of the verbal responses have not been verified like, in instances where the adolescents indicated that they are given information on health education with no records to confirm this. The clinic did not have a record of topics on health education that are formally given to adolescents. According to records, there also was no proof of partner notification, a very important strategy in controlling the spread of STIs.

5.3 FACTORS THAT IMPACT ON THE PROGRAMME

From the responses of the adolescence it seemed that 9 (37,5%) parents according to the response by 9 adolescents were not in favour of their children participating in the programme. This brought some tension as affected adolescents interpreted this as stereotype and the parents in turn were also not eager to discuss issues related to sex and sexuality with their children. Similarly there were religious issues that impacted on condom use where 4 (16,6%) of the adolescents reported some churches as not being keen on sex and sexuality education and supply of condoms. One adolescent stated that the church focused on girls and neglected boys. This, he stated was his own conclusion

5.4 SERVICE UTILISATION

From the data collected there is an increase in the number of adolescents utilising the clinic services from 414 per month in 2003 to 824 per month on 2004 with the last quarter of 2004 increasing to 5696. Through record review it was observed that more adolescents' clients registered for more than one type of service. This was confirmed by the adolescents' response when they indicated that they all know about the programme hence there is an increase in clinic utilisation

Contraceptive service utilisation also increased form 726 in 2003 to 1031 in 2004 with most adolescents making use of injectable contraceptive method than oral and there was also an increase in both injectables and oral contraceptive methods in 2004 than in 2003.

The abovementioned information was supported by eleven adolescents who indicated that they were given information and counselling on contraceptives methods in the consultation rooms and were also given pamphlets to go and read and were allowed to make informed choices. Condoms were readily available as it was confirmed by the interviewed adolescents and adolescents were given information on the use of condoms to prevent STIs and HIV and AIDS.

5.5 LIMITATIONS

In view of the importance of the programme it would have been beneficial to include other professional nurses in the clinic other than the three that were selected. This would have given a wider perspective of the programme as the impact of the programme would have been given by observers as well. The information about the programme could also have been much more valid if two or more clinics were included in the study. This would have provided a wider catchment area.

The poor record-keeping and documentation is a limitation in that it does not provide reliable support to the data collected in the interviews.

5.6 RECOMMENDATIONS

The study has provided an overview on the NAFCI programme. It has also identified some gaps that need to be attended to.

- Documentation and record-keeping. It is recommended that the number of entries that are made in the tick register be reduced by dividing the documentation into admission records and treatment and management records where the clients' information on entry into the clinic is captured by a designated person other than a nurse. The nurse should then keep the diagnosis, treatment and management records. This will reduce the number of records that the nurse has to attend to and this way improve record keeping. Proper record keeping should be mandatory and must be monitored.
- To increase VCT uptake, all adolescents who come for services like ANC, STIs and contraceptive services should be counselled to take HIV test so that they could know their status and prevent infection and or further re-infection.
- All the professional nurses working at the health centre should be trained in VCT and informed about the NAFCI programme so that they also can act as ambassadors for the programme. It is also recommended that other nursing staff categories like the enrolled nurses and the enrolled nursing assistants be trained on VCT to increase its accessibility and utilisation by adolescents.

- In view of the increase in STIs and teenage pregnancy it is recommended that campaigns on preventive measures in terms of STI and teenage pregnancy should be undertaken by the clinic in consultation with the adolescents.
- VCT, STIs and pregnancy services should be monitored and evaluated regularly, and statistics in this regard should be analysed and discussed at staff meetings with staff members making inputs on how to improve the provision of these services and measures to reduce the said ills.
- It is important that the community, parents and religious institutions, are involved in the programme from inception so that they can lend support to the initiative.
- Feedback of the gaps identified to the community is also very important for ownership and support of the programme.

5.7 CONCLUSION

The study focused on the evaluation of the impact of the NAFCI programme. The impact that was found to have been made by this programme is mainly on the utilisation of the clinic based on the acceptable environment that allows adolescents to be attended to away from adults.

Statistics indicate an increased attendance which may have also increased the workload of the professional nurses hence the reported poor documentation. The programme also provided a platform for adolescents to actualise themselves and participate in the provision of their own health. In relation to improved health status, the programme has not yet shown how teenage pregnancies and STIs are controlled. Instead, at the moment, the increased utilisation of the services also highlights the intensity of the problem, thus reinforcing the need to support the programme. Monitoring of the programme should be continued and the present data should be used as the baseline thereof.

The Department of health and Welfare in Limpopo must support the contraceptive services and other preventive services like health promotion to address the big ills, teenage pregnancy, STIs and HIV/AIDS.

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ANNEXURE A

Enquiries: GO Baloyi
Cell: 082 566 3648

PO Box 510
Letaba
0870
02 August 2005

The Head of Department
Department of Health and Social Development
Polokwane

Dear Sir/Madam

PERMISSION TO UNDERTAKE A RESEARCH PROJECT

I am a Master's student at the University of South Africa (Unisa) and request permission to conduct a research project at Nkowankowa Health Centre for the degree.

The purpose of the study is to determine the effectiveness of the National Adolescent Friendly Clinic Initiative (NAFCI) programme on the health of adolescents at Nkowankowa Health Centre in the Greater Tzaneen Municipality, Mopani District of Limpopo Province, South Africa.

I trust my request will meet with your favourable attention.

Thank you

Yours faithfully

GO Baloyi

ANNEXURE B

INTERVIEW SCHEDULE FOR RESPONDENTS (ADOLESCENTS)

Title:
THE EVALUATION OF THE NATIONAL ADOLESCENT-FRIENDLY CLINIC INITIATIVE (NAFCI) PROGRAMME IN GREATER TZANEEN SUB-DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA

INTRODUCTION

I am Onica Baloyi, a Master's student at Unisa. I am doing research on the evaluation of the National Adolescent-Friendly Clinic Initiative (NAFCI) programme in Greater Tzaneen sub-district, Limpopo Province, South Africa. The purpose of this study is to evaluate the NAFCI programme so that the strengths and weaknesses can be identified. I would therefore like you to respond to the following questions. Please feel free to ask for clarification where you don't understand. Remember that your participation is voluntary, and you are free to withdraw from the study should you wish to do so.

Questions for respondents

1. Do you know about the NAFCI programme? Y N

If yes, for how long have you known about the programme and how long have you been using the clinic services?

.....

.....

2. How would you describe service provision since the introduction of the NAFCI programme?

.....

.....

3. What factors impact negatively as well as positively on the implementation of the programme?

.....

ANNEXURE C

INTERVIEW SCHEDULE FOR KEY INFORMANTS (PROFESSIONAL NURSES)

Title:

THE EVALUATION OF THE NATIONAL ADOLESCENT-FRIENDLY CLINIC INITIATIVE (NAFCI) PROGRAMME IN GREATER TZANEEN SUB-DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA

INTRODUCTION

I am Onica Baloyi, a Master's student at Unisa. I am doing research on the evaluation of the National Adolescent-Friendly Clinic Initiative (NAFCI) programme in Greater Tzaneen sub-district, Limpopo Province, South Africa. I am requesting you to participate in this study and respond to the questions here below. Please feel free to withdraw from this study should you so wish. Your withdrawal will not influence your employment or any aspect of your relationship with the clinic or the Department of Health and Welfare in Limpopo. Your name and identity will not be reflected in any way in this study and the information that you will provide will only be used for the purposes of this study.

QUESTIONS TO RESPOND TO

1 For how long have you worked with the NAFCI programme?

.....

2 What services are provided by the NAFCI programme?

.....

.....

3 What is your perception of the programme?

.....

.....

.....

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.....

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4 How many adolescents do you see a month?

.....

5 What are the problems that adolescents present with at the clinic?

.....

.....

.....

6 How many condoms are dispensed from the clinic per month?

.....

ANNEXURE D

CONSENT FORM

Title of the study:
THE EVALUATION OF THE NATIONAL ADOLESCENT-FRIENDLY CLINIC INITIATIVE (NAFCI) PROGRAMME IN GREATER TZANEEN SUB-DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA

My name is Onica Baloyi, a Master's student at Unisa. I am doing research on the evaluation of the National Adolescent-Friendly Clinic Initiative (NAFCI) programme in Greater Tzaneen sub-district, Limpopo Province, South Africa.

I would like you to participate in this study. I assure you that your input is valuable and will not be used against you now or in future. Your participation is voluntary and you can withdraw from the study should you wish to do so, and your withdrawal will not affect the provision of services you get from the clinic. I will be using a tape recorder as an assistive device to collect data, please indicate your approval or disapproval thereof.

Your name or personal particulars will not be indicated or attached to your inputs in any manner and the information you provide will be used only for the purposes of the study.

I …… (participant) have read the above information about the evaluation of the impact of the NAFCI programme and have been verbally informed about my role as a participant. I am therefore voluntarily accepting participation thereof.

Participant's signature……

Researcher's signature……

ANNEXURE E

LETTER: ETHICS COMMITTEE