CRITICAL ANALYSIS OF ADOLESCENT REPRODUCTIVE HEALTH SERVICES IN GAUTENG PROVINCE

by

BEATRICE MAKGOALE MAGWENTSHU (NEÉ LEGODI)

submitted in accordance with the requirements

for the degree of

DOCTOR OF LITERATURE AND PHILOSOPHY

in the

Department of Advanced Nursing Sciences

at the

UNIVERSITY OF SOUTH AFRICA

PROMOTER: PROF HIL BRINK

JOINT PROMOTER: PROF MVLH LOCK

NOVEMBER 2000
DECLARATION

I declare that CRITICAL ANALYSIS OF ADOLESCENT REPRODUCTIVE HEALTH SERVICES IN GAUTENG PROVINCE 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.

BM Magwentshu

DATE
Dedication

This thesis is lovingly dedicated to:

All the adolescent in the world,
my beloved parents, Lekoba and Mankgege Legodi,
my loving husband, Mncedisi Maqwentshu and
my God-given children, Floyd, who has already been an adolescent,
Lisa and Lifa, who are adolescents,
Khitha and Jambi who will still be adolescents
and my grandson Kabelo, who at a much later stage will be an adolescent.

It is my hope that you all will become mature,
responsible adults from this complex stage.
Acknowledgements

I wish to acknowledge the important role played by all the people whose support and encouragement enabled me to complete this study. In particular I would like to express my sincerest gratitude to:

- The never changing God in an ever changing environment for having blessed me with strength, health, wisdom and steely determination to complete the study against all odds.

- My promoter, Prof HIL Brink, for willingly sharing her wealth of knowledge and experience in research with me, giving me her infinite support when I felt like throwing in the towel and simply believing in me.

- My joint promoter, Prof MVLH Lock, for painstakingly going through the thesis with a fine comb, paying attention to detail and always reminding me not to “despair” when days were dark.

- Gauteng Province Research Committee, for granting me permission to pursue this study.

- Directors/Deputy Directors-Managers in the various regions in Gauteng Province, for willingly giving me the final permission and support to continue with the study.

- Mrs T Burger and the personnel of Unisa library, for their prompt responses to my request and for tracing and obtaining those scarce resources.

- WK Kellogg Foundation, for having afforded me and the other “Kellogg Fellows” a once in a lifetime opportunity of studying at Unisa at their expense.

- Dr E Potgieter, the WK Kellogg Foundation Project Director, for her dedication and commitment towards creating a conducive environment for all “Kellogg Fellows” to achieve their dreams.

- My previous supervisors, Lulama Phorc, Nomfusi Ntloko and Ntombi Molefe, for their encouragement and support.

- My supervisors, Sue Armstrong, Lenie van Wyk and Sharon Vasuthevan, for the extraordinary support afforded to me at all times. I feel deeply appreciative that they are part of my professional life.

- Mrs Joyce Jordaan, for providing useful insights in the construction of the questionnaire and analysis of results. She has been steadfast honest and at critical times supportive.

- My dear friends and colleagues, Grace Matetoa, Bareshile Zwane, Pat Senne, Nthabiseng Serunye, Nthabiseng Makoa, Daisv Segwati, Ntsiki Mokhine, Sarah C Mojahi, Debbie Mopedi, Thandie Ntlabezo, Makkie Nong, Magda Zaaqman, Barbie Michel, Pat Banda, Nyadiwa Bookholane, Stella Dubazane and Abby Tshwaane, who listened with patience and good humour to my periodic expressions of my frustrations and provided important support.
• Shela Langa, Shirley Ntlokotsi and Eugene Moerane, for loaning me tranquility of their flats during the writing of these thesis.

• Lizzie Ramogale for being ever ready to address my initial typing issues at the drop of a hat. It is hard to imagine how I would have started this process without her.

• Lorato Mahura, for typing letters requesting permission and the questionnaire many times without complaint and cautioning me to “stop and smell the roses” in this journey called research.

• Annette Kellner and Motsomi Senne, who gave generosity of their time to read the manuscript and questionnaire and gave me useful feedback.

• Veronica Charleston, Brenda Ntombela-Motopanyane and Nomvula Nyandeni, Salome Tsekoa for giving me relevant study material.

• Mrs E Coetzer, the extraordinaire for patiently, lovingly typing this thesis over and over again with speed, dedication, care reflection and thoroughness.

• Prof MVLH Lock, editor, for her ongoing incisive and analytic editing of this thesis. She provided patience and professional assistance. I take sole responsibility for its remaining weaknesses.

• My parents, Lekoba and Mankgege Legodi, who initially instilled in me the culture of learning, teaching and giving me unconditional support throughout my life. Encouraging me to reach for higher levels of accomplishment. Thank you both for who you are, for what you have offered me and for your faith in me and this thesis.

• My loving husband, Mncedisi Magwentshu, who has been an invaluable presence in my life in a multitude of ways. I am immensely grateful for his careful reading of my work, enduring every doubt I have experienced and been present in mind and spirit throughout the writing of this thesis in ways that cannot be sufficiently described.

• My brothers and sisters, Kgati, Mamadi, Malokoe, Moloko, Lepulane and Shokky for their unwavering support.

• My God-given children, Floyd, Lisa, Lifa, Khitha and Jambi, you have been unbelievably, patient, present and proud.

• Lastly and above all, thanks to all the adolescents who participated in this study. They have taught me a great deal about the adolescence period.
Summary

Adolescent reproductive health services (ARHS) in Gauteng Province are not meeting the reproductive health needs of adolescents. There is also no formalised adolescent/youth policy laid down to assess the quality of care given to adolescents attending these clinics although the policy is currently in the process of being finalised.

The purpose of the study therefore was to critically analyse the ARHS in Gauteng Province to determine which adolescents attended the clinics, whether the clinics were accessible and available and whether they provided comprehensive care, gave information and counselling to the adolescent and whether the clinics were adolescent-friendly.

Using the quality care model as the conceptual framework for the study, the following research questions were asked to determine the quality of care in terms of the adolescent's needs at these clinics:

- Who is the adolescent using ARHS in Gauteng Province?
- Are the ARHS in Gauteng Province accessible and available to adolescents?
- Do the ARHS in Gauteng Province provide comprehensive care to adolescents?
- Are adolescents receiving information and counselling from the ARHS in Gauteng Province?
- Are the ARHS in Gauteng Province adolescent-friendly?

A quantitative cross-sectional exploratory, descriptive research design using a self-administered, researcher-designed questionnaire was used to collect data from a 203 nonprobability convenient sample, at selected ARHS in Gauteng Province.

The analysed data indicated that females in the older age group, i.e. 18-19 years used the ARHS more than the female adolescents in the younger age group and males. Findings also indicated that the ARHS in Gauteng Province are geographically accessible and available to adolescents. However, there appeared to be a need to
extend the days and hours of functioning of the ARHS so as to make them more accessible and available to adolescents. Comprehensive care is not given to adolescents attending ARHS. Adolescent gave contradictory information especially with regard to the attitudes of service providers.

Recommendations made include management strategies that will attract the adolescent in the younger age group and in particular the male adolescent. This necessitated that service providers at ARHS be equipped with the appropriate information given in an outcome-based format in adolescent care.

KEY CONCEPTS

Adolescent; adolescent reproductive health services; reproductive health services; health care; adolescent service provider: accessible and available; comprehensive; information and counselling; adolescent-friendly: Gauteng Province.
# Table of contents

## Chapter 1

### Introduction and orientation to the study

1.1 BACKGROUND TO THE PROBLEM ................................................................. 1

1.1.1 Gauteng Province ............................................................................. 3

1.1.2 District health facilities by region ..................................................... 5

1.1.3 Public health services in Gauteng Province ..................................... 5

1.1.3.1 ARHS in Gauteng Province ............................................................. 6

1.2 PROBLEM STATEMENT ........................................................................ 9

1.3 PURPOSE OF THE STUDY .................................................................... 9

1.4 RESEARCH QUESTIONS ....................................................................... 9

1.5 SIGNIFICANCE OF THE STUDY .......................................................... 10

1.6 ASSUMPTIONS (PREMISES) OF THE STUDY ..................................... 10

1.7 RESEARCH METHODOLOGY ................................................................. 11

1.8 DEFINITIONS OF KEY CONCEPTS ...................................................... 11

1.8.1 Critical analysis ............................................................................... 11

1.8.2 Adolescent ......................................................................................... 11

1.8.3 Reproductive health (RH) ................................................................. 12

1.8.4 Adolescent reproductive health services (ARHS) ......................... 13

1.9 DEMARCATION OF THE STUDY .......................................................... 14

1.10 ABBREVIATIONS ............................................................................... 14

1.12 CONCLUSION ...................................................................................... 14

1.13 ORGANISATION OF THE REPORT ...................................................... 15
Chapter 2

Literature review

2.1 INTRODUCTION ................................................................. 16
2.2 FRAMEWORK ......................................................................... 17
2.3 PROFILE OF THE ADOLESCENT (WHO IS THE ADOLESCENT?) ATTENDING ARHS ....................................................................... 22
2.3.1 The adolescent ....................................................................... 22
2.3.1.1 Adolescence: a time of rapid physical growth and development ................................................................. 24
2.3.1.2 Adolescence: a time of physical, social and psychological maturity ................................................................. 24
2.3.1.3 Adolescence: a time of sexual maturity and the start of sexual activity ................................................................. 25
2.3.1.4 Adolescence: a time of trying out experiences for the first time ................................................................. 26
2.3.1.5 Adolescence: a time when there is often lack of knowledge and skills to make healthy choices ................................................................. 27
2.3.1.6 Adolescence: a time in which immediate needs tend to have priority over long-term implications ................................................................. 27
2.3.1.7 Adolescence: a time when behavioural patterns are commended ................................................................. 27
2.3.2 Gender of the adolescent ................................................................. 29
2.3.3 Age of the adolescent and sexual practice ................................................................. 31
2.4 THE ACCESSIBILITY AND AVAILABILITY OF ARHS FOR THE ADOLESCENT ................................................................. 36
2.4.1 Convenience of the location of ARHS for the adolescent ........................................................................ 38
2.4.2 Costs issues related to adolescents attending ARHS ........................................................................ 42
2.4.2.1 Getting the best possible value for money ........................................................................ 43
2.4.3 Convenient clinic hours for the adolescent ........................................................................ 43
2.4.4 Waiting times for adolescents at ARHS ........................................................................ 45
2.5 COMPREHENSIVE CARE PROVIDED AT ARHS ........................................................................ 47
2.6 INFORMATION AND COUNSELLING GIVEN TO ADOLESCENTS AT ARHS ........................................................................ 49
2.6.1 Counselling of adolescents ........................................................................ 54
2.7 ADOLESCENT-FRIENDLY SERVICES ........................................................................ 55
2.7.1 Attitudes of service providers attending to adolescents at the ARHS ........................................................................ 59
<table>
<thead>
<tr>
<th>Table of contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.8 CONCLUSION</td>
<td>62</td>
</tr>
<tr>
<td>Chapter 3</td>
<td></td>
</tr>
<tr>
<td>Research methodology</td>
<td></td>
</tr>
<tr>
<td>3.1 INTRODUCTION</td>
<td>64</td>
</tr>
<tr>
<td>3.2 RESEARCH DESIGN</td>
<td>65</td>
</tr>
<tr>
<td>3.3 HYPOTHESIS</td>
<td>67</td>
</tr>
<tr>
<td>3.4 POPULATION AND SAMPLING METHOD</td>
<td>67</td>
</tr>
<tr>
<td>3.4.1 Sampling</td>
<td>68</td>
</tr>
<tr>
<td>3.4.2 Sampling approaches</td>
<td>68</td>
</tr>
<tr>
<td>3.4.3 Multistage/cluster sampling</td>
<td>69</td>
</tr>
<tr>
<td>3.4.3.1 First stage sampling: ARHS in Gauteng Province</td>
<td>69</td>
</tr>
<tr>
<td>3.4.3.2 Second stage sampling: adolescents visiting ARHS in Gauteng Province</td>
<td>70</td>
</tr>
<tr>
<td>3.4.3.3 Third stage sampling: registered nurses rendering health care to adolescents in ARHS in Gauteng Province</td>
<td>74</td>
</tr>
<tr>
<td>3.5 DATA COLLECTION</td>
<td>75</td>
</tr>
<tr>
<td>3.6 RESEARCH INSTRUMENT</td>
<td>75</td>
</tr>
<tr>
<td>3.6.1 Development of the questionnaire</td>
<td>75</td>
</tr>
<tr>
<td>3.6.2 Format of the questionnaire</td>
<td>76</td>
</tr>
<tr>
<td>3.6.3 Reasons for using a questionnaire</td>
<td>82</td>
</tr>
<tr>
<td>3.6.4 Advantages of self-delivered questionnaires</td>
<td>82</td>
</tr>
<tr>
<td>3.6.5 Validity and reliability of the research instrument</td>
<td>83</td>
</tr>
<tr>
<td>3.6.5.1 Validity</td>
<td>83</td>
</tr>
<tr>
<td>3.6.5.2 Pretesting of the instrument</td>
<td>84</td>
</tr>
<tr>
<td>3.6.5.3 Reliability of the instrument</td>
<td>87</td>
</tr>
<tr>
<td>3.7 ETHICAL CONSIDERATIONS</td>
<td>88</td>
</tr>
<tr>
<td>3.7.1 Principle of respect for persons</td>
<td>88</td>
</tr>
<tr>
<td>3.7.2 Principle of beneficence</td>
<td>89</td>
</tr>
<tr>
<td>3.7.3 Principle of justice</td>
<td>89</td>
</tr>
<tr>
<td>3.8 PERMISSION TO CONDUCT THE STUDY</td>
<td>91</td>
</tr>
<tr>
<td>3.9 DISTRIBUTION OF THE QUESTIONNAIRE</td>
<td>91</td>
</tr>
</tbody>
</table>
### Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.10</td>
<td>PLAN FOR DATA ANALYSIS</td>
<td>93</td>
</tr>
<tr>
<td>3.11</td>
<td>CODING OF THE COMPLETED QUESTIONNAIRES</td>
<td>94</td>
</tr>
<tr>
<td>3.12</td>
<td>CONCLUSION</td>
<td>94</td>
</tr>
</tbody>
</table>

**Chapter 4**

**Analysis and presentation of data**

- **4.1** INTRODUCTION .................................................................................. 95
- **4.2** METHOD USED FOR THE ANALYSIS OF DATA ........................................... 96
- **4.3** CONCEPTUAL FRAMEWORK USED FOR THE ANALYSIS AND PRESENTATION OF DATA ......................................................... 96
- **4.4** SECTION 1: PROFILE OF THE ADOLESCENT ATTENDING ARHS IN GAUTENG PROVINCE ......................................................... 97
- **4.5** SECTION 2: THE ACCESSIBILITY AND AVAILABILITY TO THE ADOLESCENT OF THE ARHS IN GAUTENG PROVINCE ......................................................... 107
- **4.6** SECTION 3: COMPREHENSIVE CARE SERVICES AVAILABLE FOR ADOLESCENTS IN GAUTENG PROVINCE ......................................................... 123
- **4.7** SECTION 4: INFORMATION AND COUNSELLING RECEIVED BY THE ADOLESCENT ATTENDING ARHS IN GAUTENG PROVINCE ......................................................... 131
- **4.8** SECTION 5: ADOLESCENT-FRIENDLY SERVICES ...................................... 148
- **4.9** CONCLUSION .................................................................................. 166

**Chapter 5**

**Conclusions and recommendations**

- **5.1** OVERVIEW OF THE STUDY .................................................................. 168
- **5.2** CONCLUSIONS ................................................................................ 169
# Table of contents

5.2.1 Who is the adolescent attending adolescent reproductive health services in Gauteng Province? ............................................................ 169
5.2.2 Are the adolescent reproductive health services in Gauteng Province accessible and available to adolescents? ................................................ 170
5.2.3 Do the adolescent reproductive health services in Gauteng Province provide comprehensive care to adolescents? ................................................ 171
5.2.4 Are adolescents receiving information and counselling from the adolescent reproductive health services in Gauteng Province? ........................................... 172
5.2.5 Are the adolescent reproductive health services in Gauteng Province adolescent-friendly? ............................................................. 173

5.3 RECOMMENDATIONS ..................................................... 173
5.3.1 Who is the adolescent attending adolescent reproductive health services in Gauteng Province? ............................................................ 173
5.3.2 Are the adolescent reproductive health services in Gauteng Province accessible and available to adolescents? ................................................ 175
5.3.3 Do the adolescent reproductive health services in Gauteng Province provide comprehensive care to adolescents? ................................................ 176
5.3.4 Are adolescents receiving information and counselling from the adolescent reproductive health services in Gauteng Province? ........................................... 176
5.3.5 Are the adolescent reproductive health services in Gauteng Province adolescent-friendly? ............................................................. 177

5.4 LIMITATIONS OF THE STUDY ..................................................... 178
5.4.1 Population ........................................................... 178
5.4.2 Data collection ............................................................ 179
5.4.2.1 Personnel ........................................................... 179
5.4.2.2 Data collection tool ............................................................ 179

5.5 RECOMMENDATIONS FOR FURTHER RESEARCH ..................................................... 179

5.6 ASSUMPTIONS (PREMISES) ..................................................... 180

5.7 CONCLUSION ..................................................... 181

REFERENCES ..................................................... 182
List of tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1.1</td>
<td>District health facilities by region</td>
<td>5</td>
</tr>
<tr>
<td>Table 3.1</td>
<td>Number of ARHS in the various regions</td>
<td>71</td>
</tr>
<tr>
<td>Table 3.2</td>
<td>Number of adolescents the researcher gave face-to-face questionnaires (n = 203)</td>
<td>74</td>
</tr>
<tr>
<td>Table 3.3</td>
<td>Pretesting of the instrument</td>
<td>85</td>
</tr>
<tr>
<td>Table 3.4</td>
<td>Response rate</td>
<td>92</td>
</tr>
<tr>
<td>Table 4.1</td>
<td>Money obtained by adolescents attending ARHS in Gauteng Province (n = 199)</td>
<td>104</td>
</tr>
<tr>
<td>Table 4.2</td>
<td>Name of the residential area of the adolescent attending ARHS in Gauteng Province (n = 202)</td>
<td>105</td>
</tr>
<tr>
<td>Table 4.3</td>
<td>The extent to which adolescents indicated that they would use the ARHS in Gauteng Province again (n = 203)</td>
<td>108</td>
</tr>
<tr>
<td>Table 4.4</td>
<td>Reasons given by adolescents for intending to use the ARHS in Gauteng Province again (n = 97)</td>
<td>109</td>
</tr>
<tr>
<td>Table 4.5</td>
<td>Waiting times for adolescents attending ARHS in Gauteng Province (n = 202)</td>
<td>118</td>
</tr>
<tr>
<td>Table 4.6</td>
<td>Reasons given to adolescents for not being permitted to attend ARHS in Gauteng Province during working hours (n = 21)</td>
<td>120</td>
</tr>
<tr>
<td>Table 4.7</td>
<td>Services received by adolescents attending ARHS in Gauteng Province</td>
<td>123</td>
</tr>
<tr>
<td>Table 4.8</td>
<td>Suggestions given by the adolescents to improve services provided at ARHS in Gauteng Province</td>
<td>130</td>
</tr>
<tr>
<td>Table 4.9</td>
<td>Health educational content of the material taken home to read by the adolescent attending the ARHS in Gauteng Province</td>
<td>134</td>
</tr>
<tr>
<td>Table 4.10</td>
<td>Health education topics given to adolescents attending the ARHS in Gauteng Province</td>
<td>139</td>
</tr>
<tr>
<td>Table 4.11</td>
<td>Entertainment preferred by the adolescents attending ARHS in Gauteng Province (n = 201)</td>
<td>150</td>
</tr>
<tr>
<td>Table 4.12</td>
<td>Preferred age group for the health care provider at ARHS in Gauteng Province (n = 201)</td>
<td>151</td>
</tr>
<tr>
<td>Table 4.13</td>
<td>Rating by the adolescent of each health care provider at the ARHS in Gauteng Province</td>
<td>157</td>
</tr>
</tbody>
</table>
List of tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.14</td>
<td>Reasons given by adolescents for choosing to attend a selected ARHS in Gauteng Province</td>
<td>161</td>
</tr>
<tr>
<td>4.15</td>
<td>Comments made by adolescents to improve the services offered by ARHS in Gauteng Province</td>
<td>165</td>
</tr>
<tr>
<td>Figure</td>
<td>Description</td>
<td>Page</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>1.1</td>
<td>Gauteng Province map</td>
<td>4</td>
</tr>
<tr>
<td>2.1</td>
<td>Quality Care Model</td>
<td>19</td>
</tr>
<tr>
<td>4.1</td>
<td>Gender (sex) of the adolescent (n = 203)</td>
<td>97</td>
</tr>
<tr>
<td>4.2</td>
<td>Age of the adolescent attending ARHS in Gauteng Province (n = 203)</td>
<td>99</td>
</tr>
<tr>
<td>4.3</td>
<td>Population group of the adolescent attending ARHS in Gauteng Province (n = 203)</td>
<td>100</td>
</tr>
<tr>
<td>4.4</td>
<td>Level of education of the adolescent attending ARHS in Gauteng Province (n = 203)</td>
<td>101</td>
</tr>
<tr>
<td>4.5</td>
<td>Employment status of the adolescent attending ARHS in Gauteng Province (n = 203)</td>
<td>103</td>
</tr>
<tr>
<td>4.6</td>
<td>The number of times that the adolescent had attended ARHS in Gauteng Province since 1998 (n = 197)</td>
<td>107</td>
</tr>
<tr>
<td>4.7</td>
<td>Convenient clinic days for the adolescent attending ARHS in Gauteng Province (n = 203)</td>
<td>111</td>
</tr>
<tr>
<td>4.8</td>
<td>Days on which ARHS in Gauteng Province should be open for adolescents (n = 201)</td>
<td>112</td>
</tr>
<tr>
<td>4.9</td>
<td>Hours of service convenient for adolescent visiting ARHS in Gauteng Province (n = 200)</td>
<td>113</td>
</tr>
<tr>
<td>4.10</td>
<td>Adolescents attending ARHS in Gauteng Province during school hours (n = 201)</td>
<td>115</td>
</tr>
<tr>
<td>4.11</td>
<td>Times convenient for adolescents to attend ARHS in Gauteng Province (n = 202)</td>
<td>117</td>
</tr>
<tr>
<td>4.12</td>
<td>The adolescent's preferred gender (sex) of the health care provider at ARHS in Gauteng Province (n = 202)</td>
<td>153</td>
</tr>
<tr>
<td>4.13</td>
<td>The adolescent's preferred dress code for the health care provider at ARHS in Gauteng Province (n = 201)</td>
<td>155</td>
</tr>
</tbody>
</table>
List of acts

Child Care Amendment Act 13 of 1999

Choice on Termination of Pregnancy Act 92 of 1996

Skills Development Act 97 of 1998

Sterilisation Act 44 of 1998

South African Qualification Authority Act 58 of 1995
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>Advice and contraception under twenty</td>
</tr>
<tr>
<td>AGI</td>
<td>Allan Guttmacher Institute</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immuno-deficiency virus</td>
</tr>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>ARHS</td>
<td>Adolescent reproductive health service</td>
</tr>
<tr>
<td>CD Rom</td>
<td>Compact disc read-only memory</td>
</tr>
<tr>
<td>DHS</td>
<td>District health system</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency contraception</td>
</tr>
<tr>
<td>ECPs</td>
<td>Emergency contraceptive pills</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuous professional development</td>
</tr>
<tr>
<td>f</td>
<td>Frequency</td>
</tr>
<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
</tr>
<tr>
<td>FP</td>
<td>Family planning</td>
</tr>
<tr>
<td>GEAR</td>
<td>Growth employment and redistribution</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immuno virus</td>
</tr>
<tr>
<td>ICPD</td>
<td>International conference of population development</td>
</tr>
<tr>
<td>ICW</td>
<td>International conference on women</td>
</tr>
<tr>
<td>IC</td>
<td>Information and counselling</td>
</tr>
<tr>
<td>km</td>
<td>Kilometre</td>
</tr>
<tr>
<td>MCWH</td>
<td>Mother, child, and women's health</td>
</tr>
<tr>
<td>MSS</td>
<td>Metropolitan Substructure</td>
</tr>
<tr>
<td>n</td>
<td>Sample</td>
</tr>
<tr>
<td>NAFCI</td>
<td>National adolescent-friendly clinic initiator</td>
</tr>
<tr>
<td>NHS</td>
<td>National health system</td>
</tr>
<tr>
<td>Pap</td>
<td>Papanicoloau</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary health care</td>
</tr>
<tr>
<td>RDP</td>
<td>Reconstruction and development programme</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive health</td>
</tr>
<tr>
<td>RSA</td>
<td>Republic of South Africa</td>
</tr>
<tr>
<td>SANC</td>
<td>South African Nursing Council</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical package for social sciences</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually transmitted diseases</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of pregnancy</td>
</tr>
<tr>
<td>Unisa</td>
<td>University of South Africa</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>US</td>
<td>United States of America</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>Wits</td>
<td>Witwatersrand</td>
</tr>
<tr>
<td>%</td>
<td>Percent</td>
</tr>
</tbody>
</table>
### List of annexures

<table>
<thead>
<tr>
<th>Annexure 1:</th>
<th>Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annexure 2:</td>
<td>Letter of permission to use the questionnaire from</td>
</tr>
<tr>
<td></td>
<td>the Ethical Committee, Department of Advanced</td>
</tr>
<tr>
<td></td>
<td>Nursing Sciences at Unisa</td>
</tr>
<tr>
<td>Annexure 3a:</td>
<td>Letter requesting permission from the Research</td>
</tr>
<tr>
<td></td>
<td>Committee in Gauteng Province to conduct the study</td>
</tr>
<tr>
<td>Annexure 3b:</td>
<td>Letter of approval from the Research Committee in</td>
</tr>
<tr>
<td></td>
<td>Gauteng Province to conduct the study</td>
</tr>
<tr>
<td>Annexure 4a:</td>
<td>Letter requesting permission from the Director,</td>
</tr>
<tr>
<td></td>
<td>District Health Services to conduct the study in</td>
</tr>
<tr>
<td></td>
<td>the five regions</td>
</tr>
<tr>
<td>Annexure 4b:</td>
<td>Letter of approval from the Director, District</td>
</tr>
<tr>
<td></td>
<td>Health Services in Gauteng Province to conduct the</td>
</tr>
<tr>
<td>Annexure 4c:</td>
<td>Letters requesting permission from the Directors/</td>
</tr>
<tr>
<td></td>
<td>Deputy Directors in the five regions to conduct the</td>
</tr>
<tr>
<td>Annexure 4d:</td>
<td>Letters of approval from the Directors/Deputy</td>
</tr>
<tr>
<td></td>
<td>Directors in the five regions to conduct the study</td>
</tr>
<tr>
<td>Annexure 5:</td>
<td>Covering letter to the respondents explaining the</td>
</tr>
<tr>
<td></td>
<td>study</td>
</tr>
</tbody>
</table>
CHAPTER 1

Introduction and orientation to the study

1.1 BACKGROUND TO THE PROBLEM


In South Africa, in terms of a census done in 1996, there is also compelling statistical support that this critical need be met as it was estimated that out of a population of 37 859 million, 46.7 percent were youth under the age of 19 years (South Africa 1999b:1).

In this context, Dickson-Tetteh et al (1999:1) found in their study that 21.0 percent (8.8 million) of South Africans were in the age group 10 to 19 years and that for the majority of
these adolescents access to ARHS was inaccessible due to various factors.

In relation to the above, according to the 1996 census Gauteng Province had a population of 7,35 million, 18,0 percent of the national population (South Africa 1999b:20). Gauteng Province is the most densely populated province in South Africa and has the second highest concentration of young people in the country (Gauteng Youth Directorate sa:2).

Gauteng Province also exhibits a contradictory combination of social advantages and social problems which have their roots in the province’s highly urbanised, industrialised, densely populated and economically polarised population. In this climate meeting the reproductive health needs of the adolescent will require long-term commitment and dedicated resources (South Africa 1999b:17; Webb 1998:preface).

Adolescents are also considered an important human resource because of their energy, idealism and fresh views (Friedman 1993:4). This view was also expressed by Mandela who maintained that the “youth of our country are a valued possession of our nation. Without them there can be no reconstruction and development programme. Without them there can be no future” (South Africa 1994:41). They are, however, the most vulnerable. It is therefore important to ensure that their health needs are met at a ARHS so that they become healthy, mature and responsible adults (Friedman 1993:4).

Based on the above, the South African Department of Health has recognised the importance of promoting healthy life-styles for these adolescents if they are to become healthy and responsible adults and has acknowledged the need for providing adolescent-friendly services. Adolescents and young adults are now considered the primary target groups when programmes are drawn up to improve sexual and reproductive health (Dickson-Tetteh et al 1999:4).

To achieve this goal, the Department of Health, Gauteng with respect to youth and adolescent health aims at:
• being effective in addressing the needs of the youth and adolescents
• building a network of quality youth and adolescent health services in collaboration with non-governmental and community organisations, the private sector, youth brigades, various political organisations, South African Police services, and the Departments of Labour, Trade and Industry, Economics, Social Welfare and Population Development, Safety and Security, Justice, Agriculture and Land Affairs, Sport and Recreation and Correctional Services
• monitoring and evaluating the provision of youth services to ensure the accessibility, equity, appropriateness, affordability and youth-friendly health care services
• promoting the grooming of youth and adolescents into responsible adulthood
• collaborating with international, national and regional health services

(Dickson-Tetteh et al 1999:4)

1.1.1 Gauteng Province

Gauteng (meaning a place of gold in Sesotho) is one of South Africa's nine provinces which is geographically the smallest but economically the powerhouse of the country, due not only to its goldmines but also the fact that it is the major business centre for South Africa (South Africa 1997-1998:46-47).

Gauteng Province stretches from Springs in the east, to the Magaliesburg range in the west to the Vaal River in the south and beyond Pretoria in the north and is bordered by the Northern Province in the north, Mpumalanga in the east, Free State in the south and North-West in the west (South Africa 1997-1998:46-47) (figure 1.1).

The following map depicts Gauteng Province.
Gauteng Province:
Geographic Distribution of Health Districts

Figure 1.1
Gauteng Province map
1.1.2 District health facilities by region

Gauteng Province is divided into five health regions, each with a regional office. These regions are in turn divided into health districts. There are presently 25 health districts, however, the number may change when the demarcation of the new local authority boundaries are finalised (South Africa 1999b:18). The regional offices are primarily responsible for developing the district health system which provides primary health care (PHC) services through a network of provincial and municipal clinics and community-based programmes (South Africa 1999b:19). Table 1.1 depicts district health facilities by region.

1.1.3 Public health services in Gauteng Province

Table 1.1: District health facilities by region

<table>
<thead>
<tr>
<th>Region</th>
<th>Community health centre</th>
<th>Provincial clinic</th>
<th>Municipal clinic</th>
<th>Mobile clinic</th>
<th>Total PHC facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Witwatersrand</td>
<td>14</td>
<td>47</td>
<td>99</td>
<td>35</td>
<td>195</td>
</tr>
<tr>
<td>Vaal</td>
<td>2</td>
<td>6</td>
<td>24</td>
<td>7</td>
<td>39</td>
</tr>
<tr>
<td>West Rand</td>
<td>1</td>
<td>21</td>
<td>9</td>
<td>7</td>
<td>38</td>
</tr>
<tr>
<td>Pretoria</td>
<td>3</td>
<td>26</td>
<td>61</td>
<td>7</td>
<td>97</td>
</tr>
<tr>
<td>East Rand</td>
<td>4</td>
<td>18</td>
<td>91</td>
<td>4</td>
<td>117</td>
</tr>
<tr>
<td>TOTAL ...........</td>
<td>24</td>
<td>118</td>
<td>284</td>
<td>60</td>
<td>486</td>
</tr>
</tbody>
</table>

(South Africa 1999b:19)

Table 1.1 represents the distribution of health care facilities and highlights the fact that Central Witwatersrand (Wits) has the largest number PHC facilities (195), followed by East Rand with 117 PHC facilities, in Gauteng Province. The total number of PHC facilities tallies with the densely populated regions of the Central Witwatersrand which has a population of 2,875 429 and the East Rand with a population of 1,909 435 (South Africa 1999b:19).
Each district health authority and provincial department has been given the responsibility of providing maternal, child, women, family health and nutrition services (South Africa 1996:53). It is significant to note that adolescents are not highlighted as a separate service within the maternal, child and women’s health (MCWH) services as is the case with mothers and children. It is also evident from the information provided that the Department of Health sees the health needs of adolescents as part of the range of functions of MCWH services and not as a separate function (South Africa 1997a:97).

1.1.3.1 ARHS in Gauteng Province

The current situation in Gauteng Province with regard to ARHS is as follows:

- **Health services**

  In general the health services
  - do not meet the requirements of accessibility, confidentiality, availability and affordability
  - have insufficient information to enable the young person to make an informed decision
  - display a general lack of sensitivity and negative attitudes towards youth and sexuality
  - seldom ask comments from the youth. Health professionals are perceived as “know it all”.
  - do not provide appropriate information. Education and communication material is generally not accessible to young people in particular and communities in general.
  - are not appropriately or fully utilised by the youth
  - have few health providers who are trained to meet the health needs of the adolescent (South Africa 1998b:9)
Contraceptive services

In general contraceptive services
- are not adolescent friendly
- deny the sexually active adolescent under the age of 14 years, contraceptive methods if they do not have permission from their parents/guardian
- only provide contraceptive packages and services in health institutions. This causes a barrier to contraceptive use because adolescents are scared to visit the clinics.
- lack sufficient counselling services for adolescents to enable them to make informed choices about their reproductive health
- are perceived negatively by most adolescents
- are not integrated with other services, for example PHC
- are not coordinated
- are not universal in their perceptions as to who the adolescent is in terms of age
- fail to consult the adolescent when planning training packages
- are not comprehensive
- provide pre-packed emergency contraceptives pills (ECPs) but do not give education or instructions on how to use the pack
- supply insufficient contraceptives for use in rural areas and inadequate parental guidance at this level
(South Africa 1998b:18-19)

Termination of pregnancy (TOP) services

In general, in terms of TOP services
- termination of pregnancy remains a controversial issue in South Africa despite the fact that it was made legal with the promulgation of the Choice on Termination of Pregnancy Act 92 of 1996
- are performed in public health institutions
- 7 661 TOP’s have been performed for women over the age of 18 years
- 1 561 TOP’s have been performed for women under the age of 18 years
access for these services is inadequate resulting in clients being lost between referrals due mainly to unrealistic long waiting times for clients
the constitutional rights of service providers to refuse performing TOP are respected
there is inadequate infrastructure and a shortage of manpower
TOPs are done in isolation and not as part of reproductive health care
doctors' involvement in counselling/education is lacking
community involvement and education is lacking
service providers and community users are intimidated
support groups for pregnant and teenage mothers are lacking
(South Africa 1998b:23-24)

Sexually Transmitted Diseases (STDs), Human Immuno-deficiency Virus (HIV), Acquired Immuno-deficiency Syndrome (AIDS) services

In general these services which include the adolescent

- do not supply condoms after hours
- do not collaborate with traditional religious, governmental, non-governmental and community-based organisations
- discriminate against people with HIV/AIDS
(South Africa 1998b:29)

Teenage pregnancy services

In general these services for teenagers

- are not user-friendly due to the attitude of health professionals
- are only available at provincial level in terms of counselling workshops on termination of pregnancy
- are limiting in terms of continuing with schooling as there is no ruling in schools that permit teenage mothers to go back to schools after delivery or allows them to sit for
examinations even if they are not attending classes

- lack programmes for teaching parenting skills to pregnant teenagers
- do not provide life skills programmes in or out of schools
- do not provide support groups for pregnant teenagers and teenage mothers
(South Africa 1998b:20-21)

1.2 PROBLEM STATEMENT

ARHS in Gauteng Province are not meeting the reproductive health needs of adolescents. There is also no formalised ARHS policy laid down to assess the quality of care provided to adolescents at these clinics although the policy is currently in the process of being finalised.

1.3 PURPOSE OF THE STUDY

The purpose of the study was to critically analyse the ARHS in Gauteng Province to determine which adolescents attended the clinics, whether the clinics were accessible and available and whether they provided comprehensive care, gave information and counselling services to the adolescent and whether the clinics were adolescent-friendly.

1.4 RESEARCH QUESTIONS

Using the Quality Care Model (figure 2.1) as a conceptual framework for the study, the following five research questions were asked to determine the quality of care given to adolescents who attended the ARHS in Gauteng Province:

- Who is the adolescent attending adolescent reproductive health services in Gauteng Province?
- Are the adolescent reproductive health services in Gauteng Province accessible and available to adolescents?
• Do the adolescent reproductive health services in Gauteng Province provide comprehensive care to adolescents?
• Are adolescents receiving information and counselling from the adolescent reproductive health services in Gauteng Province?
• Are the adolescent reproductive health services in Gauteng Province adolescent-friendly?

1.5 SIGNIFICANCE OF THE STUDY

The significance of the study was that it would contribute to a more reality-based approach to the services provided, based on the identified health care needs of the adolescents attending ARHS in Gauteng Province and would thus assist in the formulation of a policy that could be used in ARHS. It was envisaged too that the findings could also significantly contribute to improving nursing theory and practice at these centres.

1.6 ASSUMPTIONS (PREMISES) OF THE STUDY

"Assumption are equivalent to axioms in geometry – self-evident truths, the *sine qua non* of research" (Leedy 1997:7).

Correspondingly, the assumptions in this study influenced the research question, the data collected, techniques used to collect data, interpretations of the findings, conclusions and the recommendations made (Burns & Grove 1997:48; Nieswiadomy 1993:28 cites Meyers 1982).

Based on the above the following four assumptions provided a basis for this study.

Assumption 1: Adolescents need accessible and available adolescent reproductive health services
Assumption 2: Adolescents need to be provided with comprehensive care at adolescent reproductive health services
Assumption 3: Adolescents need to receive information and counselling at the adolescent reproductive health services if their needs are to be met

Assumption 4: Adolescent reproductive health services should be adolescent-friendly

1.7 RESEARCH METHODOLOGY

Using a quality care model as a conceptual framework for the study, a quantitative cross-sectional (sequential) exploratory, descriptive research design was used. A survey method was used to collect data from respondents in selected ARHS in the Gauteng Province. The respondents were selected using a nonprobability convenience sampling method.

1.8 DEFINITIONS OF KEY CONCEPTS

The following definitions of key concepts used in this study are provided to ensure that the readers will share the researcher's interpretation of these concepts.

1.8.1 Critical analysis

"Analysis is used to clarify and refine concepts, statements or theories and is especially useful when there is an existing body of theoretical literature. The existing whole is broken into parts where each part as well as the relationship between the parts are examined for better understanding" (Zwane 1997:39 cites Walker & Avant 1988:24).

In terms of this study critical analysis refers to an objective review of the situation in the ARHS in Gauteng Province related to the needs of the adolescent, the services and resources provided.

1.8.2 Adolescent

The concept "adolescence" according to the World Health Organization's (WHO's) definition is "a period including people aged between 10 and 19 years" (Early sex-early
motherhood: facing the challenge 1996:4). In this study an adolescent is a male or female person in the age group 10 to 19 years who attended selected ARHS in Gauteng Province. The female adolescent would either be in need of:

- reproductive health information and counselling
- contraceptives
- antenatal care
- delivery care
- postnatal care
- TOP care
- diagnosis, treatment/counselling for STD, HIV/AIDS

The male adolescent would be in need of:

- reproductive health information and counselling
- contraceptives
- diagnosis, treatment/counselling for STD, HIV/AIDS
- reproductive health disease care

1.8.3 Reproductive health (RH)

Reproductive health (RH) is a vital part of general health, it is not only a reflection of health during adolescence and adulthood, it also lays a foundation for health beyond the reproductive years for both females and males and has major intergenerational effects (WHO 1995:3).

Reproductive health is defined within the framework of WHO “as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive health systems, its functions and processes” (Birdthistle & Vince-Whitman 1997:1 cites UN 1994; WHO 1995:3).
In this study, adolescent reproductive health refers to the health and well-being of both male and female adolescent in terms of sexuality, prevention of pregnancy before marriage and maturity, promotion of safe pregnancy, labour, puerperium and TOPs, lower rates of exposure to and contraction of STDs, HIV and AIDS.

1.8.4 Adolescent reproductive health services (ARHS)

At the 1994 International Conference on Population and Development (ICPD) in Cairo, it was agreed that adolescent reproductive health needs should be met through appropriate services and programmes which provided information and counselling (Dickson-Tetteh et al 1999:4).

These programmes should address:

- unwanted pregnancy
- TOP
- STD
- HIV/AIDS
- gender relations
- sexual violence
- female genital mutilation (FGM)
- sexuality
- reproduction and contraception

South Africa is a signatory to the agreements reached at ICPD (Dickson-Tetteh et al 1999:4).

In terms of the above, in this study, the following services for the adolescent were reviewed:

- information and counselling strategies on reproductive health matters
- contraceptive methods
- antenatal care
• delivery care
• postnatal care
• TOP
• STD care
• HIV/AIDS pre- and postcounselling

1.9 DEMARCATION OF THE STUDY

The research study was conducted in selected ARHS in Gauteng Province. The rationale for selecting these ARHS as a research area were as follows:

• Logistically the area selected was convenient for the researcher.
• Gauteng Province has a considerable number of ARHS which enabled the researcher to select a representative sample.

The research study was conducted between 1994 and 2000.

1.10 ABBREVIATIONS

A list of abbreviations used throughout this study is provided on page x in order to facilitate the reader's reference to the abbreviations.

1.12 CONCLUSION

This chapter discussed the background to the problem, the problem statement, the purpose of the study, the research questions, significance of the study, the assumptions (premises) used in the study, the research methodology, definition of key concepts and demarcation of the study and the organisation of the study and conclusion. Chapter 2 will address the literature review.
1.13 ORGANISATION OF THE REPORT

In order to create a clear reference for studying the identified problem, the research report is divided into five chapters as follows:

Chapter 1: Introduction and orientation to the study
Chapter 2: Literature review
Chapter 3: Research methodology
Chapter 4: Analysis and presentation of findings
Chapter 5: Conclusions and recommendations
CHAPTER 2

Literature review

2.1 INTRODUCTION

According to Brink (1996:76) a literature review “entails searching, finding, reading, comprehending and reaching conclusions about the published research and theory on a given topic”.

The researcher conducted a literature review to

• identify what was already known about the topic of interest, namely a critical analysis of ARHS in Gauteng Province thus minimising unnecessary duplication
• obtain ideas for the research methodology that could be useful in pursuing the problem
• assist in refining certain sections of the study particularly in relation to the problem statement, the conceptual framework, the research design and the process for
analysing data (Brink 1996:76; Mateo & Kirchhoff 1999:202; Polit & Hungler 1993:67)

- establish a basis for comparison with other research when interpreting the findings of this study (Brink 1996:102)
- suggest new areas of research after comparing the results of this study with the findings of other studies (Khoza 1996:19)
- have a sound knowledge of the development of the adolescent so that recommendations for providing quality care for adolescents could be made at ARHS in terms of their needs

The literature study was done with the aid of computer-assisted subject data bases in the field of social sciences and medicine, namely:

- Compact disc read-only memory (CD Rom) and web-based search of references to periodicals, articles and books.
- Sabinet search of references to South African material, for example, references to periodicals, articles, books, theses, dissertations and government circulars.

The area of reference focussed on the development of the adolescent and type of care rendered to adolescents in ARHS. Only a few published South African/Gauteng Province studies dealing with ARHS could be found. Due to the paucity of literature, old sources were used, as well as secondary sources and policy guidelines, from the Department of Health, Gauteng Province.

2.2 FRAMEWORK

A framework is an explanation based on the literature read, of how the variables in the study are expected to relate to each other. There are two types of framework used in a research study namely, theoretical and conceptual (Brink & Wood 1994:48; Nieswiadomy 1993:95).
• **Theoretical framework**

A theoretical framework is when the variables have been studied before and have been found to be related to one another, resulting in a theory or an explanation that provides an explanation for the action of the variable, or a proposed explanation given by another author to explain the findings (Brink & Wood 1994:49).

• **Conceptual framework**

A conceptual framework on the other hand is “when the explanation based on literature and research about the variables does not contain a particular theory that explains the relationships among variables” (Brink & Wood 1994:48).

A conceptual framework was considered appropriate for this study as it assisted the researcher in organising the study and provided a context for the interpretation of the study findings.

□ **Quality Care Model**

The conceptual framework used for the study was the Quality Care Model based on the WHO recommendations (WHO 1998a:1) (see figure 2.1). The research question in terms of this model was “What is quality of care?”. In terms of the ARHS, the research question was based on the concepts outlined in this model and accordingly the ARHS should

- be accessible and available as close as possible to where adolescents live, and at the lowest level health care facility that can provide the services safely and effectively
- provide comprehensive care and/or linkages to other reproductive health services
- provide for continuity of care and follow-up
- provide information and counselling services for adolescents in terms of their health and health needs
- be acceptable to potential users and responsive to cultural and social norms, such as preferences for privacy, confidentiality and care by female health workers
Figure 2.1
Quality Care Model
(WHO 1998a:1)
• staffed by workers who provide respectful and non-judgemental care that is responsive to adolescents' needs
• involve health care participants in protecting their own health (WHO 1998a:1)

Reasons for selecting the quality care model as a conceptual framework

The researcher chose to use the above conceptual framework as it was

• easy to use/user friendly
• realistic
• relevant to the study

Quality care in ARHS

Quality of care was also seen as a critical aspect of service delivery. Analysis of the quality of care given in the ARHS also rests on the assumption that by improving the quality of service practised this actually improves the service given (El Shabrawy Ali & Eisa Ali Mahmoud 1993:51). Quality of care also links with the guiding principle of the public service in South Africa, namely that of 'service to the people'. Service to people is essential if the public service is to satisfy its role in the implementation of the Reconstruction and Development Programme (RDP) (South Africa 1995:57). Service to people is a programme which has been identified by the Parliament of the Republic of South Africa as one of the five key programmes of the RDP (South Africa 1994:9).

In terms of the above, adolescents are entitled to receive quality care when receiving health care to meet their basic needs when attending ARHS.

Emphasising quality health care for adolescents and evaluating the ARHS was considered important for the following reasons:
The adolescence period is considered a crucial time of transition when the development of social and cognitive skills are important for quality adult life. The establishment of relationships with the health care system during this transitional period is necessary for developing healthy lifestyles behaviours and for providing intervention for those with unhealthy behaviours. The need for emphasis on adolescent health has been influenced by the recognition that several factors affect adolescent morbidity and mortality rates such as unsafe sexual practices. These can be prevented. The health care setting (if appropriate) permits assessment, education and intervention (Zimmer-Gembeck, Alexander & Nystrom 1997:388).

With the Cairo Programme of Action at the ICPD and again with the Beijing Platform at the fourth International Conference on Women (ICW), the global community resolved to “protect and promote the rights of adolescents by providing and promoting the need for sexual and reproductive health information and services” (Birdthistle & Vince-Whitman 1997:1). South Africa as a signatory of these documents is committed to implementing these recommendations.

The conceptual framework used in the study

Using the research questions given below, the views of different authors and the findings of relevant research are discussed in terms of quality care and where possible linked with research in South Africa.

- Who is the adolescent attending adolescent reproductive health services in Gauteng Province?
- Are the adolescent reproductive health services in Gauteng Province accessible and available to adolescents?
- Do the adolescent reproductive health services in Gauteng Province provide comprehensive care to adolescents?
- Are adolescents receiving information and counselling from the adolescent reproductive health services in Gauteng Province?
2.3 PROFILE OF THE ADOLESCENT (WHO IS THE ADOLESCENT?) ATTENDING ARHS

2.3.1 The adolescent

The concept adolescence is derived from the Latin verb ‘adolescere’ which literally means “to grow” and refers therefore to the adolescent’s growth into adulthood when a transition is made from dependent childhood to the independent realisation of full adulthood (Johnson 1995:11; Olivier 1996:5).

Adolescence is further regarded as a developmental process marked by physical, intellectual and psychosocial change. The starting point of this transition for both males and females is usually considered at the onset of puberty, which is unique in each individual and is influenced by the family, culture, peers, socio-economic status and educational levels (Family Health International 1997:8; Klima 1998:485).

The period traditionally defined as adolescence is lengthening. The onset of puberty is occurring earlier and the age of marriage is rising. Thus adolescents face a longer period in which they are sexually mature and may be sexually active, but when pregnancy and childbearing may be neither desired nor socially acceptable (Finger 1993:16; World’s Youth 1996:no page).

Adolescence is classified into different stages with concomitant changes. There is a need to differentiate between these stages, namely young, middle and late adolescence.

Young adolescents (ages 10 to 14)

In this stage adolescents are
adjusting to the physical changes of puberty
• curious about sex
• concrete thinkers who are unable to understand the long-term consequences of their behaviours

Middle adolescence (ages 14-17)

This stage for the adolescent

• is a developmental stage
• is marked by the rising importance of the peer group
• is characterised by a struggle for independence
• involves narcissism and experimentation
• can be marked by unintended pregnancy, contracting HIV/AIDS from the "it won't happen to me" syndrome as well as an inability to conceive the long-term consequences of unprotected intercourse

Late adolescence (ages 17 to 19)

In late adolescence the adolescent

• begins to experience a sense of self
• begins to use logical thought processes
• has an understanding of the concept of the future
  (Klima 1998:485)

On the other hand, Van Coeverden De Groot (1991:1379) only differentiates between young adolescence less than 17 years and older adolescence (17 to 19 years). The latter would be fully grown and may have had substantially more education than the former. These above adolescent stages apply as well to the adolescent attending the ARHS in Gauteng Province.
2.3.1.1 Adolescence: a time of rapid physical growth and development

The various conspicuous physiological changes that occur during puberty require appraisal if the adolescent is to be better understood. It is therefore important to realise that the pituitary gland secretes the growth hormone (somatotropin). The growth hormone is accountable for the growth spurt that is noticeable during adolescence. The pituitary gland also facilitates the secretion of sex hormones – testosterone (for males) and estrogen (for females) (Bodibe 1994:26; Family Health International 1997:8).

2.3.1.2 Adolescence: a time of physical, social and psychological maturity

Physical, social and psychological maturity of the adolescent takes place, but not all at the same time (Aten, Siegel & Roghmann 1996:258; Carr 1995:36; Early sex-early motherhood: facing the challenge 1996:4; WHO 1998d:4). Physical maturity usually comes first. Johnson (1995:1) argues that “physical stature and chronological age do not mature equally. Maturational development is characterised by how one thinks about early adolescent. Thought tends to be more concrete with little abstract hypothetico-deductive characteristics. Therefore adolescents have difficulty considering tomorrow’s consequences of today, or more importantly tonight’s behaviour”.

Tolan and Cohler (1993:5) citing Hill’s (1983) have identified five sets of psychosocial issues that take on special importance during adolescence namely:

- discovering an understanding of the self as an individual (identity)
- forming close and caring relationship with others (intimacy)
- establishing a healthy sense of independence (autonomy)
- coming to terms with puberty and expressing sexual feeling (sexuality)
- becoming a successful and competent member of a society (achievement)

Development in each of these five areas takes on special meaning during the adolescent years because of the extensive biological, psychological and social changes that take place at this
period. Tolan and Cohler (1993:21) assert that "the most exciting and anxiety producing aspect of adolescence is change". Barn (1994:10) and Family Health International (1997:8) concur that together with the physical maturation new feelings emerge as the young person's body and social world change, become more important and greater interest is shown on the opposite sex.

2.3.1.3 Adolescence: a time of sexual maturity and the start of sexual activity

Tolan and Cohler (1993:95) maintain that "humans are sexual from birth, but that adolescence is a period when sexuality takes on different meanings and has different manifestation than previously". Tolan and Cohler (1993:99-100) further cite Sarrel and Sarrel's identification of nine processes of sexual unfolding that usually occur during adolescence, namely:

- An evolving sense of body towards a body image that is gender specific and fairly free of distortion (particularly about the genitals).
- The ability to overcome or modulate guilt, shame fear and childhood inhibitions associated with sexual thoughts and behaviour.
- A gradual loosening of primary emotional ties to parents and siblings.
- Learning to recognise what is erotically pleasing and displeasing and being able to communicate this to one's partner.
- Resolution of conflict and confusion about sexual orientation.
- An increasingly satisfying sexual life, free of sexual dysfunction or compulsion, including for the majority, satisfying autoeroticism.
- A growing awareness of being a sexual person and of the value of sex in one's life, including options such as celibacy.
- Becoming responsible about oneself, one's partner and society, for example, using contraceptive methods and not using sex to exploit others.
- An increasing ability to experience eroticism as one aspect of intimacy with another person to recognise that not all eroticism occurs in an intimate relationship but that the fusion of sex and love is possible.
Physiological maturity of the adolescent

Bodibe (1994:8) cites Jersild (1963) who captures the physiological impact of puberty on adolescence by noting that “before the pubertal changes occur the adolescent is a child. After these changes occur the adolescent can have a child, which can be regarded as a biological definition of adolescence, namely attainment of sexual maturity.”

The physiological urge for sexual activity is accompanied by a sense of invulnerability to harm (Keller, Duerst & Zimmerman 1996:126). A risk that the adolescent is not cognitively or emotionally able to appreciate. Zabin and Hayward (1993:60) cite Elkind’s (1967) description of the adolescent’s construction of what he calls “a personal fable characterised by a belief in the invincibility of self, a feeling of being unique and therefore not liable to risks that pertain to one’s peers leading to irresponsible behaviour”. This “egocentric phase of development” in early adolescence is a phase which has implications for those who initiate sexual intercourse early and do not use protective measures. Adolescents see themselves as being immune to pregnancy. Abstract knowledge nor the observed experienced of others translates for them into an accurate perception of their own personal risk.

In addition, a drive for increased intimacy and meaningfulness in relationships may make sexual intercourse seem desirable (Keller et al 1996:26 cites Grant & Demetriou 1988).

2.3.1.4 Adolescence: a time of trying out experiences for the first time

Adolescence is a period of experimentation with sex, love, intimacy, drugs, independence, driving motor vehicles, authority and dropping out of school. Adolescents like to try out new experiences without the knowledge and skills to make healthy choices (Early sex-early motherhood: facing the challenge: 1996:4; Newacheck, McManus & Brindis 1990:398; WHO 1998d:4).
2.3.1.5 Adolescence: a time when there is often lack of knowledge and skills to make healthy choices

Adolescents often lack knowledge and hence rely on their peers to make decisions when for instance indulging in unprotected sexual intercourse which exposes them to STDs, HIV, AIDS, unwanted pregnancy, rape, assault, running away from home and committing suicide (WHO 1998b:1).

In a study conducted by Ntombela (1992:95) on the perception of pregnancy of the black primigravida teenager in the Umlazi area of KwaZulu, pregnant teenagers cited the following reasons for having engaged in unprotected sexual intercourse: “I was risking”, “I did not know that I will fall pregnant”, “I made a mistake”, “I regret it”.

2.3.1.6 Adolescence: a time in which immediate needs tend to have priority over long-term implications

For the adolescent immediate needs tend to have priority over long-term implications (WHO 1998a:4).

Adolescents worldwide have indulged in unprotected sexual intercourse and ignored the long-term implications of teenage pregnancy, the impact on themselves, their families and the community at large. This too is the situation in South Africa (Boult 1991:16; Buga, Amoko & Ncayiyana 1996a:95; Craig & Richter-Strydom 1983:453; De Visser & Le Roux 1996:98; Kunene 1995:48; Magwentshu 1990:4; Ntombela 1992:89).

Failure of female adolescents to acknowledge the risks of sexual activity, could be due to discordance between physical and cognitive preparedness for sexual activity (Woodward 1995:211).

2.3.1.7 Adolescence: a time when behavioural patterns are commenced

The adolescent stage is the start of behavioural patterns that may become lifetime habits that
often result in health problems at a later stage (Family Health International 1997:4). Some of the unsafe behavioural practices reported by adolescents were for example that 19,0 percent of American adolescents in a recent survey by the Allan Guttmacher Institute (1994) had four or more sexual partners (Keller et al 1996:125 cites Committee on Adolescence 1990). Other problems reported included the consumption of alcohol, tobacco use, marijuana and other substance abuse, obesity, pregnancy and STD. These behavioural patterns once established can lead to long-term complications and health problems at a later stage (Aten et al 1996:259).

- Developmental tasks of the adolescent

Bodibe (1994:34) cites Havighurst’s (1972) contribution to the understanding of human development, by enunciating his concept of developmental tasks. Developmental tasks can generally be described as those tasks an individual would need to accomplish in order to make a transition from one stage of development to the other. The following have been designated as pertinent developmental tasks for the adolescent.

- Accepting one’s physique and using the body effectively. Adolescents are known for pre-occupation with their physical appearances as they approach and reach sexual maturity.
- Achieving masculinity and femininity. Appropriate sex role behaviour is learned and adopted during this period.
- Achieving emotional independence. The emotional dependence of childhood gives way to the emotional independence of the adolescent.
- Preparing for a career. During the adolescence period adolescents choose and prepare for a career.
- Preparing for marriage and family relationships. Social skills that make marital relationships work should be cultivated during the adolescence period.
- Desiring and achieving socially responsible behaviour. In this context the adolescents attempt to find meaning in life.
• Acquiring a set of values and an ethical system that acts as a basis for the behavioural pattern of the adolescent in the future (Bodibe 1994:34).

Health care providers who care for adolescents need to be aware of the psychosocial and cognitive processes that affect adolescence. If information for adolescents and their families and friends is relevant to the developmental stage of the adolescent then it is more likely to be effective at preventing the unwanted consequences of common adolescent behaviour associated with growing up (Klima 1998:483).

2.3.2 Gender of the adolescent

The term gender refers to different roles of males and females determined by society and the culture in which they live. Gender roles and norms have a major impact on the reproductive health of adolescents (Barnett 1997:10; Family Health International 1997:6).

Sociocultural factors influence adolescents’ views on sexuality. Access to information and health services affects reproductive health and well-being including the adolescent’s ability to protect themselves from unplanned pregnancy or STDs (Barnett 1997:10).

Reproductive health has been seen as concerning mainly females of reproductive age. A much broader focus is now needed for both sexes throughout their full lifespan. Males and females must be partners in reproductive health. Males today should

• take responsibility for contraceptives
• ensure access to health care during pregnancy, delivery and the postpartum period
• avoid unsafe sex and behavioural patterns that may expose their partner’s to health risks
• give support to their partner, particularly during pregnancy and breastfeeding (WHO 1998d:2).
Sexual activity of the adolescent

Gender affects the expectations of society regarding the sexual activity of boys and girls. For example, in a survey of 1,000 factory workers in Thailand, the majority of men aged between 15 to 24 years said that “premarital intercourse was expected of them and that boys who had not had intercourse were ridiculed by their peers”. Female adolescents in the same survey said that premarital intercourse was unacceptable and could taint their family’s reputation (Family Health International 1997:6-7).

In general, premarital sexual intercourse is not accepted in most countries.

In Gauteng Province, the researcher observed that females are sometimes pressurised to indulge in sexual intercourse as a result of peer pressure, boyfriends and older men in return for monetary favours. They subsequently have to bear most of the social consequences of unplanned and unwanted pregnancies, STD, HIV/AIDS and other reproductive health diseases.

Male adolescents should also be encouraged to make use of the ARHS. Birdthistle and Vince-Whitman (1997:15) caution that “because family planning has always been the domain of married women, counsellors lack experience in communicating to men, information on sexuality and contraception and also in this context, adolescent males may be reluctant to discuss their reproductive health needs with a female”.

These findings are in accordance with a study conducted by Hirsch, Zabin, Streett and Hardy (1987:307, 309) to look at users of reproductive health clinic services in a school prevention programme. The study revealed that out of a total of 818 students enrolled in the clinic, 86.6 percent of the sample were females and 56.2 percent were males. As expected, a higher percentages of females than males had been to a family planning clinic.

Service providers also apply gender differences in treatment. In a study conducted by Abdoool Karim, Preston-Whyte and Abdoool Karim (1992:358) to assess the accessibility of
condoms to teenagers at family planning services in Durban, the service provider’s treatment of male and female adolescent field workers differed. It was found that little information was given on how to use the male condom to female field workers. This attitude discouraged the female adolescents from ensuring that the male partner wore a condom. In Gauteng Province, the Department of Health stipulates that both female and male partners are provided with services that enable them to achieve optimal reproductive and sexual health (South Africa 1997a:106).

Implementation strategies that ensure that the above principles are achieved are those that

- provide information on sexuality and reproduction
- provide services for the diagnosis, management and counselling of HIV/AIDS and STD clients/patients
- provide information and consultation on a variety of contraceptive methods available to females and males
- encourage peer group education on sexuality and life skills

2.3.3 Age of the adolescent and sexual practice

Age is one of the factors that affect reproductive health needs of the adolescents. Many adolescents indulge in sexual intercourse, some apparently at a very early age (Barnett 1997:15; Few 1997:617; Finger 1993:16; Jacobson, Aldana & Beaty 1994:10; Ntombela 1992:61).

Mahomed and Masona (1991:316) reported on a case study of 200 adolescents aged 16 and under and a controlled study of 200 aged over 20 in Harare, Zimbabwe. The study revealed that adolescents sexual activity is increasing particularly among whites and young adolescents in the age group of 15 years and less.

According to Rutsch (1987:16), the youngest girl counselled at a local family planning clinic in Pietermartizburg was 13 years old who admitted to having had three sexual partners.
Buga, Amoko and Ncayiyana (1996b:524) revealed that by the age of 18 years, 73.3 percent of girls and 87.6 percent of boys in their study in Durban had already indulged in sexual intercourse at least once. Of the 126, 13 year-old girls and 67, 13 year-old boys in the survey, 63.5 percent and 71.6 percent respectively, were already sexually experienced and 12.7 percent and 45.0 percent respectively, were engaged in regular sexual activity.

Preston-Whyte and Zondi (1991:1389) reported on a qualitative study in KwaZulu-Natal which focussed on youth between the ages of 13 and about 22 years whereby both girls and boys admitted experimenting with sex before their 12th and 13th year. Some admitted to penetration even before they had reached physical sexual maturity.

According to a study conducted by Magagula (1998:68) in the Vaal Region, 12.5 percent of the respondents were in the age group 11 to 13 years and 5.7 percent were less than 10 years old when they had sexual intercourse for the first time. This information indicates that life skills education should commence at pre-primary school, to prevent unsafe sexual practices. ARHS should be accessible to adolescents of all ages.

Van Coeverden De Groot and Greathead (1991:1372) concur and elaborate on other problems related to early sexual intercourse; STDs including AIDS leading to infertility, human papilloma virus infection, carcinoma of the cervix, unplanned and usually unwanted pregnancies, serious complications in pregnancy and childbirth, increased perinatal mortality and morbidity, socio-economic deprivation, emotional guilt and exploitation. Preston-Whyte and Zondi (1991:1390) maintain that “this early involvement of African adolescents in full sexual intercourse, is confirmed both by birth statistics and recent AIDS related surveys”.

Cultural practices and sexual activity of the adolescent

Cultural practices related to gender norms, impact on the cultural acceptance of behaviours and practices that can jeopardise reproductive health. Gender norms can place girls at a risk of sexual violence including rape (Family Health International 1997:7).
Barnett (1997:11) refers to several studies where for some female adolescents' sexual intercourse was not a matter of choice. A study based on interviews with 128 adolescents in Peru and 108 in Columbia found that 60 percent had been sexually abused within the previous year. Thirty-nine of the adolescents were pregnant as a result. Studies in Botswana and Kenya found that for many adolescents the female's first sexual intercourse was forced. In rural Malawi, 55 percent of 120 adolescents surveyed revealed that they were often forced to indulge in sex. A study by the Alan Guttmacher Institute found that 60 percent of the United States adolescent girls who had sex before the age of 15 did so involuntarily (Barnett 1997:11). In some tribes of Zambian societies such as Chewa, the girl child who has reached puberty is sometimes forced into having sexual intercourse with some elders of the community (Mafulu 1996:no page).

Boys may also experience forced sex. In Mwanza, Tanzania one study amongst street children found that boys as well as girls performed survival sex (Barnett 1997:11).

**Female genital mutilation (FGM)**

FGM is dangerous and a medically unwarranted cultural practice based on gender that can jeopardise reproductive health. According to the WHO, two million girls annually undergo the procedure which involves partial or total amputation of the clitoris and in some cases removal of the labia minora. In some instances the clitoris and labia minora are removed and the labia majora are cut, then stitched together to cover the urethra and the entrance to the vagina. The immediate health risk includes infection, pain and bleeding which can lead to shock and possible death. Long-term complications can include prolonged and obstructed labour. There are no known health benefits (Barnett 1997:11; World’s Youth 1996:no page). FGM is believed to initiate girls into womanhood, protect virginity reduce promiscuity and enhance male sexual gratification (World’s Youth 1996: no page).

The researcher has observed that in Gauteng Province FGM is not practised but because immigrants from neighbouring countries are flocking to the province, the ARHS are frequented by female adolescents who have had their genitals mutilated.
The researcher has also observed that in Gauteng Province some cultures still practice circumcision for both girls and boys. Unfortunately the circumcision generally lacks the required expertise and ends up causing more harm than good. The status of females in society and how they are treated or mistreated is a crucial determinant of their reproductive health (WHO 1995:4).

For adolescents girls in many countries an unplanned pregnancy usually means expulsion from school while teenage fathers remain at school (Family Health International 1997:2). In Gauteng Province, the education department is to be lobbied to encourage the adolescent mother to continue with her school during and after pregnancy (South Africa 1998a:12). However, one school in Central Wits Region of Gauteng Province (Reashoma High School) has a different internal policy which expels an adolescent from school until after the delivery of the baby.

Sexual practices of the adolescent and STD and HIV/AIDS

Cultural practices that pairs female adolescents with older men predisposes them to STDs, because older men have had more sexual partners and female adolescents are unable to negotiate safer sex (World's Youth 1996:no page).

Females are also more vulnerable to STD including HIV than males because of the large mucosa surface exposed during sexual intercourse. Female adolescents are more vulnerable than older women because of the immature lining of the cervix (Early sex-early motherhood: facing the challenge 1996:4-5; Few 1997:616; Finger 1993:17; Kurth 1998:165; World's Youth 1996:no page).

Many female adolescents do not even know that they have contracted STD because there were no symptoms. STD can cause pelvic inflammatory disease (PID), ectopic pregnancy, infertility, poor eyesight and general poor health of children (Early sex-early motherhood: facing the challenge 1996:4-5).
It is probable that with the HIV virus having an incubation period of at least 10 years that many of the young adults who die from AIDS were probably infected with the HIV virus whilst still adolescent (Aten et al 1996:259; Equipping our youth for life 1994:14; Greenwood 1995:22; World’s Youth 1996:no page).

According to the finding of the Second National Antenatal HIV survey conducted on a yearly basis by the Department of Health, HIV seroprevalence amongst South African women is the highest in the early reproductive years. The level of HIV infection amongst pregnant adolescents is 2.62 percent rising to 3.92 percent in the 20 to 24 year age groups (Equipping Our youth for life 1994:14).

Legislation and the adolescent

In South Africa, the Child Care Amendment Act 13 of 1999, makes allowance for children over the age of 14 years to consent to their own medical treatment without the permission of a parent or a guardian. The term medical treatment probably includes the use of contraceptives. Any person over the age of 18 years can consent to surgical procedures being performed on himself/herself without the consent of a parent or a guardian.

However, the Act only legalises sexual intercourse from the age of 16 years. In practical terms, the law means that children of any age can visit a family planning (FP) clinic, for condoms or information on reproductive health and that after counselling the FP clinic can supply them with condoms, if necessary. This information is kept confidential. However, if a girl under the age of 14 years visits the clinic for contraceptives, this is considered medical treatment and she will need the consent of her parents or guardians. Over the age of 14 years, children may approach a FP clinic for any form of medical contraceptive without the assistance or knowledge of their parent or guardian (South Africa 1999a:41).

According to Wood, Maepa and Jewkes (1997:27) in a study done in the Northern Province, adolescents seeking contraceptives without parental permission were frequently a source of conflict between service providers and adolescents. Adolescents reported that they had been
told to return with their mothers. Nurses in the rural area also reported that they asked teenagers whether their mothers knew that they wanted contraceptives because the adolescents were minors. Refusal to issue contraceptives to these adolescents without parental consent was not in line with the *Child Care Amendment Act 13 of 1999* as these adolescents were over the age of 14 years.

Whilst *Choice on Termination of Pregnancy Act 92 of 1996* defines a woman as "a female of any age". A female can sign her own consent for TOP. She does not need permission of parents, guardians or husband to have a TOP. This act allows adolescents to sign their own consent in the event they request a TOP. On the other hand, the *Sterilisation Act 44 of 1998* provides for the right of sterilisation on any person over the age of 18 years if he or she is capable of consenting.

### 2.4 THE ACCESSIBILITY AND AVAILABILITY OF ARHS FOR THE ADOLESCENT

The conceptual framework on "what is quality of care" by the WHO (1998a:1) states that good quality ARHS are those which meet the following criterion:

- are accessible and available as close as possible to where adolescents live
- are provided at the lowest level facility that ensures the safety of the adolescent and the effectiveness of the services

This above written criterion is in line with the concept PHC which the ANC government is politically committed too, for the restructuring of the health care system in South Africa (ANC 1994:19).

The concept PHC has been determined at Alma-Ata as "essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community ... It is the first level of contact of individuals the family and the community with the national health system,
bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service" (WHO 1978:16).

In line with the Department of Health’s policy in South Africa MCWH (which includes adolescents) should form an integral part of PHC services. Accordingly accessible ARHS should be based on the following criteria:

- **Equity.** All adolescents should have equal access to ARHS. There should be an absence of any subgroup variability and discrepancy in care.

- **Accessibility.** Services need to be expanded to reach all adolescents in the country. Special focus being given to disadvantaged settlements. Services must be:
  - geographically accessible meaning that health services should be within a reasonable distance (the WHO suggest 5-10 kilometre (km) and that transport should be available
  - financially accessible to the adolescent and the community
  - functionally accessible in that the appropriate type of care be available to meet the need of the adolescent (Dennill, King, Lock & Swanepoel 1995:6; WHO 1998c:1)
  - attitudinally accessible to avoid poor treatment by service providers

- **Affordability.** The level of health care should be in line with what the adolescents can afford. No adolescent should be denied reproductive health care because of their inability to pay.

- **Availability.** There should be sufficient and appropriate services to meet the particular health needs of the adolescent.

- **Effectiveness.** The ARHS should do what they were intended to do and be cost effective.
• **Efficiency.** The results attained should be relevant to the input in terms of effort expended, money, resources and time.

(Dennill et al 1995:6; South Africa 1997a:101)

2.4.1 Convenient of the location of ARHS for the adolescent

The convenience of a clinic location is an important factor to the adolescent. Proximity is the key with affordable transportation as part of the equation. Reliable transportation for routine clinic use becomes even more important for reproductive health emergency. People living in remote areas travel long distances to avail themselves of public services (Finger 1997:24; Hendee 1991:441; Senderowitz 1997:28; South Africa 1997b:18).

In a study conducted by El Shabrawy Ali and Eisa Ali Mahmoud (1993:52) to determine patient satisfaction with PHC in Saudi Arabia, inconvenience of the location of the PHC was cited by 33,3 percent of the unsatisfied group using the PHC centre. Other causes of dissatisfaction were:

- "the centre's working hours are not suitable (19,4 percent)
- absence of speciality clinics in the centre (38,9 percent)
- language barrier with staff (19,4 percent)
- delays in the centre (63,9 percent)
- loses too much to come to the centre (19,4 percent)
- physician misbehaviour (30,6 percent)"

A study conducted by Kunene (1995:50) on 210 adolescents in two senior secondary schools at a black township near Empangeni, respondents in the age group 16 to 19 years cited inconvenience of the centre as their main reason for not utilising the service.

- eighty percent indicated that:
  - it is far away
  - they did not know how to get there
— they needed more transport
— they would have preferred the centre to be in the township

These findings gave emphasis to the principles of PHC and showed the importance of providing service close to where the people live in order to ensure accessibility, acceptability and optimum utilisation.

A study conducted by Abdool Karim et al (1992:356-357) to assess the accessibility of condoms to teenagers at family planning services in Durban in which four teenage field workers were used to visit selected family planning services revealed that the location of clinics made them accessible to people due to the available public transport.

National and provincial departments of health and transport must develop strategies that eliminate the disadvantage of distance by setting up mobile units and redeploying facilities and resources where there is the greatest need. Another significant factor is the lack of infrastructure in terms of difficulties of communication and travel to remote areas. Other barriers to access which should be considered are those related to social, cultural, physical, communication and attitudinal service components of the programmes (South Africa 1997b:18).

The Ministry for Welfare and Population Development outlines 24 strategies, one of which is to improve the availability, quality, accessibility and affordability of PHC services which include as well reproductive health care and ARHS with special focus on adolescents (South Africa 1997c:39).

The Constitutional Assembly (1996:10) stipulated that “everyone has the right to access of health care services, including reproductive health care ... and that the state must take steps to secure the progressive realisation of each of these rights”. Adolescents therefore have the right to have access to ARHS. The Constitutional Assembly (1996:10) further indicates the specific rights of a child. One of them being the right of basic health care services. This, therefore, applies as well to the adolescent.
In line with these constitutional rights, the Department of Health in planning for a national health system (NHS) has stipulated goals and objectives that promote equity, accessibility and the utilisation of health services in such a way that these health care services are integrated for all South Africans, with special emphasis on the needs of the rural, peri-urban and urban poor (South Africa 1997a:14-15).

In planning for these services provision has been made to

- extend the availability and ensure the appropriateness of health services by improving access to comprehensive health services
- develop health promotion activities by ensuring in particular access to reproductive health services for adolescents

ARHS therefore should be available, appropriate and accessible to adolescents if the quality of care is to be improved. Quality of care can be measured by the service provided. “Service to the people” is the basis for this and is one of the guiding principles of the public service in South Africa (South Africa 1997b:9).

☐ Batho Pele White Paper

The White Paper on Transforming Public Service delivery (Batho Pele White Paper) published in October 1997 provides a policy framework and a practical implementation strategy for the transformation of public service delivery to achieve this. The initiative – Batho Pele (a Sesotho adage meaning “people first”) is a fundamental business principle which refers to the concept “customer first”. To treat citizens as customers implies:

- “listening to their views and taking into cognizance input about the services to be provided
- treating them with consideration and respect
- ascertaining that the promised level and quality of service is always of the highest standard
Adolescents should always be treated as customers when attending ARHS.

- **Batho Pele principles**

Batho Pele consists of eight service delivery principles. The following two principles of Batho Pele are important in terms of access to ARHS for adolescents:

- **Consulting users of services**

  All national and provincial departments are required to consult regularly and systematically with all role players involved in the provision and use of new services. Consultation gives citizens the chance to contribute towards public services delivery and by doing so cooperative relationship between service providers and users are promoted and maintained. Consultation should include the views of those who were initially denied access to public services due to geography, language barriers and fear of authority ... The outcome should be a balance between what citizens want and what national and provincial departments can realistically afford and have the resources and capacity to deliver (South Africa 1997b:16).

  Adolescents should thus be consulted concerning the nature of the service they receive at ARHS if quality of care is to be maintained.

- **Increasing access**

Some South Africans enjoy public services of first world quality, while the majority live in third world conditions. One of the prime aims of Batho Pele is to provide a framework for making decisions about delivering public services to the many disadvantaged South Africans who were and still are denied access to them within the parameters of the Government’s growth, employment and redistribution (GEAR) strategy. All national and provincial
departments are required to specify and set targets for progressively increasing access to their services for those who have not previously received them (South Africa 1997b:18). Adolescents are one of the groups who have not previously received these services.

2.4.2 Costs issues related to adolescents attending ARHS

Costs for reproductive health services, if they are to be used by adolescents must be affordable. If costs are too high they act as a barrier to clinic use (Centre for Adolescent, Health Royal Children’s Hospital 1997:31; Senderowitz 1997:36; WHO 1998c:2).

Hidden costs even when formal fees are low or non-existent can pose significant barriers to adolescent attending ARHS. These costs may include the costs of transportation, drugs, food or materials (WHO 1998c:2).

A United States study reported that adolescents cited free service as a major reason for clinic choice (Reis, Herz & Olson 1987:140). On the contrary, adolescents in a cross-cultural study (Kenya and Nicaragua) indicated that they would rather pay a fee for the service because they perceived “free service” as being of poor quality (Senderowitz 1997:36 cites MSI 1995).

In an effort to make health services financially accessible, The ANC (1994:10, 47) announced that “free health care will be provided in the public sector for pregnant and nursing mothers, preventive and promotive services, antenatal and delivery services, and contraceptive services”. It was also the intention to provide clinics eventually in rural areas and where needed, free health services.

Even though adolescents were not highlighted in this directive, they fell under the above categories and receive ARHS free of charge in the public sector.

According to the Department of Health, MCWH services (which includes the adolescent) should be efficient, cost-effective and of a good quality. Accordingly standardised case
management protocol should be developed that cover all aspects of adolescent health (South Africa 1997a:105-106). Termination of pregnancy is also provided free of charge to any woman requesting it in the public sector. According to the *Choice on Termination of Pregnancy Act 92 of 1996* “a woman is a female person of any age”. Female adolescents are also considered to be women if they request TOP in a public service and as such should receive it free of charge. Universal access to reproductive health care services include family planning, contraception and TOP as well as, sexuality education and counselling programmes and services.

2.4.2.1 *Getting the best possible value for money*

One of the eight Batho Pele principles is getting the best possible value for money.

Improving service delivery and extending access to public services to all South African must be achieved alongside the government’s GEAR. These Batho Pele principle must therefore be implemented taking into account departmental resources. Improvements in the public service often do not need any additional resources. Human and material resources can sometimes even reduce costs. Failure for example, to use a contraceptive method may result in an unwanted pregnancy leading to a complicated abortion and ultimately chronic illnesses or death. A courteous and respectful greeting to an adolescent by a service provider requires no financial investment or additional resources but can encourage the adolescent to attend ARHS regularly (South Africa 1997b:22). One of the key aims of Batho Pele initiative will therefore be to look for strategies that simplify procedures, promote efficiency and eliminate waste.

2.4.3 *Convenient clinic hours for the adolescent*

Accessibility of clinic in terms of hours of attendance for the adolescent incorporates two factors, namely the hours when the clinic is open and whether there are special times for seeing the adolescent. An additional issue is whether it is acceptable for the adolescent to arrive at the clinic without an appointment (Centre for Adolescent, Health Royal Children’s
Several authors stress the need for convenient clinic hours for adolescents. These hours have been identified as late afternoons, after school hours, evenings, school holidays and weekends (Hendee 1991:441; Senderowitz 1997:28; Webb 1998:17).

In a Senegalese study, it was emphasised that service hours should be extended so that young workers, a group often overlooked, could attend after work (Senderowitz 1997:28 cites Naré et al 1996).

A specially designed adolescent clinic in Antigua was perceived to be unsuccessful as it was not accessible to adolescents after 16:00 hours.

Special hours set aside for adolescent services is thought to be more effective if the reproductive health services are integrated with many other services. Confidentiality can be compromised, if these services are not integrated due to their “separateness” (Senderowitz 1997:29).

Different views are given regarding the value to adolescents of separate hours and any possible impact on behaviour. In another study, special adolescent services were not ranked high among the reasons adolescents gave for selecting a clinic though this feature was associated with clinic use, before or soon after sexual intercourse (Zabin & Clark 1983:26). In a separate United States study, however, teens-only clinic was cited as a major reason for that choice (Reis et al 1987:135).

Special hours or special clinics is perhaps more important for adolescents who feel overwhelmed by the idea of seeking reproductive health services. A special evening clinic was found to attract many first-time clients (Senderowitz 1997:29 cites Vadies & Clark 1998). At the same time “at-risk adolescents” may need separate services to overcome their reluctance to use the traditional health care system (Senderowitz 1997:29 cites Barker & Fontes 1996).
To meet the reproductive needs of adolescents in Northshire and Staffordshire in the United Kingdom, the advice and contraception under twenty (ACT) clinics was set up in 1990. The ACT clinic was held on Sunday mornings in a town with a large shopping centre and good public transport. This facilitated access to the clinic. No uniforms were worn, no appointment secured and a friendly relaxed atmosphere was created by providing appropriate background music and posters especially directed at adolescents’ needs. The clinic provided contraception and pregnancy testing and clients were assured of confidentiality (Cook 1993:29).

The ACT clinic was evaluated for attendance and outcome of consultation and client satisfaction. In a full year the ACT clinic had a total of 300 attendances and 550 in the second year. Subsequently clinic times have been extended by 45 minutes to meet adolescents’ needs (Cook 1993:30).

In Gauteng Province some health services have an adolescent clinic once a week in the afternoon between 14:00 and 18:00 hours. This strategy does not address the needs of an “out of school adolescent”. Other clinics open during the week for adolescents between 07:00 and 16:00 hours. Adolescents do not have to make an appointment to visit the clinic. Adolescents use the ARHS frequently and consistently if they can attend at convenient times (Senderowitz 1997:14).

2.4.4 Waiting times for adolescents at ARHS

In Zimbabwe, waiting times were judged to be too long in 14.0 percent of clinics covered in a survey and in 82.0 percent of the clinics at large hospitals (World Bank 1993:43-44 cites Zimbabwe and Institute for Resource Development 1991:53).

Long waiting times are a common problem. A 1988 to 1990 study done in 26 clinics in Latin America found that the average waiting time for an initial visit was one hour and twenty minutes. The reasons given for this long delay included the late arrivals of staff, time wasted in long lunch hours, socialising, inflexible routines, inefficient filing systems, poorly timed
client bookings and failure to see clients in proper sequence (World Bank 1993:45 cites Berrio, Hudgins and Quevedo 1990).

Adolescents hate to wait. According to findings of a study conducted by Jones (1996:32-33) in Eastbourne to determine clients preference for one-stop sexual health, patients stressed the need to minimise waiting times.

In a study conducted by Chamie, Eisman, Forrest, Orr and Torres (1982:137) in selected United States countries, on factors affecting adolescents use of family planning clinics, the adolescents when asked what they disliked about the clinics, about one fifth of the adolescents indicated long waiting times as the only major complaint.

In Abdool Karim et al's (1992:358) study in Durban regarding assessing the availability of condoms to teenagers, the waiting period before being attended to varied widely. In some instances the teenage field workers waited up to 30 minutes for attention.

Management of long waiting times at clinics

Besides training and a good management information system, three possible approaches to dealing with long waiting times at health service are patient/client flow analysis, client satisfaction studies and the use of simulated or “mystery client”. Patient flow analysis is a method for recording the flow of clients that generate detailed tables on use of patient time, use of staff time and related costs. Such information makes clinic inefficiencies immediately obvious (World Bank 1993:45). One clinic in Quito increased its staff from eight to ten after seeing the results of such analysis and managed to serve 13 more clients. Clients waiting time was simultaneous cut from 62 to 32 minutes on average (World Bank 1993:45 cites in Berrio Hudgins Quevedo 1990). Client satisfaction studies may use several methods including surveys, focus groups and exit interviews. An example of what can be learned from surveys is provided by a “situational analysis” that was conducted in one of every eight Ministry of Health Service delivery points in Kenya. The survey revealed, among other things, that service providers greeted service users respectfully 88.0 percent of the time.
"Mystery client" like mystery shopper is hired to attend the clinic unannounced together with other clients but with specific items that they are trained to observe and report on afterwards (Finger 1997:23; World Bank 1993:45).

Managing waiting time in ARHS in Gauteng Province

One of the eight Batho Pele principles is setting service standards. Service standards must be relevant and meaningful to the individual user, meaning that they should cover the aspects which are important to the assets revealed in the consultation process. Standards must be precise and measurable, so that service users can judge for themselves whether or not they are receiving what was promised. In the health care centre standards might be set for the maximum time a patient (adolescent) should have to wait at a PHC clinic at ARHS in Gauteng Province (South Africa 1997b:16-17).

2.5 COMPREHENSIVE CARE PROVIDED AT ARHS

Included in the conceptual framework on "what is quality of care?" is the need to determine whether this ARHS provide comprehensive care and whether these services are integrated with the other reproductive health services and whether continuity of care and follow-up is provided. In most countries reproductive health services are normally provided by family planning clinics, sexually transmitted disease clinics and maternal and child health clinics. These services are not planned for adolescent use and adolescents often do not like using them. There is also often little coordination between these services and thus they fail to meet the specific needs of the adolescent (Early sex-early motherhood: facing the challenge: 1996:8).

In a survey study conducted in Eastbourne by Jones (1996:32), patient's views towards preference for one-stop sexual health shop were sought. Sixty six, 7,0 percent were in favour of combined sexual health services whilst 6,7 percent where against the idea.
One of the principles of attaining MCWH (including adolescents) is that these services should be comprehensive and integrated. In several South African health facilities MCWH, services are provided at separate locations within the same health facility. Furthermore these services are not comprehensive especially at clinic and community health centre level (South Africa 1997a:101).

The following implementation strategies were suggested by the Department of Health (South Africa 1997a:101) in Gauteng Province to facilitate MCWH services becoming more comprehensive and to assist in the integration of these services with other related services.

- **One-stop “supermarket” approach**

  All health facilities as far as possible, were required to provide MCWH services on a one-stop “supermarket” basis. Existing health facilities should review the allocation of available space and where possible relocate MCWH services closer to one another. The optimal integration of MCWH services is to be ensured in the design of all future health facilities (South Africa 1997a:101).

- **Minimum package of MCWH services**

  The detailed package to be provided by the MCWH services will be developed and implemented in accordance with the functions identified and planned for each level of health care in the future.

- **Training**

  Relevant training programmes should be drawn up and given to facilitate the integration of MCWH services.
Coordination with other services

The MCWH services should be coordinated with other health services to ensure maximum efficiency.

Intersectoral collaboration

The health status and needs of the adolescent should be discussed with all relevant role players to ensure maximum benefit in terms of the total needs of the adolescent.

Non-Governmental Organisations (NGO)

Much of the work done for adolescents is currently undertaken by NGOs (South Africa 1997a:101-102). Comprehensive packages drawn up should include those services that reflect the developmental needs of this age group and/or developed strategies that prevent or treat the consequences of adolescent high risk behaviour (English, Kapphahn, Perkins & Wibbelsman 1998:272).

Adolescents need comprehensive health service designed to educate them regarding the reproductive and sexual aspects of human life, train them in skills required to manage their sexual relationship and help them use contraceptive measures effectively. These services should be delivered within a comprehensive health care setting and should be accessible and designed for maximum confidentiality (Peak & Hauser McKinney 1996:276).

2.6 INFORMATION AND COUNSELLING GIVEN TO ADOLESCENTS AT ARHS

The conceptual framework “what is quality of care” clarifies that quality care also involves provision of information and counselling for clients on their health and health needs (WHO 1998a:1).
The ICPD programme for action calls for

- "countries to protect and promote the rights of adolescents to reproductive health education, information and care"
- "countries where appropriate to remove legal, regulatory and social barriers to reproductive health information" (Dickson-Tetteh et al 1999:4)

A study conducted by Abdool Karim et al (1992:356-358) to assess the accessibility of condoms to teenagers at family planning services in Durban revealed that a number of consultations lasted for only a few minutes. Unsolicited offers of verbal instructions on condom use were seldom forthcoming. When the teenage field workers asked for instructions on condom use, service providers appeared surprised. When female teenage field workers asked for instruction they were told to ask their boyfriends. Most clinics provided an explanatory pamphlet with only minimal verbal instruction. In some clinics the pamphlet had ran out and at one clinic pamphlets were only available in English. The nurse advised the field workers to go to a clinic in their own area for one in Zulu. In only two instances did clinic staff open a condom and familiarise the field worker on its use. Information on AIDS was rarely offered.

Although adolescents have expressed a need to receive reproductive health information, care should be taken not to lecture them. Findings of a study conducted by Jones (1996:33) revealed that adolescents cited long consultation times, overburdening individuals with information about different reproductive matters that were not relevant to their needs and related to this, extended waiting times at clinics were reasons why they disliked attending clinics. Based in these findings there needs to be a balance between attention to the issue at hand and a holistic approach.

In a different study conducted by Kisker (1984:216) on the effectiveness of family planning clinics in serving adolescents, the adolescent indicated a resistance to the long educational talk given at the clinic, especially if they felt that they were being preached at.
The National Health Bill stipulates that every person is entitled to be informed in an appropriate manner on the

- "available health care services and resources"
- conditions controlling access to these services and resources
- implications and consequences of using those services and resources"

(South Africa 1996:8)

The National Department of Health, each Provincial Department and each District Health Authority should develop strategies to enable the community to have effective access to adequate and comprehensive information concerning the health services which serve them.

The National Health Bill further stipulates that every health care provider must inform the service user in an appropriate manner of the

- "service user’s health status"
- range of treatment options available to the service user
- pros and cons generally associated with each option"

(South Africa 1996:10)

The National Health Bill clarifies further that the objectives of health promotion measures are to create a social, political, economic and physical environment that enables all South Africans to

- "make informed choices on health related matters"
- be health literate
- improve their health and well-being"

(South Africa 1996:49)
The Department of Health specifies further that one of its health sector goal’s and objective’s is “to develop health promotion activities that promote healthy life-styles by ensuring access to health-related information, community support and health services for adolescents that will prevent STDs and the transmission of HIV/AIDS (South Africa 1997a:15).

In line with constitutional rights, the Department of Public Service and Administration highlights one of the Batho Pele principles which states that “information is one of the most powerful tools at the disposal of the customer (adolescent) in exercising his or her right to good service”. In terms of this principle, national and provincial health departments must provide full, accurate and up-to-date information about the services they provide and who is entitled to them. The information must reach even those who have been previously disadvantaged from the provision of public services. A mechanism must be worked out to determine how, where and when the information can best be provided (South Africa 1997b:19).

Implementing the Batho Pele principles will require a total transformation of communication patterns within the community. Information will be given through a variety of media using the appropriate media and language. The Constitutional Assembly (1996:3) states that “there are 11 official languages to meet the differing needs of the different customers. Written information should be simple and free of jargon and supported by graphical material where this will make it easier to understand. There should always be a name and contact number for obtaining further information and advice. All written information should first be tested on the target audience for understanding and comprehensiveness. Provision should also be made for information to be received verbally, so that questions can be asked and understanding checked”.

Information about services should be made available at the point of delivery of service, other arrangements should be made for users staying far away from the point of delivery. In Gauteng Province, information is not yet fully given in all the official languages. The medium of delivery is mainly in English and in a few African languages. This acts as a barrier to access of information for those adolescents who come from other language
The researcher also observed that these adolescents were not always fully informed.

Information helps adolescents understand how their bodies work and what the consequences of their action will be. It dispels myths and corrects inaccuracies. Information should also include details of the services available, opening times, fees and the fact that services are confidential. There also needs to be an openness and readiness to answer questions. Schools should encourage adolescents to use health services. Teachers, parents and health care providers should also have an understanding of the stages of adolescent development so that they can respond to adolescents' questions confidently (Early sex-early motherhood: facing the challenge 1996:7).

The Department of Health's plan for MCWH policy makes provision for individuals, households and communities to have adequate knowledge and the necessary skills that will promote positive behaviour related to maternal, child and reproductive health. There is a huge potential for targeting individuals, households and communities with this relevant health information. However, the capacity for effectively implementing this information is lacking especially at the district and community level. Most service providers have poor communication skills and are unable to develop appropriate health messages for their audience in terms of the research done (South Africa 1997a:104).

This problem is compounded as the translation of this information also requires skill and sufficient resources, organisation and management at various levels especially at the community level. Assessment of the needs and available capacity of the health sector to provide meaningful communication on adolescents is to be undertaken by the Department of Health's directorate health promotion and communication section. Health workers' training will be conducted to improve communication skills and increase their capacity to conduct formative research (South Africa 1997a:104).

The provision of information to enable adolescents to have a healthy, safe and fulfilled sex life is a responsibility the health care systems shares with families, other sectors and
institutions (WHO 1995:4).

2.6.1 Counselling of adolescents

English et al (1998:272) maintains that several reproductive health problems experienced by the adolescents are preventable. A major element in the prevention continuum is individualised prevention-oriented counselling. Therefore counselling should be given to all adolescents attending ARHS. The WHO Division of Reproductive Health (Technical Support) concurs and says that “adolescents should have access to sensitive respectful and confidential reproductive health counselling and services” (WHO 1998b:3).

Adolescents are often labouring under the false impression that there is no one with whom they can privately discuss personal issues related to reproduction and sexual health. Adolescents with unwanted pregnancies, STD’s, HIV/AIDS and other complex health problems often face several emotional and physical challenges for which they need specific health counselling (Birdthistle & Vince-Whitman 1997:40 cite Duncan Igoe 1996).

In addition adolescents and children worldwide suffer the emotional physical trauma of sexual assault and rape (Birdthistle & Vince-Whitman 1997:40 cites McCouley & Salter 1995).

Birdthistle and Vince-Whitman (1997:40) cites studies done in Thailand by Sakondhavat et al (1998) which indicates that education supplemented by referrals for personal counselling can achieve its objectives. The other study by Chandeying (1991) also in Thailand found that group education and peer counselling contributed to improved knowledge and practice about HIV risk reduction. Psychosocial counselling and support received from counselling that guarantees confidentiality, can provide assistance to students with personal sexual and reproductive health problems.

Adolescents, like adults, usually respond better to explanation than to orders. Their development and behaviour is influenced much more readily by helping them to recognise
what they are doing well, rather then punishing them for their mistakes. The role of the
counsellor is to enable the adolescents to make informed decisions that give them confidence
and assist them in controlling their own lives. (Early sex-early motherhood: facing the

2.7 ADOLESCENT-FRIENDLY SERVICES

According to the conceptual framework “What is quality of care?” it was explained that
adolescent-friendly services are those that meet the following criteria. They must be

- acceptable to potential users and responsive to cultural and social norms such as
  preferences for privacy, confidentiality and care by female health workers
- staffed by workers who provide respectful and non-judgemental care that is
  responsive to adolescents needs (WHO 1998a:1)

In general, the concept “adolescent-friendly” suggest a setting that is

- pleasing, welcoming, comfortable, relaxing
- offers many services
- opens in the afternoons, weekends, school holidays, evenings
- offers empathetic, knowledgeable, trustworthy counsellors
- does not look like a clinic
- offers private, confidential, affordable accessible services

Adolescents are attracted to a place that feels comfortable. There is general consensus about
the importance of providing privacy and confidentiality for the adolescent reproductive
health client (Senderowitz 1997:14, 27).

“Privacy means freedom from unsanctioned intrusion” (Sigman, Silber, English & Gans
Epner 1997:408). In an ARHS, it involves psychological, social and physical components
in addition to confidentiality.

Confidentiality means preserving the privacy of privileged information revealed by the patient during and after the transaction with other parties, without the explicit permission of the adolescent (Purcell, Hergenroeder, Kozinetz, O'Brian Smith & Hill 1997:300; Sigman et al 1997:408).

Protection of privacy is of utmost importance to adolescents seeking advice regarding topics like HIV, AIDS and TOP. Lack of confidentiality whether real or perceived is a barrier in adolescent health promotion.

Adolescents strive for independence and autonomy in several areas including use of health care. The availability of confidential health care services is important in attaining this autonomy (Purcell et al 1997:300).

English et al (1998:273) argue that “due to their age and development status several adolescents can only visit ARHS in an adolescent-friendly site on a confidential basis”. There is an indication as well that lack of privacy and confidentiality are also reasons why adolescents do not use clinics, especially public health facilities (Senderowitz 1997:28).

Senderowitz (1997:28) cites a study conducted by Kim and Marangwada (1996) in Zimbabwe, where nearly one-fourth of the counselling sessions occurring in separate rooms, could be overheard. Outsiders could see what was happening in one-third of the sessions and more than one-third experienced interruptions usually by another staff member.

The results of the above-written study appear to confirm a study conducted in the United States by Zabin and Clark (1983:25-29) to determine institutional factors that affected the teenagers' choice and reasons for delay in attending a family planning clinic. Factors identified were those such as, doesn’t tell parents (18,1 percent) which meant that confidentiality was maintained and that staff care about teenagers (13,2 percent) and proximity (12,4 percent).
Contrary to this study, was one conducted by Kisker (1984:212) in Standshire to assess the effectiveness of FP clinics in serving adolescents. Respondents in this study did not indicate the importance of preserving privacy as an important aspect in choosing FP clinic.

According to a study conducted by Abdool Karim et al (1992:358) to assess the accessibility of condoms to teenagers at family planning services in Durban, the privacy of the respondents was not respected. These respondents had come for condoms but were usually not taken into private rooms for consultation. In some instances, the partitions did not reach the ceiling with the result that private conversations could be heard in the waiting rooms. In some instances when the field workers were taken into private rooms to demonstrate condom use, the door was not shut during the consultation. This lack of privacy was found to be unpleasant and embarrassing. These findings were a contravention of the bill of rights which stipulates that everyone has the right to privacy and includes the right not to have the privacy of their communications infringed (Constitutional Assembly 1996:6). Male field workers felt uncomfortable having to wait with women and girls at the counter and in the waiting rooms. The lack of privacy undoubtedly inhibits questions particularly when these are within earshot of the opposite sex.

The ANC (1994:20) maintains that service providers should respect the right of everybody to be treated with dignity and respect. In line with these ANC statements, the Constitutional Assembly (1996:6) confirms that every human being has inherent dignity and the right to have their dignity respected and protected, the right to privacy, which includes the right not to have ... the privacy of their communications infringed.

In an effort to provide quality service to the people, the National Health Bill indicates that "every user is entitled to confidentiality of all information concerning his/her health, including information relating to any service provided or stay in a public or private health institution" (South Africa 1996:13). Confidential information may not be disclosed by either the institution or health care provider. The adolescent is entitled to confidentiality. The National Health Bill further provides that every user is entitled to respect for their personality, human dignity, privacy, gender and age (South Africa 1996:10).
It is the duty of health care providers to treat all patients with dignity and respect and provide the best quality of care appropriate (South Africa 1996:22). Adolescents must be treated with dignity and respect. Issues of privacy, respect and dignity are aspects that should be taken into cognizance when dealing with adolescents. The ICPD programme of action calls for services to safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs (Dickson-Tetteh et al 1999:4).

The Department of Health has stated as one of its eight principles that “clear objectives and targets should be set at the national, provincial, district and community levels in accordance with the goals of the RDP, the health sector and the United Nations Conventions on the rights of the adolescents” (South Africa 1997a:102).

To implement this goal, the health sector should formulate goals and objectives. In the field of adolescent, health targets and objectives should be developed through participatory consultation with all relevant role players. To be able to achieve this goal, service providers of the adolescent should develop a caring ethos and improve their attitude towards the adolescents and the community at large (South Africa 1997a:102, 103). This caring ethos and compassion should be seen and experienced by people using the health system (South Africa 1997a:74). This applies as well to adolescents who, if they experience the caring ethos and compassion of service providers, may be encouraged to use the ARHS more frequently and cooperatively.

They then will be provided with services which enable them to achieve optimal reproductive and sexual health throughout their life-span. Their confidentiality, will be enforced depending on individual preference (South Africa 1997a:106).
2.7.1 Attitudes of service providers attending to adolescents at the ARHS

Several adolescents are bound to seek care when they can do so from service providers who have interest, experience and expertise in caring for them (English et al 1998:273). Adolescents are particularly concerned with characteristics related to services providers. Many adolescents describe service providers as unkind, rude, brusque unsympathetic, uncooperative, judgemental and outright hostile (Abouzahr, Vlassoff & Kumar 1996:449; Webb 1998:11; WHO 1998c:2).

In a United States study on adolescent perceptions concerning their decisions to seek health care, 14 of the 15 top-ranked items pertained to providers and six of these concerned interpersonal factors such as honesty, respect and confidentiality (Senderowitz 1997:27).

In a study conducted by Wood et al (1997:27) on adolescent sex and contraceptive experiences and the perspectives of teenagers on clinic nurses in the Northern Province, adolescents stated that “nurses ask them funny questions such as why they have sex so young”. If they did not respond to the questions, they were scolded. Scolding discouraged adolescents from going back to the clinics as not only did the nurses scold them, but they would not give them contraceptives.

In a study conducted by a Johannesburg-based women’s health project on girls, female adolescent’s, access to the project was very limited because of the old fashioned attitudes of the nursing staff which served as the biggest obstacle (Girls have little choice about sex: South Africa study shows 1996:2).

In Gauteng Province, Pretoria region, “mystery clients” visited an ARHS in Pretoria region and requested to be given emergency contraception. The mystery client was berated and ridiculed by the service provider. The incident appeared on television and subsequently the service providers were expelled from work.
Health care providers should not be judgemental towards pregnant adolescents, those who have contrasted STDs, HIV/AIDS or those who seek TOP or contraceptives. Consultations and treatment must be confidential and adolescents should be able to rely on this (Early sex-early motherhood: facing the challenge 1996:8).

Health care providers

Adolescents want to be attended to by health professionals who express caring and concern in regard to their health problems and who dress and act in a professional manner. They expect warmth, compassion and a willingness to communicate in a straightforward understandable fashion (Centre for Adolescent, Health Royal Children's Hospital 1997:31; Hendee 1991:439-440).

There is evidence that positive interactions between service users and service providers lead to service user confidence and compliance (Abouzahr et al 1996:456).

One of the eight Batho Pele principles demand that public servants exercise courtesy when dealing with the community. The code of conduct for public servants issued by the Public Service Commission requires that courtesy and regard for the public is one of the fundamental duties of public servants. A departmental code of conduct should cover among other things:

- “greeting and addressing customers (adolescents)"
- the identification of staff by name when dealing with customers
- an appropriate style and tone of any written communication
- gender and language"

(South Africa 1997b:13)
Contravention of this provision is misconduct and may expose a public servant to disciplinary action.

- Programmes for adolescent attending ARHS

The first ARHS for adolescents come into being in Cape Town (Van Coeverden De Groot & Greathead 1987:434). According to the Planned Parenthood Association of South Africa's (PPASA) programmes for adolescents are being planned. The pilot programmes for ARHS which offers education, training, counselling and reproductive health services in a youth sensitive environment are now in their final phase. These have been established in communities in seven provinces, namely

- Soweto (Gauteng)
- New Crossroads (Western Cape)
- Winterveld (North West)
- Motherwell (Eastern Cape)
- Nhlangwini (KwaZulu-Natal)
- Botshabela (Free State)
- Mwamitwa (Northern Province)

In a pilot partnership venture with the Gauteng Department of Health, the PPASA is running an ARHS at the Mofolo clinic in Soweto. Over the past year the ARHS has had some 17 000 clients (Planned Parenthood Association of South Africa 1998:10).

In terms of user-friendly services the national adolescent friendly clinic initiative (NAFCI) has set criteria for adolescent-friendly services. These include 12 essential elements.
Every adolescent-friendly service should have:

(1) “Health care providers who

- treat adolescents with dignity and respect
- are friendly and have non-judgemental attitudes
- maintain privacy and confidentiality
- have sound reproductive health knowledge and understanding of adolescent issues

(2) A service component that encompass the physical, mental and social needs of adolescents and

- includes the essential service package of youth services
- promotes free and informed choice
- includes social and skill building activities
- has available adolescent-friendly information, education and counselling materials”

Adolescents undergo physical, psychological and social change and development. The aim of ARHS must be to enable them to undergo these changes in safety with confidence and with the best prospects of maintaining a healthy and productive adulthood.

2.8 CONCLUSION

The adolescent period is a complex one in which rapid growth takes place physically, psychologically and socially. The needs of the adolescent are specific to these changes and need special consideration if they are to develop life skills that will lead them into healthy adulthood.

Service providers need to understand the various stages of adolescent development for them to be able to render quality care at ARHS for adolescents to receive quality care at the
ARHS. The health services should be accessible, available, affordable, comprehensive, give information and counselling to adolescent and be adolescent-friendly.
CHAPTER 3

Research methodology

3.1 INTRODUCTION

Leedy (1997:104) maintains that "methodology is merely an operational framework within which the data are placed so that their meaning may be seen more clearly".

In this chapter the methodology, adopted to conduct the study is discussed under the following headings:

- research design
- hypothesis
- population and sampling approaches
- data collection
- research instrument
- ethical consideration
permission to conduct the study
• distribution of the questionnaire
• plan for data analysis
• coding of the completed questionnaire and
• conclusion

This chapter therefore focuses on how the research questions in chapter 1, paragraph 1.2.1 can be answered using specific research methodology procedures and methods.

3.2 RESEARCH DESIGN

Research design is a set of logical steps taken by the researcher to elicit a response to the research questions and to control variance (Brink 1996:100; Brink & Wood 1994:100; LoBiondo-Wood & Harber 1998:157; Mateo & Kirchhoff 1999:269 cites Kerlinger 1986; Polit & Hungler 1993:129).

It also includes a plan, structure and strategy that will ascertain whether the eventual validity of the research findings is maximised (LoBiondo-Wood & Harber 1998:157; Mouton & Marais 1991:32).

Brink (1996:100) further states that “the purpose of the research design is to determine methods used by the researcher to obtain subjects, collect data, analyse the data and interpret the results”.

In this study, a quantitative, cross-sectional (sequential design) exploratory, descriptive research design was used. A survey method was used to collect data from the adolescents in the sample who attended selected ARHS in Gauteng Province.

Quantitative study

Leedy (1997:105) cites Kerswell (1994:2) who defines a quantitative study as “an enquiry
into a social or human problem based on testing a theory composed of variables measured with numbers and analysed with statistical procedures in order to determine whether the predictive generalisations of the theory hold true”. A quantitative approach was used in this study in order to determine whether what respondents say generally holds true.

☐ **Cross-sectional study**

Cross-sectional research design studies are one-time studies used to examine data gathered on one occasion, with different subjects rather than on the same subjects at several points in time (Brink 1996:110; Brink & Wood 1994:103; Dempsey & Dempsey 1992:146; Knapp 1998:79; LoBiondo-Wood & Harber 1998:202; Nieswiadomy 1993:181). A cross-sectional design was used because it was simple, economical and practical to apply. A longitudinal study would have taken a longer time to complete.

☐ **Exploratory study**

Mouton and Marais (1991:43) state that “an exploratory study aims to acquire new insights into a phenomenon rather than collect accurate and replicable data; to explicate the central concepts; to determine priorities for further research and to develop new hypotheses about an existing phenomenon. The research design of an exploratory study tends to be open and flexible”. Nieswiadomy (1993:127) also maintains that “exploratory studies are conducted when little is known about the phenomenon of interest”. In this study little was known about the adolescent who attended the ARHS or the nature of care given to adolescents at ARHS in Gauteng Province.

☐ **Descriptive study**

A study is descriptive when it intends to describe a phenomenon accurately within its specific context and when it is based on collected data. The emphasis is on an in-depth description of an individual group, situation or organisation (Mouton & Marais 1991:44). Nieswiadomy (1993:127) supports this by stating that in “descriptive studies a phenomenon
is described or the relationship between variables is examined". In this study the profile of the adolescent; the accessibility, and availability as well as the comprehensiveness of the services; information and counselling (IC) provided and adolescent-friendliness received at this ARHS in Gauteng Province were studied.

Survey

A survey aims at gathering data from a sample of the population (Brink 1996:109; Nieswiadomy 1993:138). A survey provides data about the present and indicates what people are thinking, planning and doing. The survey method was therefore used in this study because:

- of its ability to provide accurate data on the adolescents sampled in the ARHS in Gauteng Province
- large amounts of data could be obtained from the adolescents visiting the selected ARHS in Gauteng Province
- it enabled the researcher to be creative in the area to be surveyed

3.3 HYPOTHESIS

Since this study is descriptive in nature and did not intend to establish a cause-effect relationship it proceeded without a hypothesis. There is consensus amongst researchers that "descriptive studies may be guided by research questions and/or research objectives rather than by a hypothesis per se" (Brink 1984:42). Research questions based on the conceptual model Quality Care formed the basis for this study.

3.4 POPULATION AND SAMPLING METHOD

A population is the complete set of persons/objects, which is characterised by designated set of criteria the researcher is interested in studying (Brink 1996:132; Brink & Wood 1994:128; Brockopp & Hastings-Tolsma 1995:169; Dempsey & Dempsey 1992:79; Mouton 1996:135;
An important part of the data collection process is the selection of the study subjects who will provide relevant data in relation to the study (Dempsey & Dempsey 1992:79).

In this study the initial target populations to be sampled consisted of the following:

- ARHS in Gauteng Province.
- Adolescents visiting the ARHS in Gauteng Province.
- Registered nurses rendering health care to the adolescents in the ARHS in Gauteng Province.

Leedy (1997:203) warns that "the results of a survey are no more trustworthy than the quality of the population or the representativeness of the same".

3.4.1 Sampling

Sampling refers to the process of selecting the sample from a population in order to gather data in a way that represents the population of interest, whilst a sample is a portion or subset that is selected to represent the population of interest in a research study and the members of a sample are the subjects or participants or respondents (Brink 1996:133; Brockopp & Hastings-Tolsma 1995:169; Burns & Grove 1997:51; García-Núñez 1992:71; LoBiondo-Wood & Harber 1998:250; Talbot 1995:65). Polit and Hungler (1993:174) maintain that the sample can be considered as representative of a given population, if all members of a population have an equal chance of forming part of the sample.

3.4.2 Sampling approaches

Sampling approaches are grouped into two categories, nonprobability sampling and probability (random) sampling. In nonprobability sampling elements are chosen by nonrandom methods whilst in probability sampling every object in the population of interest
has an equal chance of forming part of the sample (Brink 1996:134; Brink & Wood 1994:131; Knapp 1998:105; LoBiondo-Wood & Harber 1998:251; Polit & Hungler 1993:175). Each of the two different approaches are further classified into various types. In this study, after intensive discussion with the promoters and the statistician, the researcher decided to carry out a probability multistage/cluster sampling approach.

3.4.3 Multistage/cluster sampling

Multistage/cluster sampling consists of successive random sampling of units that progress from large to small and satisfy sample eligibility criteria. The first stage sampling unit consists of large units, the second stage sampling consists of smaller units and the third stage sampling consists of even smaller units (Knapp 1998:105; LoBiondo-Wood & Harber 1998:260).

In this study:

- The first stage sampling was done on ARHS in Gauteng Province.
- The second stage sampling was done on adolescents visiting ARHS in Gauteng Province.
- The third stage sampling was to be done on registered nurses rendering health care to the adolescents at ARHS in Gauteng Province.

☐ Advantage of multistage sampling

The advantage of a multistage sampling method is that it is more economical in terms of time and money depending on the size of the population and its geographical scattering.

3.4.3.1 First stage sampling: ARHS in Gauteng Province

☐ Eligibility criteria (inclusion criteria, distinguishing descriptors)

The criteria used for the selection of the ARHS in Gauteng Province were that:
• The ARHS should be situated in Gauteng Province.
• The ARHS should be under the jurisdiction of the Provincial Authority.
• The ARHS should be rendering reproductive health care to adolescents.
• Permission for the use of these ARHS should be granted by the Director/Deputy Director in each of the five regions.

☐ Sampling method

The researcher, after obtaining permission (annexure 3b) from the Research Committee in the Department of Health, Gauteng, Director for District Health Services and Director/Deputy Director in the six regions in Gauteng Province, embarked on the following:

• Requested that the Director/Deputy Director using a probability simple random sampling method select two or three (depending on the availability) ARHS in each district of the five regions.

Table 3.1 depicts the number of ARHS that the researcher considered in the various regions.

3.4.3.2 Second stage sampling: adolescents visiting ARHS in Gauteng Province

☐ Eligibility criteria

The eligibility criteria for selecting adolescents to partake in this study were that they

• must visit the ARHS in Gauteng Province during the researcher’s presence
• must be either male or female
• give informed voluntary consent
Table 3.1: Number of ARHS in the various regions

<table>
<thead>
<tr>
<th>REGION</th>
<th>HEALTH DISTRICT</th>
<th>PROVINCIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaal</td>
<td>Eastern Metropolitan Substructure (MSS)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Western MSS</td>
<td>1</td>
</tr>
<tr>
<td>East</td>
<td>Alberton</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Boksburg</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Benoni</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Brakpan</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Germiston</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Heidelberg</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Midrand</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nigel</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Springs</td>
<td>1</td>
</tr>
<tr>
<td>West</td>
<td>Krugersdorp</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Randfontein</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Westonaria</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Carltonville</td>
<td>3</td>
</tr>
<tr>
<td>Pretoria</td>
<td>Northern MSS</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Southern MSS</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Eastern MSS</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Bronkhorstspruit/Cullinan</td>
<td>6</td>
</tr>
<tr>
<td>Central Wits</td>
<td>Eastern MSS</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Southern MSS</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Western MSS</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Northern MSS</td>
<td>4</td>
</tr>
</tbody>
</table>
Sampling method

A nonprobability sampling method based on convenience (accidental, incidental) and reliance on available subjects was then employed. Every prospective subject who attended the selected ARHS during the researcher’s presence in the period April, May, June and July 1999 and complied with the eligibility criteria was requested by the service provider/s and or researcher, after receiving reproductive health care, to visit the researcher’s waiting area.

A nonprobability sampling method based on convenience is not an ideal sampling method because the probability that a person will be chosen is unknown and one cannot generalise that the sample is representative of the larger population. Ntlokotsi (1999:32) cites Polit and Hungler (1991) who assert that “where the concept under study is homogeneous within the population, the chances of bias may be less”.

Brink (1996:135) contends that “if the researcher is working with cooperative and able subjects, the quality of data gathered from nonprobability sample has a possibility of being high”. In this study adolescents were cooperative and most of them were able to read and write.

In this study, the sampled adolescents were a homogeneous group, in relation to the eligibility criteria. In order to eliminate bias, it was important to distribute all the questionnaires in the same manner when visiting an ARHS.

Reasons for employing nonprobability convenience (accidental/incidental/grab/available) sampling method

A nonprobability convenience (accidental/incidental/grab/available) sampling method was employed in this study for the following reasons:

- The researcher could only visit one ARHS at a time to distribute the questionnaire.
• The availability of adolescents visiting the selected ARHS was not known in advance by the researcher.
• A matter of major concern to the researcher was to obtain a representative sample, which met the eligibility criteria.

In order to overcome the above problems, the researcher scheduled a whole working day per selected ARHS in Gauteng Province. In instances where the researcher administered questionnaires to less than five adolescents per ARHS, the researcher visited the selected ARHS for the second time round. Only one centre had less than five adolescents on the day it was visited and on the second round there were none.

☐ Sample size

An initial sample size of 2 500 adolescents drawn from the selected ARHS was thought to be more than sufficient to obtain the information needed in terms of the research questions of the study. After further discussion with the promoters and the statistician, the minimum sample size calculated for a desired alpha error of 5.0 percent with 95.0 percent confidence was only 384. This number assumes a 50.0 percent incidence of sexual experience, contraception pregnancy, labour, pueperium, TOP, STDs and sexually transmitted infections (STIs) (Buga et al 1996b:524). In this study the researcher collected data from the 203 respondents instead of 384 as anticipated, because of failure to reach this target number by the due date. The ultimate sample size was discussed and approved by the promoters and the statistician.

Table 3.2 depicts the number of adolescents per region who were given questionnaires by the researcher. This number of 203 formed the sample size used in the research.
Table 3.2: Number of adolescents the researcher gave face-to-face questionnaires (n = 203)

<table>
<thead>
<tr>
<th>Region</th>
<th>Distributed questionnaires</th>
<th>Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Rand</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Vaal</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Central Wits</td>
<td>103</td>
<td>103</td>
</tr>
<tr>
<td>East Rand</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Pretoria</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>203</td>
<td>203</td>
</tr>
</tbody>
</table>

3.4.3.3 Third stage sampling: registered nurses rendering health care to adolescents in ARHS in Gauteng Province

Eligibility criteria

The registered nurses who were to be selected to partake in the study were those who

- provided health care to the adolescents in the ARHS in Gauteng Province
- gave informed voluntary consent

Logical reasons for including registered nurses in the study

The rationale for including registered nurses in the study was to obtain a holistic picture of the quality of service provided at the ARHS to adolescents in Gauteng Province from the service providers who are regarded as the backbone of the health department. However, the researcher was not granted permission to include registered nurses in the study (annexure 3b) as a result the study ended with the second stage sampling discussed above.
3.5 DATA COLLECTION

Burns and Grove (1997:383) maintain that one of the exciting steps of the research process is the initiation of data collection. Data refers to the pieces of information obtained in the course of the study (Polit & Hungler 1993:31).

In a descriptive survey, self-reported information can be obtained from subjects by means of a questionnaire which can either be handed face-to-face or posted to them (Dempsey & Dempsey 1992: 145; Ntlokotsi 1999:35). In this study a questionnaire was handed to the subjects face-to-face by the researcher. Data was collected by means of a questionnaire from the non-probability convenience sample of 203 adolescents who attended the selected ARHS in the period April to July in 1999.

3.6 RESEARCH INSTRUMENT

A questionnaire refers to a paper-and-pencil self-report instrument, where the subject reflects his or her answers in response to a set of documented questions (Brink 1996:154; Mateo & Kirchhoff 1999:259).

3.6.1 Development of the questionnaire

After completion of an in-depth literature study pertinent to aspects being researched, perusal of selected questionnaires, personal experience of the researcher, data obtained from adolescents and service providers working in ARHS, intensive consultation with the promoters, statistician, colleagues and in accordance with the conceptual framework (see chapter 2) used for the study, a single, self-administered paper-and-pencil, anonymous 12 paged, 44 items, English structured questionnaire was designed by the researcher to answer research questions (see chapter 1).
Question construction

The nature of the questionnaire necessitated the use of several types of questions, including the following:

- Dichotomous questions were used for direct responses (yes, no, age).
- Multiple response questions were used to permit the respondents to select from predetermined choices.
- Likert scale questions tried to measure the different categories of respondents’ rating of each health care provider that has attended to him/her at this ARHS. This enabled the respondents to select an answer on a Likert scale ranging from 1 to 6. The scale was explained as follows:

  1 = friendly
  2 = unfriendly
  3 = judgemental
  4 = knowledgeable
  5 = not certain
  6 = not applicable

- The few open-ended questions were provided to elicit any additional comments the respondents wished to make.

Each questionnaire was given a five-digit code number for follow-up and tabulating purposes and for keeping data, confidential. Spaces in a column at the right side of each item were designated for later coding purposes.

3.6.2 Format of the questionnaire

For design purposes the questionnaire (annexure 1), used for this study contained four sections which attempted to answer the five research questions formulated according to the
conceptual framework "What is quality of care?". The research questions did not follow in sequential order of the sections in the questionnaire, but were given in sequential order of the research questions.

Who is the adolescent attending adolescent reproductive health services in Gauteng Province?

Section 1: The adolescent attending ARHS in Gauteng Province.

The first section contained seven items (items 1.1 to 1.7) requesting background information about the respondents such as

- gender (sex)
- age
- population group
- highest standard of education attained
- current employment situation
- pocket money obtained by unemployed adolescents
- residential area

This background information was contained in the questionnaire primarily for the following reasons:

- to portray a descriptive profile of the typical adolescent
- to obtain basis for analysing the data of the subsequent sections
Are the adolescent reproductive health services in Gauteng Province accessible and available to adolescents?

Section 2 (a): Accessibility and availability of ARHS in Gauteng Province for adolescents.

The second section contained 14 items (items 2.1 to 2.4, 4.1 to 4.5, 4.12, 4.14 to 4.17).

Respondents were asked questions in relation to:

- the frequency that adolescents attended ARHS in Gauteng Province since 1998
- the extent to which respondents indicated that they would attend ARHS in Gauteng Province again
- reasons given by adolescents for intending to use ARHS again
- reasons given by adolescents for not intending to use ARHS again
- convenience of ARHS days for adolescents in Gauteng Province
- days which ARHS should be open for adolescents in Gauteng Province
- hours of service convenient for adolescent attending ARHS in Gauteng Province
- adolescents attending ARHS in Gauteng Province during school time
- convenient times for adolescents to attend ARHS in Gauteng Province
- length of time waited by adolescents attending ARHS in Gauteng Province
- being turned away from the ARHS during working hours
- reasons given by adolescents for not being permitted to attend ARHS in Gauteng Province during working hours
- travel time taken by adolescents attending ARHS in Gauteng Province
- type of transport used by adolescents attending ARHS in Gauteng Province

The questions were drawn up to elicit the respondents' perception of whether the ARHS were accessible and available and whether they were as close as possible to where adolescents live and provided at the lowest level that could provide the services safely and effectively.
Do the adolescent reproductive health services in Gauteng Province provide comprehensive health care to adolescents?

Section 2 (b): Comprehensive health care services received by adolescents in Gauteng Province

Section 2 (b) contained one item (item 2.5) with ten subitems ((a), (b), (c), (d), (e), (f), (g), (h), (i), (j)).

Services enumerated were:

- contraceptives
- ECPs
- pregnancy test
- counselling on pregnancy
- TOP
- diagnosis of STDs
- treatment of STDs
- HIV/AIDS counselling
- maternity services
- others

Item 1.12 was an open-ended question which requested suggestions for improvement to the services provided.

Item 3.5 was a close-ended question asking the adolescent to indicate whether the health care provider did tell him/her when to come back.

The questions were designed to elicit respondents' indication as to the type of services received by respondents at the ARHS and whether these services were integrated with other reproductive health services or not and whether there was continuity of these services.
Are adolescents receiving information and counselling from the adolescent reproductive health services in Gauteng Province?

Section 3: Information and counselling (IC) received by the adolescent attending ARHS in Gauteng Province

Section 3, containing 7 items (items 2.6 to 2.8, 3.1 to 3.4) requesting respondents to indicate the following:

- whether a health procedure was carried out during their first visit to the ARHS in Gauteng Province
- whether an explanation was given to them before the health procedure was performed
- whether an explanation was given as to the outcome of the health procedure done
- whether they took any educational material home to read
- what subjects were covered in the educational material taken home
- whether they attended a health talk on the days they attended the ARHS in Gauteng Province and
- what subject matter was covered in these health talks

The questions were designed to elicit respondents' indication as to whether they were provided with information and counselling on their health and health needs.

Are the adolescent reproductive health services in Gauteng Province adolescent-friendly?

Section 4: Adolescent-friendly services

Section 4 containing 13 items (items 2.9 to 2.11, 4.6 to 4.11, 4.13 and 4.18 to 4.20).

Questions asked were designed to
• elicit an indication of the level of privacy provided for adolescents during a consultation at ARHS in Gauteng Province
• give an indication of the extent of privacy provided during a health procedure carried out on an adolescent visiting ARHS in Gauteng Province
• give an indication of the extent of failure to provide privacy during a health procedure carried out on an adolescent attending ARHS in Gauteng Province
• indicate entertainment preferred by the adolescent in the waiting area of the ARHS in Gauteng Province
• indicate the preferred age group of the health care provider for adolescent
• give reasons why adolescents preferred a selected age group for health care provider
• indicate the preferred gender (sex) of the health care provider in ARHS
• give reasons why adolescent preferred a specific gender (sex) for the health care provider
• indicate the preferred form of dress code for the health care provider in ARHS in Gauteng Province
• indicate the ratings given by the adolescent for each health care provider in the ARHS in Gauteng Province
• indicate the knowledge adolescents had of other ARHS in Gauteng Province
• indicate the reasons given by adolescents as to why they chose to attend the selected ARHS in Gauteng Province

The final question was an open-ended question to elicit from the comments by adolescents regarding ARHS in Gauteng Province.

The questions were designed to elicit respondents' indication of whether the service provided was acceptable and responsive to cultural and social norms such as preference of privacy, confidentiality and care by female health care workers and whether the clinics were staffed by health care providers who provided respectful and nonjudgemental care that is responsive to adolescents' needs.
3.6.3 Reasons for using a questionnaire

A questionnaire was selected as the most appropriate instrument for the study as it

- enabled the researcher to obtain data from subject over a wide geographical area of Gauteng Province
- could be distributed to large numbers of subjects simultaneously
- presented a standardised stimulus situation in terms of instructions, wording, sequencing of questions and response categories and as such could not be influenced by the interviewer
- allowed the subjects to remain anonymous in areas where they might feel threatened
- offered an opportunity for the subject to consider a response to each item at a pace convenient to them. Lock (1989:45) cites Bergwall (1978:69) who “maintains that perhaps in this way more valid returns will be provided”.
- was one of the easiest tools for testing reliability and validity

3.6.4 Advantages of self-delivered questionnaires

Nieswiadomy (1993:201) maintains that the researcher must focus on the practicality of the data collecting instrument before considering the reliability and validity of the instrument.

The advantages of self-delivered questionnaires were that

- a possibility existed that subjects might not return the questionnaires and it was therefore anticipated that self-delivered questionnaires would impact positively on the response rate
- questionnaires were completed at the ARHS at the time of the visit and collected by the researcher therefore the response rate could be monitored
- the researcher could assist subjects by guiding them on how to go about completing the instrument
• the researcher extended her sample to adolescents who could not read, write nor speak English by explaining the questions in their preferred African language and writing responses in instances where the subject could not write
• the researcher conducted the study without involving the service providers and as such did not disrupt the smooth running of the ARHS

3.6.5 Validity and reliability of the research instrument

When selecting an instrument for collection of data, the researcher needs to extensively analyse its reliability and validity (Burns & Grove 1997:5).

Polit and Hungler (1993:249) caution that "the validity and reliability of a data gathering instrument are not completely independent characteristics. A data gathering instrument that is not reliable cannot possibly be valid. A data gathering instrument can be reliable without being valid".

3.6.5.1 Validity

In the definition used by various authors validity is seen as the degree to which an instrument actually measures the abstract construct it purports to measure given the environment in which it is applied (Brink 1996:167; Brockopp & Hastings-Tolsma 1995:191; Burns & Grove 1997:330; Dempsey & Dempsey 1992:75; LoBiondo-Wood & Harber 1998:331; Polit & Hungler 1993:249).

The following measures (strategies) were taken into cognisance to ascertain the validity of the instrument:

• Conducting an intensive literature search, making correct references and interpretation of the literature source.
• Obtaining from experts in adolescent reproductive health care, factors that contribute towards the provision of quality care and pretesting the instrument.
• Suggestions from a panel of experts in the field of research were incorporated in the field of study.

3.6.5.2 Pretesting of the instrument

Polit and Hungler (1995:259) maintain that “pretesting is the collection of data prior to the experimental intervention ... the trial administration of a newly developed instrument to identify flaws or assess time requirements”. The researcher pretested the instrument to ensure that information concerning all identified issues would be collected.

The preliminary questionnaire was submitted to seven experienced professional nurses, two community liaison officers, one doctor, one statistician, one computer analyst, two promoters and 30 adolescents. The reason for involvement of a variety of experts is that according to researchers “a jury’s opinion is better than that of a single individual”. The jury should consist of individuals who are experts in the field under study (Brink 1984:48).

All doctors, nurses, community liaison officers, promoters who were selected to judge the content and face validity were experienced in the field of adolescent health and were therefore regarded to be experts. The statistician and the computer analyst are experienced in the field of statistics could make valuable contributions with the format and coding of the questionnaire. The adolescents completing the questionnaire provided guidelines as to whether it makes sense or not.

Table 3.3 depicts the categories, area and number of people involved with the pretesting of the instrument.
Table 3.3: Pretesting of the instrument

<table>
<thead>
<tr>
<th>Categories of persons</th>
<th>Area</th>
<th>Number of questionnaires distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional nurses</td>
<td>From Gauteng Province</td>
<td>7</td>
</tr>
<tr>
<td>Community liaison officers</td>
<td>Gauteng Province</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Health Promotion Subdirectorate</td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
<td>Reproductive Health Research Unit</td>
<td>1</td>
</tr>
<tr>
<td>Statistician</td>
<td>Department of Statistics, Unisa</td>
<td>1</td>
</tr>
<tr>
<td>Computer analyst</td>
<td>Department of Computer Science, Unisa</td>
<td>1</td>
</tr>
<tr>
<td>Promoters</td>
<td>Department of Advanced Nursing Sciences, Unisa</td>
<td>2</td>
</tr>
<tr>
<td>Adolescents</td>
<td>Pretoria Region</td>
<td>30</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

According to Nieswiadomy (1993:201) there is no set number of people needed for pretesting the instrument, the average number is ten subjects.

In this research study, pretesting of the instrument was conducted to

- assess the relevance, appropriateness, adequacy, comprehensiveness, suggestive and subjective undertones
- evaluate tools for clarity of questions, effectiveness of the instruction, completeness of response set, time required to complete questionnaire
- determine the usability of the instrument, ease of completion, distribution and collection of the completed instrument from subjects
- eliminate freedom from bias as far as possible
- assess availability of research subject, money and time required for data collection
- detect unforseen problems
- determine the feasibility of the sampling method
• identify gross inadequacies before the full scale study
• determine the reliability and validity of the research instrument
• assess the appropriateness of the format of the questionnaire

Box: Problems encountered during the pretesting of the instrument and the necessary changes made

Originally the questionnaire was drawn up into five sections in accordance with the research questions. After repeated pretesting of the instrument it was found to be more user-friendly for the adolescent in four sections. Questions were combined accordingly but in the discussion on findings were discussed under the relevant sections in accordance with the conceptual framework. The following problems were also encountered during the pretesting of the instrument:

• Some adolescents could not answer in english, for example, meaning of gender and some could not write.
• Questions related to biographical data, such as religious background, marital status, number of children and medical history, for example whether the person has ever suffered from STD, including personal questions, for example have you ever impregnated somebody or fallen pregnant, or procured a TOP were found to be inappropriate.
• Most questions focussed on family planning instead of being comprehensive.
• There was limited space for computer coding of the questionnaire, numbering each questionnaire and space for each response.
• Questions were not in line with the conceptual framework used for the study.
• It took one hour for the adolescent to complete the 20 paged questionnaire.
• Instructions were found to be confusing, for example, at the end of a “yes” and “no” question a statement would say “if yes” go to question 10, “if no” go to question 13.
• Arriving in the afternoon to deliver the questionnaire to the adolescents entailed missing some of the out of school adolescents.
**Final preparation of the questionnaire**

Based on the recommendations and suggestion made after pretesting the instrument, appropriate adjustments were made to the questionnaire as follows:

- irrelevant biographical data and personal sensitive questions, for example, marital status, number of children, pregnancy were removed
- sex was put in brackets after gender
- comprehensive questions instead of only FP questions were asked
- enough space for computer coding of the questionnaire, and for numbering each questionnaire was made
- questions were formulated in accordance with the conceptual framework used for the study
- revision was made in terms of “yes” and “no” answers

The questionnaire was redrafted at least ten times before the final draft was approved. The final questionnaire was submitted to the promoters and the statistician for approval (see annexure 1). A covering letter requesting the adolescent’s participation in the study and emphasising the nature and importance of the study as well as guaranteeing anonymity and confidentiality was written (annexure 5).

After discussion with the promoter and statistician a full pilot study was not done. Pretesting of the instrument was considered sufficient. Adolescents used in the pretesting did not form part of the main study.

**3.6.5.3 Reliability of the instrument**

Reliability is the extent to which an instrument provokes consistent responses when repeated (Brockopp & Hastings-Tolsma 1995:195; LoBiondo-Wood & Harber 1998:337; Seaman 1987:332). The researcher, after further discussion with the promoters and statistician, about the nature of the descriptive survey which included questions in which respondents could
make comments on, decided that tests for reliability would not be used.

Criteria incorporated into the questionnaire to enhance reliability

The following criteria were incorporated into the questionnaire in an attempt to enhance reliability:

- Drawing up the questions in a format as simple as possible to reduce ambiguities.
- Allowing ample time for completing the questions.
- Administering all questionnaires in a consistent manner to all the respondents by the researcher.
- Ensuring that the questionnaire was completed by the respondents in a private environment where they felt at ease, away from the service provider's eye.

3.7 ETHICAL CONSIDERATIONS

Burns and Grove (1997:200) and Polit and Hungler (1993:353) caution that when human beings are used as subjects, researchers should ensure that their rights are observed and respected. In this study the following basic ethical principles guided the researcher.

3.7.1 Principle of respect for persons

In terms of this principle, human beings are seen as autonomous (ie they have the right to self-determination and this right must be respected) (Brink 1996:39; Burns & Grove 1997:200; Miller, Fisher, Miller, Ndhlovu, Maggwa, Askew, Sanogo & Tapsoba 1997:17).

The adolescents in this study were treated as autonomous agents by informing them about the proposed study, allowing them to voluntarily choose to participate or not participate and allowing them to withdraw from the study without refusing them reproductive health intervention. Their right to refuse to give information or to ask for clarification about the purpose of the study was accepted.
3.7.2 Principle of beneficence

The principle of beneficence is concerned with maximising benefits and doing no harm (Burns & Grove 1997:206; Miller et al 1997:17).

In this research study the researcher received approval from the ethical committee of the Department of Advanced Nursing Sciences at the University of South Africa (Unisa) (annexure 2) to use a questionnaire, treated the subjects with respect and dignity thus protecting them from emotional or psychological trauma. The researcher did not ridicule the subjects on their reproductive health needs.

3.7.3 Principle of justice

The principle of justice requires that subjects are treated equally and that the subjects are also beneficiaries (Miller et al 1997:17). In this study subjects were treated equally irrespective of the nature of reproductive intervention sought. The subjects would also benefit if the quality of care was elevated.

Brink (1996:40) highlights that the principle includes subjects' right to fair selection and privacy. The selection of the sample in this study was done according to the eligibility criteria set out previously (see chapter 3).

Privacy is the right an individual has to determine time, extent and conditions under which private conditions will be shared with or withheld from others (Brink 1996:40; Burns & Grove 1997:203). In this research study the subjects' privacy was assured by

- informing subjects about the study
- obtaining their voluntary informed consent to participate in the study
- voluntarily sharing private information with the researcher
- assuring them that data gathered from or about them would remain private by ensuring anonymity and confidentiality
Anonymity

Anonymity relates to keeping subjects nameless in relation to their participation in the study (Brink 1996:41; Brockopp & Hastings-Tolsma 1995:137). In this research study anonymity of the subjects was protected by:

- Requesting subjects not to reflect any identifying data, for example name of self and/or organisation or address on the questionnaire.
- Allocating code numbers to each completed questionnaire for later review and analysis of the questionnaire.
- Entering data collected into the computer using code numbers.
- Group analysis of the data collected so that the respondent could not be identified individually by their responses.

Confidentiality

Confidentiality refers to the researcher's responsibility to refrain from sharing gathered data from subjects with outsiders (Brink 1996:41; Brockopp & Hastings-Tolsma 1995:173; Burns & Grove 1997:204). In this research study the following mechanisms were put in place to maintain confidentiality:

- Parents of the sampled adolescents and service providers at the selected ARHS could not gain access to raw data of the study. The researcher kept all the completed questionnaires in her bag and supervised the adolescents in the sample when questionnaires were being completed.
- Subjects were informed on an ongoing basis that they have the right to withhold information.
- The subjects were informed before participating in the research study that the researcher intended to report the results of the study in group form to Unisa and the Department of Health in Gauteng Province.
- Destroying the questionnaire database at the end of the research.
3.8 PERMISSION TO CONDUCT THE STUDY

Ethical consideration was ensured by securing permission from:

- Ethical Committee from the Department of Advanced Nursing Sciences at Unisa (letter of approval to use the questionnaire) (annexure 2).
- Research Committee in Gauteng Province (letter requesting permission to conduct the study - annexure 3a and letter of approval to conduct the study - annexure 3b).
- Director, District Health Services (letter requesting permission to conduct the study in the five regions - annexure 4a and letter of approval from the Director, District Health Services - annexure 4b).
- Directors/Deputy Directors, District Health Services (letters requesting permission to conduct the study in the five regions - annexure 4c and letters of approval from the Directors/Deputy Directors in the five regions to conduct the study - annexure 4d).
- The managers of the selected ARHS in Gauteng Province (verbal consent).
- The sampled subjects at the ARHS in Gauteng Province. A covering letter (annexure 5) explaining the study which was read and given to the respondents.

3.9 DISTRIBUTION OF THE QUESTIONNAIRE

The researcher telephoned the different Director/Deputy-Directors in the six regions to obtain names of the selected ARHS and the contact persons telephone numbers at each ARHS. The researcher telephoned the registered nurse in charge of the ARHS to secure an appointment day. Upon arrival of the researcher on the appointment day, the researcher explained again her presence to those involved at the ARHS.

The service provider subsequently introduced the researcher to the prospective adolescents in the waiting area. The researcher, in return, read out the covering letter (annexure 5) to adolescents in the waiting area. The service providers referred the prospective subjects to the researcher in the office area after they had received their health treatment.
The respondents completed the questionnaire under the supervision of the researcher in a private room or an available quiet space using similar strategies to that used in examinations. The researcher answered questions from the respondents, as they arose. The respondents were asked to hand in the completed questionnaire to the researcher. Submissions of a completed questionnaire signified consent. Some adolescents indicated that they were in a hurry to go back to school and write examinations/tests or attend lecturers as a result did not partake in the completion of the questionnaire.

Table 3.4: Response rate

<table>
<thead>
<tr>
<th>Province</th>
<th>ARHS</th>
<th>Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauteng</td>
<td>44</td>
<td>203</td>
</tr>
</tbody>
</table>

Problems encountered in distributing questionnaires and the solutions effected

The following discussion indicated the problems encountered by the researcher and the steps taken to overcome them:

- Waited for a year before receiving permission from the Department of Health, Gauteng to conduct the study.
- Researcher continued with the literature review and adjusting and adapting the questionnaire.
- Discussed the problem with the promoters who in return advised her to follow it up with the Gauteng Province Research Committee.
- Lack of rationalisation between the provincial and local authorities at health services level resulted in confusion when the study was to be conducted in premises where both authorities were present, especially as permission had been obtained only from the provincial authorities. Resultant from this, the researcher was in some instances unable to continue with her research at a specific clinic.
- The researcher was advised by service provider to come in the afternoon because adolescents flock to the ARHS after school closes. This resulted in the researcher
missing out on the out of school adolescents.

• The researcher decided to come at the official opening time and leave when the clinic closed.

• Staff unfriendliness. In such instances the researcher treated personnel with respect and maintained a professional stance.

• Some adolescents were not interested in participating in the study. No one was forced to participate.

• Some adolescents left in a hurry after completion of the questionnaire. The researcher did not have time to check with the adolescent whether all the questions had been answered.

• Some adolescents felt the questionnaire was too long as they needed to go back immediately to school or home. These adolescents were asked to tick just the accepted answer from their perspective.

• It was an expensive exercise due to
  — travelling through Gauteng Province with one's own vehicle and the high petrol price
  — photocopying the questionnaires
  — telephoning and faxing various service providers to secure appointments
  — having conducted the study on her own

3.10 PLAN FOR DATA ANALYSIS

The researcher should consider how data collected should be analysed in the design stage to avoid collecting a lot of data and not being certain what to do with it once it has been obtained (Clifford 1997:72). The plan for data analysis in quantitative research is to organise the description of observation in such a way that it becomes manageable. Descriptions are balanced by analysis and lead to interpretation (Mouton & Marais 1991:215).

The nature of questions in the study and the data obtained dictated the use of computer and the methods used for analysing data. Data was coded, prepared and fed into the statistical packages for the social science (SPSS) computer program by the personnel of the Department
of Computer Services at Unisa.

Data was displayed in tables and figures using frequencies and percentages where appropriate.

3.11 CODING OF THE COMPLETED QUESTIONNAIRES

Each questionnaire was coded by the researcher. The coding was done on the right hand margin of the first page of the questionnaires itself in a space provided for that purpose at the time it was printed. Each questionnaire was then checked a second time by the statistician and the researcher.

3.12 CONCLUSION

Emphasis in this chapter was given to the following aspects: research design, population and sampling methods, data collection methods, the research instrument, ethical consideration, permission to conduct the study, distribution of the questionnaire, plan for data analysis, coding of the completed questionnaire and conclusion. Chapter 4 will present findings and analysis of data.
CHAPTER 4

Analysis and presentation of data

4.1 INTRODUCTION

The goal of this chapter was to analyse the data and present the major findings of this study so as to provide answers to the research questions. The results presented are those obtained from administering a single researcher designed anonymous self-administered questionnaire to the defined nonprobability convenient sample of 203 adolescents attending the selected ARHS in Gauteng Province. Not all the respondents responded to all items of the questionnaire. This is reflected in the relevant tables and figures. Missing responses were excluded from the analysis.

- The first section indicates the profile of the adolescents attending ARHS in Gauteng Province.
- The second section indicates the accessibility and availability of ARHS to adolescents in Gauteng Province.
• The third section indicates the comprehensive health care services available for adolescents at ARHS in Gauteng Province.

• The fourth section indicates the information and counselling received by the adolescents attending ARHS in Gauteng Province.

• The fifth section indicates whether the ARHS in Gauteng Province are adolescent-friendly or not.

4.2 METHODS USED FOR THE ANALYSIS OF DATA

The data was analysed using the SPSS computer program. Statistical measures included frequency distribution, percentages, cross-tabulations and chi-square tests. A total of 203 adolescents responded to the questionnaire. The items in this chapter are not presented in numerical order according to the format of the questionnaire, but according to the research questions used for the study. Because a computer program was used, the estimation of percentages did not always equal precisely 100 percent.

4.3 CONCEPTUAL FRAMEWORK USED FOR THE ANALYSIS AND PRESENTATION OF DATA

The analysis and presentation of data is presented in accordance with the conceptual framework selected for the study ("What is quality of care?") discussed in chapters 1 and 2.
4.4 SECTION 1: PROFILE OF THE ADOLESCENT ATTENDING ARHS IN GAUTENG PROVINCE

Item 1.1: Gender (sex) of the adolescent (n = 203)

Out of the 203 adolescents who responded to this question 99.5 percent (202) were females with only 0.5 percent (1) being a black male. These findings are similar to other research findings in which it was found that more females than males attended family planning clinics (Cook 1993:28, 30; Hirsch et al 1987:309).

The rationale for these findings according to Swanson, Swenson, Oakley and Marcy (1990:88) citing Forrest (1987) are that family planning and related services are widely available to females in the United States. The outcome of these findings were also expected in this study as females are seen as the main users of ARHS in Gauteng Province. Kurth (1998:177) states as well that family planning clinics and other health services that reach
women are often designed in such a way that they seem uninviting to males. Unlike females, males do not receive consistent health messages such as the need for annual papanicalaou (PAP) smears or prenatal care. When males need reproductive health intervention they have to camouflage it for something acceptable.

The provision of comprehensive care should include males in the sexual health equation. Involving males in reproductive health and that of their partner can yield positive results. A study conducted in Rwanda by Kurth (1998:177) found that "HIV testing and counselling of couples had beneficial long-term effect on condom use and HIV related communication." Similarly positive results were seen in a European study where couples counselling was associated with large increases in protected sexual behaviour. The outcome of the findings in this study was expected because the researcher observed that females are the main users of ARHS in Gauteng Province. Poor attendance of males at ARHS in Gauteng Province causes concern. According to a study conducted by Buga et al (1996b:526) on sexual behaviour contraceptive practice and reproductive health among school adolescents in Transkei, it was reported that boys initiate sexual activities at a younger age are more sexually experienced and active and have more sexual partners than girls do. This is one of the main reasons why they should also be seen to be using the ARHS at an earlier age, more frequently and more consistently.

Gauteng Province the Department of Health is committed to ensuring that both females and males will be provided with services that allow them to achieve optimal reproductive and sexual health (South Africa 1997a:98).
Figure 4.2

Age of the adolescent attending ARHS in Gauteng Province (n = 203)

Figure 4.2 indicates that the majority of the respondents 51.2 percent (104) were aged between 18 to 19 years followed by 33.0 percent (67) respondents between 16 to 17 years, 14.3 percent (29) of the respondents were between 14 to 15 years, to 1.5 percent (3) of the respondents were between 10 to 13 years. It is apparent that the older adolescents use the ARHS in Gauteng Province more frequently than the younger adolescent.

The significance of this finding is that service providers, families and communities should develop strategies that will attract all age groups starting with the young adolescents visiting the ARHS. Values, attitudes and behaviours are still in the formative stage during young adolescence. Research has revealed that programmes that target adolescents before they indulge in sexual intercourse are more likely to lead to adolescents postponing sexual activity and using contraception when they do indulge in sexual intercourse (Klima 1998:485; World’s Youth 1996:no page).
Adolescents should not only visit the ARHS for contraceptives services, TOP services, maternity services, but should also receive health promotion information that will enable them to make informed choices on health-related matters which will improve their health and well-being and prevent the consequences of unsafe sexual practices (South Africa 1996:49).

**Item 1.3: Population group of the adolescent attending ARHS in Gauteng Province (n = 203)**

Figure 4.3 illustrates that 99.5 percent (202) respondents were black and only 0.5 percent (1) was a coloured female. This finding was expected because the research was conducted in ARHS utilised mainly by blacks. It is a coincidence that these findings were exactly the same as the male-female ratio (figure 4.1).
Figure 4.4 indicates that 49.5 percent (100) of the respondents had passed Grades 10 to 12, 38.1 percent (77) had attained Grades 7 to 9, 6.9 percent (14) had attained Grades 4 to 6, 3.0 percent (6) were post-matriculants, 1.5 percent (3) had attained Grade 1 to 3 and only 1.0 percent (2) had never been to school.
It is encouraging to note that 49.5 percent (100) of the respondents had completed their schooling at Grade 10 to 12. Formal education prepares adolescents to take care of themselves and their families in the future. They will also be in a position to understand better how ARHS function.

Cross country studies done showed that an extra year of schooling for girls reduced fertility rates by 5.0 to 10.0 percent. Research has also indicated that education is more likely to improve a young women's economic earning potential, strengthen her decision-making and negotiation skills, her self-esteem and productivity. Furthermore ensuring access to education can reduce the likelihood of girls falling pregnant as a result of commercial sex. These findings highlight the importance of keeping girls at school (Birdthistle-Vincent-Whitman 1997:4; World's Youth 1996:no page).

It was of major concern to note that 1.0 percent (2) of the respondents had never been to school. The researcher observed that these respondents had never been to school because their parents did not have money to send them to school.
Item 1.5: Employment status of the adolescent attending ARHS in Gauteng Province (n = 203)

It is apparent from the findings in figure 4.5 that the majority 80.8 percent (164) of the respondents were still students. This finding was expected because the age group ranged between 10 and 19 years. In Gauteng Province compulsory school attendance is between 7 and 15 years (Gauteng Youth Directorate sa:6). Of those who were not students, 2.5 percent (5) were either pregnant or had delivered a baby and no longer attended school. The
researcher observed that those who were unemployed looking for work had either completed tertiary education and were looking for work or had stopped schooling because of financial constraints.

Item 1.6: Money obtained by adolescents attending ARHS in Gauteng Province (n = 199)

Table 4.1: Money obtained by adolescents attending ARHS in Gauteng Province (n = 199)

<table>
<thead>
<tr>
<th>Money obtained from ....</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>120</td>
<td>60,3</td>
</tr>
<tr>
<td>Father</td>
<td>13</td>
<td>6,5</td>
</tr>
<tr>
<td>Parents</td>
<td>40</td>
<td>20,1</td>
</tr>
<tr>
<td>Grandmother</td>
<td>9</td>
<td>4,5</td>
</tr>
<tr>
<td>Nobody</td>
<td>8</td>
<td>4,0</td>
</tr>
<tr>
<td>Brother</td>
<td>4</td>
<td>2,0</td>
</tr>
<tr>
<td>Grandfather</td>
<td>3</td>
<td>1,5</td>
</tr>
<tr>
<td>Sister</td>
<td>2</td>
<td>1,0</td>
</tr>
<tr>
<td>Total</td>
<td>199</td>
<td>99,9</td>
</tr>
</tbody>
</table>

The researcher asked this question to determine whether the adolescents were able to pay for their transport to come to the clinic if this was needed.

The findings in table 4.1 indicate that adolescents in this study were dependant on other family members for pocket money. They did not generate their own income.
Item 1.7: Name of the residential area of the adolescent attending ARHS in Gauteng Province (n = 202)

Table 4.2: Name of the residential area of the adolescent attending ARHS in Gauteng Province (n = 202)

<table>
<thead>
<tr>
<th>Name of residential area</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kagiso</td>
<td>15</td>
<td>7.4</td>
</tr>
<tr>
<td>Krugersdorp</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Mohlakeng</td>
<td>9</td>
<td>4.4</td>
</tr>
<tr>
<td>Khutsong</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td>Bekkersdal</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Randfontein</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Hekpoort</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Graceland</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Palmspring</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Freitinpark</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Protea Glen</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Pimville</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Orlando West</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Evaton</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Sebokeng</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Small Farm</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>De Deur</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Walkerfruit Farm</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Meadowlands</td>
<td>34</td>
<td>16.7</td>
</tr>
<tr>
<td>Ndafaya</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Soweto</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Alexandra Township</td>
<td>17</td>
<td>8.4</td>
</tr>
<tr>
<td>Diepkloof</td>
<td>17</td>
<td>8.4</td>
</tr>
<tr>
<td>Klipspruit</td>
<td>2</td>
<td>1.0</td>
</tr>
</tbody>
</table>
Table 4.2 indicates the names of the residential areas of the adolescent attending ARHS in Gauteng Province. It is apparent from the responses in table 4.2 that the respondents came from a wide residential area in Gauteng Province. This item was included in the study to establish how many adolescents came from a given residential area in Gauteng Province. Adolescence is a period that is mainly shaped by peers. Peer influence can impact on utilisation of ARHS by adolescents (Klima 1998:485; Rutsch 1987:17; World’s Youth 1996:no page). Noteworthy among the findings is that the majority of respondents 16,7 percent (34) came from Meadowlands, 8,4 percent (17) and 8,4 percent (17) reside in Alexandra and Diepkloof respectively, 7,4 percent (15) stay in Kagiso whilst 5,9 percent (12) and 5,9 percent (12) stay in White City and Daveyton respectively.
of these findings is that adolescents can be encouraged to bring their friends/colleagues/family members to the ARHS for information and services. The researcher observed that most of the respondents were being accompanied by friends/peers/schoolmates to the ARHS.

Profile of the adolescent

The majority of the adolescents were females in the age group 18 to 19 years, from a Black population group, having completed their schooling at Grades 10 to 12, were still students dependant on their mothers for pocket money, and resided mainly in Meadowlands, Alexandra and Diepkloof, Kagiso, White City and Daveyton. Males and adolescents (male and female) in the younger age group did not appear to be attending these ARHS.

4.5 SECTION 2: THE ACCESSIBILITY AND AVAILABILITY TO THE ADOLESCENT OF THE ARHS IN GAUTENG PROVINCE

Item 2.1: The number of times that the adolescent had attended ARHS in Gauteng Province since 1998 (n = 197)

![Pie chart](image)

Figure 4.6
The number of times that the adolescent had attended ARHS in Gauteng Province since 1998 (n = 197)
It was gratifying to observe that 58.9 percent (116) used the service three or more times since 1998. The significance of this finding is that service providers can devise strategies that will encourage adolescents to continue to return to the ARHS including those adolescents who had attended the ARHS less than three times. These adolescents could also invite their friends, families and colleagues to attend the ARHS so as to be able to make informed decisions on reproductive health matters such as preventing unwanted pregnancies.

**Item 2.2: Extent to which adolescents indicated that they would use the ARHS in Gauteng Province again (n = 203)**

In this item respondents could choose one response from a possibility of five (5).

**Table 4.3: The extent to which adolescents indicated that they would use the ARHS in Gauteng Province again (n = 203)**

<table>
<thead>
<tr>
<th>Use again</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely</td>
<td>179</td>
<td>88.2</td>
</tr>
<tr>
<td>Probably</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>If in the area</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Do not know</td>
<td>9</td>
<td>4.4</td>
</tr>
<tr>
<td>Will not use</td>
<td>7</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>203</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The findings revealed that 88.2 percent (179) would definitely use the ARHS again, 1.0 percent (2) may probably, 3.0 percent (6) if in the area, 4.4 percent (9) did not know, whilst 3.4 percent (7) said they will not use the ARHS again.

It is encouraging to realise that 88.2 percent (179) would definitely use the ARHS as this positive response can only benefit the adolescents as it will assist them in meeting their reproductive health needs. Service providers would also need to develop strategies that would retain those adolescents and others who said they "do not know".
The researcher observed that the respondents who mostly indicated that they will not use the ARHS again were either requesting TOP or had just given birth to a baby. In that case they would visit their nearest ARHS in Gauteng Province.

**Item 2.3:** Reasons given by adolescents for intending to use the ARHS in Gauteng Province again (n = 97)

**Table 4.4:** Reasons given by adolescents for intending to use the ARHS in Gauteng Province again (n = 97)

<table>
<thead>
<tr>
<th>Reasons for using the ARHS again</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent pregnancy</td>
<td>95</td>
<td>50.4</td>
</tr>
<tr>
<td>Caring staff</td>
<td>56</td>
<td>29.8</td>
</tr>
<tr>
<td>Medical examination</td>
<td>21</td>
<td>11.2</td>
</tr>
<tr>
<td>Nearer home</td>
<td>9</td>
<td>4.8</td>
</tr>
<tr>
<td>Receive advice</td>
<td>5</td>
<td>2.7</td>
</tr>
<tr>
<td>Prevent contracting STD</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>188</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

A follow-up open-ended question was presented to adolescents to obtain information as to why they intend attending the ARHS again. The reasons cited are illustrated in table 4.4 in descending order of importance.

Of the respondents who answered this question, 1.1 percent (2) was to prevent contracting STD, 2.7 percent (5) to receive advice, 4.8 percent (9) indicated that it was nearer home, 11.2 percent (21) needed to be medically examined, 29.8 percent (56) revealed that staff was caring and the majority, 50.4 percent (95) for prevention of pregnancy.

According to Reis et al (1987:136-138) “knowledge of why clients return to services, help plan clinic programmes more effectively in retaining the adolescents”. The majority of
respondents, 50.4 percent (95) reported that they do not want to fall pregnant. Surprisingly only 1.1 percent (2) revealed that they did not want to contract STD. This is a cause for concern because estimates suggest that one out of every 20 adolescent worldwide contracts STD each year. Frequent exposure to STDs predisposes to HIV/AIDS (Webb 1998:1).

"For females increased susceptibility to HIV may be attributable to STD-induced compromise of the mucosal or cutaneous surfaces of the genital tract, which serve as a barrier to HIV" (Burst 1998:431).

The AIDS pandemic brought to light that females across the colour line carry the greatest burden of unwanted pregnancy and also STDs/HIV. Helping people to make decisions about contraceptives should reflect both the need to prevent STDs/HIV infection and to prevent unplanned pregnancies. Health care providers should help clients to choose methods in the light of their combined needs and on the basis of a careful assessment of their sexual risks (South Africa 1999a:70).

The significance of this finding is that health care providers should when educating the adolescent on the prevention of pregnancy and STDs/HIV/AIDS promote the use of dual protection and dual method use which means using one contraceptive method that will prevent both unwanted pregnancy and STDs/HIV or the use of a barrier method condom with spermicides male condoms or female condoms in addition to their preferred method of pregnancy prevention respectively (South Africa 1999a:70).

Item 2.4: Reasons given by adolescents as to why they did not intend to use the ARHS in Gauteng Province again

Another follow-up open-ended question was asked to establish the reasons as to why they would not attend the ARHS again. The majority, 7.8 percent (50) of the respondents indicated that they would not use the ARHS again because it was far from home. These findings concur with Kunene’s (1995:50) in which 80.0 percent of the 210 respondents in two senior schools in a Black township near Empangeni stated that they would not use the
clinic because it is faraway from home. Adolescents do not want to travel far to access services.

**Item 4.1:** Convenient clinic days for the adolescent attending ARHS in Gauteng Province (n = 203)

![Bar Chart]

The findings revealed that 85.7 percent (174) of the respondents indicated that clinic days were convenient, whilst 7.4 percent (15) indicated they were not convenient. Notably 6.9 percent (14) indicated that they did not know. The significance of these findings is that the
Clinic days were convenient for the majority of the respondents but inaccessible for the 7.4 percent (15) whose reproductive health needs also need to be met. The Department of Health stated that ARHS "must be universally accessible to children including infants, children under five years and adolescents and women". The researcher asked follow-up questions to determine which days would be convenient for adolescents to attend ARHS (South Africa 1997a:97).

Item 4.2: **Days on which ARHS in Gauteng Province should be open for adolescents in Gauteng Province (n = 201)**

This was a follow-up closed-ended question whereby three responses were given. The respondents were expected to indicate the day(s) which the ARHS in Gauteng Province should be open for adolescents.

![Pie chart showing days ARHS should be open for adolescents](image)

**Figure 4.8**

*Days on which ARHS in Gauteng Province should be open for adolescents (n = 201)*
The findings illustrated that 48.8 percent (98) of the respondents prefer weekdays, 16.4 percent (33) prefer weekends. Notably 34.8 percent (70) prefer seven days a week. This finding does not link with item 4.1, where 85.7 percent (174) revealed that clinic days were convenient for them. According to figure 4.8 51.2 percent (103) respondents prefer both weekends or seven days a week.

The ARHS in Gauteng Province provide ARHS during the week. The significance of this finding is that the ARHS could consider working over the weekend, for example from 08:00 to 13:00 hours on Saturdays to meet the unique needs of all adolescents attending the ARHS.

Item 4.3: Hours of service convenient for adolescent visiting ARHS in Gauteng Province (n = 200)

![Pie chart showing the distribution of preferences for service hours.]

**Figure 4.9**

*Hours of service convenient for adolescent visiting ARHS in Gauteng Province (n = 200)*
Item 4.3 links up with items 4.1 and 4.2. The researcher asked this question to find out the hours that are suitable for respondents to attend ARHS. Some of the ARHS open for adolescents during specific hours of the day.

The majority of the respondents, 71.0 percent (142) stated that the hours were convenient, whilst 21.0 percent (42) indicated that the hours were not convenient for them. Surprising 8.0 percent (16) indicated that they do not know whether the hours were convenient for them or not.

In a study related to patient satisfaction with PHC services in Saudi Arabia, El Shabrawy Ali and Eisa Ali Mahmaud’s (1993:49) findings revealed that 40.0 percent were dissatisfied with the services. 19.4 percent of this group complained that the working hours of the centre were not suitable. Inconvenient working hours are considered an accessibility problem. Adolescents may be reluctant to use a service that is inaccessible.

Hours of service is one of the important factors in providing a quality service which is accessible, available, effective and safe. ARHS are a component of MCWH which is a component of PHC. PHC services are supposed to be available, accessible, affordable and acceptable to the service users for them to be utilised (De Haan 1994:9).
Item 4.4: Adolescents attending ARHS in Gauteng Province during school hours (n = 201)

Of the 201 respondents, 49.3 percent (99) indicated that they do not take time off from school to attend ARHS, 19.4 percent (39) indicated that it was not applicable, i.e., they do not attend school. Notably 31.3 percent (63) respondents indicated that they do take time off from school to attend ARHS. This finding is unsatisfactory as attendance at ARHS should not interfere with adolescents’ school attendance. In Kunene’s (1995:50) study, respondents indicated that hours of service in the centre clashed with school hours.
This behaviour is disturbing when one looks at the poor Grade 12 (Standard 10) results common in Black schools in Gauteng Province. On the contrary, according to the findings of a study conducted by Wood et al (1997:27) on adolescent sex and contraceptive experiences, perspectives of teenagers and clinic nurses in the Northern Province, adolescents reported that nurses scolded them when they did not attend ARHS in the morning during school hours. Nurses, on the other hand, complained that "if adolescents did not request permission from teachers to attend ARHS during school hours the adolescents exert pressure on them when they are already exhausted".

The significance of this finding is that service providers, together with school-going adolescents, should plan opening hours of ARHS in such a way that they do not clash with school hours. School-going adolescents (wearing school uniform) who visit ARHS during school hours should not be seen unless in an emergency, for example rape.

**Item 4.5: Times convenient for adolescents to attend ARHS in Gauteng Province**  
\( n = 202 \)

This was a follow-up close-ended question to item 4.3. It was an attempt to determine what time would be the most convenient for adolescents to attend the ARHS in Gauteng Province. Four possible answers could be given as indicated in table 4.4 plus an option for individual preferences.
Figure 4.11

Times convenient for adolescents to attend ARHS in Gauteng Province \((n = 202)\)

The majority of family planning (FP) clinics in Gauteng Province attend to adolescents between 13:00 and 16:00 on certain days of the week. Out of the 202 respondents, 29.2 percent (59) chose the generally accepted time for attending ARHS because it coincided with school closure. However, 28.7 percent (58) of the respondents preferred the opening times between 07:00 and 10:00 hours. It is presumed that this finding indicated that the school was located near the ARHS.

Some ARHS open at 07:00 hours, whilst schools start at 07:45 hours. Adolescents attending the ARHS at 07:00 hours may report late for school if the queue is too long. In such instances they would not be interested in listening to any health education talks provided at the ARHS.

The option of opening the ARHS from 07:00 to 18:00 hours on weekdays and 08:00 to 13:00 hours on Saturdays would have to be looked into in terms of shortage of man-power, as well as the safety and transport of the adolescent and the health care provider in terms of the
current crime situation in Gauteng Province. Staffing and the cost-effectiveness of this option in terms of human resources and material would also need to be considered if the ARHS are to open between 08:00 and 18:00 hours during the week and between 08:00 and 13:00 hours on Saturdays.

When cross-tabulation was done between the current employment status of the adolescent (item 1.5) and the times most convenient for attendance at ARHS it was found that apparently adolescents would like to attend the clinic throughout the 24 hour period. Most PHC clinics operate between 07:30 and 16:00 hours. They do not function during the night. If ARHS are to be accessible to adolescents then they should consider opening between 08:00 and 18:00 hours during the week and between 08:00 and 13:00 hours on Saturdays. This would depend on the feasibility of this option in terms of human and material resources.

Item 4.12: Waiting times for adolescents attending ARHS in Gauteng Province (n = 202)

Table 4.5: Waiting times for adolescents attending ARHS in Gauteng Province (n = 202)

<table>
<thead>
<tr>
<th>Waiting time</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 30 minutes</td>
<td>108</td>
<td>53,5</td>
</tr>
<tr>
<td>30 minutes - 1 hour</td>
<td>41</td>
<td>20,3</td>
</tr>
<tr>
<td>1 hour - 2 hours</td>
<td>23</td>
<td>11,4</td>
</tr>
<tr>
<td>2 hours and more</td>
<td>30</td>
<td>14,8</td>
</tr>
<tr>
<td>Total</td>
<td>202</td>
<td>100,0</td>
</tr>
</tbody>
</table>

Table 4.5 indicates that the majority of the respondents 53,5 percent (108) waited from 0 to 30 minutes before being seen. This time frame was considered acceptable by the adolescents because they would be rushing either from or to school. Adolescents hate to wait. Surprisingly 20,3 percent (41) indicated that they waited for 30 minutes to an hour, whilst 11,4 percent (23) waited for one hour to two hours. A staggering 14,8 percent (30) waited
for two hours and more. This long waiting period could be due to overcrowding in clinics, a common problem in Gauteng Province.

A study conducted by El Shabrawy Ali and Eisa Ali Mahmoud (1993:49-51) of patients satisfaction with PHC services in Saudi Arabia revealed that almost two thirds (63.9 percent) of the dissatisfied group complained about the waiting times in the health centre. This may be a reflection of undue overcrowding, and/or the ineffective use of time, or a poor work flow distribution. These factors can be remedied through managerial processes, shortening consultation time and improving the deficiencies in the numbers of working physicians.

The findings do not seem to be consistent with Abdool Karim et al’s (1992:358) finding on teenagers seeking condoms at FP services (part 1) whereby the fieldworker waited up to 30 minutes for attention.

A study conducted by Chamie et al (1992:126, 137) in the United States on factors affecting adolescents’ use of FP clinics revealed that adolescents major complaint with the clinic was long waiting times for service. Long waiting times can easily discourage the adolescents from attending ARHS for patients stress that waiting times need to be minimised (Family Health International 1997:31; Jones 1996:33; Jones, Namerow & Philliber 1982:229; Namerow, Philliber & Hughes 1983:174).

According to the Department of Health, if long waiting times are not reduced patients (the adolescent) may default and not attend and as such, fail to benefit from the services provided at ARHS (South Africa 1997b:106-107).

Item 4.14: Indication given by adolescents for not being permitted to attend ARHS in Gauteng Province during working hours (n = 202)

The findings revealed that the majority of respondents 78.3 percent (159) were never turned away from the ARHS during working hours, whilst 7.9 percent (16) indicated that it was not applicable to them because it was the first time they had visited the clinic. Surprisingly 13.8
percent (20) indicated that they had been turned away from the ARHS during working hours.

Item 4.15: Reasons given to adolescents for not being permitted to attend ARHS in Gauteng Province during working hours (n = 21)

This was a follow-up open-ended question to obtain a better perspective as to the reasons given by the service providers for not permitting adolescents to attend ARHS in Gauteng Province. Table 4.6 indicated the reasons give.

Table 4.6: Reasons given to adolescents for not being permitted to attend ARHS in Gauteng Province during working hours (n = 21)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff busy</td>
<td>3</td>
<td>14.2</td>
</tr>
<tr>
<td>Came late</td>
<td>7</td>
<td>33.3</td>
</tr>
<tr>
<td>Lunch break</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>Tea break</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td>Wrong date</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>Referred to the nearest clinic</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Pay day</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Bring mother along</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4.6 shows the reasons given to the adolescents for not being permitted to attend the ARHS.

The main reason given to the adolescent, 33.3 percent (7) as to why they could not be seen at the ARHS during working hours was that they came near the closing time of the clinic and the staff were too busy with administrative work to attend to them. The other reasons as to
why they were turned away was that the staff were too busy or were on tea break. These findings indicate that in many of the clinics it would appear that the services are not adolescent-friendly.

The findings illustrated in table 4.6 does not comply with the Department of Health’s guiding principle which states that no client requesting contraception should be turned away from an ARHS without counselling and a suitable method of his/her choice, unless this is the choice of the client (South Africa 1999a:44).

**Item 4.16: Travel time taken by adolescents attending ARHS in Gauteng Province**

*(n = 202)*

Travel time as an indicator of distance to the clinic should be relatively short. The findings revealed that the majority of respondents 71.8 percent (145) took between 0 and 30 minutes to reach the ARHS.

These findings comply with PHC approach in which PHC is seen as the first level of contact of individuals’ family and communities, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service. In terms of the above, 5 to 10 km is considered a reasonable travelling distance. The travel time may be different in rural areas where patients have to travel for a long distance before reaching the ARHS (Dennill et al 1995:6 cite WHO 1988). According to Dickson-Tetteh et al (1999:1) extensive research has established that South African public health facilities are failing to provide adolescent-friendly health services because they are physically inaccessible.

These findings appear to concur with Reis et al’s (1987:139) study in which it was found that 87.0 percent of the teenagers surveyed travelled a maximum of 30 minutes to attend a family planning clinic in Washington and of the total group, 57.1 percent reported that they had to travel 15 minutes or less to come to the clinic.
In Lock's (1989:150) study conducted in rural hospitals in the Republic of South Africa, respondents were asked to indicate the distances patients needed to travel in order to reach health services. The distances given ranged from 1 kilometre to 480 kilometres with a mean distance of 50 kilometres. Hopefully the PHC approach will reduce inequities between rural and urban communities with regard to these health services (African National Congress 1994:19).

Item 4.17: Type of transport used by adolescents attending the ARHS in Gauteng Province (n = 203)

In a follow-up question to elicit the type of transport used by the adolescent visiting the ARHS in Gauteng Province, it was found that the majority of respondents, 82,2 percent (167) walked to the clinic, whilst 15,8 percent (32) boarded a taxi and 2,0 percent (4) used a private car. The reported travel time and mode of transport appear to indicate that over half of the adolescents came from neighbouring schools or townships.

It is reassuring to note that the respondents who could not walk to the ARHS had access to public transport. The findings of this study concur with Dennill et al's (1995:6) who recommended that "health services should be within a reasonable distance and that transport should be available".

In item 1.6 it was found that 63 percent (120) of the respondents indicated that they obtained pocket money from mothers and 20,1 percent (40) indicated that they obtained pocket money from parents. In the event where parents were unable to provide the respondents with pocket money, the ARHS would then be inaccessible to these adolescents who would not have money to pay for transport to the ARHS. These findings do not appear to be consistent with Reis et al (1987:139) study done in Washington whereby the mode of transport was split almost equally between public transport 43,1 percent and walking 51,0 percent. the reason for this being probably the type of public transport available.
123

4.6 SECTION 3: COMPREHENSIVE CARE SERVICES AVAILABLE FOR ADOLESCENTS IN GAUTENG PROVINCE

Item 2.5: Services received by adolescents attending ARHS in Gauteng Province

More than one answer was possible for this question.

Table 4.7: Services received by adolescents attending ARHS in Gauteng Province

<table>
<thead>
<tr>
<th>Services received by adolescents</th>
<th>n</th>
<th>Yes</th>
<th></th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptives</td>
<td>198</td>
<td>164</td>
<td>82,8</td>
<td>34</td>
<td>17,2</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>194</td>
<td>4</td>
<td>2,1</td>
<td>190</td>
<td>97,9</td>
</tr>
<tr>
<td>Pregnancy test</td>
<td>194</td>
<td>8</td>
<td>4,1</td>
<td>187</td>
<td>95,9</td>
</tr>
<tr>
<td>Counselling on pregnancy</td>
<td>189</td>
<td>189</td>
<td>100,0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Termination of pregnancy</td>
<td>195</td>
<td>6</td>
<td>3,1</td>
<td>189</td>
<td>96,9</td>
</tr>
<tr>
<td>Diagnosis of sexually transmitted diseases</td>
<td>195</td>
<td>1</td>
<td>0,5</td>
<td>194</td>
<td>99,5</td>
</tr>
<tr>
<td>Treatment of sexually transmitted diseases</td>
<td>195</td>
<td>5</td>
<td>2,6</td>
<td>190</td>
<td>97,4</td>
</tr>
<tr>
<td>HIV/AIDS counselling</td>
<td>195</td>
<td>7</td>
<td>3,6</td>
<td>188</td>
<td>96,4</td>
</tr>
<tr>
<td>Maternity services</td>
<td>196</td>
<td>33</td>
<td>16,8</td>
<td>163</td>
<td>83,2</td>
</tr>
<tr>
<td>Others (Specify)</td>
<td>26</td>
<td>6</td>
<td>23,1</td>
<td>20</td>
<td>76,9</td>
</tr>
</tbody>
</table>

The findings in table 4.7 illustrate the services received by adolescents at the ARHS in Gauteng Province. The subsequent discussion will look into all services provided.

- Contraceptives

As illustrated in table 4.7, 82,8 percent (164) of the respondents received contraceptives at the ARHS, whilst 17,2 percent (34) did not receive contraceptives. It is apparent from the
responses that the adolescents visit ARHS mainly to receive contraceptives.

The results of this study concurs with the activities of the ACT which was set up by the community unit of North Straffordshire Health Authority in April 1990. The bulk of the activities done related to the provision of contraceptives to adolescents (Cook 1993:28-29).

Even though South Africa has a comparatively high contraceptive prevalence rate (53.0 percent) compared with other developing countries, the MRC study found that the females interviewed who used contraception used it incorrectly. This was mostly due to ignorance (Jewkes, Wood & Maforah 1997:417).

Reis et al (1987:137) suggest that since public health clinics provide adolescent mainly with contraceptive services, service providers have a unique opportunity to provide basic information on human reproduction and the effectiveness of various contraceptive methods.

Moore (1987:43) citing AGI (1981) stated that with the substantial increase in number of teenagers seeking contraceptive service the problem of overcrowded clinics has arisen. This could lead to failure to reach some adolescents timeously to prevent unwanted pregnancy and them contracting STDs, HIV/AIDS.

- Emergency contraception (EC) (n = 194)

As reflected in table 4.7 only 2.1 percent (4) respondents reflected that they had received emergency contraception, whilst the majority of 97.9 percent (190) of the respondents reflected that they had not received emergency contraception at the ARHS.

Emergency contraception (EC) has been available since 1984 but has been labelled the best kept secret (Bell & Millward 1999:601 cite Winfield 1995). EC was originally termed the "morning after pill" and because several people interpreted this literally the opportunity to use this method was lost.

There has been a steady increase in the use of EC since 1985. There is still evidence, however, that the female adolescent in particular has little knowledge of its existence (Bell & Millward 1999:601 cite Zeibland & Maxwell 1996).

According to Klima (1998:488-489) adolescents require access to age appropriate and culturally sensitive reproductive health care services including emergency contraception to meet their reproductive health needs.

- Pregnancy test (n = 195)

As shown in table 4.7 only 4.1 percent (8) respondents revealed that they received pregnancy tests, whilst 95.9 percent (187) reported that they have not received pregnancy tests at the ARHS. In a study conducted by Zabin and Clark (1981:205) when adolescents were asked what triggered their clinic visits, suspicion of pregnancy was the most commonly cited reason given. In this context they wanted to have a pregnancy test.

It is important for pregnancy test to be available at ARHS, so that in the event that the adolescent has experimented with unprotected sexual intercourse, they can later request a pregnancy test. If found to be pregnant, they can be counselled in terms of keeping the pregnancy or having a TOP done with a minimum of delay (Cook 1993:30; Hadley 1990:16).
• Counselling on pregnancy (n = 189)

Notably and of considerable concern is the fact that 100.0 percent (189) of the respondents revealed that they had not received any counselling on pregnancy.

• Termination of pregnancy (TOP) (n = 195)

Termination of pregnancy is a usual consequence of unintended pregnancy. Unintended pregnancy is common amongst adolescents. As illustrated in table 4.7 3.1 percent (6) respondents reported that they received TOP at the ARHS, whilst 96.9 percent (189) had not received TOP, because they did not need it. The Choice of Termination of Pregnancy Act 92 of 1996 promulgated in 1996, made termination of pregnancy legal, safe and free of charge in designated areas in South Africa.

In a Safe Motherhood Newsletter of Worldwide Activity it was maintained that lack of information about contraception and lack of access to friendly FP services are the two main reasons why adolescents do not use contraception and end up terminating pregnancy (Helping young people avoid unwanted pregnancy 1996:3).

• Diagnosis of sexually transmitted diseases (STDs) (n = 195)

As is evident from table 4.7 only 0.5 percent (1) of the respondents reported that they had been diagnosed with STDs. Worldwide adolescents suffer a disproportionate share of STDs and other reproductive health problems (Goldberg 1997:9).

It is not surprising that the majority of respondents 99.5 percent (194) were not diagnosed with STDs since the majority of respondents were females 99.5 percent (202) in this study. Females usually lack the capacity to identify STD symptoms when they have them (World’s Youth 1996:no page).
Previously clinics in Gauteng Province that diagnosed and treated STDs primarily served males or prostitutes creating a social stigma that bared females from seeking treatment. In South Africa, the Department of Health maintained that services for diagnosis, management and counselling of HIV and STDs would be made available at all health centres for males and females (South Africa 1997a:106). The significance of these services is that the current epidemic of HIV/AIDS represents the tragic consequence of risk-taking sexual behaviour. STDs/HIV/AIDS common among adolescents once established, leads to long-term sequella and problems (Aten et al 1996:259). There is no cure. It can, however, be prevented. Such services should be available at all health centres to avoid stigmatisation and ensure appropriate information and preventive measures.

- Treatment of sexually transmitted diseases (STDs) (n = 195)

In South Africa it is estimated that approximately four million episodes of STDs occur each year (Dickson-Tetteh et al 1999:1). The reasons why adolescents are susceptible to STDs are multifold. These include

- peer pressure to indulge in sex
- engaging in risk-taking sexual behaviour
- unable to negotiate safe sexual practices

The findings as depicted in table 4.7 indicate that 2.6 percent (5) indicated that they were treated for STDs, whilst 97.4 percent (190) had not received STD treatment.
• HIV/AIDS counselling (n = 195)

As is evident from the findings in table 4.7, 3.6 percent (7) of the respondents reported that they had received HIV/AIDS counselling. The majority of respondents 96.4 percent (188) revealed that they had not received HIV/AIDS counselling. If a person has to undergo HIV testing, the person has a right to have pre- and post-test counselling.

According to the HIV and infant feeding: an interim statement (1996:11) “access to voluntary and confidential HIV counselling and testing should be facilitated for females and males of reproductive age in a supportive environment”. In Gauteng Province, the Department of Health (1997:107) stipulates that “services for the diagnosis, management and counselling of HIV/AIDS and STD patients will be available at all health centres for females and males” (see page 116).

Cross-tabulation between HIV/AIDS counselling and the age of the adolescent (item 1.2), revealed that the older adolescent received counselling more often than the younger adolescent. Of the 36.0 percent (7) respondents who indicated that they had received HIV/AIDS counselling 85.7 (6) were in the older age bracket.

This could be attributed to the fact that older adolescents are more sexually active, chances are they have been permissive and are aware of the possibility of contracting HIV and AIDS.

Significance of this finding is that adolescents should receive age-related, sensitive HIV/AIDS education from their pre-school years to prevent exposure before they indulge in sexual intercourse.

• Maternity services (n = 196)

This item was included to establish how many respondents were pregnant or had already given birth to a baby. It is apparent from the responses that 16.8 percent (33) revealed that they had received maternity services. It is somewhat disquietening that despite the fact that
contraceptives and ECPs are given free of charge at public institutions, some adolescents still fall pregnant. If adolescents are to become leaders of tomorrow, they should concentrate on developing themselves academically to be able to function successfully in the new millennium.

Teenage pregnancy presents problems both for the mother and baby. Adolescent girls run a higher risk of complications related to pregnancy, labour, puerperium and abortion than women in their twenties and early thirties. The risk is higher for their infants as well. To compound this problem the spread of HIV and AIDS is also on the increase (Boult 1991:16; De Visser & Le Roux 1996:98; Jejeebyoy 1998:1282; Smith & Maurer 1995:591; World’s Youth 1996:no page; Van Coeverden De Groot 1991:1380-1381; Van Coeverden De Groot & Greathead 1991:1372; Woodward 1995:210). Boult (1991:16) cites Blum and Goldhagen (1981:338) who see teenage pregnancy as “a syndrome of failure, failure to fulfil the functions of adolescence, failure to remain at school, failure to limit family size, failure to establish a vocation and become self-supporting and failure to have children who reach their potential in life”.

Bam (1994:1) cites Ferguson (1987:211) who agrees that adolescents are parents of tomorrow and their health is a prerequisite of the health of their families and generations to come. Moreover the behavioural patterns and attitudes which they developed during adolescence will influence their capacity to guide their own children. However, if they have children before they are sufficiently mature they jeopardise their own health and well-being as well as their children’s health.

Of the 196 respondents who answered the question 83.2 percent (163) reported that they had not received maternity services at the ARHS because they did not need them.
Item 2.12: Suggestions given by the adolescents to improve services provided at ARHS in Gauteng Province

In this item, an open-ended follow-up question to item 2.11 was asked to determine suggestions for improvements to services provided at the ARHS. Respondents could give more than one suggestion.

Table 4.8 reveals the suggestions made by the respondents to improve service.

Table 4.8: Suggestions given by the adolescents to improve the services provided at ARHS in Gauteng Province

<table>
<thead>
<tr>
<th>Suggestions given by adolescents</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses to stop being rude and impatient towards adolescents and display positive attitude</td>
<td>150</td>
</tr>
<tr>
<td>Nurses to conduct home visits after the mother has delivered a baby</td>
<td>30</td>
</tr>
<tr>
<td>Clinics that have antenatal care should also offer labouring facilities</td>
<td>15</td>
</tr>
<tr>
<td>Clinics to be kept clean at all times and have heaters</td>
<td>30</td>
</tr>
<tr>
<td>Food to be served to clients</td>
<td>30</td>
</tr>
<tr>
<td>The number of nurses and doctors working at the clinics to be increased</td>
<td>100</td>
</tr>
</tbody>
</table>

It is apparent that 150 respondents would want nurses to stop being rude and treat them with dignity and respect. Surprisingly 30 would prefer nurses to conduct home visits after delivery. This practice is no longer possible due to the crime situation prevailing in the townships. Notably 15 of the respondents indicated that they would wish their babies to be delivered at the same place where they have been attending antenatal clinics. This could be an indication that respondents hate travelling to faraway places which is unknown to them or it could be that they are quite happy with the service received.

Respondents (30) want the clinic to be kept clean and food to be served whilst waiting for service. The budgetary constraints may inhibit the possibility of food being served at the
clinics, but the clinic should be kept clean at all times. The majority of the respondents (100) want the staff establishment at the clinics to be increased. This could be attributable to the fact that adolescents hate to wait for services.

Item 3.5: Information on dates for return visits given to adolescents attending ARHS in Gauteng Province (n = 200)

One of the most vital aspects of the provision of reproductive health services to adolescents is a ARHS capacity not only to attract adolescents to attend in the first place, but also to ensure that they make properly scheduled return visits (Namerow et al 1983:172).

The findings revealed that 83,5 percent (167) of the respondents were told when to come back for another visit, although 15,0 percent (30) were not told. Respondents attended the ARHS to receive various services. Some of the services require that the adolescent should come back for continuation purposes in terms of treatment or in the event that the adolescent experiences problems. Some adolescents could be referred to other services. It is encouraging to note that most respondents were told when to come back.

Increasing service use may require that a follow-up is done to ensure that the respondents needs have been met and to assist the adolescent in establishing a pattern of consistent use of services over time (World’s Youth 1996:no page).

4.7 SECTION 4: INFORMATION AND COUNSELLING RECEIVED BY THE ADOLESCENT ATTENDING ARHS IN GAUTENG PROVINCE

Item 2.6: Health procedures received by the adolescent during the first visit to the ARHS in Gauteng Province (n = 201)

Respondents who indicated that they received a health procedure were 54,7 percent (110), whilst 45,3 percent (91) indicated that they did not receive any health procedure during the first visit.
According to item 3.2, the majority of respondents indicated that they visit the ARHS to receive contraceptives. The fact that adolescents did not undergo a health procedure during the first visit is in contrast with the Department of Health policy guidelines for South Africa which stipulates that service users should be examined before treatment, for example when prescribing contraceptive methods (South Africa 1999a:69).

**Item 2.7: Explanation on health procedures received by the adolescent attending ARHS prior to the health procedure being performed (n = 108)**

In this item, a close-ended follow-up question to item 2.6 was asked to determine whether an explanation was given to the adolescent before a health procedure was carried out at the first visit. Although 64.8 percent (70) respondents received an explanation before the health procedure was performed 35.2 percent (38) received no explanation.

The adolescents have a right to know what procedure is to be performed on them and the rationale surrounding the procedure before being exposed to the procedure.

**Item 2.8: Explanation received by the adolescent on the outcome of a health procedure done at the ARHS in Gauteng Province (n = 105)**

Regarding explanation on the results of the health procedure done, 47.6 percent (50) respondents received an explanation, whilst 52.4 percent (55) received no explanation after the health procedure was completed.

The Centre for Adolescent, Health Royal Children's Hospital (1997:74) states that it is important to realise that "adolescents have a focus on body, image and are preoccupied about normality. Explaining procedure as you go along and commenting on normality are vital strategies to reassure the adolescent, but warns that negative findings should be communicated in a sensitive and straightforward simple manner". 
According to the Constitutional Assembly (1996: 12), Department of Health and National Health Bill health care providers must inform service users of their health status. This includes full information on procedures to be done and their outcome (South Africa 1996: 10; South Africa 1999a: 12).

**Item 3.1: Health educational material taken home by the adolescent attending ARHS in Gauteng Province (n = 202)**

It was alarming to note that 67.3 (136) of the respondents on the day they were interviewed, indicated that they did not take any educational material home to read. This could be attributed to the fact that ARHS keep the same educational material for some time and that 97.0 percent (197) of these respondents had used the ARHS three or more times since 1998 (item 2.1). Surprisingly 32.7 percent (66) of the respondents indicated that they had received and/or taken educational material home to read. This finding is disturbing when one looks at item 1.5, page 9 which indicated that 80.8 percent of the respondents were students. This material would be of great value to them.

**Item 3.2: Health educational content of the material taken home to read by the adolescent visiting ARHS in Gauteng Province**

This was a close-ended follow-up question to determine the educational content of the material taken home to read by the adolescent. A list of nine subjects from which to choose one or more response and an opportunity to add subjects that were not reflected on the list was given to respondents (table 4.9).
Table 4.9: Health educational content of the material taken home to read by the adolescent attending the ARHS in Gauteng Province

More than one response was possible.

<table>
<thead>
<tr>
<th>Subject of health educational material</th>
<th>n</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>f</td>
<td>%</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>60</td>
<td>25</td>
<td>41,7</td>
</tr>
<tr>
<td>Emergency contraceptive pills</td>
<td>55</td>
<td>5</td>
<td>9,1</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>58</td>
<td>25</td>
<td>43,1</td>
</tr>
<tr>
<td>STDs</td>
<td>56</td>
<td>10</td>
<td>17,9</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>59</td>
<td>15</td>
<td>25,4</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>54</td>
<td>6</td>
<td>11,1</td>
</tr>
<tr>
<td>Gender issues</td>
<td>55</td>
<td>2</td>
<td>3,6</td>
</tr>
<tr>
<td>Decision-making</td>
<td>55</td>
<td>3</td>
<td>5,5</td>
</tr>
<tr>
<td>Money generating scheme</td>
<td>52</td>
<td>2</td>
<td>3,8</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>9</td>
<td>81,8</td>
</tr>
</tbody>
</table>

Table 4.9 indicates the respondents that had taken home educational material to read. According to the results as shown in table 4.9 the educational content of the material which the adolescents visiting ARHS in Gauteng Province took home flyers on the following subjects:

- Contraceptives (n = 60)

Out of the 60 respondents who answered this question, 41,7 percent (25) indicated having received educational material, while 58,3 percent (35) were not exposed to educational material on contraceptives.

Several researchers have alluded to the fact that contraceptive use is sporadic amongst adolescents (Felton 1996:223; Keller 1997:26; Keller et al 1996:125; Woodward 1995:210).
It is apparent that adolescents have no valid information on how contraceptives work. Adolescents need accurate information on contraceptives to be able to make an informed choice on the contraceptive method of choice. Felton (1996:224) highlights the fact that contraceptive use requires having appropriate information and the cognitive and behavioural skills to use the information accordingly.

In a study conducted by Abdool Karim et al (1992:358) when teenage field workers asked for instructions on how to wear a condom most service providers provided an explanatory pamphlet with minimal or no additional verbal health education. When the teenage field workers asked for verbal health education service providers appeared uncomfortable.

A study conducted by Buga et al (1996b:525) in Rural Transkei illustrated the following reasons given by 554 sexually experienced noncontraceptive users. Reasons cited were as follows: ignorance of contraceptives (33.7 percent), no need because no current boyfriend (23.3 percent), no particular reason (15.3 percent), fear of parents finding out (13.9 percent), shy of going to a family planning clinic.

The significance of this finding is that educational material should be accompanied by health education talks/demonstrations (or vice versa).

- Emergency contraceptive pills (ECPs) (n = 55)

It is disturbing to note that only 9.1 percent (5) respondents indicated that they had received educational material on ECPs, whilst 90.9 percent (50) received no literature on ECPs. This finding is in contrast with the Department of Health’s policy which maintains that extensive promotion of ECPs should be conducted to all service users capable of falling pregnant (females) so as to prevent unwanted pregnancies and TOP (South Africa 1999a:66). These findings also coincide with the findings on emergency contraceptives given in item 2.5 (page 123).
• HIV/AIDS (n = 58)

The findings in table 4.9 reveal that 43.1 percent (25) of the 58 respondents received educational material on HIV and AIDS. The majority of respondents 56.9 percent (33) had not taken any educational material on HIV/AIDS home to read. The implication of this finding is causing grave concern since the spread of HIV/AIDS is high amongst the adolescents and since there is no cure, the only way of stopping the epidemic is by prevention. The adolescents should continuously read about HIV/AIDS to understand the reality of the situation, particularly in terms of their vulnerability and the need for sensitive and responsive educational messages on HIV/AIDS (WHO 1995:5). ARHS should provide this information to adolescents so that they can take the necessary precautionary actions.

• Sexually transmitted diseases (STDs) (n = 56)

Table 4.9 shows that 17.9 percent (10) of the respondents indicated that they had received information on STDs, however, 82.1 percent (46) indicated that they had not received information on STDs. This is a cause for concern because frequent exposure to STDs predisposes the individual to HIV/AIDS (Kurth 1998:164). Adolescents need to receive information and prevention strategies to avoid contracting STDs.

• Pregnancy (n = 59)

Table 4.9 shows that 25.4 percent (15) of the respondents received educational material on pregnancy, however, 74.6 percent (44) did not receive any educational material on pregnancy. According to item 2.3, the majority of respondents indicated that they would use the ARHS again in Gauteng Province to prevent pregnancy. One would then expect them to receive educational material on pregnancy in terms of prevention or what to do in the event that they fell pregnant.
• Sexual abuse (n = 54)

Only 11.1 percent (6) of the respondents indicated that they had received information on sexual abuse. These findings are worrying as the media frequently report on the gravity of sexual abuse amongst women and children in the country. Magagula (1998:99) cited The Sowetan (1977:1) which gave a shocking report on 15 children aged between 9 and 15 years who were allegedly raped by a farmer in Tzaneen. This indicates the urgent need at a younger age to broaden the content of sexuality education related to life skills, at the ARHS, in schools and in homes, to include sexual abuse.

• Gender issues (n = 55)

Gender issues was one of the areas in which the least educational material had been received by the adolescents visiting ARHS in Gauteng Province. Only 3.6 percent (2) of the respondents received educational material on gender issues. The majority of respondents 96.4 percent (53) had not received any educational material on gender issues.

• Decision-making (n = 55)

Table 4.9 shows that only 5.5 percent (3) of the respondents had received educational material on decision-making. Cognisance should be taken of the fact that adolescents have to make several decisions which may impact positively or negatively on their reproductive health, for example, to indulge in safe sex or not, negotiating contraceptive use and whether to carry pregnancy to term or terminate it (Family Health International 1997:25) It is discouraging to note that 94.5 percent (52) had not received any educational material on decision-making.

• Money generating schemes (n = 52)

Money generating schemes were another important area in which minimal educational material had been received by the adolescent visiting ARHS in Gauteng Province. Only 3.8
percent (2) of the respondents indicated having received educational material on money generating schemes. The researcher asked this question because most of the adolescents are still attending school. These adolescents for example, need money to commute to the ARHS or to purchase snacks whilst at the ARHS. The adolescents may also be tempted to indulge in sexual intercourse with older men for monetary favours.

- Other (n = 11)

Of the 16.7 percent (11) respondents 81.8 percent (9) revealed that they had received educational material on menstruation, nutrition of the baby and hygiene.

Item 3.3: Health education given to adolescents visiting ARHS in Gauteng Province (n = 76)

Surprisingly 37.4 percent (76) respondents indicated that they had received a health talk, whilst the majority 62.6 percent (127) were not exposed to any health talks. This is disturbing because there is a great need for ensuring that adolescents have access to appropriate information about reproductive health issues if they are to maintain a good reproductive health status and make appropriate informed choices (De Haeck 1995:23; WHO 1995:5).

The provision of information, guidance and support to enable people to have a healthy, safe and fulfilled sexuality is a responsibility the health care systems shares with families, other sectors and institutions (Constitutional Assembly 1996:12; South Africa 1997a:106; South Africa 1999a:44; WHO 1995:5).

Item 3.4: Health education topics given to adolescents attending the ARHS in Gauteng Province

A follow-up close-ended question was asked to determine the health education topics given to respondents by service providers. Respondents were given nine topics to choose from
including an option for "other". Depth of information was not determined. Table 4.10 shows the number of adolescents who received a given health talk.

Table 4.10: Health education topics given to adolescents attending the ARHS in Gauteng Province

More than one topic could be selected.

<table>
<thead>
<tr>
<th>Health talk topics</th>
<th>n</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td>%</td>
<td>f</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>72</td>
<td>20</td>
<td>52</td>
</tr>
<tr>
<td>Emergency contraceptive pills</td>
<td>69</td>
<td>5</td>
<td>64</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>70</td>
<td>22</td>
<td>48</td>
</tr>
<tr>
<td>STDs</td>
<td>69</td>
<td>14</td>
<td>55</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>72</td>
<td>18</td>
<td>54</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>69</td>
<td>11</td>
<td>58</td>
</tr>
<tr>
<td>Gender issues</td>
<td>69</td>
<td>2</td>
<td>67</td>
</tr>
<tr>
<td>Decision-making</td>
<td>69</td>
<td>3</td>
<td>66</td>
</tr>
<tr>
<td>Money making scheme</td>
<td>65</td>
<td>6</td>
<td>59</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>23</td>
<td>2</td>
</tr>
</tbody>
</table>

The findings reflected in table 4.10 illustrate the health talk topics given by the adolescents attending ARHS in Gauteng Province as follows:

- **Contraceptives (n = 72)**

Only 27,8 percent (20) respondents received a health talk on contraceptives, whilst 72,2 percent (52) did not receive any health talk. This is disturbing when you consider that item 2.5 indicated that the majority 164 of the respondents received contraceptives at ARHS in Gauteng Province. They need access to accurate information on contraceptives if they are
to use them correctly, consistently and make informed voluntary choices.

Family Health International (1997:37) maintains “that adolescents lack accurate information about contraceptives and tend to rely on unreliable sources which overwhelm them with myths and misconception. They may not use methods consistently and correctly and tend to have sporadic and unplanned sexual activity which tends to be unprotected”.

Webb (1998:2) concurs by stating “that adolescents initiate sexual activity with minimal knowledge and use of contraceptives”. The significance of this finding is that providers should consider giving adequate two-way health education to adolescents on contraceptives to enable them to make informed voluntary choices on the best contraceptive method available.

Van Coeverden De Groot and Greathead (1991:1372) highlight the reasons given as to why contraceptives were not used.

- seldom admit that they are sexually active
- seldom plan to have sexual intercourse
- feel uncomfortable or even afraid to attend a FP, enjoy leading a risky lifestyle
- believe they are too young to fall pregnant, feel that contraceptives takes away the romance, are afraid parents may discover the contraceptives
- have religious or moral objections to contraception
- sometimes want to fall pregnant

- Emergency contraceptive pills (ECPs) (n = 69)

Amazingly it can be seen from table 4.10, that only 7.2 percent (5) of the respondents received health talk on ECPs whilst 92.8 percent (64) received no education at all. It is a cause for concern since adolescents tend to have unprotected sexual intercourse (Buga et al1996b:525; Family Health International 1997:37).
Family Health International (1997:37, 48) and Hadley (1990:16) indicate that adolescents lack knowledge about and access to emergency contraception which must be used within 72 hours of a single episode of unprotected sexual intercourse. Emergency contraception is particularly valuable to adolescents because they may have unprotected sex for various reasons including neglecting to use a barrier method with each act of sexual intercourse, unexpected sex with no contraceptives available, using a contraceptive method incorrectly, condom breakage, slippage or rape. Hadley (1990:16) asserts that ECPs offer a chance of preventing unplanned pregnancy while bringing the adolescent into contact with a service to discuss a suitable contraceptive method.

The emergency contraceptive method should be readily available for every woman at risk of coitus and widely publicised before it can reduce the number of unwanted pregnancies and TOPs (Hadley 1990:16; Van Coeverden De Groot and Greathead 1991:1369). The Department of Health maintains that "extensive promotion of ECPs as a safe and effective method with few contraindications is to be used for episodes of failed contraception or unprotected sexual intercourse" (South Africa 1999a:66).

- HIV/AIDS (n = 70)

As depicted in table 4.9, 31.4 percent (22) of the respondents reported that they received health education on HIV/AIDS. The overwhelming majority of respondents, 68.6 percent (48) had not received health education on HIV/AIDS.


In South Africa, the National HIV survey conducted among females attending public antenatal clinics found the prevalence of positive HIV among pregnant teenagers to be 9.5
percent (Wood et al 1998:233 cites Swanavelder 1996). The 1998 national antenatal sero-prevalence survey revealed that HIV prevalence among South African women under the age of 20 years was 21.0 percent (Dickson-Tetteh et al 1999:1). This is close to double the 1997 figures of 12.7 percent and by far the largest increase in any age group.

A number of authors maintain that females are more susceptible to contracting HIV from infected males than vice versa (Burst 1998:431, 433; Family Health International 1997:16; World's Youth 1996:no page; WHO 1995:4; Zabin & Hayward 1993:59 cite Althaus 1991).

Item 1.1 indicated that the majority of the respondents, 99.5 percent (202) were females, who are more susceptible to AIDS. Improving the sexual health of adolescents in South Africa is a major challenge for all those involved in health promotion, policy-making and research (Wood et al 1998:233).

The Department of Health is committed to developing health promotion activities which will promote healthy behaviour to prevent STDs and HIV transmission (South Africa 1997a:15). Family Health International (1997:16) asserts that "the rate of HIV infection among adolescents is detrimental to the larger society, weakening the workforce and reducing the number of future leaders and the social fabric of a country".

The findings of this study are in accordance with Abdool Karim's et al (1992:358) study where out of the 48 visits to clinics by teenage field workers only one clinic initiated discussion on the issue of AIDS. The killer disease, AIDS, is an incurable disease but preventable through safe sex. The significance of this study indicates the need for service providers to emphasise dual promotion strategies every time they have an encounter with the adolescent (ie methods that can serve two purposes, preventing pregnancy and STDs/HIV/AIDS, for example condoms or condoms with another contraceptive method that prevents pregnancy only).
Sexually transmitted diseases (STDs) (n = 69)

Only 20.3 percent (14) of the respondents received health education on STDs whilst an overwhelming majority of the respondents 79.7 percent (55) did not receive any health education on STDs.

There is a general paucity of knowledge amongst adolescents with regard to STDs and their prevention. They also face major barriers in relation to accessing the ARHS that help them reduce their exposure to STDs. They also are unable to negotiate safe sex practices (Dickson-Tetteh et al 1999:1) Many do not seek treatment or they try to treat themselves first and later seek treatment at the clinic (Family Health International 1997:15).

To indicate the gravity of this situation Keller et al (1996:126) cite Grant and Demetriou (1988) who maintain that “the physiological urge for sexual activity accompanied by a sense of invulnerability to harm, causes adolescents to believe that STDs, pregnancy and other negative implications will not happen to them”.

According to Dickson-Tetteh et al (1999:1) “adolescents have indicated that they need information on issues such as STDs”. This tallies with a study conducted by Kunene (1995:50) where 89.0 percent of the boys highlighted the advantages of health information on dangers of sexual relations with multiple partners.

Contrary to popular belief, knowledge about transmission of STDs, does not predict consistent safer sex practices. Several researchers have highlighted that adolescents with in-depth knowledge about STDs/HIV continue to practise unsafe sex (Keller et al 1996:125).

Pregnancy (n = 72)

Adolescent pregnancy is labelled by the AGI as “the problem that has not gone away, it appears as perplexing now as a decade ago” (Moore 1987:43).
Several researchers have alluded to the fact that teenage pregnancy is a universal problem that has concerned both general society and the medical community (Aten et al 1996:258; Buga et al 1996a:95; Goldberg 1997:9; Keller 1997:27; Magwentshu 1990:5; Sapire 1986:418, 422; Smith & Maurer 1995:581; Van Coeverden De Groot 1991:1379).

Nationally the adolescent pregnancy rate is estimated to be 330 per 1,000 women under 19 years of age (Wood et al 1998 cites RSA 1995). It is estimated that South Africa has one of the highest teenage pregnancy rates in the world (Equipping our youth for life 1994:14).

The International Governmental organisation has recommended a programme aimed at reducing adolescent pregnancy and improving the health care of adolescents which includes the following: health education for men and women that includes information on sexuality and responsible sexual behaviour to prevent pregnancy and STDs (Klima 1998:489).

Table 4.10 shows that only 25.0 percent (18) of the respondents received health education on pregnancy whilst 75.0 percent (54) did not receive health education on pregnancy. This is disturbing because in item 2.3, 50.5 percent (95) of the adolescents indicated that they attend ARHS to prevent pregnancy. The researcher assumes that to meet these needs, they should have, together with other subjects, been given information on sexuality and reproduction in accordance with the proposals of the Department of Health (South Africa 1997a:106).

In a study conducted by Ntombela (1992:88-90) on the perception of pregnancy among the black primigravida teenagers in the Umlazi area of KwaZulu-Natal, the findings revealed that pregnant teenagers expected the following services from health personnel: “looking after them, teaching them, teaching them about the prevention of pregnancy and giving them advice with regard to the use of contraceptives”.

The Ministry for Welfare and Population Development further maintains that “prevention of high risk teenage pregnancy can be promoted through the provision of inter alia gender sensitive education” (South Africa 1997c:9). The significance of this finding is that service
providers should give sexuality education to adolescents to prevent unwanted pregnancy and information on how the process of reproduction works.

- **Sexual abuse (n = 69)**

  Sexual abuse as revealed in table 4.10, indicates that 84.1 percent (58) of the respondents had not received health education on sexual abuse. It was disheartening to observe that only 15.9 percent (11) received education on sexual abuse. There is an increasing awareness of the magnitude of the problem of sexual abuse. A study conducted in Kingston, Jamaica found that 17.0 percent of randomly selected primary school girls between the ages of 13 and 14 reported having experienced an attempted or actual rape (WHO 1998b:2).

  This study concurs with a national study conducted in Kenya which surveyed 10,000 secondary school girls aged 12 to 24 years and found that about 40.0 percent of those who were sexually active said they had been forced into indulging in sexual intercourse (WHO 1998b:2). Few (1997:617) cites Clare et al (1990) who found that out of the 56 girls they surveyed, 23.0 percent reported initial sexual intercourse before the age of 11 due to abuse.

  According to Magagula’s (1998:75) finding in the Western District of the Vaal Region 22.1 percent (17) of the 77 respondents reported that they were forced to have sex by partners. Notably only 1.3 percent (1) stated clearly that she was raped. The results were consistent with Maforah et al’s findings cited by Wood et al (1998:239) whereby 31.0 percent of pregnant and 18.0 of nonpregnant teenagers said they were forced to have sexual intercourse the first time. In addition 71.0 percent of pregnant teenagers and 60.0 percent of nonpregnant teenagers reported having had sex against their will, with 11.0 percent of the pregnant and 9.0 percent of the nonpregnant teenagers indicating in response to a direct question that they had been raped.

  The above study concurs with one conducted by Buga et al (1996b:526) amongst school girls in Transkei, where one quarter of the girls experienced their first act of coitus under duress. This demonstrates the position of girls in male-dominated rural Transkeian community.
Generally girls have little bargaining power. It is thus the responsibility of the ARHS, families, communities and other institutions to educate the community, especially vulnerable groups for example, adolescents about sexual abuse. Information should be provided as to where they can go for information and assistance regarding sexual abuse (Johnson 1995:12).

- Gender issues (n = 69)

Gender affects the expectations society has regarding the sexual behaviour of boys and girls (Family Health International 1997:28). Boys initiate sexual activity at a younger age, are more sexually experienced and active and have multiple sexual partners (Buga et al 1996b:526). Adolescent boys indulge in sexual intercourse because they are afraid of being branded by their peers whilst girls fear losing their boyfriends (Preston-Whyte & Zondi 1991:1390).

Gender also affects the cultural acceptance of practices such as sexual abuse or FGM, as well as responsibility for contraception and unplanned pregnancy. Incorporating gender into reproductive health programmes for youth can be an opportunity to emphasise shared responsibility between young men and women (Family Health International 1997:28-29). Including male adolescents in various reproductive health discussions and education can lead to a lifelong involvement in reproductive health issues. The findings illustrated in table 4.9 indicate that only 2.9 percent (2) of the respondents received education on gender issues, 97.1 percent (67) did not receive any health education on gender issues.

- Decision-making (n = 69)

This item was included to elicit how the ARHS in Gauteng Province prepare adolescents to make decisions. The adolescence period involves amongst other things having to make sexual decisions, which include intimate touching versus none, sexual intercourse versus abstinence, contraception versus no contraception, marriage versus singlehood, abortion versus childbearing, placing the child up for adoption or abandoning it. Choices made, reflect the way adolescents think (cognitive development) as well as what they think about
themselves, their (self) identity (Johnson 1995:12).

The findings presented in table 4.10 suggest that adolescents do not receive health education on decision-making. Only 4.3 percent (3) of the respondents indicated that they had received education on decision-making, whilst 97.0 percent (66) had not received health education on decision-making.

Buga et al (1996b:526) indicated that “adolescents are forced into indulging in sexual intercourse against their will”. This illustrates the position of girls in a male-dominated society. Girls have little bargaining power. Adolescents must be taught decision-making skills to counteract all pressures levelled against them. Decisions taken to report to the police any form of sexual abuse is also important.

Webb (1998:37) maintains that “the adolescents’ ability to make informed decisions will be essential for them, and their families, communities, nations and the world. The investment we make now and over the subsequent ten years determines the quality of life for subsequent generations to come”.

- Money generating scheme (n = 65)

As illustrated in table 4.10 only 9.2 percent (6) received health education on money generating schemes, whilst 90.8 percent (59) had not received any health education. Expanding money generating opportunities for adolescent girls assists them in improving their ability to provide for their own needs as well as that of their families (WHO 1998b:3).

In South Africa, many older men use their financial and community status to procure adolescents as sexual partners (Jewkes et al 1997:417). This exercise places the adolescent in danger of contracting STD, HIV/AIDS, unwanted pregnancy and other reproductive illnesses. The researcher is of the opinion that if adolescents can generate their own income (no matter how small) they will not be tempted to indulge in premature sexual intercourse in favour for financial gain.
• Other (n = 25)

Of the 100.0 percent (25) respondents who answered this question, 92.0 percent (23) received health education on baby care, baby feeding and menstruation. These topics were relevant to the respondents because some of them were pregnant or had delivered babies.

Information and counselling needs to be available and accessible to help adolescents to delay sexual relationships until they are physically and psychological mature; to develop mutually responsible and satisfying relationships; to prevent unwanted pregnancy and make appropriate contraceptive choices; to reduce unsafe abortion; promote safe pregnancy and delivery and to prevent, treat and control STDs, HIV/AIDS.

4.8 SECTION 5: ADOLESCENT-FRIENDLY SERVICES

Item 2.9: Privacy provided for adolescents during a consultation at ARHS in Gauteng Province (n = 106)

Although 84.9 percent (90) of the respondents indicated that their privacy was considered, 15.1 percent (16) indicated that their privacy was compromised. The failure to respect the adolescent privacy is not in accordance with recommendations of the Centre for Adolescent Health Royal Children's Hospital (1997:40), the Department of Health and the National Health Bill which states that the privacy of the adolescent should be respected (South Africa 1996:10; South Africa 1999a:64).

Item 2.10: Privacy during health procedures for adolescents attending ARHS in Gauteng Province (n = 90)

This was a follow-up open-ended question to item 2.9 to determine whether privacy was considered during the health procedure of the 90 respondents who indicated that their privacy was considered. Of the respondents, 94.4 percent (85) indicated that during consultation the service provider closed the door and allowed nobody to come inside. This finding was
unexpected in view of the overcrowding at clinics in Gauteng Province.

**Item 2.11: Failure to consider privacy when health procedures were carried out for adolescents visiting ARHS in Gauteng Province** \[(n = 16)\]

This was a follow-up open-ended question to determine why privacy was not considered during a health procedure. Of the 16 respondents who answered this question, 18.7 percent (3) indicated that there were more than two people in a consultation room, whilst 6.2 percent (1) indicated that the consultation took place behind the door.

The findings concur with Abdool Karim et al.'s (1992:358) findings which indicated that the teenage field workers did not receive condoms in the private rooms available. In some instances, the partitions did not reach the ceiling so that private information could be heard in the waiting rooms. In other situations, the door was not shut when condom use was demonstrated to them. The apparent lack of privacy inhibits questions especially when asked within the hearing of the opposite sex.

Adolescents should be seen alone and confidentiality should be introduced (Centre for Adolescent Health, Royal Children’s Hospital 1997:40). Zabin and Hayward (1993:7) maintain that "confidentiality is the sine quanoni of teen services". Thus adolescents will not open up if their privacy is not respected. They feel that an imaginary audience is watching and they do not want to give themselves away.

**Item 4.6: Entertainment preferred by the adolescents attending ARHS in Gauteng Province**

The creation of a conducive environment is seen as an attribute that could be made by service providers in consultation with adolescents to ensure adolescents' satisfaction. In table 4.11 the responses of adolescents are given in relation to four entertainment possibilities plus an option to give their own preference.
Table 4.11: Entertainment preferred by the adolescents attending ARHS in Gauteng Province (n = 201)

<table>
<thead>
<tr>
<th>Entertainment preferred</th>
<th>n</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td>%</td>
<td>f</td>
</tr>
<tr>
<td>Music</td>
<td>173</td>
<td>88</td>
<td>85</td>
</tr>
<tr>
<td>Videos</td>
<td>162</td>
<td>55</td>
<td>107</td>
</tr>
<tr>
<td>Television</td>
<td>163</td>
<td>53</td>
<td>110</td>
</tr>
<tr>
<td>Indoor games</td>
<td>158</td>
<td>16</td>
<td>142</td>
</tr>
<tr>
<td>Other (preferred quietness)</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

More than one answer was possible for this question.

The majority of the respondents, 50.9 percent (80) preferred music to be played in the waiting areas. 34.0 percent (55) videos, 32.5 percent (53) television and 10.1 percent (16) indoor games. These preferences concur with the ACT clinic set up in Staffordshire which had a friendly relaxed atmosphere, created by a suitable background, music and posters, especially directed at young people (Cook 1993:29).

According to the findings illustrated in table 4.11 only 1.5 percent (3) of the adolescents reported that they would not prefer any entertainment in the waiting area. These findings are significant in that adolescent entertainment needs should be met. The waiting area could be made to have a friendly environment by playing background music to calm adolescents who have to wait for a very long time. Adolescents who preferred no entertainment could be placed in a suitable quiet environment until they are ready to be seen (Centre for Adolescent, Health Royal Children's Hospital 1997:40).

Item 4.7: Preferred age group for the health care providers at ARHS in Gauteng Province (n = 201)

Table 4.12 indicates the views of the adolescents regarding the preferred age group of the
health care providers. Five age groups were given and respondents were asked to indicate which one they preferred plus an option to give any other age group.

Table 4.12: Preferred age group for the health care provider at ARHS in Gauteng Province (n = 201)

<table>
<thead>
<tr>
<th>Age group of health care provider</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-22 years</td>
<td>76</td>
<td>37.8</td>
</tr>
<tr>
<td>23-27 years</td>
<td>35</td>
<td>17.4</td>
</tr>
<tr>
<td>28-32 years</td>
<td>36</td>
<td>17.9</td>
</tr>
<tr>
<td>32 years and older</td>
<td>33</td>
<td>16.4</td>
</tr>
<tr>
<td>Any age group</td>
<td>19</td>
<td>9.5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>201</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The majority of the respondents, 37.8 percent (76) indicated that they preferred the age group of the health care provider to be between 18 and 22 years. A study conducted by Solombela (1999:11, 118) on development of interpersonal relationships of student nurses in the Eastern Cape Region of the Republic of South Africa revealed that 35.0 percent of the first-year students who participated in the study were between 19 to 21 years and 65.0 percent were 22 years and above. Twelve percent of the fourth-year students who participated in the study were between 19 to 21 years, 87.0 percent were 22 years and above.

The results of the above study concurs with a study conducted by Manzini (1998:243) on student drop-out rates in the Northern Province which revealed that although student nurses started their training at different ages, 47.5 percent started between the ages 18, 19 and 20 years which is the average age at which pupils complete their Grade 12 (Standard 10). From this information it is highly unlikely that service providers working in the clinic could be between age 18 to 22 years.
Notably 17.4 percent (35) of the respondents preferred the age group 23 to 27 years, 17.9 percent (36) the age group 28 to 32 years, 16.4 percent (33) the age group 32 years and older, whilst 9.5 percent (19) preferred any age group. Only 1.0 percent (2) preferred the age group below 18 years of age.

Item 4.8: Reasons given by adolescents for the preferred age group of the health care provider (n = 147)

This was a follow-up open-ended question to determine the reasons for the preferred age groups. In the researcher's view these findings are of considerable interest, particularly in the age group 18 to 22 years as these nurses would in most instances be newly qualified and would probably lack practical experiences. Of the respondents, 37.8 percent (76) who preferred the age group 18 years to 22 years indicated that they were in the same age group and hence understood the needs of the adolescent which facilitated communication with the adolescents. These respondents indicated that they did not prefer the older age group because they were mostly adults with children and that they lectured them. This finding concurs with Finger (1997:23) who maintains that "health care providers who are mostly adults may have personal or religious views about sexuality that influence how they assist the youth". The respondents, 17.4 percent (35) who preferred the age group 23 to 27 years indicated that because they were not so young, they understood how to deal with adolescents where as those between 18 years to 22 years were impatient, uncaring and inexperienced. Those respondents 17.9 percent (36) who preferred the 28 years and older age group stated that they had experience about life as a whole and that when dealing with adolescents they were patient, caring, understanding and respected adolescents.

Item 4.9: The adolescent's preferred gender (sex) of the health care provider in ARHS in Gauteng Province (n = 202)

The respondents were asked whether the sex of the health care provider is of importance to them when receiving reproductive health care. Figure 4.12 shows the adolescents gender preference.
Significantly 63.9 percent (129) of the respondents preferred female health care providers. It was of interest to note that 7.4 percent (15) indicated that they would prefer males, whilst 28.7 percent (58) indicated that it did not matter.

**Item 4.10: Reasons given by adolescents for the preferred gender of the health care provider at ARHS in Gauteng Province**

According to Abouzahr et al (1996:456) "females may be unhappy to be examined by males or may be unwilling to report their problems and needs". Sometimes females are prevented by religious or cultural consideration to be examined by male health care providers.

A follow-up open-ended question was asked to elicit information as to why preference was given for a gender (sex). Those who preferred women, 63.9 percent (129) felt that they were the same sex and would understand their needs and felt safe under their care. They further indicated that men are untrustworthy and can rape them. Those who said it doesn't matter,
28,7 percent (58) said that because they had all undergone training it would depend on the individual’s characteristics. Those who preferred males, 7,4 percent (15) said males were gentle, caring and not jealous.

When a cross tabulation was done between preferred gender of provider and gender of adolescent, the findings revealed that 0,5 percent (1) male preferred to be attended to by a male service provider. As expected the majority of female respondents, 63,9 percent (129) indicated that they preferred female service providers.

The significance of this finding is that ARHS should be manned by both female and male health care providers in the age group 18 to 22 years displaying a caring ethos and are non-judgemental, patient and experienced, if they are to adequately serve and retain both males and female adolescents at the ARHS in Gauteng Province.
Item 4.11: The adolescent’s preferred dress code for the health care provider at ARHS in Gauteng Province (n = 201)

Figure 4.13

The adolescent’s preferred dress code for the health care provider at ARHS in Gauteng Province (n = 201)

Figure 4.13 shows that contrary to popular belief the majority of adolescents, 83.6 percent (168) preferred service providers to wear a uniform whilst on duty. The researcher is of the opinion that a uniform reassures the adolescent that the person attending them is an official service provider and not an untrained person. The other possibility is that a uniform is associated with status.
Item 4.13: Rating by the adolescent of each health care provider at the ARHS in Gauteng Province

Respondents were given five concepts by which to judge the health care providers at the ARHS in Gauteng Province. They were asked to rate each service provider on a scale from 1 to 5 with an option for “not applicable”.

1 = friendly
2 = unfriendly
3 = judgemental
4 = knowledgeable
5 = certain
6 = not applicable

English (1998:273) asserts that “adolescents are most likely to seek care when they can do so from providers who have interest, experience and expertise in caring for them”.
Table 4.13: Rating by the adolescent of each health care provider at the ARHIS in Gauteng Province

<table>
<thead>
<tr>
<th>Scale</th>
<th>Receptionist (n = 187)</th>
<th>Nurse (n = 201)</th>
<th>Counsellor (n = 188)</th>
<th>Clerk (n = 190)</th>
<th>Doctor (n = 195)</th>
<th>Other staff (n = 35)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f</td>
<td>%</td>
<td>f</td>
<td>%</td>
<td>f</td>
<td>%</td>
</tr>
<tr>
<td>Friendly</td>
<td>71</td>
<td>38,0</td>
<td>160</td>
<td>79,6</td>
<td>6</td>
<td>3,2</td>
</tr>
<tr>
<td>Unfriendly</td>
<td>14</td>
<td>7,5</td>
<td>27</td>
<td>13,4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judgemental</td>
<td>1</td>
<td>0,5</td>
<td>4</td>
<td>2,0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledgeable</td>
<td>1</td>
<td>0,5</td>
<td>1</td>
<td>0,5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not certain</td>
<td>6</td>
<td>3,0</td>
<td></td>
<td></td>
<td>2</td>
<td>1,0</td>
</tr>
<tr>
<td>Not applicable</td>
<td>100</td>
<td>53,5</td>
<td>3</td>
<td>1,5</td>
<td>182</td>
<td>96,8</td>
</tr>
</tbody>
</table>
The receptionist (n = 187)

The receptionist needs to be friendly, well-trained and one who understand the adolescent (Centre for Adolescent Health, Royal Children's Hospital 1997:34).

Table 4.13 shows that the receptionist was considered friendly by 38,0 percent (71) of the respondents, unfriendly by 7,5 percent (14), judgemental and knowledgeable respectively by 0,5 percent (1). The majority of the respondents, 53,5 percent (100) reported that it was not applicable.

The researcher is of the opinion that as receptionists are present in most of the ARHS, the adolescents may not have understood who the receptionist was.

The nurse (n = 201)

Table 4.13 shows that 79,6 percent (160) of the respondents reported the nurse to be friendly, 13,4 percent (27) unfriendly, 2,0 percent (4) judgemental and 0,5 percent (1) knowledgeable, 3,0 percent (6) not certain.

Contrary to popular belief the data from table 4.13 indicates that 79,6 percent (160) of nurses displayed friendly behaviour towards the adolescent using ARHS in Gauteng Province. The study does not seem to be consistent with WHO (1998c:2) report that "many consumers describe service providers as unkind, rude, brusque, unsympathetic and uncaring". Family Health International (1997:20) maintains that "providers are often judgemental about unmarried women who are pregnant regardless of the circumstances leading to pregnancy".

In a study conducted in the Northern Province by Wood et al (1997:26, 28) clinic nurses were described by adolescents as rude, arrogant and short tempered. Respondents reported that on requesting contraceptives they were harassed and scolded by nurses wanting to know why they were indulging in sexual intercourse so young and whether they had told their mothers that they were using contraceptives. (This was contrary to the fact that by law
teenagers over 14 can receive contraception). They said they were lectured by nurses and told that they were far too young to be indulging in sex.

The adolescents reported that scolding provoked feelings of shame, unhappiness and fear. Adolescents chose not to challenge nurses when they were scolded. Those clients who did resist had already decided to change clinics and stop going around with men.

Findings of a study conducted by Abdool Karim et al (1992:359) revealed that when she requested an explanation on how to use condoms. She was told to ask the boyfriend instead of the nurse and when she indicated that her boyfriend did not know how to wear them.

"The nurse told her to tell him to ask his other girlfriends".

In Gauteng Province, nurses in Pretoria Region harassed a "mystery client" requesting emergency contraceptive pills. This incident was televised. The nurses were said to be rude and disrespectful to the mystery client. The culprits were ultimately sacked from their jobs.

The nurses behaviour contradicted the policy of the Department of Public Service and Administration which requires that public servants are courteous when interacting with clients (customers) (South Africa 1997b:18).

Solombela (1999:212-213) revealed that first year student nurses claimed that student nurses must never perform their duties towards patients affectionately with warmth and care. Whilst fourth year student nurses revealed that it is a right to shout at patients who do not want to obey rules and regulations. These finding appear to indicate that the development of positive interrelationship might be a neglected area in the education curriculum for nurses.

- The counsellor (n = 188)

Notably the majority of respondents, 96.8 percent (182) indicated that it was not applicable to them. Apparently counsellors do not feature on the staff establishment of the various ARHS in Gauteng Province. This is a disturbing finding when one considers the overcrowding present in ARHS and the need of the adolescent to be counselled on many
developmental issues.

- The clerk ($n = 190$)

Table 4.13 illustrates that 95.8 percent (182) of the respondents indicated that they were not attended to by a clerk. However, 4.2 percent (8) of the respondents revealed that clerks were friendly.

- The doctor ($n = 195$)

An overwhelming majority, 84.6 percent (165) of the respondents indicated that they were never attended to by a doctor. This was an expected finding as doctors in general are not available in ARHS, because most of the PHC clinics are manned by registered or PHC nurses. The 13.8 percent (27) adolescents who were seen by a doctor indicated that the doctor was friendly, though 0.5 percent (1) viewed the doctor as unfriendly.

- Other staff ($n = 35$)

The "other" categories that were mentioned was the porter, cleaner and security personnel. Of the 35 respondents, 8.6 percent (3) regarded the other as friendly, 2.8 percent (1) regarded them as judgemental, 2.8 percent (1) felt they were knowledgeable and 85.7 percent (30) indicated that it was not applicable.

Item 4.18: The extent of knowledge adolescents had of other ARHS in Gauteng Province ($n = 199$)

The findings illustrated that the majority of respondents, 62.8 percent (125) indicated that they did know of other health services available in Gauteng Province, whilst 37.2 percent (74) indicated that they do not know of any other ARHS.
Item 4.19: Reasons given by adolescents for choosing a selected ARHS in Gauteng province

In an attempt to determine the reasons for choosing to attend the selected ARHS in Gauteng Province, respondents were asked to select or give responses in terms of the items listed in table 4.14 with an option for "other". More than one response was possible.

Table 4.14: Reasons given by adolescents for choosing to attend a selected ARHS in Gauteng Province

<table>
<thead>
<tr>
<th>Reasons for choosing the selected ARHS</th>
<th>n</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>f</td>
<td>%</td>
</tr>
<tr>
<td>Convenient opening times</td>
<td>193</td>
<td>15</td>
<td>7,8</td>
</tr>
<tr>
<td>Entertainment facilities</td>
<td>193</td>
<td>8</td>
<td>4,1</td>
</tr>
<tr>
<td>Good quality service</td>
<td>196</td>
<td>37</td>
<td>18,9</td>
</tr>
<tr>
<td>Enough services available</td>
<td>194</td>
<td>21</td>
<td>10,8</td>
</tr>
<tr>
<td>Want to be anonymous</td>
<td>194</td>
<td>3</td>
<td>1,5</td>
</tr>
<tr>
<td>Friends come here</td>
<td>194</td>
<td>12</td>
<td>6,2</td>
</tr>
<tr>
<td>Nearer home</td>
<td>194</td>
<td>124</td>
<td>63,9</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>18</td>
<td>8,9</td>
</tr>
</tbody>
</table>

The findings in table 4.14 illustrate the reasons cited by adolescents for choosing the selected ARHS. The five most popular reasons will be given in order of priority.

- Nearer home (n = 194)

The majority of the respondents, 63,9 percent (124) reported that they were using a ARHS because of its geographical proximity. This is in accordance with the principles of PHC approach which advocates the importance of providing services close to where the people live in order to ensure accessibility, acceptability and optimum utilisation.
The findings also concur with Kunene's (1995:50) study whereby 80.0 percent of the respondents cited the inconvenience of the centre as their main reason for not utilising it. It was reported that it was too faraway, they did not know how to get there and they needed money for transport.

- **Good quality service (n = 196)**

Providing a good quality service was the reason given by 18.1 percent (37) of the respondents and is in accordance with the National Health Bill which advocates that "health care providers must satisfy every duty owed to each client/patient including the duty to provide the best quality of care appropriate" (South Africa 1996:22). The Department of Health concurs and states that the quality of services rendered in MCWH should be improved (South Africa 1997a:97).

- **Enough services available (n = 194)**

It would appear that only 10.8 percent (21) of the respondents indicated that the availability of complete services for their needs motivated them to choose the ARHS. The availability of comprehensive services is in accordance with the objectives of the Department of Health which maintains "that MCWH services should be comprehensive and integrated and should form an integral part of PHC services" (South Africa 1997a:98, 101).

- **Convenient opening time (n = 193)**

It would appear that only 7.8 percent (15) of the respondents indicated that the opening times were convenient for them, whilst the majority of respondents 92.2 percent (178) indicated that opening times were not convenient for them. This finding is in contrast with item 4.3 which revealed that 70.0 percent (142) reported positive views in terms of convenient opening times. The researcher's view on this finding is that the adolescents do not understand what they want.
• **Friends come here** \((n = 194)\)

Only 6.2 percent (12) respondents indicated that they choose the selected ARHS because their friends attended the ARHS. The adolescence period is influenced by peer pressure whether this be negative or positive. The significance of why they chose to come to the ARHS was that if the ARHS was perceived to be adolescent-friendly by the respondents, they, in turn, would invite their peers to come to the clinic where they would be empowered to make informed decisions in relation to their reproductive health.

A study conducted by Chamie et al (1982:126) in the United States to determine factors affecting adolescents' use of family planning clinics, revealed the following findings: clinics were selected where staff were friendly (80.0 percent), where fees were low (65.0 percent), where good medical care was given (52.0 percent) and a convenient location was provided (47.0 percent).

A study conducted by Kisker (1984:212) in the United States to determine patient satisfaction or dissatisfaction with aspects of care at family planning clinics illustrated the following findings: staff were friendly (71.8 percent); doesn't cost a lot of money (58.6 percent); good medical care (46.5 percent); easy to get to (40.2 percent); have a woman doctor (35.3 percent); parents are not told (34.6 percent); special programmes for teenagers (23.9 percent) and do not wait long (8.8 percent).

Zabin and Clark (1983:25-27) in the United States on institutional factors affecting teenage choice and reasons for delay in attending family planning clinics indicated that the Black respondents cited the following reasons: doesn’t tell parents (10.4 percent); people care about teenagers (14.1 percent), closed and to where we live (15.7 percent); friends come (8.0 percent); only clinic known (10.2 percent); others chose it (12.9 percent) and doctors are women (3.6 percent).

Reis et al's (1987:135) study on reasons for initial and subsequent visits to a public health teenage family planning clinic in Chicago reported 45 first time and 105 repeat visits were
as follows: first institutional service free and secondly confidential issues such as no parental consent required and staff won’t tell anyone were cited most frequently as motivating reasons for initial attendance. Other factors mentioned by at least one-fifth of the participants included: convenience of scheduling and location (open in the afternoon, easy to get here), staff factors (staff friendly) and peer factors (friends come here).

Other motivating reasons given were that clinics were only for teenagers (37.0 percent), offered free services (36.0 percent) and teenagers felt comfortable when talking to staff (34.0 percent). Return patients were asked to indicate why they kept coming back to the teen clinic, rather than going elsewhere for services. At least one-third of the respondents indicated that location (easy to get there); staff factors (staff friendly, comfortable talking to staff); peer factors and the fact that clinics were for teenagers only. Opening services in the afternoon was judged as important by over one-fourth of the return patients.

The significance of the findings is that when rendering care in ARHS note should be taken of all the factors that attract adolescents to the services as well as on those factors that discourage adolescents from attending the services if the quality of care provided is to be improved.

Item 4.20: Comments made by adolescents to improve the services offered by ARHS in Gauteng Province (n = 105)

In order to identify what adolescents perceive as satisfying or dissatisfying factors in the ARHS, the final question to be answered in the study was an open-ended question that allowed the adolescents to give their comments. Many did not respond to this question. Those who responded indicated similar views with those items given as suggestions to improve services in item 2.12.
Table 4.15: Comments made by adolescents to improve the services offered by ARHS in Gauteng Province

More than one response was possible for this section.

<table>
<thead>
<tr>
<th>Comments</th>
<th>f</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses to display positive attitudes</td>
<td>49</td>
</tr>
<tr>
<td>Examine adolescents before prescribing medicine</td>
<td>10</td>
</tr>
<tr>
<td>Nurses to work faster</td>
<td>15</td>
</tr>
<tr>
<td>Youth programme at Mofolo clinic is ideal</td>
<td>10</td>
</tr>
<tr>
<td>Increase number of nurses and doctors at clinics</td>
<td>7</td>
</tr>
<tr>
<td>Operation times should start from 07:00 to 16:00</td>
<td>5</td>
</tr>
<tr>
<td>Opening times should be from 06:00 onwards</td>
<td>5</td>
</tr>
<tr>
<td>Provide entertainment</td>
<td>2</td>
</tr>
<tr>
<td>Open on Saturdays</td>
<td>1</td>
</tr>
<tr>
<td>Environment to be clean</td>
<td>1</td>
</tr>
</tbody>
</table>

The findings in table 4.15 illustrate the comments cited by adolescents regarding ARHS in Gauteng Province. The five most frequently made comments are discussed.

It is apparent that 49 adolescents felt that health care providers needed to display positive attitudes towards them. Adolescents want to be accepted by them so as to use the ARHS at their disposal. This finding is surprising when one considers that item 2.3. indicated that the respondents said nurses were caring.

These findings revealed that 15 of the respondents want the nurses to work faster. The adolescents hate waiting and sitting at the clinic for a long time. If nurses were to examine them thoroughly before putting them on treatment, would the adolescent want to wait.

Ten respondents also indicated that they want to be examined when they visit the clinic so that disease prevention strategies can be implemented. Ten respondents who attended a
youth programme at Mofolo clinic stated that this programme was ideal as it catered for the needs of the adolescent. Convenient opening times were also cited by five of the respondents. Respondents preferred the ARHS to be opened from 07:00 to 16:00 hours to facilitate access for the adolescents. The need for the number of nurses and doctors to be increased at the clinics was a possible indication by seven of the respondents who stated that they did not want to wait.

The youth programme at Mofolo has been discussed in chapter 2. The programme catered only for adolescents between the age of 10 and 19 years. The health care providers did not wear uniforms on duty. The service provided, related mainly to contraceptives use, health education on related reproductive health issues identified as needs by the adolescent.

4.9 CONCLUSION

The analysis and presentation of data was presented in accordance with the conceptual framework “What is quality of care?” selected for the study, namely:

- Profile of the adolescent attending ARHS in Gauteng Province

It would appear that the ARHS do not meet all the needs of the adolescent in terms of the male adolescent, the adolescent in the younger age group and the out of school adolescent.

- The accessibility and availability of the ARHS to the adolescent in Gauteng Province

It would appear that the ARHS are geographically accessible, but the fact that adolescents were turned away during working hours of the clinics may indicate that the customer first principle is not being implemented at this clinics and there may be staff shortage.
Comprehensive care service available for adolescents in Gauteng Province

Services offered at the ARHS were not comprehensive as the main emphasis was given to contraceptive methods and to a lesser extent maternity service.

Information and counselling received by the adolescents attending ARHS in Gauteng Province

It would appear that the majority of adolescents are not being fully informed on all aspects related to adolescent reproductive health and in particular the prevention measures needed to ensure safe sexual practices.

Are ARHS in Gauteng Province adolescent-friendly?

The ARHS in Gauteng Province do no appear to be adolescent-friendly because comments in terms of the quality of care provided indicated that the attitude of service providers needed to be improved, that there was insufficient counselling services provided and that clinic times were not always convenient.
CHAPTER 5

Conclusions and recommendations

5.1 OVERVIEW OF THE STUDY

This chapter gives a brief overview of the study with emphasis on the conclusions and recommendations made based on the findings of the study.

The purpose of the study was to critically analyse the ARHS in Gauteng Province to determine which adolescents attended the clinics, whether the clinics were accessible and available, whether they provided comprehensive care, gave information and counselling services and whether the clinics were adolescent-friendly.

The significance of the study was to contribute to a more reality-based approach to the services provided based on the identified health care needs of the adolescents attending ARHS in Gauteng Province that would also facilitate the formulation of a policy that could be used in ARHS. The results too could significantly contribute to improving nursing theory
and practice at these centres.

The conclusions and recommendations made are drawn from the findings of the study presented and analysed in chapter 4 and will be discussed in accordance with the conceptual framework used as follows:

- Who is the adolescent attending adolescent reproductive health services in Gauteng Province?
- Are the adolescent reproductive health services in Gauteng Province accessible and available to adolescents?
- Do the adolescent reproductive health services in Gauteng Province provide comprehensive care to adolescents?
- Are adolescents receiving information and counselling from the adolescent reproductive health services in Gauteng Province?
- Are the adolescent reproductive health services in Gauteng Province adolescent-friendly?

5.2 CONCLUSIONS

5.2.1 Who is the adolescent attending adolescent reproductive health services in Gauteng Province?

In this section questions were asked related to demographic data which the health care providers need to be aware of when interacting with adolescents.

The majority of adolescents attending the ARHS in Gauteng Province were females, black, in the age group 18 years to 19 years, still students, having reached the educational level of Grades 10 to 12, still dependant on their mothers for pocket money and staying in Meadowlands, Alexandra, Diepkloof and Kagiso. The findings link up with Magagula (1998:113-115) discussed in chapter 2. The finding indicated that males and the younger female adolescent do not appear to be attending ARHS. It was also found that the out of
school adolescent used the services to a lesser extent. In this context it would appear that
the ARHS do not meet all the needs of the adolescents in terms of the male adolescent, the
adolescent in the younger age group and the out of school adolescent.

5.2.2 Are the adolescent reproductive health services in Gauteng Province accessible
and available to adolescents?

In this section, questions were asked as to whether the ARHS in Gauteng Province were:

- accessible and available as close as possible to where the adolescent live
- provided at the lowest level that ensured the safety of the adolescent and the
effectiveness of the services

A substantial number of adolescents had used the services three or more times since 1998.
The majority (88.2 percent) had indicated that they would definitely use the services again.
The main reasons given for intending to use these services again were that the adolescent did
not wish to fall pregnant and realised the need for a comprehensive medical examination.
The other main reason given was that the staff were interested and caring.

Clinic days and times were for the majority of adolescents considered convenient although
the majority of school-going students felt that the clinic days and times could be extended
to accommodate the out of school adolescents as well as the school-going adolescents, ie
ARHS operating for five days a week from 07:00 to 18:00 and 08:00 to 13:00 on Saturdays.

Waiting times at these clinics were usually between 0-30 minutes which is considered a
reasonable waiting time. However, there is concern that in this time frame, a comprehensive
examination and counselling may not have been given.

The majority of adolescents walked to the ARHS and those who could not walk had access
via public transport indicating that the clinics were situated nearer the homes and/or schools
of the adolescent and were geographically accessible to the adolescent. In certain instances,
the services at the ARHS were not available for the adolescent during working hours. The main reason given for this were that the adolescent came late to the clinics and/or the staff were busy.

The fact that adolescents were turned away during working hours of the clinics may indicate that the principle "the customer must come first" is not being implemented at these clinics and there may be a staffing problem.

5.2.3 Do the adolescent reproductive health services in Gauteng Province provide comprehensive care to adolescents?

In this section questions were asked related to the comprehensiveness of the service rendered at ARHS and linkage to the other reproductive health and follow-up services.

Services offered at the ARHS were not comprehensive as the main emphasis was given to the contraceptive methods available and to a lesser extent maternity services. Little attention was given to meeting the needs of the adolescent in relation to emergency contraception (EC), the diagnosis and treatment of STD, HIV/AIDS and counselling related to these issues. It would appear that very few pregnancy tests and TOPs were done. In terms of the services provided, the majority of adolescents were informed when the adolescent visit should be made.

In an open-ended question, the adolescent was asked to indicate what improvements could be made to improve the comprehensiveness of the services offered. The responses obtained indicated that the adolescents were not aware of the type of services they should receive and that the question should have been more specific.

Responses given related to the quality of the services provided and which, in terms of the adolescents' views would make the services more user-friendly. Aspects indicated were:
• the attitude of the service providers (rude and impatient) indicating a possible need to review the staff establishment
• the cleanliness and warmth of the clinics and the need for meals to be served
• the need for comprehensive maternity services

In terms of follow-up visits, the majority of adolescents were informed when to visit the clinic.

5.2.4 Are adolescents receiving information and counselling from the adolescent reproductive health services in Gauteng Province?

In this section questions were asked related to the extent adolescents attending the ARHS received information and counselling on their reproductive health needs and the associated needed preventive measures.

Basically it would appear that health examinations were not always conducted at the clinic or given comprehensively, as only just over half of the adolescents indicated that a health procedure had been done with only a few of these adolescents indicating that they had been given information before or after the procedure carried out.

Educational material was also not always available at the clinics, nor was it comprehensive in terms of the needs of the adolescents. The content of the educational material related mainly to HIV/AIDS, contraceptive methods, pregnancy and STDs. Less than half of the adolescents had received a health talk whilst at the clinic. The main content of the health education talk given related to HIV/AIDS, contraceptive methods and pregnancy.

In conclusion it would appear that the majority of adolescents attending these clinics are not being fully informed on all aspects related to adolescent reproductive health and in particular the preventive measures needed to ensure safe sexual practices.
5.2.5 Are the adolescent reproductive health services in Gauteng Province adolescent-friendly?

In this section questions were asked related to the acceptability of the quality of services in relation to the social and culture norms of the adolescent.

Privacy was considered during consultation. The adolescents also indicated that they would like music to be played in the waiting area and preferred health care providers to be females in the age group 18 to 22 years because of their peer group relationship. The adolescent also preferred service providers to wear uniform when on duty.

The ARHS in Gauteng Province do not appear to be adolescent-friendly because comments in terms of the quality of care provided indicated that the attitude of service providers needed to be improved, that there was insufficient counselling and that clinic operating times and days were not always convenient. It would also appear that the adolescents were not always examined at the first visit.

5.3 RECOMMENDATIONS

Arising from the findings and conclusions, the recommendations relevant to nursing management and nursing education will be discussed under the conceptual framework used in the study as follows:

5.3.1 Who is the adolescent attending adolescent reproductive health services in Gauteng Province?

Nursing management

The services offered at the ARHS with the assistance of male adolescents need to be reviewed so as to incorporate services that would attract and sustain male adolescents as partners in reproductive health care.
In the review, attention needs as well to be given to services that will attract younger adolescents before they indulge in sexual activities, so as to empower them to make informed decisions when it comes to their reproductive health choices. The following strategies could be considered:

Reviewing the quality of care in the clinic in terms of the specific needs of the adolescent in relation to

- the needs of adolescents, both male and female, in all age groups
- staffing levels
- services provided

This could be achieved by

- having open days
- giving talks at schools and in the community
- conducting workshops for staff at these clinics
- giving quality care to adolescents attending the ARHS so that they in turn recruit other adolescents by word of mouth

☐ Nursing education

If the quality of care provided at the clinics is to meet effectively the needs of the adolescent according to the South African Qualification Authority Act 58 of 1995, the service providers, need to attend adolescent health care courses or workshops given in an outcomes-based format. Emphasis in these courses should be given in terms of the needs and the management of the adolescent in the different age groups and in particular, the male adolescent.
5.3.2 Are the adolescent reproductive health services in Gauteng Province accessible and available to adolescents?

Nursing management

- The workload of the service providers at the ARHS needs to be reviewed to ensure that staffing levels are adequate so that the adolescent can be attended to during working hours.
- Although the waiting times were considered satisfactory, the procedures carried out for the adolescent should be reviewed to ensure that a comprehensive service is being offered and is in accordance with laid down policy for adolescent health care to be provided at ARHS.
- The feasibility of expanding clinic days and times to be reviewed bearing in mind the staff establishment, financial implications, and the prevailing crime situation in Gauteng Province.

Nursing education

- In accordance with the Skills Development Act 97 of 1998 and South African Qualification Authority Act 58 of 1995, service providers should in workshops or in-service programmes, be given the necessary skills in clinic management and specifically in time management.
- Review strategies should be implemented to ensure that service providers are implementing what they have learned.
- Service providers should be permitted to evaluate the relevance of the workshops and in-service programmes in terms of the needs of the adolescent and the effective management of the services.
5.3.3 Do the adolescent reproductive health services in Gauteng Province provide comprehensive care to adolescents?

☐ Nursing management

- The overall quality of care should be reviewed in terms of physical and emotional environment of the ARHS and the actual services provided to ensure that the adolescent receives comprehensive health care.
- Staffing levels to be reviewed in terms of the above needs identified.

☐ Nursing education

- Basic curriculum for nurse training should include comprehensive adolescent health care needs given on an outcomes-based format to prepare newly qualified health care providers to meet the needs of adolescents in an ARHS.
- Post-basic curricula on PHC, midwifery and relevant short courses to include comprehensive adolescent health care information based on outcomes-based format to prepare the newly qualified health care providers to meet the needs of adolescents in an ARHS.

5.3.4 Are adolescents receiving information and counselling from the adolescent reproductive health services in Gauteng Province?

☐ Nursing management

Clinic times should be planned so that service providers can give adolescents more comprehensive information and counselling related to

- information and education on sexual and reproductive health
- information, counselling and appropriate referral for sexual violence/abuse and substance abuse
• contraceptive information and counselling, provision of methods including oral contraceptive pills, ECPs, injectables and condoms
• pregnancy testing and counselling and antenatal care, labour and postnatal care
• pre and post TOP counselling and referral
• STD information, dual protection, counselling and syndromic management of STDs including partner notification
• HIV information and pre- and post-counselling and appropriate referral for voluntary testing if services are not available
• Training of peer group educators to give this service

☐ Nursing education

Regular in-service education programmes should be given to service providers on the latest approaches used to meet the reproductive health care needs of the adolescent. These could be in the format of workshops, attending symposium or in-service courses at the clinic.

5.3.5 Are the adolescent reproductive health services in Gauteng Province adolescent-friendly?

☐ Nursing management

Quality care in the clinics should be reviewed on a regular basis. This review should include:

• staffing levels
• the comprehensiveness of the services provided
• appropriateness of the operating time
• selection criteria for service providers to meet the adolescents reproductive health care needs
• recruitment and placement strategies in terms of the service providers related to age groups, and other characteristics including gender
providing adequate support systems for the younger service providers
allowing/encouraging adolescents to give continuous constructive anonymous, verbal and written feedback in a “suggestion box”
conducting workshops with adolescents to obtain their views on management
using “mystery clients” to assess the quality of care given to adolescents at ARHS

Nurse education

In-service education, workshops and debates should be conducted on a regular basis with service providers using an outcomes-based format on adolescent health care.
Adolescent health care should be included in the curriculum for nurse training and in education programmes/short courses using an outcomes-based format as required by the SAQA, so that newly qualified service providers understand the quality of service they are to render in an ARHS.
Nurse lecturers, in workshops, who successfully teach adolescent health to student nurses should share their expertise with other nurse lecturers and professionals.
Continuous professional development (CPD) programmes should be provided for all health care providers working with adolescents at ARHS.
In-service courses on appropriate management strategies in ARHS and counselling skills should be given on a regular basis.
Regular accreditation visits to the ARHS by the South African Nursing Council (SANC) should be carried out.

5.4 LIMITATIONS OF THE STUDY

5.4.1 Population

The population used in this study was small, for further research:

ARHS in hospitals, school health services, local authorities, private organisations, NGO and mobile clinics could be included.
• The population attending the ARHS could be more heterogeneous in terms of sex, age, race, school attendance and non-school attendance.

• Health care providers working at ARHS should also form part of the study, so that a holistic picture of the type of care adolescents received at ARHS can be reviewed.

5.4.2 Data collection

5.4.2.1 Personnel

If the population is to be expanded, the help of trained research assistants in the collection of data will be needed.

5.4.2.2 Data collection tool

• Questionnaire to be structured in English and two commonly used African languages to accommodate adolescents who do not understand English.

• More open-ended questions to be included in the questionnaire to elicit more in-depth information from the respondents.

• Questionnaire A (for adolescents) and questionnaire B (for service providers) should correlate.

5.5 RECOMMENDATIONS FOR FURTHER RESEARCH

This study found several areas that need further investigation which are identified as follows:

• The specific needs of the male adolescent in terms of reproductive health and the extent to which they utilise the services offered at ARHS.

• The extent to which health care providers are prepared for their role at ARHS.

• The recruitment and retention of suitably qualified service providers at ARHS.

• The use of peer group educators in ARHS.

• The factors hampering service providers from rendering quality care at ARHS.
• The views of health care providers on the needs in ARHS that would facilitate quality care at these clinics.
• The needs of the younger adolescent and the out of school adolescent attending ARHS.

5.6 ASSUMPTIONS (PREMISES)

☐ Assumption 1. Adolescents need accessible and available adolescent reproductive health care services.

In terms of distance, days and times of attendance this assumption was found to be true.

☐ Assumption 2. Adolescents need to be provided with comprehensive health care at adolescent reproductive health services

In terms of receiving contraceptives, pregnancy, labour, puerperium, TOP, STD and HIV/AIDS services, this assumption was found to be true.

☐ Assumption 3. Adolescents need to receive information and counselling at the adolescent reproductive health services to meet their health needs

In terms of health status and the need for information and counselling on safe sexual practices, this assumption was found to be true.

☐ Assumption 4. Adolescent reproductive health services should be adolescent-friendly

This assumption was also found to be true and was substantiated by the need

• to be treated with dignity and respect
• for friendly and nonjudgemental health care providers
• for music to be played in the waiting room
• health care providers to be females between 18 and 22 years of age
• for a caring ethos to be shown by health care providers
• for health care providers to work faster
• to increase the staff establishment at clinics

5.7 CONCLUSION

This chapter focussed on the overview of the study which entailed purpose of the study, significance of the study, conclusions and recommendations drawn from the findings, presented and analysed in chapter 4 and was discussed in accordance to the conceptual framework used in the study. Limitations of the study and assumptions were also discussed.

ARHS must strive towards implementing strategies that will attract both male and female adolescents of all age groups to attend ARHS and enjoy the age-related reproductive health care benefits. It is difficult to conclude whether ARHS in Gauteng Province are adolescent-friendly or not because adolescents gave conflicting statements when it come to these issues. It would appear, however, that for all adolescents the services were not user-friendly. In quoting Mandela’s words in chapter 1 when he said “adolescents are the future leaders and that without them there can be no reconstruction and development”. ARHS need to be available, accessible, comprehensive, provide education and counselling and be adolescent-friendly to allow the adolescents to become mature and responsible leaders of the future.

This will require innovative management strategies and new approaches in the education and development of not only the service providers but the adolescents themselves.
REFERENCES


ANC see African National Congress.


WHO see World Health Organization.


Annexure 1

Questionnaire
Questionnaire

Your completion of this questionnaire indicates your consent to participate in this study.

All information will be treated as strictly confidential. Participation in this study is voluntary. In no way will this questionnaire be linked to your name.

Instructions:

Please answer all the questions. Answer each question objectively, as it applies to your situation.

Kindly respond to the following questions by marking (X) over the appropriate numbered circle or writing the required information in the open space.

<table>
<thead>
<tr>
<th>FOR OFFICE USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
</tr>
</tbody>
</table>

### Section 1: Profile of the adolescent attending ARHS in Gauteng Province

1.1 Are you
   - Male
   - Female

1.2 How old were you at your last birthday?
1.3 To which population group do you belong?

- Black
- Coloured
- Indian
- White
- Other (specify) ........................................

1.4 What is the highest standard of education you have attained?

- Never been at school
- Grade 1-3 (Sub A - Std 1)
- Grade 4-6 (Std 2 - 4)
- Grade 7-9 (Std 5-7)
- Grade 10-12 (Std 8-10)
- Postmatric (eg technikon, university, nursing college, etc)

1.5 What is your current employment situation?

- Employed permanently
- Employed temporarily
- Unemployed - looking for work
- Unemployed - not looking for work
- Looking after children or family at home
- Student
### Section 2: Services provided at ARHS (accessibility, availability and comprehensiveness)

#### 2.1 How many times have you attended this adolescent reproductive health service since last year (1998)?

- Once
- Twice
- Three or more

#### 2.2 Do you think that you will attend this adolescent reproductive health service again? (Tick one only).

- Definitely
- Probably
- If I am in the area
- I do not know/unsure
- No
### 2.3 If yes, why will you attend the adolescent reproductive health service again?


### 2.4 If no, why will you not attend the adolescent reproductive health service again?


### 2.5 Have you received any of the following services today or previously at this adolescent reproductive health service? (Tick more than once).

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Emergency contraceptive (post coital contraception)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pregnancy test</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Counselling on pregnancy</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Termination of pregnancy (abortion)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diagnosis of sexually transmitted diseases</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Treatment of sexually transmitted diseases</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>HIV/AIDS counselling</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Maternity services</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Others (specify)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### 2.6 During your first visit, did you receive any health procedure?

Yes = ① No = ②
2.7 If yes, did you receive an explanation before the health procedure was performed?  
Yes = ①  No = ②  □ 27

2.8 Did you receive an explanation on the outcome of the health procedure?  
Yes = ①  No = ②  □ 28

2.9 In your opinion, did you have sufficient privacy during your consultation with the health care provider?  
Yes = ①  No = ②  □ 29

2.10 If yes, in what way was your privacy ensured during the consultation?

2.11 If no, in what way was your privacy lacking during the consultation?
### Section 3: Information and counselling (IC) on adolescent reproductive health

#### 3.1 During this visit, were you given or did you take any educational material home to read?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>
### 3.2 If yes, what content was covered in the educational material provided? (Tick if applicable).

<table>
<thead>
<tr>
<th>Topic</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>Emergency contraception pills</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>Sexually transmitted disease</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>Pregnancy</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>Gender issues</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>Decision-making</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>Money generating scheme</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
<tr>
<td>Others (specify)</td>
<td><img src="https://example.com/yes.png" alt="Yes" /></td>
<td><img src="https://example.com/no.png" alt="No" /></td>
</tr>
</tbody>
</table>

---

### 3.3 Did you attend a group or individual health talks at this adolescent reproductive service today? Yes = ![Yes](https://example.com/yes.png) No = ![No](https://example.com/no.png)
### 3.4 If yes, which topics were covered in the health talks given?

<table>
<thead>
<tr>
<th>Topic</th>
<th>Yes</th>
<th>No</th>
<th>I don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>Emergency contraception pills</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>Sexually transmitted disease</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>Gender issues</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>Decision-making</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>Money generating scheme</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
<tr>
<td>Others (specify)</td>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
</tbody>
</table>

### 3.5 Did the health care provider tell you when to come back for another visit?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>I don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
</tbody>
</table>

### Section 4: Adolescent-friendly services in the ARHS

#### 4.1 Are the days this adolescent reproductive health service is open, convenient for you?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>I don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>I don't know</td>
</tr>
</tbody>
</table>

#### 4.2 On which days should the adolescent reproductive health service be open? (Tick one).

<p>| Weekdays  | 1 |
| Weekend   | 2 |
| Seven days a week | 3 |</p>
<table>
<thead>
<tr>
<th>4.3</th>
<th>Are the hours the adolescent reproductive health service is open convenient for you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes = ① No = ② I don't know = ③</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.4</th>
<th>Do you sometimes take time off from school to come to the adolescent reproductive health service?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes = ① No = ② Not applicable = ③</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.5</th>
<th>What time would be most convenient for you to attend this adolescent reproductive health service?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>07:00-10:00                                   ①</td>
</tr>
<tr>
<td></td>
<td>10:00-13:00                                   ②</td>
</tr>
<tr>
<td></td>
<td>13:00-16:00                                   ③</td>
</tr>
<tr>
<td></td>
<td>16:00-19:00                                   ④</td>
</tr>
<tr>
<td></td>
<td>Other                                           ⑤</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.6</th>
<th>What type of entertainment would you prefer to have in the waiting area of this adolescent reproductive health service?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Music                                                                   Yes = ① No = ②</td>
</tr>
<tr>
<td></td>
<td>Watching videos                                                         Yes = ① No = ②</td>
</tr>
<tr>
<td></td>
<td>Watching television                                                      Yes = ① No = ②</td>
</tr>
<tr>
<td></td>
<td>Playing indoor games                                                    Yes = ① No = ②</td>
</tr>
<tr>
<td></td>
<td>Other (specify)                                                         Yes = ① No = ②</td>
</tr>
</tbody>
</table>
### 4.7 In which age group would you prefer your health care provider to be? (Tick one only).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Ticks</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-22 years</td>
<td>1</td>
</tr>
<tr>
<td>23-27 years</td>
<td>2</td>
</tr>
<tr>
<td>28-32 years</td>
<td>3</td>
</tr>
<tr>
<td>32 years and above</td>
<td>4</td>
</tr>
<tr>
<td>Any age group</td>
<td>5</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>6</td>
</tr>
</tbody>
</table>

### 4.8 What are your reasons for choosing this age group?

- 
- 
- 
- 
- 

### 4.9 Which gender (sex) for the health care provider would you choose?

<table>
<thead>
<tr>
<th>Gender</th>
<th>Ticks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should be male</td>
<td>1</td>
</tr>
<tr>
<td>Should be female</td>
<td>2</td>
</tr>
<tr>
<td>It doesn’t matter</td>
<td>3</td>
</tr>
</tbody>
</table>

### 4.10 Please give reasons for the preferred gender (sex).

- 
- 
- 
- 
- 

FOR OFFICE USE ONLY
4.11 Which type of clothing would you prefer to the health care provider to wear?

- Uniform
- Own clothes
- Own clothes and white coat
- Other (specify)

4.12 How long did you have to wait before being seen today?

- 0-30 minutes
- 30 minutes - 1 hour
- 1 hour - 2 hours
- 2 and more hours

4.13 The following lists the health care providers at this adolescent reproductive health service. Using the guidelines given, please rate each category of staff that has helped you at this ARHS on a scale from 1-6. (Tick one or more, if necessary).

1 = Friendly
2 = Unfriendly
3 = Judgemental
4 = Knowledgeable
5 = Not certain
6 = Not applicable

<table>
<thead>
<tr>
<th>Receptionist</th>
<th>Nurse</th>
<th>Counsellor</th>
<th>Clerk</th>
<th>Doctor</th>
<th>Other staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
<td>1 2 3 4 5 6</td>
</tr>
</tbody>
</table>
4.14 Have you ever been turned away from this adolescent reproductive health service during working hours?

| Yes | 1 |
| No  | 2 |
| Not applicable | 3 |

4.15 If yes, what were the reason for being turned away?

| .......................... |

4.16 How long did it take you to come here today? (Tick one only).

| 0-30 minutes | 1 |
| 30 minutes - 1 hour | 2 |
| 1 hour - 2 hours | 3 |
| 2 and more hours | 4 |

4.17 What means of transport did you use to reach this adolescent reproductive health service? (Tick more than once).

| Walked | Yes = 1, No = 2 |
| Bus    | Yes = 1, No = 2 |
| Taxi   | Yes = 1, No = 2 |
| Private car | Yes = 1, No = 2 |
| Other (specify) | Yes = 1, No = 2 |
### 4.18 Apart from this adolescent reproductive health service, are you aware of any other adolescent reproductive health service?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**FOR OFFICE USE ONLY**

### 4.19 Which of the following reasons made you decide to attend this adolescent reproductive health service today?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenient opening times</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Entertainment facilities</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Good quality service</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Enough services available</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Want to be anonymous</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Friends come here</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nearer home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**FOR OFFICE USE ONLY**

### 4.20 Indicate other comments that you would like to make regarding this adolescent reproductive health service.

[Blank space for comments]

---

Thank you for completing the questionnaire. Please put it in an envelope, seal it and hand it back to the researcher.
Annexure 2

Letter of permission to use the questionnaire from the Ethical Committee,
Department of Advanced Nursing Sciences at Unisa
3 October 2000

Mrs BM Magwentshu
Private Bag X085
MARSHALLTOWN
2107

Dear Mrs Magwentshu

APPROVAL GIVEN TO CONDUCT YOUR RESEARCH BY THE RESEARCH COMMITTEE, DEPARTMENT OF ADVANCED NURSING SCIENCES

In connection with the above, I am confirming that your questionnaire was accepted by the Research Committee and that you could therefore continue with your research.

I trust that this is sufficient proof and will replace the letter that was originally sent to you.

Yours sincerely

Prof MVLH Lock
JOINT PROMOTER
Annexure 3a

Letter requesting permission from the Research Committee in Gauteng Province to conduct the study
PERMISSION TO CONDUCT RESEARCH IN THE ADOLESCENT REPRODUCTIVE HEALTH SERVICES IN GAUTENG PROVINCE

I intend conducting a research project entitled *Critical analysis of adolescent reproductive health services in Gauteng Province* in order to comply with the requirements for a D Litt et Phil degree in Nursing Science (Community Nursing) with the Department of Advanced Nursing Sciences at the University of South Africa (Unisa).

The research also deals with one of the priority areas laid down by the global network of the WHO Collaborating Centres for nursing and midwifery of which the Department of Advanced Nursing Sciences, Unisa is a member thereof. The study will be done under the supervision and guidance of professor HIL Brink and Professor MVLH Lock of the Department of Advanced Nursing Sciences, Unisa.

The purpose of the study is to critically analyse the ARHS in Gauteng Province with regard to:

- determining which adolescents attend the ARHS
- whether the clinics are accessible and available to adolescents attending ARHS
- whether the clinics provide comprehensive care to adolescents attending ARHS
- whether the clinics give information and counselling to the adolescents attending the ARHS
- whether the clinic/s is/are adolescent-friendly
- the role of the registered nurse in the ARHS
For the purpose to be achieved a quantitative, exploratory, descriptive survey in nature is envisaged. It is estimated that 2 500 adolescents visiting ARHS will be required to participate in the study by completing a self-administered questionnaire at ARHS during the researcher’s presence.

Selection of respondents will be done by utilising a nonprobability sampling, should the researcher be granted permission as required. The respondent will be asked by the researcher (without disturbing the smooth running of the ARHS) to complete the questionnaire after receiving reproductive health intervention. Their identity will be protected by requesting them not to indicate their names nor the name of the organisation. The questionnaires will be number-coded to assist with data analysis.

Respondents in this research project will be required to give informed consent and they reserve the right to withdraw their consent at any stage during the research process, if they so desire.

Needless to say the respondents, the community, nursing education and service in this country stand to benefit directly or indirectly from the outcome of this research study.

Research results will be made available to your department as well as to respondents on request. Results will not be published.

I will be glad to answer any queries about this research project.

NB: Attached are the proposal for the study, questionnaire for you perusal and comments and letter of approval to use the questionnaire from the Ethical Committee from the Department of Advanced Nursing Sciences.

Thank you.

Yours faithfully

Makgoale Magwentshu
D LITT ET PHIL COMMUNITY NURSING SCIENCE STUDENT
Annexure 3b

Letter of approval from the
Research Committee in Gauteng Province
to conduct the study
Ms M Magwenshu
Human Resource Development

7th December 1998

Dear Ms Magwenshu

Your protocol "Critical Analysis of Adolescent Reproductive Health Services in Gauteng" was considered by the Clinical Trials Committee on the 19th November 1998.

We understand that you no longer intend to interview the nurses in the services and that you now have ethics approval from the University Research Ethics Committee.

The Committee therefore approved your study.

We wish you luck with your work

Yours sincerely

Dr Julia Moorman
Annexure 4a

Letter requesting permission
from the Director, District Health Services
to conduct the study in the five regions
To: Director, District Health Services
From: Makgoale Magwentshu

Telephone: (011) 355-3404
Fax: (011) 355-3430

Date: 1999, February 16

PERMISSION TO CONDUCT RESEARCH IN THE ADOLESCENT REPRODUCTIVE HEALTH SERVICES IN GAUTENG PROVINCE

I intend conducting a research project entitled *Critical analysis of adolescent reproductive health services in Gauteng Province* in order to comply with the requirements for a D Litt et Phil degree in Nursing Science (Community Nursing) with the Department of Advanced Nursing Sciences at the University of South Africa (Unisa).

The research also deals with one of the priority areas laid down by the global network of the WHO Collaborating Centres for nursing and midwifery of which the Department of Advanced Nursing Sciences, Unisa is a member thereof. The study will be done under the supervision and guidance of professor HIL Brink and Professor MVLH Lock of the Department of Advanced Nursing Sciences, Unisa.

The purpose of the study is to critically analyse the ARHS in Gauteng Province with regard to:

- determining which adolescents attend the ARHS
- whether the clinics are accessible and available to adolescents attending ARHS
- whether the clinics provide comprehensive care to adolescents attending ARHS
- whether the clinics give information and counselling to the adolescents attending the ARHS
- whether the clinic/s is/are adolescent-friendly

For the purpose to be achieved a quantitative, exploratory, descriptive survey in nature is envisaged. It is estimated that 2 500 adolescents visiting ARHS will be required to
participate in the study by completing a self-administered questionnaire at ARHS during the researcher’s presence.

Selection of respondents will be done by utilising a nonprobability sampling, should the researcher be granted permission as required. The respondent will be asked by the researcher (without disturbing the smooth running of the ARHS) to complete the questionnaire after receiving reproductive health intervention. Their identity will be protected by requesting them not to indicate their names nor the name of the organisation. The questionnaires will be number-coded to assist with data analysis.

Respondents in this research project will be required to give informed consent and they reserve the right to withdraw their consent at any stage during the research process, if they so desire.

Needless to say the respondents, the community, nursing education and service in this country stand to benefit directly or indirectly from the outcome of this research study.

Research results will be made available to your department as well as to respondents on request. Results will not be published.

I will be glad to answer any queries about this research project.

NB: Attached are permission letter from the Research Committee in Gauteng Province and and the questionnaire for your perusal and comments.

Thank you.

Yours faithfully

Makgoale Magwentshu
D LITT ET PHIL COMMUNITY NURSING SCIENCE STUDENT
Annexure 4b

Letter of approval from the Director, District Health Services in Gauteng Province to conduct the study
Ms Makgoale Magwentshu
AD: Nursing Education and Training Sub-Directorate
Gauteng Health Department.

Dear Ms Magwentshu,

RE: Permission to conduct Research in the Adolescent Reproductive Health Services in Gauteng.

I would like to inform you that you have been granted permission to conduct your research project entitled 'Critical Analysis of Adolescent Reproductive Health Services in Gauteng' with the following qualifications:

♦ It must be submitted to the Provincial Clinical Trials Committee for approval;

♦ You need to consult / negotiate with the Regional Directors when determining the venues for the study in the Region;

♦ That you submit a copy of your report to this Chief Directorate on completion of your study.

Thank you.

Dr B N Desai.
Annexure 4c

Letters requesting permission
from the Directors/Deputy Directors
in the five regions to conduct the study
PERMISSION TO CONDUCT RESEARCH IN THE ADOLESCENT REPRODUCTIVE HEALTH SERVICES IN GAUTENG PROVINCE

I intend conducting a research project entitled Critical analysis of adolescent reproductive health services in Gauteng Province in order to comply with the requirements fir a D Litt et Phil degree in Nursing Science (Community Nursing) with the Department of Advanced Nursing Sciences at the University of South Africa (Unisa).

The research also deals with one of the priority areas laid down by the global network of the WHO Collaborating Centres for nursing and midwifery of which the Department of Advanced Nursing Sciences, Unisa is a member thereof. The study will be done under the supervision and guidance of professor HIL Brink and Professor MVLH Lock of the Department of Advanced Nursing Sciences, Unisa.

The purpose of the study is to critically analyse the ARHS in Gauteng Province with regard to:

- determining which adolescents attend the ARHS
- whether the clinics are accessible and available to adolescents attending ARHS
- whether the clinics provide comprehensive care to adolescents attending ARHS
- whether the clinics give information and counselling to the adolescents attending the ARHS
- whether the clinic/s is/are adolescent-friendly

For the purpose to be achieved a quantitative, exploratory, descriptive survey in nature is envisaged. It is estimated that 2 500 adolescents visiting ARHS will be required to
participate in the study by completing a self-administered questionnaire at ARHS during the researcher’s presence.

Selection of respondents will be done by utilising a nonprobability sampling, should the researcher be granted permission as required. The respondent will be asked by the researcher (without disturbing the smooth running of the ARHS) to complete the questionnaire after receiving reproductive health intervention. Their identity will be protected by requesting them not to indicate their names nor the name of the organisation. The questionnaires will be number-coded to assist with data analysis.

Respondents in this research project will be required to give informed consent and they reserve the right to withdraw their consent at any stage during the research process, if they so desire.

Needless to say the respondents, the community, nursing education and service in this country stand to benefit directly or indirectly from the outcome of this research study.

Research results will be made available to your department as well as to respondents on request. Results will not be published.

I will be glad to answer any queries about this research project.

NB: Attached are permission letters from the Research Committee in Gauteng Province and from the Director of District Health Services in Gauteng Province as well as the questionnaire for your perusal and comments.

Thank you.

Yours faithfully

Makgoale Magwentshu
D LITT ET PHIL COMMUNITY NURSING SCIENCE STUDENT
Annexure 4d

Letters of approval from the Directors/Deputy Directors in the five regions to conduct the study
Ms Makgoale Magwentshu  
Assistant Director  
Nursing, Education and Training Sub-Directorate  
Fax: 355 3404  
Cell: 083 297 3104  

Dear Ms Magwentshu,  

RE: RESEARCH IN THE ADOLESCENT REPRODUCTIVE HEALTH SERVICE SITUATED IN GAUTENG PROVINCE  

Permission is granted for you to carry out your Research in Adolescent Reproductive Health Services.  

You could also approach Ms M. Mashaba at 720 2560 x 2738 or Cell 082 672 1880 or the Chairperson of our District Health Systems Teams in each of the 4 districts for assistance.  

Please find the following names and numbers for your attention:  

Western District - Ms S. Dass - 674 1200  
Eastern District - Ms C. Terblanche - 720 1121 ext. 3116  
Southern District - Dr Olufemi - 082 653 2904  
Northern District - Ms T. Mathloko - 082 773 2569  

We would appreciate a report back on the Research findings and wish you good luck in your investigations.  

Thank you  

[Signature]

REGIONAL DIRECTOR
8 April 1999

Ms Magwentshu
Gauteng Health Department
Bank of Lisbon
Private Bag X 085
MARSHALLTOWN
2107

RESEARCH IN THE ADOLESCENT - REPRODUCTIVE HEALTH

Permission is hereby granted to conduct the practica study in the Youth Centres and Family Planning Clinics of the Greater Benoni Health District in April 1999.

You are however requested to furnish the dates for the visits as well as the preferred facilities as there are 13 Clinics.

Yours faithfully

[Signature]

DR M.A.R. SELAHLI
MEDICAL OFFICER OF HEALTH
Ms Makgoale Magwentshu
Assistant Director
Nursing Education and Training – Sub directorate

Dear Ms Magwentshu

RESEARCH IN THE ADOLESCENT REPRODUCTIVE HEALTH SERVICES SITUATED IN GAUTENG PROVINCE.

Permission is granted for you to carry out your research in adolescent reproductive health services.

We would appreciate a report back on the research findings and wish you well in your research.

Thank you

Deputy Director
Ms Z Saloojee
Ms. Makgoale Magwentshu
Assistant Director
Nursing Education & Training

Fax: 355 - 3404
Cell: 083 297 3104

RE: RESEARCH IN THE ADOLESCENT REPRODUCTIVE HEALTH SERVICE IN GAUTENG PROVINCE

Dear Ms. Magwentshu,

Permission is granted for you to carry out your research in Adolescent Reproductive Health Services.

Please approach the following district co-ordinators for assistance:

Carletonville District: P Mtshemla - (018) 788 - 2289
Westonaria District: A Victor - 082 923 2943
Randfontein District: J Malebo - 693 - 5270
Krugersdorp District: K Ndlovu - 953 -4515

Arrangements have already been made with the following clinics:

Carletonville - Khutsong Main Clinic
Khutsong East Clinic
Khutsong West Clinic

Westonaria - Bekkersdal West Clinic
Bekkersdal East Clinic
Randfontein - Mohlakeng Clinic
              Ya Rona Clinic

Krugersdorp - Kagiso A Clinic
              Muldersdrift Clinic
              Itumeleng Clinic

Feedback on research findings will be highly appreciated.

Good luck with your research.

[Signature]

[Regional Director]
Ms M. Magwentshu
P. B. X 085
MARSHALLTOWN
2107

PERMISSION TO CONDUCT RESEARCH IN THE ADOLESCENT REPRODUCTIVE
HEALTH SERVICES SITUATED IN GAUTENG PROVINCE

This refers to your request.

Permission is hereby granted for you to conduct the research as stated on the Adolescent
Reproductive Health Services.

Good luck with your study.

Yours Sincerely,

[Signature]

DR S S ASMALL
Acting Regional Director: Pretoria Region
Annexure 5

Covering letter to the respondents explaining the study
The researcher read the cover letter to each adolescent sitting in the waiting area of each adolescent reproductive health service/s that she visited in Gauteng Province.

The cover letter included the following pieces of information:

- greetings
- introduction of self
- invitation to participate in the scientific study
- the fact that the data provided by or obtained from the subjects will be used in a scientific study
- the purpose of the study
- the type of data to be collected
- the nature and extent of the subjects' time commitment
- the procedures to be followed in collecting the research data
- how subjects came to be selected
- potential benefits to subjects (including whether or not a stipend is being offered) and potential benefits to others
- a description of the voluntary nature of participation and the right to withdraw at any time without penalty
- a pledge that the subject's privacy will at all times be protected
- assurance of anonymity and confidentiality
- the names of people to contact for information of complaints about the study
- offered to answer all questions
- results to be reported in group form to Unisa and Gauteng Department of Health

Thank you.

Makgoale Magwentshu
D LITT ET PHIL COMMUNITY NURSING SCIENCE STUDENT