THE FACILITATION OF YOUTH FRIENDLINESS IN A YOUTH ACTIVITY CENTRE (YAC) IN BOTSWANA

by

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Declaration

I declare that **"THE FACILITATION OF YOUTH FRIENDLINESS IN A YOUTH ACTIVITY CENTRE (YAC) IN BOTSWANA"** is my own work and that all the resources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

__________________________ ____________________

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Abstract

The concept of youth activity centre (YAC) has not yet been evaluated. The purpose of this study was to evaluate the YAC in Botswana. Accordingly, the researcher explored and described the lived experience of young people utilising the YAC as well as the perceptions of service providers at the Mochudi Centre in the Kgatleng District, in Botswana. Furthermore, the objective was to develop and describe guidelines for the facilitation of youth-friendly services (YFS) at YAC.

A phenomenological, qualitative, explorative, descriptive and contextual research design was used to extract young people's experiences and perceptions of service providers. Thirty-two young people and 27 service providers (peer educators and service delivery officers [SDOs]) were purposefully selected. Methods of data collection used were unstructured individual in-depth interviews, focus group discussions and observations in the forms of field notes. The data, mainly tape-recorded interviews and field notes were transcribed verbatim for data analysis. Tesch's eight-step data analysis model (Creswell 1994:155) was used.

One major theme, youth friendliness emerged with three categories, namely: physical, administrative, and psychological aspects of youth-friendly services. All the respondents indicated that they benefited and affirmed they were empowered and better people after using the facility. However, limited access to the facility by the target group due to location, cost of reaching the facility, and attitudes of service providers as well as failure to implement planned activities due to financial and staff shortage were obstacles to youth friendliness of the YAC.

Based on the findings and literature review, the researcher developed guidelines to facilitate YFS and improved access to the YAC. Recommendations made are for practise in the YAC, education of SDOs and for further research.

Key concepts

Youth activity centre; youth-friendly services; youth friendliness; young people; adolescents; lived experiences; empowerment; participatory/experiential learning; interventions; health promotion; programmes for young people; service delivery officers; HIV and AIDS; sexual and reproductive health; adolescent sexual and reproductive health;

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Dedication

To my parents, Koone and Olebile Matshediso

as well as

my children to come, Atlang and Kago

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List of abbreviations

ABC	Attitudes-Behaviour-Change
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Clinic
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASRH	Adolescent Sexual and Reproductive Health
ARH	Adolescent Reproductive Health
AYA	African Youth Alliance
BFHS	Botswana Family Health Survey
BIAS II	Botswana AIDS Impact Survey II
BIDPA	Botswana Index Development Policy Assessment
BOFWA	Botswana Family Welfare Association
BNYC	Botswana National Youth Council
CBDs	Community Based Distributors
CBOs	Community Based Organisations
CBS	Community Based Services
CSO	Central Statistics Office
CPR	Contraceptive Prevalence Rate
DHT	District Health Team
FHD	Family Health Division
FHI	Family Health International
FGD	Focus Group Discussion
FLE	Family Life Education
FMOH	Federal Ministry of Health
FP	Family Planning
FWEs	Family wellbeing Educators
HIV	Human Immuno-deficiency Virus
HPV	Human Papiloma Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPC	Interactive Population Centre
MCH	Maternal and Child Health
MFDP	Ministry of Finance and Development Planning
MI	Male Involvement
MLG	Ministry of Local Government
MOE	Ministry of Education and Skill Development
MOH	Ministry of Health
MOLHA	Ministry of Labour and Housing Authority
MVA	Manual Vacuum Aspiration
NACA	National AIDS Control Agency
NBTS	National Blood Transfusion Service
NDP	National Development Plan

List of abbreviations

NGO	Non Governmental Organization
PAC	Post Abortion Care
PATH	Program for Appropriate Technology for Health
PC	Population Council
PE	Peer Educator
PEPFER	President Emergency Plan for E Relief
PHC	Primary Health Care
PMH	Princess Marina Hospital
PMTCT	Prevention of Mother-to-child Transmission of HIV/AIDS
PLWA	People Living with HIV/AIDS
RH	Reproductive Health
RNs	Registered nurses
SDO	Service Delivery Officer
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
SIAPAC	Social Impact Assessment and Policy Corporation
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
TOT	Training of Trainers
TV	Television
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YAC	Youth Activity Center
YFHS	Youth Friendlily Services
YFS	Youth Friendlily Services
YP	Young People

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CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

In the endeavour to prevent Human Immuno-deficiency Virus (HIV) infection and other sexually transmitted infections (STIs), as well as teenage pregnancy, it is essential to provide reproductive health services that are youth friendly to reach young people. Youth activity centres (YAC) and youth-friendly services (YFS) are fundamental in reaching out and offering reproductive health services to young people to address their health needs as well as the health problems they encounter. In the United States of America (USA), HIV and Acquired Immune Deficiency Syndrome (AIDS) are on the rise, mostly affecting African-American young people (Jemmott & Jemmott 2007:243-263). Between 2000 and 2003, many individuals in the age group 15 to 24 became HIV infected, mainly through unprotected or unsafe sex. A baseline study conducted among high school students in the USA revealed that at least 65% of them were having casual sex and less than 21.6% reported not using condoms every time (Benner 2008:224). The above findings indicate the need to reach out to young people.

According to the Program for Appropriate Technology in Health (PATH) (2003:1), young people today are confronted with several challenges, including teenage pregnancy, dropping out of school, drug use, STIs, HIV and AIDS, as well as sexual abuse. In a study of the determinants of health care-seeking behaviour of adolescents attending STI clinics in South Africa, Meyer, Reddy, van den Borne, Kok and Pietersen (2000:741-742; 745-746) found that many young people had STI infections. Moreover, for some it was the second or third episode in a twelve-month period. In addition, the majority (55%) sought health care within 7 days of noticing the symptoms. Seeman and Leinhos (2007:535) found that sexually active adolescents "have high rates of STDs and may be less likely to obtain health care than other persons". Limited financial resources, restricted admittance to convenient care, a sense of invulnerability, feelings of humiliation, and the desire to prevent their parents knowing that they were seeking STI care are among the obstacles to accessing adequate sexual health care (Seeman

& Leinhos 2007:536). Chase and Aggleton (2006:84-85) point out that young people are faced with sexual and reproductive health needs and challenges and that the situation is worse for those who are homeless. They find it difficult to access services because they are detached from the normal settings therefore there is less access to programmes – information and services. In addition, their situation is worsened by the attitudes of service providers towards them for engaging in activities such as exchanging sex for basic commodities and intoxicating substance (drugs and alcohol), and procuring backstreet abortions.

Much could be achieved in addressing young people's needs with health promotion or intervention programmes (Hornik 2002b:7). For example, in Switzerland, "Swiss Stop AIDS", a programme promoting condom use, brought about an increase from 8% to 60% in condom usage with "casual" partners among young people (Hornik 2002b:7-8). A similar change was also noted in the Netherlands where the increase was from 9% to 40% between 1987 and 1989. In another intervention programme entitled "FOCUS" implemented among high school students, 23.9% of the control group reported STIs and unintended pregnancies compared to 17% of the intervention group (Benner 2008:224). In a programme to prevent pregnancy among junior high school students in the USA, only 23% of the intervention group failed to abstain compared to 50% of the control group who did not refrain from sexual intercourse (Gurdin, Niego, Park & Mince 2008b:42).

This supports the assumption that well-designed and targeted health promotion programmes should develop and empower individuals by giving them balanced power, hence decision-making power. Middlestadt (2007:129) maintains that for health promotion programmes to be effective (successful), they must be based on behavioural theory and targeted at specific behaviour. Health promotion programmes addressing the barriers that limit young people's access to service should use a participatory learning approach, promote safer sex, and influence policy makers positively (Ingham & Aggleton 2006a:230). The establishment of YACs using peer education is an example of a participatory approach and is effective in lowering sexual activity among young people (Tripp & Viner 2006:590-593).

Nowadays, interventions targeting young people should include the provision of information and reproductive health services, with the key aim of reducing the incidence of HIV and AIDS amongst young people. According to Barnett and Schueller (2000:13), the need for comprehensive services offered in a youth-friendly environment has greatly increased because of the challenges facing young people. Jackson (2002:103) emphasises that youth-friendly health services are needed and should therefore be more widely established because young people are a hard-to-reach group. Both YACs and/or YFS are designed to eliminate the barriers commonly found in traditional health facilities that deter young people from seeking and using services. Among the matters addressed by YFS are HIV and AIDS, teenage pregnancy, STIs, unsafe abortions; family planning, condom use, and abuse of alcohol and other substances (African Youth Alliance-Botswana [AYA-Botswana] [Sa]:136).

The above-mentioned problems greatly affect young people because their needs are not fully met. Young people need information, especially about the facts of life, youth-friendly reproductive health services, and most importantly unlimited access to the services. The Joint United Nations Programmes on HIV and AIDS (UNAIDS) and the World Health Organization (WHO) (2007:4) emphasise that people become infected and die of HIV and AIDS because of limited access to prevention and treatment services. Sub-Saharan Africa is the most affected area. In Sub-Saharan Africa, HIV and AIDS affect more females than males in the age group of 20 to 29 years (Central Statistics Office [CSO] 2005:33). In particular, HIV/AIDS is a cause of grave concern as young people form a larger portion of the world's population and also constitute a larger portion of the infected population.

Botswana, a land-locked country in Southern Africa bordered by Namibia, South Africa, Zambia and Zimbabwe, is currently among the countries with the highest HIV prevalence rates. In Botswana, young people under the age of 15 years form 37% of the population and the age group 0 to 29 years represent about 67.84% *(68.25% Batswana only)* of the country's population (CSO 2003:14; 2005:5). Consequently, young people in Botswana form a bigger part of the infected population. Specifically, in Botswana, females between 20-24 and 25-29 years old account for 26.2% and 41%, respectively, while their male counterparts account for 9.1% and 22.9%. The aggregation of males and females aged 20-24 years and 25-29 years is 32% for males and 67.2% for females (CSO 2005:35). The Ministry of Health (MOH) (2006:31)

indicates that the most infected age groups among antenatal clinic (ANC) attendees are 30 to 34 (48.7%), followed by 35 to 39 (42.7%), 25 to 29 (41.8%) and 20 to 24 (29.4%). Although females are the most affected, the UNAIDS (2001:211) emphasises that the men's attitudes and behaviour are responsible for fuelling the scourge. A behaviour of males that drives HIV and AIDS is having sexual intercourse with young girls more than ten years younger than them, thereby increasing their risk of infection, as these men are more likely to be HIV positive (Ray 2001:43).

In 2001, the HIV prevalence among pregnant women aged 15 to19 and 20 to 24 years was 24.1% and 39.5%, respectively (NACA 2002:24). In 2002 and 2003, the prevalence rate among pregnant females aged 15 to 19 ranged between 21% and 23%; among those aged 25-29 years the rate was 49.7%, and for the 20-24 year old group, 38.6% (NACA 2003:1). In addition, young people represent the larger section of the women attending antenatal clinics. In 2003, the teenage pregnancy rate had declined from 24% to 17% (MOH 2003:3). A study of rape in Botswana commissioned by the Botswana Police Service indicates that the rape incidence rate is high among adolescents of the age group 11 to 15 years, accounting for 52% of the under-16 survivors (Matshediso 2005b:3).

The HIV and AIDS epidemic has caused immense economic, social and other strain globally. The number of people living with HIV and AIDS (PLWA) continued to increase until it reached a plateau, before a decline was recorded. In 2005 and 2007, the estimations were at 40.3 million and 33.2 million, respectively (UNAIDS & WHO 2005a:2; 2007:3). A decline was noted in 2006 with a record of 39.5 million and has continued, as revealed by 2007 statistics (UNAIDS & WHO 2007:3). There has been a further decline and stabilisation of the epidemic despite some nations still recording high levels of both new HIV infections and deaths (UNAIDS & WHO 2008:32). Southern Africa continues to lead in reporting high numbers, with the region accounting for 35% of new infections and 38% of deaths in 2007. In addition, the region accounts for 67% of PLWA (UNAIDS & WHO 2008:32).

Efforts to prevent infection and spread as well as to support, care for and treat those who are infected have drained resources to a level where budgets allocated for other projects and development have been diverted to HIV and AIDS interventions. Sub-Saharan Africa remains the hardest hit with 25.8 million PLWAs, and at the same time

accounts for 57% of infected women aged 15 to 49 worldwide (UNAIDS & WHO 2005a:2). In many countries in Southern Africa three quarters of young people are living with HIV and AIDS. Furthermore, young women aged 15 to 42 years are three times more infected than males of the same age (UNAIDS & WHO 2005b:9).

It is therefore evident that certain factors make girls and women more vulnerable compared to men. These factors include gender inequality, gender-based violence, and economic disempowerment of women, sexual abuse, early marriage, and infidelity of partners. To make a difference, it is imperative that prevention programmes target all ages. Despite the interventions and new approaches to combating HIV/AIDS, the epidemic continues to escalate in some countries and regions, particularly in Southern Africa. For example, Botswana and Swaziland have recorded a prevalence of above 30% among pregnant women (UNAIDS & WHO 2005b:4).

HIV and AIDS have reversed all Botswana's past merits. Botswana recorded the best health indicators in the region, particularly in infant and under-five mortality, antenatal clinic attendance and deliveries conducted by skilled health care providers. These results were attained through provision of comprehensive, quality and timely health services. Consequently, the country's economic growth also earned it a credit and this was achieved and maintained through adherence to good governance practices since the country's independence. However, Botswana experienced a reversal of gains after 1986 and the emergence of HIV and AIDS. In 1992, the prevalence among pregnant women was 18% and steadily increased to 38.5% in 2000. In 2001 and 2002, the HIV prevalence rate among pregnant women was 36.2% and 35.4%, respectively, which marked a decline between the two years (National AIDS Coordinating Agency [NACA] 2002:ii). In 2003, the rate rose to 37.4% (NACA 2003:1; MOH 2007:41). However, a decline was noted in 2005 (33.4%) and 2006 (32.4%) amongst pregnant women attending ANC (MOH 2007:41). In 2007, the prevalence rate amongst pregnant women attending ANC again rose slightly (33.7%).

For some time the prevalence rate escalated and affected individuals, families, and communities. The increased prevalence among pregnant women implied the same for the general public. In 2004, the Botswana national HIV prevalence rate was 17.1% (CSO 2005:35; MOH 2007:1). In 2008, an increase was noted in the national prevalence rate (17.6%) and an incidence rate of 2.9% for the country (CSO 2009:1).

The epidemic has adversely affected economic development and the quality of life at national, community, family and individual level because resources for development are diverted to HIV and AIDS interventions. Moreover, in many cases the breadwinners lost their jobs or died, leaving families in dire straits. According to the Ministry of Finance and Development Planning (MFDP) (2006:3), HIV and AIDS have drained financial resources, trained personnel, and family income.

All sections of the population, including young people, are affected. The majority of the infected contracted the virus at a young age. Despite several interventions put in place, the country continues to experience a toll in infection rates as well as AIDS cases and deaths, leaving children orphaned and vulnerable. There is a serious need for interventions to assist individuals to adopt positive behaviour and attitudes to prevent the infection. The provision of YFS is one of the strategies hence the YACs to provide young people with reproductive health, STI, HIV and AIDS services. Botswana's focus on critical issues includes HIV and AIDS with the aim of arresting the scourge (MFDP 2006:3).

1.2 BACKGROUND TO THE PROBLEM

Efforts to stop the spread of and prevent HIV and AIDS, particularly programmes aimed at prevention, have proved limited in reaching young people to make them internalise the problem. The interventions have not succeeded in reducing the infection rate among the sexually active. Jackson (2002:123-125) maintains that for people to change their behaviour and develop and maintain healthier behaviour requires more than knowledge alone. People need skills to apply the knowledge (Jackson 2002:123-125). According to Levinsohn, Dinkelmann and Majelantle (2006:11-13), knowledge is central to preventing new HIV infections because people with better knowledge and education are more likely to adopt and practise safer behaviours. In the USA, Fan (2002:254-255) found that persuasive information has a positive impact on secular trends in health-related behaviours, specifically high school cocaine addicts and gay men. Therefore, giving information and personal empowerment is a strategy that should be applied to assist young people to stay safe from HIV and AIDS and other social ills.

Behavioural change and empowerment of individuals is crucial and central to the reduction of the incidence of HIV and AIDS. The main factors that fuel the infection rate

are behavioural. Therefore, efforts to prevent HIV and AIDS should assist and guide people to change their sexual behaviour. Behaviour is normally displayed in response to some influence in the environment. Individuals' behaviour can be predicted by the attitudes displayed towards the object (Glanz, Lewis & Rimer 2002:68). Hill, White, Marks and Borland (2002:174) maintain that behaviour is directed by the attitudes that an individual has about a given thought. Attitudinal change precedes behavioural change. Consequently, to change behaviour, interventions should target people's attitudes to influence the change and persuade them to change the behaviour.

Behaviour is practised for satisfaction purposes and thus becomes "pleasurable behaviour" and therefore difficult to forego. For changes in knowledge, attitudes and behaviour, people must be exposed to influential and persuasive messages for a consistent period of time. Influence occurs when a source deliberately tries to change a receiver. Persuasion occurs when a source deliberately uses communication to change a receiver's attitude. An attitude is a person's evaluation of an object of thought (Fan 2002:255). Clearly, then, people's behaviour is directed by their attitudes. Consequently, to change their behaviour, their attitudes should be affected positively to nurture the desired behaviour.

Even though attitudes drive behaviour, there are times when people act in a manner not consistent with their attitudes because of the pressure prevailing in the environment. In other words, the environment has an influence on how people behave. The researcher is of the opinion that for behavioural change to occur, the environment should also be altered to be conducive to nurturing the desired behaviour. This implies that at times people engage in risky behaviour not because they have a positive attitude about it, but due to pressure presenting in the environment. Changing behaviour involves first changing attitude and secondly, getting the attitude to drive behaviour. To get "attitude-behaviour-consistency" (ABC), certain factors or conditions prevail. These conditions are attitude availability and attitude relevance. Attitude availability is the active or operative thinking prompted by teaching or priming people about the desired behaviour. Attitude relevance refers to useful or applicable or pertinent thinking that applies to the situation at hand (Hill et al 2002:174-176).

Environment has a powerful influence on subsequent behaviour, which means that the existing environment acts as a control for the way people behave. If the environment

controls behaviour, then, to change behaviour, the environment has to be modified to nurture the desired behaviour. People intrinsically use antecedent cues to predict the outcomes of a situation to make a decision on how to act. Intentions have been found to be only modestly related to later behaviour. Good intentions account for only 20% to 30% of the variance in the desired behaviour and strong intentions have more influence than weak ones, even though both sometimes fail (Ottati & Krumdick 2007:105). However, there are ways to increase the power of the environment in order to implement interventions to trigger intentions.

Condom use in sexual intercourse is key to HIV and AIDS prevention. Besides abstinence, condoms remain the only effective and efficient commodity for the prevention of HIV infection among the sexually active segment of the population. Therefore, it is imperative to assess whether the interventions in place are effective in influencing condom usage. This study wished to examine and determine the effectiveness of these interventions in behaviour change. According to Berer (2006:13), "safer sex or use of condoms is not only based on knowledge but the social norms and cultural influence play a role". This could be the reason for low condom use among married couples compared to single people. For example, condom usage at most recent sexual intercourse by young women in Sub-Saharan Africa was reported as 4.5% and 28.4% for married and single people, respectively (Cleland, Ali & Shah 2006:18).

The Government of Botswana employs several interventions throughout the country to create an environment to influence young people to change their sexual behaviour (NACA 2003:1). The Kgatleng District, in particular, has interventions in place aimed at assisting young people to prevent HIV infection and AIDS disease. The YAC and YFS are among the strategies employed to combat HIV. Health facilities, the YAC and other related information services are in place to facilitate access to services such as information, educational sessions on HIV and AIDS and condom provision, voluntary counselling and testing (VCT) to assist individuals to change behaviour and prevent HIV infection (NACA 2003:1). Although the hospital and clinics have been in existence for the last ten years or more, the information, education, communication and counselling were inadequate. Now in the era of HIV and AIDS and with the country re-examining the strategies and interventions employed, the health facilities strengthened their approaches with the aim of reaching adolescents particularly for HIV/AIDS prevention.

The YAC was introduced as a new approach to reach and address young people's issues.

A YAC is a facility that offers YFS targeted specifically at young people between the ages of 10 and 29 years. The facility is unique as the providers and staff are young adults and young people who are friendly, accepting and responsive to youth, and the environment and facilities ensure privacy. Moreover, the facility is guided by flexible and comprehensive policies and procedures to nurture the needs of the target audience. Most importantly, youth involvement is central to the delivery of services. Involving young people in the delivery of sexual and reproductive health services targeted at them means identifying and implementing initiatives with their full participation daily and in planning the programme. The intervention is therefore more likely to be successful and achieve the desired outcome (McDowell & Mitchell 2006:189).

Botswana has expanded reproductive health services to include young people. The Maternal and Child Health/Family Planning (MCH/FP), now Sexual and Reproductive Health (SRH) programme, has adolescent health services incorporated in the framework. In particular, Botswana Family Welfare Association and Population Services International, as one of the organisations offering YFS, is supported by the Government through the Botswana National Youth Council (BNYC) to take condom programmes to young people (United Nation Population Fund-Botswana [UNFPA-Botswana] 2003:41).

The involvement of young people not only provides a youth-friendly environment but also bridges the gaps in knowledge and understanding between the programme implementers and their target audience. The aim of YFS is to create an environment that encourages and assists young people to seek services with no barriers, as is the case with public health facilities. In 2001, the Social Impact Assessment and Policy Corporation (SIAPAC) (2001:62) found that young people do not utilise public health services due to nurses' attitudes, long waiting periods, and lack of privacy as they more often meet aunts and neighbours while waiting to be helped. Accordingly, the services at YAC are designed to eliminate all the barriers that hinder access. The services are youth friendly as the young people are the primary target to assist them avert HIV infection and AIDS disease.

The main characteristics of YFS can be divided into three categories, namely service providers and staff; policies and procedures; and environment and facilities (Adamchak, Bond, Maclaren, Magnani, Nelson & Seltzer 2000:286-287). AYA–Botswana ([Sa]:140) categorises the characteristics of YFS as facility/physical environment; staff/providers; service provision, and policies/administration. The different categories or characteristics all attract young people, put young people's needs first and make access to services much easier for young people compared to the traditional health facilities, which have barriers that hinder young people from accessing services. The literature review describes these categories or characteristics (see chapter 2).

The YAC has a holistic approach to meeting young people's needs. Most of the activities at the YAC may be health oriented, but some essential information such as academic or educational and employment opportunities are also accessed. The key functions of the centre are to reach out to young people and provide information on sexual and reproductive health including HIV and AIDS as well as provision of condoms. The activities of the YAC include health talks, group discussions, video shows, counselling, question-and-answer sessions, the distribution of information, education and communication (IEC) materials, educational activities, and the provision of condoms and voluntary counselling and testing (VCT). VCT is an important strategy in the prevention of HIV infection. VCT may help in many ways to prevent HIV infection as it provides information and assists people to make informed decisions.

The SIAPAC (2001:22) cites Mature (2000:15), who emphasises that

> Most studies have shown that Voluntary Counselling and Testing (VCT) works well as an HIV/AIDS prevention strategy, even in countries where anti-retroviral treatment is not available. Knowledge of aerostats [sero-status] empowers individuals to plan and make important life decisions. People can seek care, support and treatment, where possible. Individuals can be assisted in developing personal risk-reduction plans based on their aerostats [sero-status], and sexual relationships. Together, couples can learn their aerostats [sero-status], discuss risk reduction and plan their future. With information, decisions can be made whether to have more children or whether to breastfeed and provision can be made for the care and support of children.

All the activities at the YAC, including VCT, aim at equipping young people with knowledge and skills to guide them in making decisions and behaving in a responsible manner. The researcher therefore deemed it essential to know the experience of young people utilising the services.

1.3 RATIONALE FOR THE STUDY

The Botswana Government has employed varied intervention programmes and strategies to deal with HIV/AIDS and other health problems. To curb the epidemic, a multi-sectoral approach was adopted as the most appropriate and effective strategy (NACA 2004:1). In particular, the Government in partnership with UNFPA, the Botswana Family Welfare Association (BOFWA), a non-governmental organisation, and the BNYC have pioneered and established YAC concept as a new intervention to reach young people and increase their access to adolescent sexual and reproductive health services. The intention is to provide services that will assist young people to prevent being infected with HIV.

No efforts have yet been made to establish the experiences of young people in utilising the YAC as a facility or to examine the effectiveness of the intervention in preparing, influencing and/or empowering their sexual behaviour. This motivated the researcher to undertake the present study.

1.4 STATEMENT OF THE PROBLEM

In many countries, young people are the most affected by HIV and AIDS and also form a larger percentage of the population. Botswana is among the countries with the highest HIV prevalence rate and young people constitute a large portion of the infected (MOH 2006:33).

The Kgatleng District showed a similar escalation to the national level prevalence rates between 2001 and 2005 until a decline was recorded in 2006 (see table 1.1). However, table 1.1 shows that the district has always had a prevalence rate below the national one.

Table 1.1 HIV prevalence rates for Kgatleng District and national level amongst pregnant women, 2001-2007

Level	2001	2002	2003	2005	2006	2007
Kgatleng District	24.2	30.9	30.6	31.1	24.3	30.8
National level	36.2	35.4	37.4	33.4	32.4	33.7

Source: Computed from 2006 and 2007 Botswana Second-Generation HIV/AIDS Surveillance (MOH 2006:34; MOH 2007:96)

Kgatleng District also experienced a steady increase in HIV prevalence among pregnant women between 2001 and 2003, with rates of 24.2%, 30.9% and 30.6%, respectively. However, the prevalence rate appears to be stabilising (NACA 2003:26; MOH 2007:41). Young people aged 25 to 29 years (1,396) and 20 to 24 years (1,104) are the most affected. For these age groups to be sick, it is evident that they were affected in the adolescence. Many young people in Mochudi and the vicinity engage in sexual relationships with people who are in Gaborone City and frequent or commute to and from the city and/or Mochudi. This exposes young people to meeting people from varied places. Kgatleng District has a challenge to employ strategies and programmes that could motivate young people to adopt or change sexual behaviour in order to prevent HIV and AIDS.

It is significant that many young people are victims of HIV and AIDS, teenage pregnancy, STIs, and sexual abuse, particularly incest, rape and coerced sex. Despite initiatives by health facilities and programmes on health instituted by the government and non-governmental organisations, it is evident that adolescents remain vulnerable and face many challenges, which lead them to being HIV infected.

Young people know about STIs, including HIV and AIDS; family planning methods; condom use, and ways of transmitting HIV and AIDS, but their behaviour and choices are contrary to their high level of knowledge. Almost all people between 15 and 24 years of age have heard of at least one STI while three-quarters of those aged 10 to 14 have also. When asked if they had heard about AIDS, all those aged 15 to 24 had and 90% of those aged 10 to 14 reported having heard (SIAPAC 2001:8). This signifies that efforts to equip young people with knowledge have been employed and been effective. In addition, the same study revealed that 60% of males aged 10 to 14 and 68% of those aged 15 to 24 agreed that it was ‘unrealistic to believe that sexually active people would use a condom every time’. Females’ percentages were higher, with 78.1% for the

10 to 14 year-olds and 72.8% for those aged 15 to 24, which indicates a serious challenge (SIAPAC 2002:8-9).

The knowledge is high but the attitudes and behaviour are different from what one would expect. The males (71.3%) and females (88.1%) aged 15 to 24 were able to identify at least three methods of preventing pregnancy. This evidence that even if young people have the knowledge it does not govern the choices they make. According to SIAPAC (2002:22), 77% of female students and 61% of males reported being sexually active. The knowledge is high as virtually 100% of the 15 to 24 year-old respondents had heard about condoms and many had attended condom demonstrations.

Young people hold positive views about the need for condoms to be used when one is sexually active. However, young people think it is unrealistic to use a condom every time one has sex (SIAPAC 2002:22). It is clear that even though the knowledge is high, there is a need to emphasise consistent use of condoms. Furthermore, if the positive attitudes of young people about condom use are not translated into action, the likelihood of the infection continuing to escalate will be high. The knowledge is high but what young people practise and how they behave shows a lot of disparity. Many young people apparently lack the skill to apply the knowledge they have to their daily lives. The above findings evidence the significance of targeting young people by designing and implementing youth-friendly programmes that aim at equipping young people with skills to empower them for behaviour change. Therefore, there is a need to determine if the strategies employed to affect their attitudes and behaviour have indeed empowered them and have influenced their sexual behaviour. According to Jemmott and Jemmott (2007:243), where there is high practice of unprotected, unsafe sex therefore leading to HIV infection, health promotion should emphasise prevention.

1.5 PURPOSE OF THE STUDY

The purpose of the study was to seek young people's lived experiences in utilising the youth activity centre (YAC) in Botswana.

The purpose of the study was twofold, namely to

- evaluate the Botswana Family Welfare Association YAC in Mochudi in the Kgatleng District Council
- explore and describe the experiences of young people utilising the YAC as well as the experiences and perceptions of service providers at the facility including peer educators

1.5.1 Objectives

In order to achieve the purpose, the objectives of the study were divided into two phases:

- Phase 1
  - (i) To explore and describe the experiences of young people utilising the YAC in Kgatleng District.
  - (ii) To explore and describe the experiences and perceptions of service providers including peer educators.

- Phase 2
  To develop and describe guidelines to facilitate youth friendliness of the YAC.

1.5.2 Research questions

The study wished to answer the following research questions:

- What is the “lived experiences” of young people in using the YAC in the Kgatleng District, Botswana?
- What are the experiences and perceptions of service providers (including peer educators) at the YAC in Kgatleng District, Botswana?
- What are the guidelines that can be used to facilitate youth friendliness at a YAC?

1.6 SIGNIFICANCE OF THE STUDY

The reduction in HIV/AIDS infection and prevalence rates in young people is highly determined by improved access to sexual and reproductive health services by the target group. Improved access depends on the experiences encountered by the users. The lived experiences may either attract one to return for services or deter the recipients. According to Barnett and Schueller (2000:13), young people need services but the prevailing barriers are deterrents. Therefore, where policies and guidelines of implementing YFS are correctly and properly followed, improved access to service should be achieved.

Barnett and Schueller (2000:87) argue that knowledge acquired and skills developed would influence and guide young people to make informed decisions and take responsible actions. The development of the guidelines for implementation of YFS will improve the youth friendliness of the YAC and increase access to information and other services. This will ultimately lead to a reduction in the infection and the prevalence of HIV and AIDS among young people and the nation of Botswana.

1.7 PARADIGMATIC PERSPECTIVE OF THE STUDY

Lincoln and Guba (1985:15) define a paradigm as “a worldview, a general perspective, a way of breaking down the complexity of the real world”. Ulin, Robinson and Tolley (2005:12, 13) describe a paradigm as “a worldview that presents a definition of the social world linked to related sources of information (data) and appropriate ways (methods) to tap these sources” and “a broad theoretical framework (theoretical orientation) that influences how people perceive and understand the world”. For Polit and Beck (2008:761), a paradigm is a manner of examining a natural phenomenon that has several theoretical postulations thereby directing the researcher’s technique of investigation.

A paradigm is a perspective orientation normally given to the view of the social world expressed in terms of concepts and assumptions. It is implicit that paradigms differ not only in concepts and assumptions but also in research problems *(researcher’s opinion)*. Creswell (1994:4) emphasises that paradigms and assumptions of paradigms are important as they guide the design. Moreover, studies are based on specific paradigms

and influenced by the values of the researcher as well as establishing boundaries for scientific inquiry.

Table 1.2 outlines the assumptions of the qualitative paradigm, where each is briefly presented with regard to questions it answers and its naturalistic paradigm. Polit and Beck (2008:25) state that in the naturalistic paradigm the presumed reality is an entity that changes and it is a creation of the human mind hence reality is a combination of varying factors. The naturalistic or constructivist paradigm is another view of the traditional positivist paradigm that believes that there are several explanations of reality, hence research aspires to find out how individuals build and conceptualise reality (Polit & Beck 2008:759).

Table 1.2 Assumptions of qualitative paradigm

Assumptions	Question	Naturalistic paradigm
Ontological	What is the nature of reality in the phenomenon under study?	Reality of the world view of young people utilising the YAC?
Epistemological	What is the relationship of the researcher to phenomenon being studied?	The researcher will interact with the participants by conducting both focus group discussion and in-depth interview. However subjective interaction is given but it will be minimised.
Axiological	What is the role of value in the phenomenon studied?	Values and subjective interaction do exist.
Rhetorical	What is the language of researcher in the study?	The language of the study is acceptable, informal and decision will be made.
Methodological	What is the process of research in this study?	The design, methods of the research will be described and explained in detail in the methodology chapter. This is qualitative phenomenological using the descriptive approach.

The field of public health highly utilises the qualitative paradigm in an effort to understand people's beliefs, attitudes and behaviours. Qualitative methods are suited for answering the how and why questions that yield the lived experience required by public health researchers and programmes to design interventions. Streubert and Carpenter (2003:3) point out that a qualitative approach offers answers to questions on how and gives meaning to human life. The paradigm provides the researcher with a clear set of concepts, principles, and rules for carrying out the research (Ulin et al 2005:12). It was, therefore, appropriate to apply the qualitative paradigm to understand the lived experience of young people who utilise the YAC.

Public health as a discipline aims to promote and protect people's health by establishing and understanding the socio-cultural and socio-economic factors and life styles that threaten the health of the population with the ultimate goal of prolonging life by providing affordable, acceptable, accessible, and appropriate services (Walley, Wright & Hubley 2001:2-4). Qualitative methods, therefore, help public health experts to understand underlying behaviours, attitudes, perceptions and culture in a way that quantitative methods alone cannot. Furthermore, qualitative methods not only help practitioners to understand the problem, but also guide the development of effective interventions that address contemporary public health issues (Ulin et al 2005:xiii).

Public health research has three theoretical paradigms, namely positivist, interpretivist and feminist. The positivist perspective depicts the "social world as being constructed with observable facts and that reality is objective and independent of the researcher. A qualitative researcher for an interpretivist paradigm views the social world as constructed of symbolic meaning observable in human acts, interactions, and language. Reality is subjective and multiple as seen from different perspectives while from the feminist perspective social world is governed by power relations that influence acts and perceptions and that reality is negotiated and differs according to power" (Ulin et al 2005:16). Rice and Ezzy (1999:12) point out that the positivist paradigm uses standardised and repeatable ethnology.

1.7.1 Paradigmatic approach

Babbie (2007:294) states that research anchors on the phenomenologist paradigm; that reality is not observed but rather socially constructed and that people describe the world as they view it thereby underlining the direct description of the experience with regard for its foundation or roots. The paradigm examines the complexity of the phenomenon of "lived experiences" of young people utilising the YAC. Van Manen (1990:4) states that human science requires description, interpretation and self-reflective or critical analysis, which aims at explicating the meaning of human phenomena and understanding the lived structures. The researcher therefore found the phenomenological paradigm suitable for studying the "lived experiences" of young people utilising the YAC.

Public health experts as human scientists who design health interventions emphasise a holistic approach to the amelioration of public health problems. The researcher found the ecological model for health promotion applicable and relevant as it focuses on individuals and linking them to their environment. The ecological models in general recognise the importance of intra-psychic and social environments. The models explain "how environments affect behaviour and how environments and behaviour affect each other" (Sallis & Owen 2002:463). The individual's interaction with the environment is of the utmost importance in the ecological model. Health is influenced by four major elements, namely human biology, environment, lifestyle, and health care organisation. In addition, the ecological model for health promotion is supported by systems theory which describes and links people to their environment and also shows how the parts or systems affect each other (Stanhope & Lancaster 2000:198-199).

The concept of YAC was engineered on the grounds that the intervention will provide the target group with holistic and comprehensive services, where the person is assisted, trained and developed to link to their environment and made to understand that their health is influenced by their environment. Above all, the YAC was intended to empower individuals to take control of their situation (researcher's opinion).

The qualitative research paradigm adopted in this study sought to understand life in a way that the perspectives and experiences of the people who lived them were considered important (Ulin et al 2005:4). The study wished to explore and describe the lived experiences of young people who utilised the YAC.

1.7.2 Assumptions

Polit and Beck (2008:14) outline four assumptions, namely ontological (meta-theoretical); theoretical (epistemological); anxiological, and methodological assumptions. Botes (1995:4) refers to three, namely ontological (meta-theoretical); theoretical (epistemological), and methodological assumptions. This study discusses only three assumptions common to Polit and Beck (2008:15), Creswell (1994:5) and Botes (1995:4). These assumptions each answer a specific question as indicated in table 1.2.

1.7.2.1 Ontological (meta-theoretical/meta-paradigm) assumption

Polit and Beck (2008:15), Creswell (1994:5) and Botes (1995:4) concur that ontological assumptions answer the question 'what is the nature of reality'? They are not testable and address human beings and society. The assumption has its origins in philosophy and influences the researcher's decision.

In this study the researcher was influenced by her values and assumptions emanating from her professional background and experience. In this study the researcher made the following ontological assumptions:

- *Target population/client* – Clients targeted by the research or interventions to meet their identified needs or the problems facing them.

- *Service provider* – Service providers as health care workers have a role to play in influencing the health of the population. They provide information, educate and advise clients or patients. According to Walley et al (2001:238-239), service providers have a role in teaching clients about diseases.

- *Environment* – Environment represents the physical, social and psychological constructs in which a person exists. Environment is linked to the health of the population. Whent (2000:41) argues that environment is correlated to the economy and the health of the people.

- *Health promotion* – Health promotion interventions are essential to improve people's health. Health promotion interventions should equip people with information, assist them to acquire knowledge and adopt safer behaviour. Naidoo and Wills (2005:4) emphasise that health promotion aims to empower individuals to have control over their health.

- *Health* – Heath is an integral part of a human being. Therefore, being at one's best health improves the quality of life. The WHO (Modeste 1996:44) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". According to Whent (2000:41), in protecting and promoting human health five programme areas need to be

covered, namely "meeting primary health care needs, control of communicable disease, protecting vulnerable groups, meeting the urban health challenges, and reducing health risk from environment pollution and hazards".

1.7.2.2 Theoretical (epistemological) assumption

The theoretical assumption addresses the question "what is the relationship of the research to the researcher". The assumption is testable and offers epistemic pronouncement about the field of research (Botes 1995:6). The programme documents, policies, the origin and philosophy of the YAC, and public health interventions are paramount. The researcher must conduct a thorough review of pronouncements. Theoretical assumptions can also be stated after data collection, to shape the hypothesis, or central theoretical statements and the conceptual framework.

- *Ecological model for health promotion*

The researcher applied the ecological model for health promotion to the findings of the study to enhance understanding of the results. The use of the ecological model for health promotion is advocated for the design of health promotion programmes. The model emphasises the use of the interaction of the individual with the environment (Sallis & Owen 2002:465). Stanhope and Lancaster (2000:199) describe the relationship of the individual and the environment subparts and the parts of the system. Young people grow and develop in an environment that has several players which need to be recognised by the YAC. The interplay influences the behaviour, and could be healthy or unhealthy. Health is influenced by four key elements, namely human biology, environment, lifestyle, and health care organisations.

- *Ottawa Charter for Health Promotion*

The 1986 Ottawa Charter for Health Promotion emphasises the importance of socio-cultural and physical environment's influence on health. The Ottawa Charter strongly urges health promotion approaches that accord same status to the creation of supportive environments alongside the development of personal skills and the reorientation of health service (Naidoo & Wills 2000:288-9; 2005:151-2). Health

promotion interventions must address the environmental resources that may either facilitate or hinder the targeted health behaviour change.

➢ *Theory of practice of discipline*

The theory of practice of discipline gives a survey list that links theory, practice and research. Dickoff, James and Wiedenbach's (1968:420) survey lists six aspects of activities for an intervention. The survey list was applied in the development of the guidelines of facilitating youth friendliness in a YAC.

Therefore the researcher entered the field not guided by any theory, but using bracketing and intuiting.

1.7.2.3 Methodological assumption

The assumptions deal with the process of research, the researcher's view of the nature or world, and the structure of science and research in the discipline (Polit & Beck 2008:15; Creswell 1994:5; Botes 1995:7). In addition to the meta-theoretical and theoretical assumptions, the researcher also does methodology assumption. The assumptions have their origins based in the science philosophy. The researcher's methodological assumptions are influenced by theoretical assumptions and the assumption made by the research directs the research design.

In this study, the researcher inductively synthesised themes from the information provided by the participants. Focus group discussions were held and questions asked without the researcher specifying the themes. The methodological assumptions are discussed under research design, and data collection and analysis in chapter 4.

1.7.3 Central theoretical statement

The researcher's formulated central theoretical statement for this study was as follows:

The exploration and description of the experience of young people utilising the YAC in Kgatleng District in Botswana will reveal the views, values and concerns as well as challenges of the target group and how programmes aiming at reaching young people

could be improved. The information then forms the foundation for the development of the guidelines for facilitating youth friendliness in a YAC to improve access to quality services. The adequacy of information and improved knowledge along with skills to make informed decisions coupled with responsible behaviour will result in a reduction of HIV and AIDS incidence and prevalence rates, hence improved quality of life for young people.

1.8 RESEARCH DESIGN AND METHODOLOGY

The researcher conducted a qualitative study. Chapter 3 discusses the methodological framework in detail.

1.8.1 Design

The description of the research design is meant to direct the process. In particular, the research design for this study was qualitative and followed a descriptive phenomenology where the experience of the population under study was explored and described. Studying the lived experience of young people who utilised the YAC required the researcher to explore and describe their "worldview".

1.8.2 Methodology

The design and methods for this study were carried out in two phases. These involved the collection of data on the experience of both young people and service providers at the YAC, and the design or formulation of the guidelines meant to facilitate the youth friendliness at the facility.

1.8.2.1 Phase 1: Exploration and description of the "lived experiences" of the young people utilising the youth activity centres (YAC)

In this phase background information to the study is given, followed by a literature review. The review explicated the need for YAC and YFS, as well as examining past programmes that target young people. Special investigation and attention was given to HIV and AIDS because it is one of the major sexual and reproductive health problems affecting young people in large numbers. Subsequent to this, work commenced when

the researcher, using a qualitative method, gathered the "lived experiences" of young people who utilised the YAC and service providers. The informants narrated their worldview and what it meant to them. The researcher's written descriptive report based on the information gathered from the informants paved the way for the analysis, which was based on the findings and the literature control. The completion of phase 1 then guided phase 2 of the study.

1.8.2.2 Phase 2: Formulation and description of guidelines on facilitating youth friendliness at the youth activity centres (YAC)

In this phase, the researcher applied her knowledge and expertise to develop and describe guidelines to facilitate youth friendliness of the YAC. In addition, conclusions and recommendations were made to further guide and improve the YAC. Moreover, suggestions were made on research needed to better comprehend and implement successful youth intervention programmes.

1.9 SCOPE OF THE STUDY

The study addressed the concepts of YAC and YFS as key strategies that have been widely employed in an effort to reach young people to tackle the issue of HIV and AIDS and other sexual and reproductive health issues. The study delineated the ecological model of health promotion so that the development of the guidelines for facilitating youth friendliness at the YAC could be based on the latter.

1.10 DEFINITION OF TERMS

The following terms are used in the study as defined below.

- **Adolescent**

An adolescent is a person in the age group in transition between childhood and adulthood, commonly defined as ages of 10-24 (Adamchak et al 2000:229). Adolescent in the dissertation refers to young people in the growing stages of 10 to 29 years of age. These are the ages served by the YACs in Botswana.

- **Ecology**

The *Oxford Advanced Learner's Dictionary* (2006:465) defines ecology as "the relation of plants and living creatures to each other and to their environment". According to Sallis and Owen (2002:462), ecology is the interrelations between organisms and their environments. In public health, the ecological perspective of the payment focuses on the nature of people's transactions with their physical and socio-cultural surroundings. In this study, ecology was applied to relate to the young people and the YAC, to understand how the YAC environment affects the young people.

- **Ecological**

Ecological refers to "models, frameworks or perspectives rather than specific variables" (Sallis & Owen 2002:462). The *Oxford Advanced Learner's Dictionary* (2006:465) defines ecological as "connected with the relation of plants and living creatures to each other and to their environment". In this study, the ecological framework was employed to guide understanding and interpretation of the results.

- **Experience**

The *Oxford Advanced Learner's Dictionary* (2006:513) defines experience as "the knowledge and skill that you have gained through something for a period of time". In this study, experience referred to the expressed feelings, knowledge, skills and physical sensations undergone by the users of the YAC.

- **Health promotion**

Naidoo and Wills (2005:vii) state that "health promotion refers to efforts to prevent ill health and promote positive health with the central aim to enable people to take control of their own health". Health promotion is a component of public health that deals with designing interventions to promote health and prevent disease through active involvement of the individual or the community.

Walley et al (2001:274) define health promotion as an empowering process that equips people through giving them information, knowledge, skill and necessary means to take

action, be in control of their life to change the lifestyles they lead and creating environment conducive to positive behaviour leading to improved health.

- **Intervention**

The *Oxford Advanced Learner's Dictionary* (2006:782-783) defines intervention as "an act of coming between two situations to influence positively". Walley et al (2001:275) define an intervention as "the means to address a problem through planned program activities". In this study, an intervention referred to an activity put in place to ameliorate existing circumstances and bring improved health and quality of life.

- **Service providers**

These are individuals who are professionally trained to deliver certain services to the target group or the population being served. In this study, service providers included both professional and peer educators.

- **Youth activity centre (YAC)**

YAC in this study refers to a facility that offers YFS targeted specifically at young people aged 10 to 29 years.

- **Youth friendliness or youth friendly**

In this study, youth friendliness or youth friendly denotes an entity that has characteristics needed for the facility or services to attract young people because it is convenient for them and meets their needs.

- **Youth-friendly services (YFS)**

In this study YFS refer to the planned and implemented programme activities that are tailored to attract young people, meet their needs as well as being suitable for them.

- **Young people**

In this study young people refer to all those aged between 10 to 29 years, regardless of their sex, marital status and parity.

- **Utilising**

The *Oxford Advanced Learner's Dictionary* (2006:1629) defines utilising as "to use something, especially for a practical purpose". *Collins Concise Dictionary* (2001:1484) defines utilising as "to make practical or worthwhile use of". In this study, utilising refers to the practice of seeking and receiving services at the BOFWA YAC in Mochudi by the target group.

1.11 OUTLINE OF THE STUDY

Chapter 1 describes the rationale for, purpose and objectives of the study, and the research design, and outlines the paradigmatic perspective of the research.

Chapter 2 discusses literature review for the study.

Chapter 3 describes the research design and methodology.

Chapter 4 discusses the data analysis, interpretation and literature control.

Chapter 5 develops and describes guidelines for facilitating youth friendliness in a YAC.

Chapter 6 concludes the study and makes recommendations for practice and further studies.

1.12 CONCLUSION

This chapter discussed the background to, rationale for, and the purpose, objectives and significance of the study, briefly described the research design and methodology, and defined key terms. The study was conducted in Mochudi, in Botswana in the Kgatleng District. This is one of the few YACs that is well established and has a

comprehensive programme. YACs value young people and have a holistic approach to provision of services. The researcher considered it important to know how young people experience the implementation of programmes in these centres.

Chapter 2 discusses the literature review undertaken for the study.

CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter discusses the literature review conducted for the study. The review focused on attributes of YACs, particularly YFS; participatory learning (experiential learning) and empowerment; HIV and AIDS; the need for youth programmes, and programmes aimed at reaching out to young people.

Young people are the YACs' target audience and are actively involved and participate in the planning and delivery of services. The reason for this is that the programme and the activities are more likely to be relevant when the target audience is part of the implementing machinery, as they know the needs of their peers and what will interest them (Barnett & Schueller 2000:83).

The YAC learning approach is participatory, also known as experiential learning. This approach demands that participants be actively involved in the planning, implementation and delivery of services. Participatory learning as a medium and technique for imparting information has the ability to empower and, therefore, prepares learners for behaviour change through their determination of priority needs and problems (Matshediso 2005a:5). Participants are an important part of the learning process because the programmes are designed to equip them with the necessary knowledge and skills to change their attitudes. Participatory learning creates opportunities for learners to explore and exercise their capabilities. It allows self-empowerment through self-exploration. The participants are exposed to self-directed and collective learning (interacting with others), hence individualised as well as shared discovery or learning (Matshediso 2005a:8). Members become empowered through participatory experiences, which enable a group to be proactive and knowledgeable in areas of their needs such access to treatment for STIs and reproductive rights.

Empowerment is vital in influencing behaviour change, as it prepares individuals to deal with challenging situations positively and effectively because they are equipped with life and livelihood skills (Matshediso 2005b:8). For example, empowering individuals or communities enables them to facilitate and utilise local and available resources efficiently and effectively to tackle their problems.

According to Meyer et al (2000:741-742), young people are an important group in endeavours to prevent STIs and HIV infection. Jemmott and Jemmott (2007:243) emphasise that young people are the most afflicted by HIV and AIDS. In South Africa a survey among adolescents between 15 and 24 years old found that one in five are already infected by HIV by 23 years of age (Ndaki 2004:52-53).

2.2 PURPOSE OF THE LITERATURE REVIEW

A literature review is undertaken to assist researchers to comprehend and extend their knowledge of the phenomenon being researched (Polit & Beck 2008:105). According to Crosby, DiClemente and Salazar (2006:8), the purpose of a literature review is to ensure the researchability of the topic before the actual research commences and to equip the researcher with an understanding of the topic being investigated to guide and enable the formulation of the goal, which communicates the purpose of the research. Literature reviews share the results of other studies related to the phenomenon under study by examining what has already been done on the topic, the key issues and theories on the subject area thereby making the researcher knowledgeable on the topic prior to data collection (Polit & Beck 2006:55).

2.3 SCOPE OF THE LITERATURE REVIEW

In this study, the literature review covered YFS, the strategy applied through the establishment of the YAC; participatory learning and empowerment; the global HIV and AIDS situation, and how young people are affected in Botswana, with special focus on the Kgatleng District. The study further wished to examine how effective the YAC and its youth-friendly programmes had been in reaching out to young people in the district, and compare existing research findings with those of the present study to identify gaps and similarities (Polit & Beck 2008:106-107).

2.4 YOUTH-FRIENDLY SERVICES

Young people in Sub-Saharan Africa face huge problems in accessing sexual and reproductive health services, and youth-friendly services (YFS) will remove the challenges hindering utilisation (Moya 2002:1). Moya (2002:1) describes YFS as programmes and services that have policies, procedures and practices that attract young men and women of various ages to utilise services. According to Barnett and Schueller (2000:83), youth-friendly programmes "must actively involve adolescents in the design and delivery of service; and must consider how adolescents' needs differ from those of adults and provide services that specifically meet the needs of young people". YFS provide young people with a comfortable and appropriate setting, meet their needs, and retain them for follow-up and repeat visits (AYA-Botswana [Sa]:136). YFS are free of barriers that impede young people from accessing services. Jackson (2002:103) maintains that youth-friendly health services providing sexual and reproductive health care should be more widely established because young people are the hardest group to reach. Young people fear being seen in traditional health facilities by adults who label them as sexually active. In addition, parents' and service providers' attitudes are a deterrent because they judge youth who access health facilities for sexual and reproductive services (SIAPAC 2001:17).

Senderowitz, Hainsworth and Solter (2003:3) emphasise that YFS "have policies and attributes that attract youth to facilities or programmes, offer comfortable and appropriate settings for youth, meet the needs of young people, and are able to retain their clients". AYA-Botswana ([Sa]:136) stipulates that YFS should provide a comfortable, acceptable, accessible environment to ensure privacy as well as confidentiality. The delivery of YFS programmes takes into consideration young people's physical, psychological and emotional development. It takes a holistic approach to delivery of services and, most importantly, YFS apply participatory learning and empowerment techniques that enhance the meaningful involvement of participants in the design, implementation and delivery of services (Barnett & Schueller 2000:85).

2.4.1 Participatory learning/experiential learning

Participatory or experiential learning is key in the provision of YFS. Participatory or experiential learning promotes participants' active involvement in the learning process. Participatory and experiential learning are synonymous. Experiential learning enables

learners to see, feel, and experience the issues being addressed. As participants learn, they gain a sense of the feelings experienced by the victims of the problem. Thinking about the activities and who they are, helps to trigger the motivation to change or make an effort to acquire the desired behaviour (Matshediso 2005a:3). Participatory or experiential learning promotes dialogue within the group because of interaction and sharing of experiences. Participation, then, brings transparency between young people and service providers (Interactive Population Centre [IPC] [Sa]:1).

In Cambodia, Busza and Schunter (2001:73) found that participatory learning and empowerment brought people together to work in harmony to solve problems. The United Nations Development Programme (UNDP) (2006:24-25) maintains that local problems are best solved by local solutions.

Participatory learning was used in a pilot project of YFS in Botswana in 1998, when the participants were introduced to peer education as a way of transformative change for them (Seboni, Seloilwe & Mnsimanga 2002:10). The pilot projects were up-scaled and the young people seemed to enjoy the participatory approach (Matshediso 2005a:3). In participatory or experiential learning, participants learn through self-directed, participatory and collaborative efforts where there is self-discovery of information. Participatory learning leads to increased understanding, feelings of unity and willingness to cooperate, participate and work with others.

This method allows the exchange of ideas and uses a problem-posing element that creates a learning experience and growth for participants and facilitators. This experiential activity enables participants to see and know reality, hence individualised or shared discovery of ideas. Experiential learning fosters practical, critical thinking because participants discover things for themselves in solving problems.

2.4.2 Empowerment

According to then UN Secretary-General, Kofi Annan (Park 2002:23), young people "should be in the forefront of global change and innovation. [When] empowered they can be key agents for development and peace. Let us ensure that all young people have every opportunity to participate fully in the lives of their societies." Empowerment is central to improving young people's health by providing them with YFS. Access to

services, training and involvement empowers the target audience with information, knowledge and skills. Mackinnon (2007:194) maintains that empowerment is more than just participation. Young people must have knowledge; their views should be considered and acknowledged, and action taken on what they propose.

Collins English Dictionary (1999:511) defines empower as “to give or delegate power or authority to; authorise; to give ability to; enable or permit”. *Collins Concise English Dictionary* (2001:503) defines empowerment as “the process of giving a person or group of people power and status in a particular situation”. The *Oxford Advanced Learner’s Dictionary* (2006:479) defines empower as “to give somebody more control over their own life or the situation they are in”. Matshediso (2005b:2) found that empowerment is a social-action process that equips people with knowledge and skills through individual, family and community participation to achieve the goal of attaining control over their lives and improved quality of community life as well as social justice.

The end result of empowerment is “power”, therefore programmes on empowerment use “power holders” to transfer power to those less powerful (Ozaralli 2002:2). Empowerment is essential in any intervention that aims to improve or change the lives of individuals and communities. Empowerment improves individual and group strengths by helping them overcome help-seeking behaviour and deal with obstacles proactively rather than become more dependent on service providers. The researcher is of the opinion that since the aim of health promotion and education programmes is to enable individuals to achieve better health by taking control of their lives, empowerment is appropriate to balance the power and ability of the target group to be proactive. Empowerment shifts control to individuals or communities.

Empowered individuals, groups or communities are committed to their members; understand and solve community problems; are flexible and creative; are effective in enforcing standards of behaviour, and focus on capacities rather than deficiencies (Matshediso 2005b:8-9). Therefore empowerment of individuals, groups and communities is the cornerstone of delivering health promotion and education intervention programmes that aim at behaviour change.

In this study, empowerment refers to a process of assisting and guiding individual young people, the users of the YAC, by means of systemically organised activities delivered by professionals or trained service providers to equip and train them to acquire knowledge and develop skills and ultimately apply the behaviour in their everyday life.

2.5 HUMAN IMMUNO-DEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Botswana is among the countries with a high prevalence of HIV and AIDS. Young people are most affected and they account for 40% of new infections (UNAIDS & WHO 2006:3). They are vulnerable as they are exposed to peer pressure and are at a stage where they explore and experiment with things. Therefore, health promotion and education intervention programmes are vital to empower young people with knowledge and skills to enable them to avoid HIV and AIDS.

2.5.1 Global overview of HIV and AIDS epidemic

The HIV and AIDS epidemic has global socio-economic and development problems. The infection rate has taken an alarming toll in a short period of time. Between 2005 and 2006, the number of PLWA rose from 40.3 million to 47.1 million (UNAIDS & WHO 2005a:1; 2006:3). At the same time, the number of new infections dropped from 5 million in 2005 to 4.3 million in 2006, and the number of deaths from 3.1 million and 2.9 million (UNAIDS & WHO 2005a:1; 2006:3). In 2003, there were 40 million PLWA worldwide, of whom 2.5 million were children under 15 years old; 5 million people were infected, and 3 million died from AIDS (UNAIDS & WHO 2005a:1). In 2007, 2.1 million deaths were recorded, indicating a decline compared to the 2005 and 2006 statistics (UNAIDS & WHO 2007:3).

Current statistics show that 6 800 people are infected each day (UNAIDS & WHO 2007:4). In 2007, of 33.2 million PLWA, 30.8 million were adults and 2.5 million were children. The HIV pandemic continues to be the most serious infectious disease causing major concern to the field of public health (UNAIDS & WHO 2007:4).

2.5.1.1 Transmission

Heterosexual activities are the main mode of transmission in Sub-Saharan Africa and Asia. Most infected are women hence the high mother-to-child transmission. The regions and countries with highest prevalence have shown that both heterosexual and vertical transmissions are the commonest transmission routes. Botswana and Swaziland are examples of such countries with a prevalence of above 30% among pregnant women (UNAIDS & WHO 2005b:4). Both Botswana and Swaziland are still mentioned as countries with high infection despite evidence of the decline in infection rate (UNAIDS & WHO 2007:11). Southern Africa has persistently reported high numbers, with 35% of new infections and 38% of deaths in 2007 (UNAIDS & WHO 2008:32-33).

2.5.1.2 Infection rate

Southern Africa remains the epicentre of the global HIV epidemic with 32% of people living with HIV in the sub-region. The infection rates vary widely, from 1% in Mauritania to 39% in Botswana and Swaziland. Young people are among the most affected, particularly young women between 15 and 24 years of age. They are 2.5 times more likely to have HIV than men of the same age. The infection rates in Sub-Saharan Africa, mainly in Mozambique, South Africa and Swaziland, continue to rise (UNAIDS & WHO 2006:6). In 2007, a slight decline in the infection rate was reported in some African countries, including Botswana (UNAIDS & WHO 2007:6). UNAIDS and WHO (2008:32) categorise Botswana as having a statistically significant decrease in HIV prevalence.

In 2003, Southern Africa accounted for 30% of PLWA while in 2007 the number rose to above 35% and reached 67% by the end of 2007 (UNAIDS & WHO 2007:15; 2008:32). Women are particularly affected, as they are more likely to be economically disempowered and experience unequal power sharing with their spouses or partners. Only 23% of the 4.6 million of the PLWA in the region receive antiretroviral therapy (ART) (UNAIDS & WHO 2006:10).

2.5.1.3 *Prevalence*

Currently, Sub-Saharan Africa accounts for 68% of people with HIV (UNAIDS & WHO 2007:5). Africa is a continent with too many vulnerable nations and different patterns of the epidemic in East, West and Southern Africa. East Africa has a higher prevalence compared to West Africa and Southern Africa has the highest prevalence of affected people. The reason given for these trends is that colonial experience in East and Southern Africa were more socially disruptive. Societal disruption could have contributed to higher levels of prostitution, multiple partners, high mobility and migration of individuals, higher urban population density and better transportation (UNAIDS & WHO 2007:2).

In 2005, Botswana was reported to have a prevalence rate of 17.1% among the general public (CSO 2005:33).

2.5.1.4 *Gender*

Women aged 15 to 42 years are three times more infected than their male counterparts (UNAIDS & WHO 2005:9). In 2005, Botswana and Swaziland recorded a prevalence of above 30% among pregnant women and in Botswana, VCT found a significantly higher HIV prevalence among young women than men (UNAIDS & WHO 2005b:4).

Factors such as gender-based violence, unequal power sharing, economic disempowerment of women, early marriage for girls, sexual abuse, and infidelity of partners exacerbate females' position. Sharma and O'Malley (2007:1) found that women are at higher risk because many of them resort to commercial sex work because of men's failure to provide for them. Furthermore, the risk is even greater because many of their clients refuse to use a condom and women will opt for unprotected sex as long to get a higher fee. At the same time, some men blame women for behaviours that expose them to the risk of being HIV infected and feel women should be responsible by ensuring consistent condom use (Sharma & O'Malley 2007:2).

2.5.2 Botswana overview of HIV/AIDS epidemic

The first case of AIDS in Botswana was diagnosed in 1985. By 1988 there were twenty-four (24) cases. The cases steadily increased, and by 2000 AIDS cases had risen to 1,141. In 2003, an estimated 283 764 people were living with HIV and AIDS and of these 9 228 had enrolled in the ART programme (NACA 2003:3). Botswana was the second highest country in the world by 2004 with a prevalence rate of 37.3% among women attending antenatal care (Levinsohn et al 2006:6).

Warren, Hellmuth and Strzepek (2001:11) found that most deaths occurred between 30 and 39 years of age, which meant that they were infected at an early age. However, the mortality rate would gradually drop as a result of the introduction of ART. Therefore, to empower young people to avoid HIV and AIDS, the interventions should be introduced much earlier. According to Amon and Amon (2002:143-149), health promotion should improve by including younger adolescents in the prevention messages. Excluding younger adolescents makes them vulnerable hence increasing their chances of being infected with HIV. Stone and Ingham (2006:197) hold that it is easier to instil and secure safe behaviour in young people before or at the time of starting sexual relations than changing them when they are already practising and comfortable with those behaviours. Levinsohn et al (2006:7) stress that knowledge is central to preventing new HIV infections because people with better knowledge are more likely to practise safer behaviours. Besides the message of abstinence, being faithful and using condoms, the insight gained over the years led to also preventing mother-to-child transmission of HIV and AIDS (PMTCT), extending the anti-retroviral (ARV) programme and intensifying educational campaigns on de-stigmatising HIV and AIDS (Levinsohn et al 2006:7).

2.5.2.1 Transmission

Adult infection is mainly through heterosexual contacts. Vertical transmission accounts for the majority of infant and child infections. The availability of ARV drugs through the PMTCT programme is intended to reduce vertical transmission. Without ARV therapy during pregnancy, vertical transmission was about 23% while therapy reduced it to 8% and to 3.6% in 2007 (NACA 2003:7; MOH 2007:5). Vertical transmission is of grave concern, especially because African culture values high fertility, therefore, women might opt for pregnancy even if infected. The availability of PMTCT greatly reduced

transmission to unborn child, during delivery and at infancy stage. The screening of blood started in 1987 and this also decrease transmission (NACA 2003:7). In 2006, the MOH (2006:26) reported that the crude HIV prevalence rate among pregnant women was 32.4%, with the age groups 30-34 years (48.7%), 35-39 years (42.7%) and 25-29 years (41.8) being the most infected groups.

2.5.2.2 Infection rates

The infection rates among 15 to 19 year-old pregnant adolescents attending ANC dropped from 22.8% in 2003 to 17.5% in 2006 (MOH 2006:33). According to CSO (2009:1), the national incidence rate is 2.9%. Women have a rate of 3.5% and men a rate of 2.3%, while Kgatleng District recorded a rate of 2.62%. Women in Kgatleng District had an incidence rate of 3.41% whereas men had a rate of 1.65%.

2.5.2.3 Prevalence

The national prevalence rate is 17.6%. Males have a lower prevalence rate (14.2%) compared to women (20.4%). The Kgatleng District has a prevalence of 15.8%. Males and females in the district recorded a prevalence rate of 14.5 and 16.8%, respectively (CSO 2009:17). In 2004 the national prevalence rate was 17.1% (CSO 2005:5). In 2003, the HIV prevalence among pregnant women in Botswana was 37.4%, with the age group 25 to 29 the hardest hit (NACA 2003:1). Between 2002 and 2003, VCT showed a rise among older groups while the rate for the 15 to 19 year-olds stabilised at 23%. Table 4.2 presents the infection rate among pregnant women from 2000 to 2007 (MOH 2006:33).

Table 2.1 HIV prevalence rate among pregnant women by age group, 2000-2007

Age group	2000	2001	2002	2003	2005	2006	2007
15-19	22.9	24.7	21.0	22.8	17.8	17.5	17.2
20-24	39.4	38.7	37.4	38.6	30.5	29.4	27.9
25-29	35.5	40.0	40.5	42.8	40.7	39.4	43.7

Source: (MOH 2006:35; MOH 2009:41)

Since 2001 all the districts in Botswana have been included in the annual HIV/AIDS sentinel surveillance (NACA 2001). Although cases were previously concentrated mainly in the major cities, the gap has narrowed and there is no significant difference in prevalence in urban and rural areas. At present the sentinel survey captures data from different programmes including the behavioural surveillance (NACA 2003:5). Botswana recorded a decline of 25% in the rural areas but no significant reduction in the urban areas (UNAIDS & WHO 2006:9).

2.5.2.4 Gender

Women are the most affected by HIV and AIDS compared to men (NACA 2003:5; UNAIDS & WHO 2005b:4). Several factors are responsible for why women are the most affected, including their anatomical make up; low social status, which makes them unable to use safer or preventive measures; lack of negotiation skills, and unequal power sharing with men. In addition, marital as well as inheritance law discriminates against women. For example, in customary law, men are allowed polygamous marriages (BIDPA 2003:30). The majority of the infected population are women and girls compared to men and boys of the same age (UNAIDS & WHO 2007:1). MacPhail and MacPhail (2003:141-149) emphasise that cultural norms have become a hindrance to HIV prevention interventions. Consequently, it is imperative that programmes address sexuality as well as social norms that facilitate risky behaviour such as multiple partners, perpetuation of power imbalance, and negative attitudes towards condom use.

The distribution of inheritance assets, such as cattle or land, is skewed towards men. This leaves women poor and vulnerable hence dependent on men for the basic necessities of life such as food, shelter and clothing, as well as decision making on sexual relationships.

2.6 YOUNG PEOPLE’S SEXUAL BEHAVIOUR

Karl Max held that “human behaviour is meant to change the world, to change it into a better one by developing theories and transferring the knowledge gained from them to fit with societal needs’’ (Krishnan 2003:1). Understanding factors that modify or shape behaviour would guide in establishing mechanisms to benefit the individual and society

at large to pursue the desired behaviour to promote better health and health living. In this end behaviour change remains crucial.

A study in Nigeria signified that female adolescents, in large numbers, practise premarital sex and are more exposed to STIs despite their knowledge of the risk of infections transmitted sexually (Moronkola & Adio-Moses 2003:16-19). Fako (2005:348-349) concurs stating that young people engage in multiple sex partners and have the urge to have children even if they are not married. A study by Sengstock (2005:29) into male youth-friendly approaches found that young males indulge in risky behaviours such as use of illicit drugs and alcohol particularly to show and enjoy their development, maturity and autonomy. The above results emphasise the urgency of designing and implementing programmes that inform and empower young people to change sexual behaviour.

Behaviour change has been found lacking, however, despite availability and high knowledge of HIV. For example, despite the intensive HIV and AIDS programmes in Botswana, there is still a gap in changing behaviour. Behavioural change "still lags behind the knowledge of HIV and AIDS, but there are indications that progress is being made" (MFDP 2004:53). Oster (2007:1) points out that sexual behaviour change is important in HIV-prevention interventions because a large percentage of Africans' infection is through heterosexual encounters. Levinsohn et al (2006:11-13) stress the central role of knowledge in preventing new HIV infections.

The median age for first intercourse was 17 years for both females and males (SIAPAC 2001:41). Sexual communication and condom use are important in making responsible decisions and creating understanding between partners. Risky sexual behaviour and excessive alcohol consumption fuel the epidemic. Therefore reduction in prevalence could be achieved through positive changes in individuals' behaviour.

2.6.1 Sexual communication/sexual health communication

Good communication creates the environment for partners to express their affection, find mutual vocabulary, and communicate their likes and dislikes. In addition, good communication enables individuals to negotiate and compromise. However, Alexander, Garda, Kanade, Jejeebhoy and Ganatra (2006:151) found that there is little

communication between partners regarding sexual matters. In their study of young women and men in India, Alexander et al (2006:152) found that only about 19.3% women discussed contraception before sex and only 17.5% used a condom during first sexual inounter. The above results depict the need for interventions to improve sexual communication. Ingham and Aggleton (2006a:174) point out that an understanding of "the context in which young people send, receive, and internalise or decode messages about sexual health is central to the design of effective communication strategies".

Sexual cues and body language can be misinterpreted therefore it is best and good for people in a relationship to say what they want and/or do not want. Communicating with a sex partner is critical and imperative because it is a self-protective health behaviour (Fan 2002:254-255). Sexual communication is a means of promoting safer sex. In a relationship or in seeking help, individuals should state what they want and their concerns and problems. People have the right to set sexual limits and to communicate them. Communication is essential in relations and in the implementation of programmes. Fan (2002:254) describes communicating views and even persuading the other party as "persuasive information". Sexual communication should reflect values and even persuade the other party to adopt healthy sexual behaviour (Fan 2002:256). McDowell and Mitchell (2006:174) stress that the perspective that young people will give, accept and interpret communication on sexual health is mainly influenced by the communication technique employed.

Sexual communication is imperative in a relationship, but it is not an easy process because it is influenced by skills, confidence, assertiveness, sexual control and other factors. Moreover, self-efficacy in communicating as an important element that health promotion programmes should address in tackling the escalating infection rates among young people (Baele, Dusseldorp & Maese 2001:421-431; Halpern-Felsher, Kroppy, Boyer, Tschann & Ellen 2004:443-456).

2.6.1.1 Factors hindering sexual communication among partners

Family Health International (FHI) (2002:21-43) emphasises that most people cannot prevent unwanted pregnancies and sexually related health problems due to a failure to talk about sex and related issues. Consequently, facilitating communication between

husbands and wives helps the couples to agree upon and meet their reproductive goals. The following are some of the hindrances to communication (FHI 2002:42-43):

- The belief that fertility should be left to God.
- Partner opposition to family planning.
- Such discussions raise suspicion of infidelity among partners.
- Violence may arise due to discussion.
- Fear of withdrawal of economic support if the woman insists.
- Difference in race and ethnicity.

2.6.1.2 Strategies to improve sexual communication among partners

The following are some of the strategies that could be employed by health intervention planners or implementers (FHI 2002:21-43):

- Incorporate interpersonal relations and communication in family planning programmes.
- Establish and/or strengthen SRH information services to men.
- Incorporate interpersonal relations and communication in senior secondary and tertiary education.
- Introduce dialogue with public or community and ward meetings.

2.6.2 Condom use

Condom use is effective in HIV prevention but also challenges sexual relationships. Condom use predicts young people's vulnerability. Condom use has significance as a physical device as well as a social meaning. Not using a condom when having sexual intercourse is regarded as a sign of trust (Ingham & Aggleton 2006a:33). This could be a reason for inconsistent condom use. If one partner feels the other is "unclean" then a condom is used and there is power dynamics between partners. Even if one partner had and was willing to use a condom, if the other partner refused, they would have unprotected sex. Crosby and Yarber (2001:2) found incorrect and inconsistent condom use among young people because they were sometimes coerced into sex.

Although young people are well informed on different brands of condoms and their use, many nonetheless distrust them hence do not use them (Osei-Hwedie & Namutosi 2004:197). The commonest reason given was that during sexual intercourse the condom was likely to slide and remain in the vagina hence making sex unsafe. At the same time, 80.8%, mostly females, indicated that they could ask their partners to use a condom (Osei-Hwedie & Namutosi 2004:199).

According to Crosby and Yarber (2001:2), HIV and STD education programmes targeting young people particularly those at school lack correct condom use. In an effort to create a positive attitude towards condom use, people should be given skills to cope with the social pressure to engage in unprotected intercourse. According to Akers and Mince (2008:309) HIV prevention programmes do increase the individuals' intension to use and self-report use of condoms. Osei-Hwedie and Namutosi (2004:203) emphasise the need for sex education programmes (family life education and/or life skills) to include condom use and behaviour change, thus making empowerment vital to achieve social change. In Switzerland, Hornik (2002b:7-8) found that a programme promoting condom use brought about considerable condom usage among young people. An increase from 8% to 60% in self-reported condom use with "casual" partners was reported, while the Netherlands reported an increase from 9% to 40%.

2.6.2.1 Effectiveness of condoms

Stine (2004:274-277) points out that condoms are tested for defects and quality standards before being dispatched for use. In the first and second World Wars American soldiers proved that condoms protect against STDs. Condoms have also been found effective in preventing the transmission of HIV between partners during sexual intercourse. Warner and Stone (2007:234) state that laboratory investigation have proved that latex condoms effectively prevent the passage of micro organisms responsible for causing STIs, including HIV as well as the bacteria of hepatitis B. Alford (2005:2) found that condoms give protection even against such viruses as the human papilloma virus (HPV).

Condoms are effective in preventing HIV transmission and, if used together with lubricants or some micro-bicides, the protection rate increases. However, in some cases a high dosage of micro-bicides particularly nonxynol-9 could cause ulceration in

the vagina, thereby increasing the likelihood of transmission of the HIV infection (Warner & Stone 2007:23). According to Stine (2004:281), even though condoms do not give 100% protection, they save a lot of people from being infected and are tested for defects and quality control.

The quality of the condom is crucial to the effectiveness of reducing infection. Latex and polyurethane materials are effective against HIV infection. Although there is a slight possibility of condoms breaking during intercourse, condom use remains the single most effective and successful means of preventing HIV prevention (Berer 2006:6-16; Darden 2006:63-67; Ditmore & Neth 2006:171-173; Garcia, Yam & Firestone 2006:53-63; Maharaj & Cleland 2006-104-112; Rojanapithayakorn 2006:43-52). In addition, condoms are affordable hence the need to intensify health promotion interventions to eliminate barriers to condom use and emphasise empowerment of the target population.

A comparison of efficacy of protection shows a great difference between infection rate in those who used condoms and those who did not use. Laboratory tests revealed that particles as small as sperm and HIV could not penetrate through latex and polyurethane (Stine 2004:277). According to the UNFPA ([Sa]:3), condom programmes at all levels should address the issues of quality assurance and protection.

2.6.2.2 Access to condoms

Most students at primary, secondary and tertiary schools are aware of where to access condoms but the attitudes of teachers, parents and society at large hinder their access (BIDPA 2003:13). Moreover, students are often denied condoms on the basis that they are too young (BIDPA 2003:13). School projects suggest that public education campaigns promoting condom use and their distribution can be effective without increasing the proportion of adolescents who are sexually active and, in fact, delay the onset of sexual activity (Stine 2004:280; 285). Wellings (2002:141) found that behaviour change in regard to condom use reduced the number of sexual partners and casual sex. Effective condom programmes ensure that service providers have positive attitudes, accurate knowledge, and good counselling skills (PATH [Sa]:36).

Pitso (2004:61) found that HIV spread and lack of condom use are also linked to alcohol abuse. Having sex while drunk was highly linked to inconsistent as well as improper condom usage. Moreover, when people are drunk they tend to reject or refuse to use a condom.

Limited access to nearby condom outlets discourages youth from using them (Meeker & Klein 2001:37). Rwanda has consistently reported low levels of condom use despite the increasing HIV prevalence, even among high-risk groups such as long distance truckers and sex workers. About 10% of sexually experienced youth reported having ever used a condom. A survey of youth aged 15-24 years in Butare Province found that only 24% of sexually experienced males and 14% of females had ever used a condom. Of those with regular partners, 35% of the males and 28% of the females reported using a condom (Meeker & Klein 2001:37).

Sexual initiation in Rwanda is done late or delayed, thus many youth aged 15 to 19 years are not sexually active. In Rwandan culture, women are not supposed to agree to men's sexual advances. Girls avoid temptation by not drinking alcohol and do not participate in activities that put them at risk. There are low levels of sexual activity among youth in Rwanda and this is corroborated by the low fertility rate in this age group (Meeker & Klein 2001:37).

Young people who did not use a condom were more likely not to have completed secondary or higher education than their counterparts (BIDPA 2000:4). Women who reported risky sexual behaviour (e.g. trade sex) were twice as likely not to have completed secondary or higher education, and not married or living with partners.

2.6.2.3 Barriers to condom use

Myths and misconceptions act as barriers to condom use. However, Alford (2005:1) found that despite myths regarding sex education, many parents and youth agree that the provision of information on condoms and other contraceptive is essential. There are still challenges, however, because asking "one's sexual partner to use a condom may be taken as an accusation, while an offer to use a condom may be viewed as a confession" (Stine 2004:261). Crosby and Yarber (2001:1) found that misconceptions about condom use exist particularly among adolescents aged between 15 and 21. A

lack of communication between partners and differences in race and ethnicity also act as barriers (FHI 2002:2143).

- *Myths about condom use*

There is a widely held myth that education about condom efficacy promotes sexual activity. In the USA, HIV education and sex education, which included condom information, either had no effect upon the initiation of intercourse or led to the postponement of onset of intercourse (Stine 2004:280, 285). Alford (2005:2) dispels the myth that HIV can pass through condoms and that they are not effective because latex has holes. Latex condoms, in fact, provide a highly effective barrier for HIV and other microorganisms as well as sperm (Jackson 2002:107). Even the hepatitis B virus cannot pass through (Stine 2004:281). Many people harbour the misconception that condoms are not effective, but when used correctly, condoms fail to prevent pregnancy only in 2 and 5 women out of 100 using male and female condoms respectively (Alford 2005:2).

Pitso (2004:63) found a strong perception that condoms reduce men's pleasure during sex and actually prevent them from having "sexual release". Moreover, many find it embarrassing to use a condom. The perception is one of those which is a barrier in efforts to promote condom use among the sexually active people.

According to BIDPA (2003:17-18), sex and HIV and AIDS education is not common in schools. Where information is provided, students feel it is mostly inadequate and many youth dislike condom use because of misconceptions that condoms reduce sexual pleasure; may be laced with HIV, or can get lost in the vagina.

- *Lack of access to condoms*

Barnett and Schueller (2000:14) found a lack of access to services and programmes a barrier because young people do not have money to pay for services, or transport to reach the service points. Therefore, lack of adequate supply hindered access and facilitated inconsistent condom use. The unavailability of varied and nearby condom access points hinders and discourages youth from using condoms (Meeker & Klein 2001:37).

- *Lack of assertiveness and negotiation skills*

BIDPA (2003:17) points out that young people are less likely to use condoms at first sex, despite their knowledge and access to information. This is because of lack of skills to negotiate for condom use and/or they are shy about discussing the issue with their partners. Furthermore, condom use at first sex is lowest among primary (31%) and junior secondary (38%) school students while at senior secondary and tertiary level use is quite high at 68% and 63%, respectively. Sexually active young people need comprehensive information regarding correct condom use (Crosby & Yarber 2001:1). Ziyone (2006:48) found that women's position in society hinders them from negotiating condom use, as doing so would lead to arguments, quarrels, and fights. Halpern-Felsher et al (2004:443-456) found that highly self-efficient people used condoms regularly and had positive attitudes towards condom use. Halpern-Felsher et al (2004:443-56) further emphasise the need to have prevention programmes include communication skills as a component. Baele et al (2001:421-431) maintain that self-efficacy is vital in condom use, and is facilitated by individuals' skills, confidence, assertiveness, sexual control as well as power to purchase condoms.

- *Violence against women*

Moreno and Watts (2000:182) point out that violence against women leads to feelings of inferiority. The inequality of power in sexual relations has nurtured violence where women and girls find themselves infected because they fear to negotiate condom use. Therefore sexual violence must be integrated into HIV prevention programmes. The UNAIDS and WHO (2008:65) emphasise that gender relations play a major role in HIV spread and prevention. In particular, gender inequality, lack of empowerment, discrimination, stigma and social marginalisation are prevalent in many parts of the world.

2.7 PROGRAMMES ON SEXUAL AND REPRODUCTIVE HEALTH FOR YOUNG PEOPLE

In attempting to combat HIV and AIDS and other sexual health problems, intervention programmes aimed at prevention target young people. Chase and Aggleton (2006:92) state that it is crucial to have programmes that target young people because of the

complex circumstances in which they find themselves, particularly their vulnerability to sexual and reproductive health problems such as HIV and AIDS. Furthermore, it is vital that adolescent education programmes include young people as primary targets and gatekeepers as secondary targets. The gatekeepers should not be left without the necessary information, knowledge, education and service provision, as they have a responsibility to support, inform and educate young people. Chase and Aggleton (2006:95) identify five key principles central to programmes for young people, namely putting young people first; promoting meaningful participation; gender equity; a rights-based approach, and tackling risk and vulnerability within the distinct context of the young person's life. Moreover, the approach will minimise or eliminate the barriers to young people's accessing service.

Barriers to accessing reproductive health services are basically facility oriented such as the design of services and service providers' attitudes and actions (Moya 2002:1). BIDPA (2003:4) identifies the following shortcomings of youth programmes:

- They tend to focus on messages relating to behaviour change, such as "use a condom" or "abstain" – without giving information on decision making and developing skills of people to realise the intended outcome.
- They fail to address social norms.
- They regularly miss significant groups of young people.

The researcher is of the opinion that programmes for young people must be based on the responses, beliefs, information, and knowledge needs identified by young people themselves. Young people are best placed to express their feelings, explain their challenges as well as their needs.

According to Hornik (2002:13), health promotion/health education programmes should aim at influencing behaviours and address health needs by producing messages that deal directly with desired actions. Programmes should target the knowledge, beliefs, or social norms and strengthen or support the behaviour instead of advocating for new behaviour.

Stine (2004:262-263) describes HIV and AIDS prevention as a "hard sell" because donors and the targeted audience do not easily support the notion of prevention.

However, Stine emphasises that an effective health promotion intervention is one that is holistic and deals with prevention, programming for the public, women, risky behaviour, and policy. Three objectives for HIV and AIDS prevention intervention are to prevent new HIV infections; to provide support and care to those already infected; and to link international efforts in the fight against HIV infection and AIDS (Stine 2004:262-263).

2.7.1 Why programmes for young people are essential

According to PATH (2003:1), it is essential to equip young people with facts on their sexuality and skills to assist them to make right choices because adolescence is packed with emotions of excitement, new feelings, uncertainties, questions, changes and complicated options. Young people encounter greater sexual and reproductive health risk than adults because they are less willing and able to access SRH services due to lack of information and barriers in the SRH services (Senderowitz et al 2003:1). In the UK, Moasor, Liffin and Kloep (2000:40) found that young people require access to information and that sex education is good and they value it. Seeman and Leinhos (2007:535-536) found that several reasons hinder young people from accessing service although they have higher STI rates compared to adults. Strydom (2003:199) asserts that since young people have positive attitudes towards the problem, it is imperative to inform them and use influential measures to reach to them because information needs to continually "sound the alarm". According to Strydom (2003:202), boys and girls should be addressed separately in order to feel free to share and discuss with people of the same age. Among the barriers to young people accessing services are financial costs; lack of a sense of vulnerability to disease, privacy and confidentiality, and the feeling that it is inconvenient.

The reasons for addressing adolescent sexual and reproductive health and rights arose from the expressed needs and problems encountered by young people mainly due to lack of information, lack of access to services, and delaying realising or admitting the problem or need for SRH services. Barnett and Schueller (2000:4) state that programmes for young people are imperative and should deal with the prevention of unplanned pregnancies and STIs, including HIV and AIDS. Young people need to be equipped and trained to be assertive and negotiate, and services should be provided for them. Young people are a neglected audience in the provision and delivery of

reproductive health services, yet many of them need information that is timely, relevant and comprehensive (Barnett & Schueller 2000:4).

FMOH-Ethiopia ([Sa]:7-8) emphasise that adolescent sexual and reproductive health (ASRH) programmes and services are needed for several reasons. Their sexual and reproductive health needs are crucial as adolescence is the "age of maturing". This is the period when the individual is in transition from childhood to adulthood. Early pregnancy and child bearing pose increased health risk to girls because they are not yet developed to carry pregnancy compared to adult women. Pregnant adolescents resort to abortion more often than older pregnant women, and adolescents are more at risk of contracting STIs and HIV because of biological and socio-economic factors. In addition, Gurdin, Niego and Mince (2008:124) maintain that intervention programmes bring change in the lives of young people because they provide them with information and services to assist them to have better knowledge and skills. Interventions targeting young people must take an approach that will involve and keep them constantly interacting with services delivery officers, this will enable sustainability of safer behaviour because of continued access to services (Sengstock 2005:29).

2.7.2 Young people's intervention programmes

Various programmes, differing in emphasis, topics and specific target audiences, have been piloted and implemented throughout the world.

2.7.2.1 AIDS education programmes for young people

AIDS education programmes are implemented all over the world because of the epidemic. In Uganda, one of the first African countries most affected by HIV and AIDS, both adults and young people were battered or killed for refusing to have unprotected sex with their HIV and AIDS-infected partners (Stine 2004:463-464). Uganda is one the countries in sub-Sahara Africa to take concrete measure to curb HIV and AIDS. Intensive education programmes were established to address different groups including young people at school and out of school. The programmes had a significant impact in equipping young people with knowledge, changing sexual behaviour, and empowering individuals and communities to prevent HIV and AIDS (Matshediso 2005b:7).

2.7.2.2 Family life education or sex education programme (FLE)

The Family Life Education (FLE) programme aims at equipping students with basic knowledge of sex-related topics. Social concerns about young people led to the implementation of the FLE programme (UNFPA 1998:46). The programme is integrated into the school curriculum to teach students about sexual and reproductive as well as social problems they face and covers teenage pregnancy, STDs, family, weakening family ties, contraception, relationships, gender issues, decision making and skills development. Teachers are trained to teach sensitive and secretive issues.

Kuate-Defo (1998:315) emphasises that education is “the best guarantee for responsible sexual behaviour and safe motherhood”. Education on sex-related issues is a major strategy to address problems of adolescent sexuality. Sex education emphasises personal relationships, values, sexual health, information and education about sexuality (Measor, Tiffin & Miller 2000:7-8; Stone & Ingham 2006:201). The programme consists of physiological and biological knowledge, which are the strengths that young people need to make informed decisions. Major activities include curriculum development, IEC message, needs assessment, use of media to carry messages for adolescents, community seminars and workshops for community groups covering issues related to adolescent sexuality.

2.7.2.3 Life skills

Life skills aim at imparting knowledge on different life challenges and equipping young people with livelihood skills. According to Strydom (2003:65), life skills programmes should include HIV and AIDS education and should be incorporated in the school curriculum. Young people need information and skills to put what they learn into practice. Life skills imparted to young people include negotiation, conflict resolution, critical thinking, decision-making, entrepreneurial skills and communication (United Nations Children’s Fund [UNICEF], UNAIDS & WHO 2002:29). According to Elford, Sherr, Bolding, Maguire and Searle (2000:210), training of peer educators is essential to equip peer educators with knowledge and skills. The use of peer education in HIV infection prevention discouraged unprotected sex and reduced the practice by one-third.

In Namibia, young people were trained in life skills to help them avoid teenage pregnancy, HIV and AIDS, substance abuse and rape. Other young people facilitated the programme after they were trained. This eliminated the barrier of age difference between providers and recipients, made providers more confident in discussing and influencing the recipients' attitudes, and succeeded in reaching a large number of young people. In Bangladesh, life skills' training was geared towards equipping the target audience with entrepreneurial and marketing skills. The rationale was that many girls had no education and therefore needed to enhance their opportunities of getting jobs, as well as equip them with skills to run businesses. In Vietnam, school children from Grades 1 to 12 use role play and other interactive methods to learn how to protect themselves from HIV and AIDS and other STIs (UNICEF, UNAIDS & WHO 2002:30).

2.7.2.4 Peer education programme (peer leadership programme)

According to Ingham and Aggleton (2006:183), peer education is "the teaching or sharing of health information, values and behaviours by members of similar age or status groups". Mackinnon (2007:178, 193) points out that young people turn to each other for advice and support. Their peers are one of their most important and influential sources of information. Peer education as a strategy mainly targets change at individual level, but has a strong chance of influencing group norms, practices, and collective action to bring about policy change. Mackinnon (2007:186) emphasises that young people spend a lot of time together and discuss, share and exchange information and experience.

The peer education programme uses young people to reach out to their contemporaries. Peer education, one of the components family life education, is commonly used and is successful in reaching the target population *(researcher's opinion).* Peer education is a process through which an individual can bring about change and reinforce positive behaviour among members in the same situation (MOH 2002:9). In peer education, a team of young people volunteer or are selected and are given training to equip them with basic knowledge and skills so that they can provide services to their peers. Therefore, as peer educators are peers to the target audience, the target group can easily identify with them as the peer educators reach them in their own territory, speak the same language and treat them with respect.

According to Alford and Feijoo (2002:3), a peer education programme “can be a powerful approach to educating youth and changing their attitude. Teenagers receive most of their information about sexual expression from other youth and the media, and peer influence becomes increasingly important as adolescents mature. Peer groups are highly important in influencing adolescents’ values and behaviour.”

Many young people distrust adults and/or relatives, and professionals. The peer education approach programme is an effective strategy to raise awareness about HIV/AIDS and STIs and increase the self-esteem of young people as agents of change (Pearlman, Camberg, Wallace, Symons & Finison 2002:31-39).

In Massachusetts, the programme increased the peer educators’ confidence in their leadership abilities and knowledge on how to prevent HIV and AIDS. In addition, the peer leaders benefited from the training and implementation of activities that were valuable to them and their peers (Pearlman et al 2002:31-39).

A family planning clinic using peer education found that between the initial and return visits, the contraceptive usage of teenage clients attended to by peers increased by 40% while that of teenagers served by adult professionals only increased by 10% (Alford & Feijoo 2002:3). Social learning theory emphasises that similarities in age and interest between those giving and those receiving educational messages increases the persuasiveness of the message. Peer-based interventions are applicable and work in different settings and for different target groups with varied needs and problems (Alford & Feijoo 2002:3). Peer education is widely recognised as a useful as well as a credible way of reaching young people with important information (Alford & Feijoo 2002:7).

A school-based peer education programme known as SHAPE was implemented in Athens, Greece, to deliver HIV and AIDS education in schools with the goal of reducing risk-taking behaviour, delaying sexual activity and assisting young people to change behaviour (Adamchak, Wong, Tucker, Otterness & Janowitz 2005:1). The programme proved that the approach could influence the behaviour of young people regarding personal protection and HIV infection (Merakuo & Kourea-Kremastinoun 2006:128-132).

2.7.2.5 Youth-friendly services (YFS) programmes

YFS programmes have two major/outstanding elements, namely effective involvement of young people in programme design and service delivery. In addition, they recognise that the needs of young people are different from those of adults therefore services address the needs of young people (Senderowitz et al 2003:15). In Asia and the Pacific Islands, Insixiengmay and Chan (1999:1) found a gap in existing services failing to meet the growing health care needs of youth between 12 and 24 years. Furthermore, the youth in Asia and the Pacific Islands showed increased sexual activity but with evidence of relatively less knowledge about safer sex methods and little understanding of HIV.

For services to be 'youth friendly', they should provide a wide range of activities including prevention, health promotion, curative, advocacy and counselling services tailored to the needs, concerns, worries, questions, fears and expectations of young people as well as be culturally appropriate (FMOH-Ethiopa [Sa]:15-17). Systems and structures should be adaptable to children and youth as partners in the initiatives. Mackinnon (2007:192-195) argues access to reproductive health services by the target group is hindered by community members' negative attitudes that, to a certain extent, impact on adolescents' health-seeking behaviour. Therefore health promotion activities are necessary to also address the community.

Adamchak et al (2000:286-287) and AYA-Botswana ([Sa]:140) list the following characteristics of adolescent reproductive health programmes:

- *Environment and facilities.* The environment and facilities are the pillar of YFS. ARH services are provided at convenient (and separate) hours for youth clients (special times to serve young people); decorations and surroundings are inviting and comfortable to youth clients (i.e., non medical); counselling and examination rooms ensure privacy for youth clients; separate space is used for youth clients; facilities are conveniently located for youth; education materials are displayed and available to youth clients; youth clients report overall satisfaction with ARH services, and signs showing the hours of operation and available services are prominently displayed. Young people are part of the service delivery thus ensuring relevance; acceptability; dedication to programme objectives; long-term

effectiveness, and personal development for participating youth (Senderowitz 1998:10).

- *Service providers and staff.* Service providers and staff are crucial in the delivery of YFS, including ongoing training of staff and providers in ASRH; having staff that is friendly and responsive to youth clients; having staff that is respectful to and ensure privacy of youth clients; providing privacy, and treating clients' information confidentially. Other essential characteristics are having counsellors and medical providers that are non-judgmental and approachable, and most importantly having well-trained peers that are available to provide information and services, where appropriate (Senderowitz 1998:10). Service providers should keep the clientele comfortable and attracted to the services. Sengstock (2002:29) states that accessibility; flexibility; mobility; communication, and emotional safety are key factors in YFS. In deed service providers have to improve services by going beyond the common practice in provision of services.

- *Service provision.* The provision of services is the cornerstone in the delivery of YFS. Youth must be served without regard for their age, gender, or marital status. Young people are involved in the education and outreach; staff should be sensitive to the needs of males and females; IEC materials must be available and appropriate, and counselling provided by trained professionals (Insixiengmay & Chan 1999:1). In addition, young people should be counselled on dual protection; the pelvic exam can be delayed on the first visit, if desired, and supplies and equipment must be adequate and appropriate for young people. These key characteristics ensure that young people will come back and continue to utilise services. Karki (2006:324-330) found that both male and female adolescents came to seek services; some were illiterate while others were students, and all presented with varying problems such as anaemia, skin problems, symptoms of STIs, menstrual problems while others were pregnant and needed services.

- *Policies and procedures/administration.* Policies and procedures or administration are important in the delivery of services. Many countries established YFS programmes after realising that traditional health services were more tailored to adults and unwelcoming to young people. YFS involve

adolescents in programme design and service delivery; take into consideration that adolescents' needs differ from those of adults, and provide services that specifically meet the needs of young people (Barnett & Schueller 2000:83).

In Thailand, health corners were set up for adolescents in health clinics and in Zambia youth clinics were set up with both nurses and peer educators delivering services such as providing information on HIV/AIDS, STDs and other reproductive health-related issues; treating illness; providing counselling, and providing condoms at the clinics. Peer educators use different methods such as role-plays, music, poetry, health talks, presentations and discussions Both initiatives succeeded in opening and increasing services that young people felt comfortable to use. There was an increase in the number of young people seeking services compared to prior to the implementation of the programmes (UNICEF, UNAIDS & WHO 2002:29). According to a student peer educator in Haiti (quoted in Barnett & Schueller 2000:83), with "someone of your own age, you will be serious. You will feel at ease, with someone older, you don't want to discuss some things, problems, what's in your heart."

According to AYA-Botswana ([Sa]:136), the minimum package of youth-friendly reproductive health services should include information and counselling on sexuality, safe sex and reproductive health; contraception and protective method provision, diagnosis and management; HIV counselling and referral for testing and care; pregnancy testing, antenatal and post-natal care; counselling on sexual violence and abuse (and referral for other needed services), and post-abortion care (PAC) counselling and contraception (with referral when necessary). Gurdin et al (2008a:124) concur by stating that educational service, reproductive health counselling, parenting and others are important element of YFS. FMOH-Ethiopia ([Sa]:15) maintains that standards are important for guiding and creating uniformity in practice of services, most importantly for ensuring quality of services.

2.8 CONCLUSION

This chapter discussed the literature review conducted for the study. The review covered the attributes of YACs, particularly YFS; participatory learning (experiential learning) and empowerment; as well as HIV and AIDS. In addition, the need for youth programmes and the programmes aimed at young people were examined. According to

Akers, Benner and the Educational Development Centre Staff (2008:8), it is essential to have programmes because they empower the target group with knowledge and social skills to cope with the setting they exist in and provides them with opportunities.

Successful programmes had young people who are YFS and YACs' target audience actively involved and participated in the planning and delivery of services. Programmes and activities are more likely to be relevant when the target audience is part of the implementing machinery, as they know the needs of their peers and what will interest them (Barnett & Schueller 2000:83). Moya (2002:1) emphasises that YFS mainly aims to remove obstacles that normally make access to services by young people difficult.

Chapter 3 describes the research design and methodology.

CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter describes the overall research design and methodology of the study. The study wished to:

- evaluate the Botswana Family Welfare Association's YAC in Mochudi in the Kgatleng District Council in Botswana
- explore and describe the experiences of young people utilising the YAC in Mochudi in the Kgatleng District Council in Botswana as well as the service providers at the facility
  - experiences and perceptions of service providers and peer educators at the YAC in Mochudi in Kgatleng District in Botswana
  - explore, describe and develop the guidelines that can be used to facilitate youth friendliness at a YAC?

The study was conducted in two phases. Phase 1 explored and described the experience of young people utilising the YAC in Kgatleng District in Botswana. Phase 2 developed guidelines to facilitate YFS at the YAC.

3.2 RESEARCH DESIGN AND METHODOLOGY

Polit and Beck (2008:66) stress that the research design and methodology are crucial to reduce bias and increase the interpretability of the findings. In addition, the research design reveals other information such as how to collect data, and the place where the research takes place. Salazar, Crosby and DiClemente (2006:75) describe choosing a research design as "selecting or laying out the strategy for the study". Furthermore, it is essential to choose a suitable design as it influences the accomplishment of the study. In this study, the researcher selected a qualitative research design that was phenomenological, explorative, descriptive and contextual.

3.2.1 Qualitative

According to Polit and Beck (2008:763), qualitative research is a systematic inquiry with the aim of examining the phenomenon under study in-depth and holistically. In qualitative research, insight is gained into the social life or problem by means of participants' narrative descriptions of their lived experiences. Qualitative studies seek to establish meanings and patterns of relationships by reporting the detailed views and knowledge of informants (Babbie 2007:293). Qualitative research seeks to discover knowledge to develop or formulate a theory from authentic sources. It is concerned about how social world is interpreted, understood, experienced or produced (Ulin et al 2005:27).

Lincoln and Guba (1985:37) refer to qualitative research as constructivist or naturalistic; an interpretive approach or post-positivist or post-modern perspective. The qualitative research paradigm is naturalistic because of the unique characteristic of "investigating a phenomenon in its natural setting free of manipulation" (Streubert & Carpenter 2003:363). Qualitative methods guide and help researchers to comprehend the underlying behaviours, attitudes, perceptions and culture in a way that quantitative findings could not. Ulin et al (2005:xiii) point out that qualitative designs and methods guide the understanding of the "how" and "why" questions of the phenomenon being studied. Qualitative research has the advantage of taking an emic perspective thus allowing the insiders' view to be known and draws on the lived experiences and meaning of the population under study.

The researcher considered a qualitative research design appropriate to this study since the purpose was to explore and describe the lived experiences of young people who utilised the YAC in Botswana. Lived experience is a reflection of the significance of situations and relating it to the life-world (Van Manen 1990:1). The study sought to extrapolate meaning and understanding from the participants' described lived experiences.

There are several strategies or traditions in qualitative research. Polit and Beck (2008:222), outline the following qualitative research strategies or traditions: ethnography; ethno science (cognitive anthropology); phenomenology; hermeneutics; ethnology, ecological psychology, grounded theory; ethno methodology; semiotics;

discourse analysis and historical analysis. Phenomenology; ethnography; grounded theory; ethno science and ethnology are some of the strategies in the qualitative paradigm (DiCenso, Guyatt & Ciliska 2005:32; Salazar et al 2006:174). The selection of the research tradition is directed by the purpose of the study; the nature of the research question; the investigator's skill as well as the existence of resources to meet the cost of the study.

Moreover, each tradition has a unique way of viewing certain elements of reality more easily than others and highlighting findings relevant for specific use (Salazar et al 2006:173). In this research, phenomenology has been applied as it the most relevant tradition in exploring and describing the experiences of the participants.

3.2.2 Phenomenology

Phenomenology is the study of lived experiences or the study of the life-world. The world is as people immediately experience it pre-reflectively rather than as they conceptualise, categorise or reflect on it. Phenomenology aims at having a deeper understanding of the nature or meaning of people's everyday experience (Van Manen 1990:9). Phenomenology is appropriate for capturing the lived experiences and studying the lives of people in human sciences. Human sciences aim to explicate the meaning of human phenomenology and understand the lived structures of meanings (Van Manen 1990:3).

Phenomenology is commonly used in qualitative health research (Annells 2006:55; Lopez & Willis 2004:726-727). According to Salazar et al (2006:176), human experiences are learnt by exploiting and specifying the descriptions of the population being studied to reach the "lived world". Husserl, Heidegger, Sartre and Merleau-Ponty's phenomenological philosophy guides understanding the "lived experiences" (MacCann 1993:19; Salazar et al 2006:176). A phenomenological design involves a deliberate attempt to reach the lived world by endeavouring to know the way people experience the world (Lopez & Willis 2004:727; Van Manen 1990:5). Phenomenology may be achieved through the use of in-depth conversations with participants and observations of the research field (Salazar et al 2006:175).

Phenomenology always begins with the life-world, the naturalistic attitude of everyday life, which Husserl describes as the original, pre-reflective, pre-theoretical attitude. In addition, phenomenological research has inner meaning, the ethos or essence (Cohen & Omery 1994:139; Van Manen 1990:361).

This study used a phenomenological design and qualitatively explored, described and contextualised the lived experiences of young people who utilise the YAC. The study adopted a descriptive phenomenological approach. The aim of descriptive phenomenology is to provide a comprehensive description of the phenomenon or an exploration of some lived experience by explaining people's feelings, hearing, seeing, believing, remembering, deciding, evaluating what they have lived (Polit & Beck 2008:220). Descriptive phenomenology stimulates perception of lived experience while emphasising the richness, breadth and depth of those experiences (Streubert & Carpenter 2003:61). Descriptive phenomenology consists of four steps, namely bracketing, intuiting, analysing and describing (Polit & Beck 2008:228).

- ***Bracketing***

In bracketing, researchers hold in abeyance identified preconceived ideas, thoughts, opinions and beliefs in relation to the phenomenon being studied. Researchers do bracketing by taking note of the areas of interest; spelling out personal values and areas of bias; identifying areas of conflict, and recognising and respecting leaders and gatekeepers. In addition, researchers note and describe emotions that may lead to being biased; document and describe surprises, and reflect on how to write findings (Polit & Beck 2008:228). According to Streubert and Carpenter (2003:23), bracketing is crucial to enable the researcher to bring out freely the informants' views on the phenomenon under study. In this study, the researcher was interviewed before data collection to identify her knowledge of the youth utilising YACs. This helped the researcher to avoid mixing prior knowledge with that of the participants.

- ***Intuiting***

Intuiting requires researchers to be wholly immersed in the phenomenon being investigated and remain open to meaning as ascribed and attributed by informants from the world-view of their experience (Polit & Beck 2008:756). This allows researchers to

be as knowledgeable about the phenomenon as the informants. Researchers should avoid all criticism, evaluation or opinion and just concentrate on the phenomenon being studied. In intuiting, researchers are the data-collection instruments as they listen during interviews to capture the experiences. Researchers then study the data and focus on the experiences as expressed by the informants. Researchers make no alterations while transcribing and reviewing what the participants described as the meaning of lived experiences (Streubert & Carpenter 2003:60). In this study, the researcher focused on the experience the youth utilising the YAC.

- ***Analysing***

Analysing identifies the essence of the phenomenon under study based on the data obtained. Researchers distinguish the phenomenon and explore the relationships and connections adjacent to the phenomenon. Polit and Beck (2008:747) describe analysing as the stage at which researchers systematise, arrange and synthesise data to answer the question and to test the hypothesis. As researchers listen to the descriptions and the meanings, common themes begin to emerge (Streubert & Carpenter 2003:60-61). In this study, the researcher used Tesch's (1990) eight steps of systematic data analysis (Creswell 1994:153-155).

3.2.3 Explorative

According to DiCenso et al (2005:28), qualitative research normally starts with exploratory questions before doing observation. An exploratory design was appropriate as the purpose of the study was to capture and establish the experiences of the youth utilising the YAC. Exploratory designs primarily use flexible, open-ended, unstructured qualitative data-collection methods, capturing verbatim reports or observation characteristics and yielding data that usually do not take numerical forms while descriptive designs combine qualitative and quantitative methods. Exploratory designs require substantial knowledge of the phenomenon under study, and explicate all factors related to and underlying the processes of the phenomenon (Polit & Beck 2008:21).

Exploratory research is used where there is little or no theory or prior research on the specific variable under study. Researchers measure many possibilities at a time and later scrutinise the results to reach a conclusion (Polit & Beck 2008:21).

3.2.4 Descriptive

Researchers have the task of describing situations and events. This means that researchers have to observe and then describe what they examine (Babbie & Mouton 2001:43). This study wished to describe the experiences of youth utilising a YAC in Botswana and develop/describe guidelines for the facilitation of YFS in YACs.

3.2.5 Contextual

After a detailed and comprehensive description of the phenomenon under study, qualitative researchers have to understand events and process in their context. According to Salazar et al (2006:155), qualitative research is interested in and values context. In contextualisation, researchers attempt to bring into perspective the experiences of the population in relation to the social setting that prevailed at the time of the life-world (Salazar et al 2006:162). In this study, the experiences of young people were studied in the context/social setting of the YAC.

3.3 PERMISSION

Fieldwork is "inherently dialectical, the researcher affects and is affected by the phenomenon she or he seeks to understand. Gaining entry is imperative in conducting research and therefore the researcher has to seek permission from 'gatekeepers'" (Rice & Ezzy 1999:159). Wilson (1989:422-423) emphasises that to proceed with fieldwork, the researcher needs to start by clearing the initial hurdle of gaining entry to the location. Building rapport and trust with the participants is crucial in order to gain entry.

Wilson (1989:424) points out four principles for researchers to achieve rapport in order to gain entry, namely:

- Reduce social distance and other interpersonal barriers to increase trust in them.
- Present themselves positively.
- Be aware that what they reveal about themselves becomes a factor in establishing interaction.
- Put themselves in the other person's shoes, which improves cooperation and the quality of data.

Gaining access is easier when researchers build a good working relationship by explaining the purpose of the study, and indicating how the participants' confidentiality will be protected. In addition, offering to take part in the activities of the community or population under study may help facilitate the research. Gaining access or entry through the use of appropriate procedures facilitates the building of trust needed for the fieldwork to be successful (Streubert & Carpenter 2003:165).

The researcher sought and obtained permission to conduct the study from the:

- Ministry of Health through the Heath Research and Development Committee (see annexure B and C). The application for the research permit was submitted after the UNISA Health Studies Research and Ethics Committee granted the researcher 'Clearance Certificate' for the study (see annexure A).

In addition, the researcher worked and continually communicated with the service delivery officers (SDOs) and peer educators to identify interviewees. The researcher introduced herself and explained the purpose of the study before the focus group discussions and interviews. The participants were informed that participation was voluntary and they had the right to withdraw at any time should they so wish and they were assured of confidentiality and anonymity. The participants signed informed consent to participate (see annexure D).

3.4 POPULATION

A research population refers to all those who fit the specified characteristics being studied (Babbie 2007:9; Polit & Beck 2006:259). Crosby et al (2006:7) state that to define a population, researchers should have knowledge of the epidemiology of the problem or phenomenon under study. In this study, the population was young people between 10 and 29 years of age who utilised the BOFWA YAC at Mochudi in the Kgatleng District in Botswana and the professional staff at the facility.

3.5 SAMPLING AND SAMPLE

Sampling is the process of selecting a portion of the population to represent the entire population (Babbie 2007:180). Non-probability, purposeful sampling was used to ensure that the participants were selected based on their knowledge of the phenomenon.

Purposeful sampling is done when the researcher selects the sample based on existing knowledge of the population and the purpose of the research (Babbie & Mouton 2002:166; DiCenso et al 2005:125). Purposive sampling ensures that people with in-depth knowledge and information are selected (Burns & Grove 2001:376; Streubert & Carpenter 2003:67). In qualitative research, sampling is not concerned with statistical representativeness of the whole population but rather the processes involved in a phenomenon hence the deliberate effort to get cases that will provide full knowledge and sophisticated understanding of all aspects of the phenomenon under consideration (Rice & Ezzy 1999:42; Streubert & Carpenter 2003:24).

Purposive sampling does not provide a statistically representative sample but seeks naturalistic inquiry (Lincoln & Guba 1985:102; Streubert & Carpenter 2003:67). The researcher selects a particular group or groups based on certain criteria and decides who will represent the population under study choosing those who are knowledgeable and have access to the relevant information (Wilson 1989:261). This technique is employed to choose a sample for a specific purpose and is mostly based on information and experience as well as the judgment of the researcher (Polit & Beck 2008:763). In this study, the area and the facility were purposively sampled because it was the only model YAC in the district and the country with the basic satisfactory requirements for a YAC.

The sample consisted of fifty-nine (59) participants. Forty-nine (49) persons in focus group discussions and ten (10) in face-to-face interviews. The tables 3.1, 3.2 and 3.3 illustrate the demographic characteristics of participants according to the sample strata.

Table 3.1 is showing demographic profile of young people who were participants. The majority were females accounting for 59.4% of young people who participated. In addition the larger percentage of young people was students (53.1%). The participants fell in the age groups ranging from 10 to 29 years. The data analysis revealed that YAC

is targeted to the young people of 10 to 29 years. Therefore, the demographic profile tallies well with targeted group. The profile for service providers participants are depicted in tables 3.2 and 3.3. Peer educators have a good representation of both males and females while SDO (nurses and youth coordinator) were all females.

Table 3.1 Demographic profile of young people (participants)

YOUNG PEOPLE				
Sex	**Number of participants**	**Age ranges and number**	**Education level and number**	**Occupation and number**
Males	13	10-14 = 1 15-19 = 7 20-24 = 3 25-29 = 2	Primary = 0 Form 1 = 1 Form 2 = 1 Form 3 = 4 Form 4 = 2 Form 5 = 1 Diploma = 4	Student = 5 Out of School = 4 Employed = 0 Unemployed = 4
Females	19	10-14 = 4 15-19 = 8 20-24 = 6 25-29 = 1	Primary = 2 Form 1 = 4 Form 2 = 4 Form 3 = 4 Form 4 = 0 Form 5 = 0 Diploma = 5	Students = 12 Out of School = 2 Employed = 2 Unemployed = 3
	Total = 32	**Total = 32**	**Total = 32**	**Total = 32**

Table 3.2 Demographic profile of peer educators (participants)

PEER EDUCATORS				
Sex	**Number of participants**	**Age ranges and number**	**Education level and number**	**Number of months/years serving as peer educator**
Males	7	10-14 = 0 15-19 = 0 20-24 = 6 25-29 = 1	Form 1 = 0 Form 2 = 0 Form 3 = 0 Form 4 = 0 Form 5 = 4 Diploma = 3	Less than year = 0 1-2 years = 6 2-3 years = 0 3-4 years = 1 4-5 years = 0
Females	17	10-14 = 0 15-19 = 1 20-24 = 5 25-29 = 11	Form 1 = 0 Form 2 = 2 Form 3 = 8 Form 4 = 0 Form 5 = 7 Diploma = 0	Less than year = 0 1-2 years = 8 2-3 years = 5 3-4 years = 3 4-5 years = 1
	Total = 24	**Total = 24**	**Total = 24**	**Total = 24**

Table 3.3 Demographic profile of SDO (participants)

PROFESSIONAL STAFF				
Sex	**Number of participants**	**Age ranges and number**	**Education level and number**	**Profession and number**
Males	0	0	0	0
Females	3	30-34 = 1 35-39 = 1 40-44 = 1	Diploma = 2 Bachelors = 1	Nurse = 2 Teacher = 1
	Total = 3	**Total = 3**	**Total = 3**	**Total = 3**

3.6 DATA COLLECTION AND DATA-COLLECTION TECHNIQUES

The aim of collecting data was to elicit information from individuals and/or groups to establish the experience of young people utilising the YAC. The researcher selected focus group discussions (FGDs), unstructured individual in-depth interviews and observational notes as data-collection methods. The three methods were meant to complement each other. According to Ulin et al (2005:71), observation, in-depth interviews and focus group discussions are the bedrock of qualitative data collection. The methods differed with respect to the relationship between the researcher and the participants.

3.6.1 Focus group discussio*ns*

In FGDs participants discuss issues from their emic perspective. This approach reduces bias because the etic or researcher's/outsider's perspective is not used hence only insiders' views are reflected (Streubert & Carpenter 2003:157). The researcher conducted eight (8) FGDs. Out of the eight (8) FGDs, three (3) were for peer educators while five (5) was for young people. All the groups had a mix of both males and females. The groups consisted of five (5) to nine (9) members, with a total of forty-nine (49) participants. The participants were young people and peer educators who had used the centre for a reasonable time to had lived experience to share (Rice & Ezzy 1999:72; Burns & Grove 2001:798) (see tables 3.1 and 3.2). The researcher used no structured questionnaire or interview guide, but probed on issues that emerged from the general question, "What is your experience as a young person utilising the youth activity centre or as a peer educator in the youth activity centre?"

3.6.2 Unstructured in-depth interviews

Unstructured individual in-depth interviews are one data collection method/strategy commonly used in qualitative research. According to DiCenso et al (2005:128), unstructured individual in-depth interviews are useful in getting personal experience and perspectives particularly on sensitive issues. Salazar et al (2006:181-182) point out that in unstructured individual in-depth interviews, no prepared specific questions are asked, but instead topics and questions emerge from the discussion. In this study, unstructured individual in-depth interviews were used for peer educators and service delivery officers (n=10). To start the discussion, the participants were asked to relate their experience as peer educators or service delivery officers. Follow-up (probing) questions were asked based on what the participants described. The professional staff interviewed had also been involved in service delivery for a reasonable time. At the time of data collection, the centre had eleven (11) peer educators working with professional staff (see table 3.2). Normally the centre is staffed with two (2) professional staff (a nurse and youth coordinator), but at the time of the study, there were three (3) professional staff because the nurse who had been with the centre for more than five years was leaving and the replacement nurse had already been hired to allow better orientation (see table 3.3).

3.6.3 Observation

In addition to the FGDs and the interviews, the researcher observed the facility set-up, delivery of services, activities, physical environment and processes and compiled field notes. The researcher took observational notes, which are descriptions of the events and activities, The note were generated through watching and listening (Wilson 1989:434). Observations detail the “who, what, where and how”, and in addition provide little interpretation. Longer periods of observation are usually more beneficial than shorter ones because they allow participants to be accustomed to the observer’s presence and return more easily to their interaction (Ulin et al 2005:73). The researcher observed and noted the facility set-up, activities, interactions of service providers and recipients of services, and the friendliness of the environment, which was key in this study. An observation of the facility and the processes was done to yield information on issues of access to the centre and empowerment of the young people as well as the friendliness prevailing.

3.7 DATA ANALYSIS

The data analysis occurred simultaneously with data collection, data interpretation and narrative reporting (Creswell 1994:153). The researcher analysed the data according to emerging themes. The themes emerged from the participants' descriptions of their experience of in utilising the YAC (see table 4.3). The researcher used Tesch's eight steps (Creswell 1994:155) to analyse the data from the recorded audiotapes of the interviews. Transcription of recorded interviews was done and a sample for each strata is attached (see annexures F, G and H). Accordingly, the researcher:

- Obtained a general sense by transcribing the data verbatim, reading the transcriptions carefully and noting any ideas as they came to mind.
- Reviewed the transcriptions, reading them in no particular order. In reading, the researcher answered the questions: What is coming out of the description? What is it about? What is the underlying meaning?
- Made a list of all the topics and clustered similar topics together in columns arranged as major topics or unique topics, and put others together or separately.
- Examined the list along with the data and allocated codes to the topics. The codes were written next to the appropriate segments in the text to identify whether any new categories and codes emerged.
- Found the most descriptive words for the topics and turned them into categories, then drew lines between the categories to show interrelationships.
- Decided on the abbreviations for each category and arranged these codes alphabetically.
- Assembled the data belonging to each category in one place and performed a preliminary analysis.
- Recoded existing data, where necessary.

The researcher clustered major categories as appropriately as possible. The researcher consulted her supervisor and a colleague with experience in qualitative data for analysis and interpretation to identify whether the research questions had been answered.

3.8 LITERATURE CONTROL

For the purposes of this study, the researcher conducted a literature review before data collection and after data analysis. Conducting a literature review after data analysis is essential to place the results in the context of existing research (Streubert & Carpenter 2003:21). The first literature review allowed the researcher to establish how much related work has been done in the area of YAC, including similarities, differences and gaps. The literature review after data analysis enabled the researcher to indicate how the results fitted into the existing knowledge/research on the phenomenon under study; in other words, to focus or support the findings of the study (Streubert & Carpenter 2003:21).

3.9 MEASURES TO ENSURE TRUSTWORTHINESS

In this study the researcher applied Guba's model of trustworthiness, which has four criteria: truth-value, applicability, consistency and neutrality (Lincoln & Guba 1985:290).

3.9.1 Truth-value

Mavundla (2000:1570-1) states that truth-value is assured by employing the strategy of credibility and applicability through transferability; consistency is assured by the strategy of dependability, and neutrality by the strategy of confirmability. According to Ulin et al (2005:27), credibility, dependability, confirmability and transferability are the standards for evaluating the rigor of qualitative studies. To address truth-value four strategies namely: credibility, triangulation, conformity and transferability are used. Credibility deals with the ability of the researcher to establish confidence (Lincoln & Guba 1985:303-304). Credibility involves prolonged engagement, which gives the study a better scope hence acceptance, and persistent observation. Credibility gives the study depth leading to identification of characteristics and elements relevant to the study therefore adding salience (Lincoln & Guba 1985:304).

In this study, prolonged and varied field experience; member checking, and triangulation ensured credibility.

➢ ***Prolonged and varied field experience***

As the principal investigator the researcher has perceptions, knowledge, skills and experience on designing and implementing public health interventions, sexual and reproductive health, behaviour change and she brings to the study. The researcher also has perceptions, knowledge and skills she attained while studying for her first and second degrees where she studied theories of individual health behaviour. The researcher's thesis for Master of Public Health degree studied theatre as a participatory learning approach to examine how it empowered the members. The researcher examined the guidelines they followed and observed their performance before she carried the interviews with individual members.

In addition, the researcher has work experience in adolescent sexual and reproductive health services, and knows how such services should be offered. Therefore, the knowledge, skills and the experience that the researcher has brings positive inputs to the study particularly no how health promotion intervention and how the services of programmes target to young people should be delivered. However, the knowledge, skills and experience she has may bring bias into the study. Although the researcher made an effort to be objective, the bias may influence the way she views, comprehends and interprets the data. According to DiCenso et al (2005:548), bias is a systematic error that may occur at different stages of conducting research.

In an effort to ensure trustworthiness, engagement with the YAC was prolonged by continued communication with the services providers, visits to the center for completion and confirmation of things, and engagement with a structure overseeing the YAC.

➢ ***Member checking***

The participants served as a check throughout data collection. Follow-up interviews and consultations were done as and when necessary to ensure the truth-value of data. In this study, there was ongoing dialogue regarding the researcher's interpretation of the informants' reality and meaning to ensure the truth-value of the data. DiCenso et al (2005:560) argue that member checking "involves sharing draft findings with informants to verify if their perspectives have been well presented, and also to check if the findings make sense".

- ***Triangulation***

According to Streubert and Carpenter (2003:303), triangulation refers to using two or more research methods in one study. Triangulation can be applied at the design level, also referred to as *between-method triangulation*, and again at the data-collection stage, often called *within-method triangulation.* Triangulation strengthens reliability as well as internal validity (Creswell 1994:174). Triangulation assumes that using more than one method or source will neutralise bias.

According to Lincoln and Guba (1985:283), triangulation is vital in naturalistic studies and no information should be given consideration if it is not triangulated. In this study, triangulation occurred at data collection. FGDs, unstructured individual in-depth interviews, and observational notes were used to triangulate, to ensure the informants' trustworthiness. Combining data-collection techniques provides more holistic and better understanding of the phenomenon under study. To combine data-collection techniques, researchers should know the strengths and weakness of each method and therefore combine them so that each overcomes the other's weakness.

3.9.2 Applicability

Applicability determines the depth at which results of an inquiry are applicable to other situation and subjects (Lincoln & Guba 1985:290). In the naturalist paradigm, applicability is more relevant than internal validity and rejects the axiom of generalisation arguing that transferability is more valid as a criterion for applicability because it examines the degree of similarity (Lincoln & Guba 1985:290). Salazar et al (2006:154) contend that qualitative studies should be carried out in a naturalistic setting where only a few variables are controlled, as the different situations are unique and therefore less consenting to generalisation. Streubert and Carpenter (2003:39) define transferability or fittingness as the likeliness of research results having the same meaning in similar situations. The "burden of proof" of transferability lies with the individual to provide empirical evidence that the sending and receiving context are satisfactorily similar (Lincoln & Guba 1985:298; Streubert & Carpenter 2003:39). In this study, to ensure applicability the researcher examined and reviewed other research on programmes targeted at young people.

3.9.3 Consistency

Consistency refers to whether the findings of a study would give the same results if replicated in similar circumstances (Lincoln & Guba 1985:290). To measure consistency, researchers test whether repeated administration of the instrument in a similar context will yield equivalent results. In qualitative research the key is to learn from rather than control the participants. Researcher and participants are the instruments assessed for consistency (Krefting 1991:216). In this study the researcher ensured consistency by means of a dependability audit, dense description, triangulation and member checking.

- ***Dependability audit***

For data collection, the researcher conducted and tape-recorded FGDs and in-depth interviews, thereby making an audit trail possible. Ulin et al (2005:27) describe dependability as the extent to which findings can be replicated.

- ***Dense description***

The researcher explicitly explained the data-collection method and analysis.

- ***Triangulation***

Triangulation was used to ensure both credibility and consistency.

- ***Member checking***

The researcher was in constant dialogue with the participants.

3.9.4 Neutrality

In qualitative research, neutrality is concerned with the data not the researcher. Neutrality seeks to establish the degree to which the findings are truly from the informants but not influenced by bias (Lincoln & Guba 1985:290). According to Mavundla and Netswera (2006:10), neutrality can be achieved when truth-value and

applicability are established. In this study the researcher applied confirmability, triangulation, member checking and reflexivity to ensure neutrality.

- ***Confirmability***

According to Ulin et al (2005:27), confirmability refers to minimising the influence of the researcher's values on the process of inquiry. An expert was appointed by the University to supervise the study audit and examine the standards of the research.

- ***Triangulation***

Triangulation was used to ensure credibility and consistency as well as neutrality.

- ***Member checking***

The researcher used member checking for credibility, as there was constant interaction and dialogue with the participants.

- ***Reflexivity***

During fieldwork the researcher kept notes on her experiences and noted observations during focus group discussion and interviews.

3.10 CONCLUSION

The chapter discussed the research design and methodology, including population, sampling and sample, data collection and data-collection instruments, and literature control to explore and describe the lived experience of young people utilising the YAC and further contextualise the findings. After the participants' lived experiences were captured and analysed, the researcher developed guidelines for facilitating YFS.

Chapter 4 discusses the data analysis and interpretation with reference to the literature reviewed.

CHAPTER 4

Data analysis and interpretation

4.1 INTRODUCTION

This chapter discusses the data analysis and interpretation and findings with reference to the literature review in order to conceptualise the participants' lived experience of the YAC. Qualitative research focuses on the emic or insider's perspective (Streubert & Carpenter 2003:18).

Polit and Beck (2008:225) describe the emic perspective as the manner in which the participants see their world as insiders, and the etic perspective as the view of or meaning given by outsiders to the phenomenon under study. Patton (2001:84) refers to the emic perspective as the insider's perspective and adds that insiders usually have a deeper understanding of the phenomenon being studied. Burns and Grove (2001:69) emphasise that an emic approach explores the phenomenon from within.

4.2 SAMPLE

The participants of the study were purposively selected for their experience of the phenomenon under study (Streubert & Carpenter 2003:56-57). In qualitative research, sampling attempts to obtain cases that present a wealth of knowledge and comprehension of the phenomenon.

To be eligible to participate in the study, the young people had to be regular users of the YAC for a period of three months or longer. Since there were only eleven peer educators and three SDOs at the centre at that time they were all selected. The participants gave informed consent prior to participation in the study. Data was collected by means of FGDs, unstructured individual in-depth interviews as well as observation and field notes (see table 4.1). In qualitative studies probing triggers additional thoughts thereby gathering detailed information (Salazar et al 2006:184).

This technique uses small group discussions to identify the views of individuals in a group on the subject under scrutiny.

Table 4.1 Sample and data-collection methods and number of participants

Sample	Data-collection method	Total number of participants
SDOs	Unstructured individual in-depth interviews	3 (Pilot -1)
Peer educators	Unstructured individual in-depth interviews	7 (Pilot - 2)
	Focus group discussion x 3 FDG – Pilot - 6 FDG 1 = 5 FDG 2 = 6	17
Young people	Focus group discussion x 5 FDG – Pilot - 5 FDG – Pilot - 6 FDG 1 = 6 FDG 2 = 6 FDG 3 = 9	32
TOTAL		**59**

The researcher used no structured questionnaire or interview guide, but probed on issues that emerged from the general question, “What is your experience as a young person utilising the youth activity centre or as a peer educator in the youth activity centre?”

The researcher conducted eight (8) FGDs; five (5) with young people and three (3) with peer educators. It is worth noting that almost half of peer educators used for the pilot had left the YAC at the time of actual data collection. In addition, two (2) of the peer educators who had recently left were interviewed as they had valuable experiences. Unstructured individual in-depth phenomenological interviews were also done with seven (7) of the peer educators and the three (3) professional staff members referred to here as SDOs. The FGDs consisted of five (5) to nine (9) members, with a total of forty-nine (49) participants. The participants were young people and peer educators who had used the centre for a reasonable time and had lived experience to share (Rice & Ezzy 1999:72; Burns & Grove 2001:798).

The researcher outlined the demographic profile of all the participants in chapter 3. (see tables 3.1, 3.2 and 3.3).

The profile also included those who participated in the pilot testing. The purpose of the pilot study was to guide and assist the researcher in testing the participants' acceptance and willingness to give information as well as for the researcher to cultivate and hone her interviewing skills.

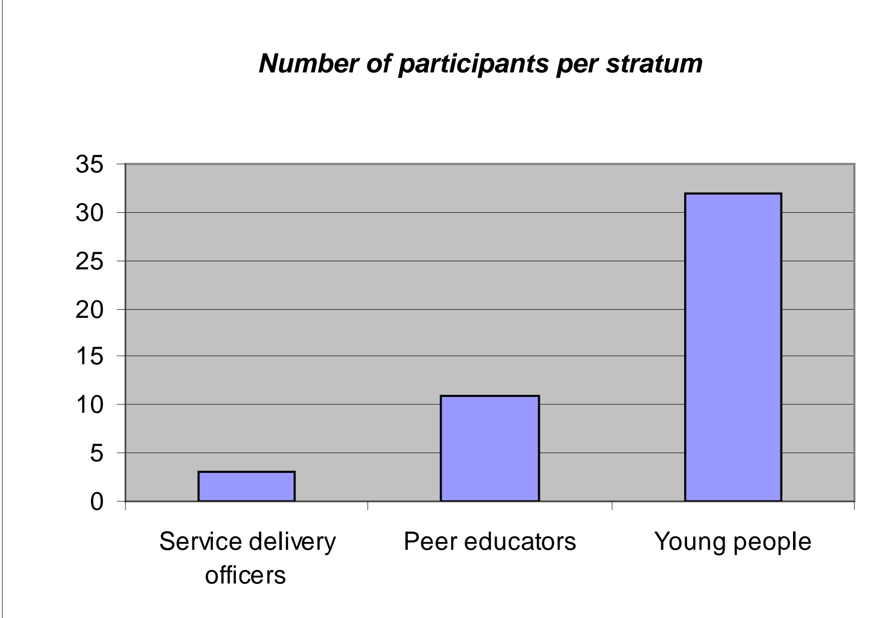


Figure 4.1: Frequency of participants' strata

Figure 4.1 shows the frequencies of the participants according to the study strata, while figure 4.2 gives the percentage of the strata representation. It is evident from figures 4.1 and 4.2 that a larger number of the participants were young people with a representation of 69%.

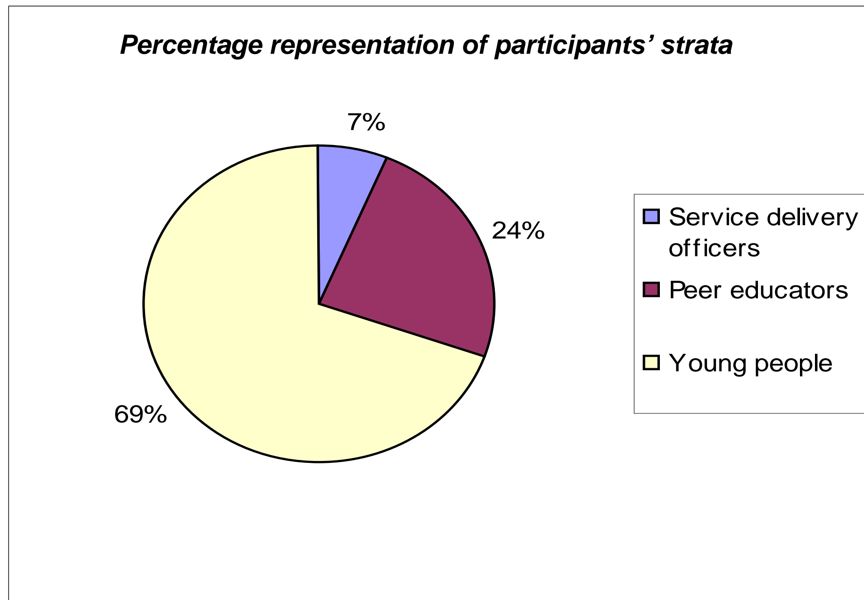


Figure 4.2: Participants' strata

Figure 4.3 indicates that the majority of the participants were for the age group 20 to 24 years.

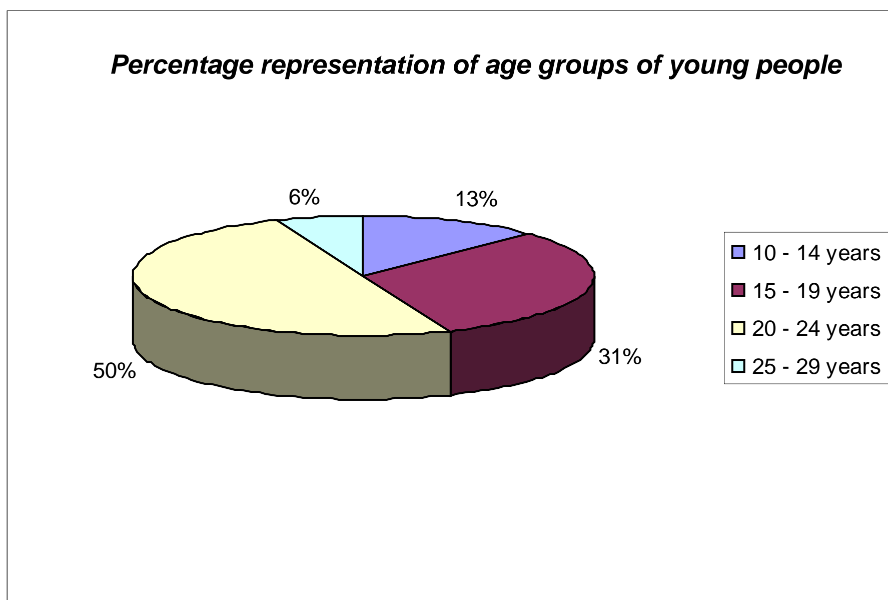


Figure 4.3: Young people participants' ages

In examining the SDOs' bio data profile, the study found that the SDOs were between 32 and 41 years old. The peer educators were between 19 and 29 years, while young people's age ranged between 11 and 26. Figure 4.4 shows both the frequencies and

percentage of age group representation among peer educators and that the age group 0 to 14 years were not represented among the peer educators.

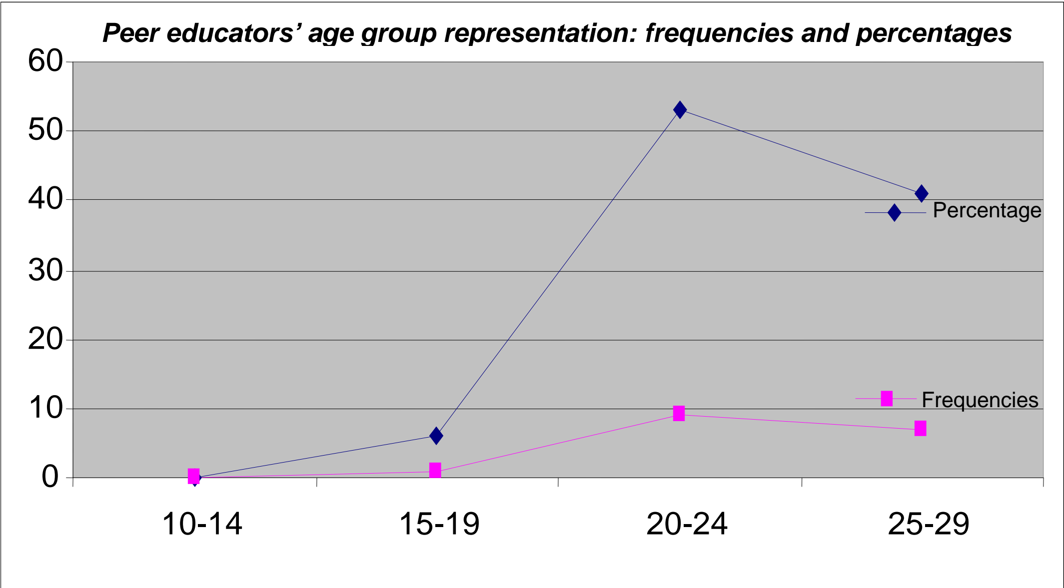


Figure 4.4: Peer educators' ages

4.3 DATA COLLECTION

The BOFWA and the young people showed keen interest in the study because it was the first to explore and describe the experience of the YAC users. No study or evaluation of the users' experience had been done since the implementation of the programme.

The researcher conducted unstructured individual in-depth interviews with the SDOs and peer educators, and focus group discussions with the young people and peer educators (see table 4.2). The researcher scheduled individual interviews with the SBOs and peer educators at the YAC in advance. Arrangements were made for focus group discussions with young people and peer educators. The young people who participated were selected on the days of the group discussions. The researcher targeted the days during school holidays when the activities planned drew more youth to the centre. The young people generally had no objection to participating, and contributed freely and shared their lived experiences. Data was collected until saturation was reached. Wilson (1989:485) states that saturation is reached when no new information, categories or themes emerge from the data.

The interviews were conducted in English while the focus group discussions with the peer educators and young people used both English and Setswana. Most were comfortable with both languages, but a few were more confident in English or Setswana. During transcription, data in Setswana was translated into English.

Table 4.2 Data-collection methods and strata

Method of data collection	Target groups
Unstructured individual in-depth interview	- SDO - Peer educators
Focus group discussions	- Young people - Peer educators

The participants were asked to describe their lived experiences in utilising the YAC. The discussions allowed the participants to narrate their life-world experiences or the world of lived experiences. Narrating the lived-world gives the individuals' lived meaning. Manen (1990:183) describes lived meaning as "the way that a person experiences and understands his or her world as real and meaningful … lived meanings describe those aspects of a situation as experienced by the person in it". Lopez and Willis (2004:727) emphasise that subjective information, which is gathered to get lived experience, is vital in science. Such information enables researchers to understand that human motivation is influenced by what is perceived to be real.

During data collection the researcher applied bracketing in order to ensure that her preconceived ideas and biases on young people's use of a YAC did not contaminate the information and interfere with the findings (De Vos 2001:337). In bracketing, researchers hold in abeyance identified preconceived ideas, thoughts, opinions and beliefs in relation to the phenomenon being studied.

4.4 DATA ANALYSIS

The researcher used Tesch's (1990) eight steps (Creswell 1994:155) to analyse the data systematically. Accordingly, the researcher:

- Read through all the transcriptions carefully. Then picked one document to review and went through it, asking what it was about.
- Tried to discover the underlying meaning, and wrote notes in the margin.
- Made a list of all the topics and clustered similar topics together. Arranged similar topics together in columns that could be identified as major and unique topics.
- Took the list and went back to the data. Allocated codes to the topics, which allowed for an abbreviated form, and wrote the code next to the appropriate segments in the text. Using this preliminary organising scheme, the researcher identified whether new categories and codes emerged. Grouped related topics together in order to reduce the total list of categories.
- Found the most descriptive words for topics and turned them into categories. Divided the categories further into sub-categories.
- Made a final decision on the abbreviations for each category and arranged the codes alphabetically.
- Assembled the data belonging to each category in one place and performed a preliminary analysis.
- Where necessary, recoded the existing data.

The researcher immersed herself in the data by reading the transcriptions repeatedly to get a clear picture and understanding of the information. Direct quotations were used to ensure that the stories told remained focused and gave a sense of the participants' perspective. Polit and Beck (2008:747) describe analysis as a process whereby the data is segregated into sections for the purpose of answering the question of the research and communicating answers. Interpretation of data is done to identify themes, trends, patterns, qualities and exemplars.

To maintain the trustworthiness of the study, the researcher followed Lincoln and Guba's model (1985:290). The participants were key in getting the experience of utilising a YAC. In addition, the researcher kept records, noted observations and

thoughts as well as ideas and reactions to the interviews. According to Polit and Beck (2008:768), trustworthiness is “the amount of assurance and confidence a researcher has in the data”.

4.5 YOUTH FRIENDLINESS OF THE YAC

The overall theme that emerged from the data analysis was the “youth friendliness of the YAC” to the users, mainly young people. Three categories emerged from the theme of “youth friendliness of the YAC” namely: physical, administrative, and psychological aspects.

- **Physical**. The physical aspect refers to the facility location, set-up, environment of facility, the structures, equipment and tools, and amenities that constitute the YAC. Adamchak et al (2000:287) maintain that the environment is one of the most important characteristics of youth-friendly centres and services.

- **Administrative**. The administrative aspect comprises policies and procedures, the daily operations in the facility and communication channels.

- **Psychological**. This aspect includes the service providers’ prevailing attitudes towards and perceptions of the users as well as the facility interpersonal relationships among the staff, peer educators and young people. Young people who are the users become the recipients of the services, and react psychologically to the situation.

Table 4.3 presents the themes, categories and subcategorise from the SDOs’, peer educators’ and young people’s perspectives. Barnett and Schueller (2000:83) emphasise that youth friendliness “does not mean building a new facility but rather calls for changes in the administration. The way services are offered and where they are provided as well as who provides them determine their youth friendliness.”

Youth friendliness should allow staff time to reflect on and assess their beliefs, attitudes and values regarding ASRH (Karki 2006:324-330). This makes it possible for staff to ensure that they do not compromise the delivery of health services and health rights of

young people. Moreover, this facilitates improved youth-friendly services and action plans as the providers frequently take stock of their behaviours and attitudes.

According to MacFarlane and McPherson (2007:138-139), health facilities have a responsibility to provide information in a positive and attractive way to young people. Service providers are advocates for young people therefore their knowledge and skills are important to assist delivery of health promotion programmes. Consequently, the SDOs' perception of the experience of young people was also important.

Table 4.3 lists the theme, categories and subcategories that emerged from the data.

4.5.1 Category 1: Physical aspect of the youth friendliness of the YAC

The physical environment of the YAC plays a major role in facilitating youth friendliness. The area or location of a centre or a facility and its set-up determine its friendliness. If, for example, a facility set-up displayed pictures and poster of girls on the walls and notice boards, it would be more appealing to girls and less welcoming to boys. The category physical aspect of the youth friendliness of the YAC has three sub-categories: access to the YAC, set-up of the YAC, and IEC. Each sub-category is discussed reflecting the experience of the service providers, peer educators and young people.

Sub-category 1.1: Access to the YAC / Location

Describing the participants' experience of access to YAC meant examining the location of the facility in relation to the centre of the village and the main road; how convenient the YAC was for young people to reach; freedom to get service in relation to the neighbourhood and how many users there are.

The Mochudi BOFWA YAC is located in an area that is more towards the outside of the village. It is one street away from the main road, which is used by public transport that enters and leaves the village. When one gets out of the taxi they walk a short distance to the centre. The YAC occupies approximately 2 400 square metres. It is situated in the residential area thus surrounded by homes. On both sides and in the front of the premises are gravel roads and an undeveloped plot is at the back.

Table 4.3 Theme, categories and subcategories

Theme	**Youth friendliness of the YAC**		
Categories	1 Physical aspect of the youth friendliness of YAC	2 Administrative aspect of the youth friendliness of YAC	3 Psychological aspect of the youth friendliness of YAC
Participants	***Sub-category***	***Sub-category***	***Sub-category***
1 Service delivery officers	1.1 Access to the YAC / Location 1.2 Set-up of the YAC 1.3 Health education/IEC materials availability	2.1 Shortage of staff 2.2 Shortage of funds 2.3 Policies and procedures of operating YAC 2.4 Services and activities offered	3.1 Involvement of young people 3.2 Empowerment of young people 3.3 Stigmatisation of the YAC 3.4 Lack of parent-child communication 3.5 Attitudes of service delivery officers
2 Peer educators	1.1 Access to the YAC / Location 1.2 Set-up of the YAC 1.3 Health education/IEC materials availability	2.2 Shortage of funds 2.4 Services and activities offered 2.5 Hours of operation of the YAC 2.6 Poor communication between staff and peer educators	3.1 Involvement of young people 3.2 Empowerment of young people 3.5 Attitudes of service delivery officers 3.6 Peer educators as role models and peer interaction
3 Young people	1.1 Access to the YAC / Location 1.2 Set-up of the YAC 1.3 Health education/IEC materials availability	2.2 Shortage of funds 2.4 Services and activities offered 2.5 Hours of operation of the YAC	3.1 Involvement of young people 3.2 Empowerment of young people 3.5 Attitudes of service delivery officers 3.6 Peer educators as role models and peer interaction

As the centre is located on the outskirts of the village, this means that many young people are far from the YAC and need to use public transport to reach the place. In Botswana everyone above 6 years old pays on public transport. Most young people cannot afford to pay, as they are not working. Many of their parents are also unemployed and therefore cannot provide the fare for their children to visit the YAC.

- ***SDOs' experience with the location of the YAC***

All the SDOs pointed out that the YAC is located in an area where most young people have to use public transport to reach it. Young people have to take public transport (a kombi or minibus) from their homes to the village centre (main shopping centre) and then again from the village centre to the YAC. The location is a problem not only for young people but even for peer educators as well, who sometimes fail to report for duty because of the cost of transport the YAC:

> *Another challenge is the location of our centre. It is just far away, out of town and far from other facilities. Even when a young person comes to the shops to buy, she may want to come to BOFWA but transport is a challenge because they have to take another kombi to reach here. If it was near town, young people could come in when they had been sent on errands by their parents.*
>
> *Our centre's location is not accessible to everyone. It is not in the centre of town, which makes it difficult for children to access it because they will need transport fare. Remember, this is a village set-up and not every parent is working.*

- ***Peer educators' experience with the location of the YAC***

The peer educators expressed concern because the centre is outside the village. They emphasised that most young people had to use public transport to reach the facility:

> *I think the location of our centre is the reason why youth are not using it, because it is very far from them. For them to come here they must have money to pay for transport and lunch. The centre is outside the village.*
>
> *I think the majority have to come here by transport and do not have money.*

I have something to add. Most people who come here they need transport like it has already been mentioned. The centre is located on the end of the village. Most who come here from the different wards in Mochudi, need transport.

- ***Young people's experience with the location of the YAC***

Most of the participants had to use public transport to reach the facility and added that it was not easy to ask their parents for money:

We come from different places and the centre is not located conveniently.

The centre [YAC] is not in the centre of the village. BOFWA should transport young people, to make it easy for them to use it.

I think we come from different places and the centre is not located properly. It is more on the outsider of the village.

The data indicated that young people's access to the YAC is limited by the location of the centre on the outskirts of the village, most young people having to use public transport to the centre, and lack money to pay taxi fares. To access the YAC, they have to pay taxi fares twice and pay the same amount again to go home. Therefore, the location of the Mochudi YAC is a major obstacle to accessing the services.

According to Senderowitz et al (2003:3), convenient location is a crucial characteristic of youth-friendly services. Moreover, young people are also a sensitive group therefore any inconvenience may deter them from accessing services.

Brabin (2002:29) found that among the service factors that promote youth friendliness is mobility; that is, how much travelling is needed for reaching the services. Barnett and Schueller (2000:14) emphasise that little or no money to pay for services and transport is a hindrance to accessing services.

According to Thomas, Murray and Rogstad (2006:916-924), access is improved by creating linkages between the facility and the school and community settings. Barnett and Schueller (2000:13) state that lack of access to services and programmes is a

major barrier affecting young people. In particular, access is important for young people because they are concerned with privacy and confidentiality.

Sub-category 1.2: Set-up of the YAC

The set-up of the YAC included the arrangement of the buildings and the sports fields; furniture in the facility; arrangement and flow of services and activities; freedom at the facility; set-up and environment at the facility; as well as the ease of interaction with staff and other users.

The study found the set-up pleasant and suitable for young people. The set-up influences the youth friendliness of a facility because privacy, confidentiality, and freedom are important to young people. During observation the researcher noted that the clinic rooms are located towards the back. The counselling room is also situated in such a way so that when clients enter, others do not know whether they are going to the library or the counselling room. Moreover, young people move around all the time, which distracts people from paying close attention to which rooms others go. The YAC makes provision for basketball, volleyball, soccer, tennis, table tennis, and games rooms. In addition there are computer, counselling/education, and television (TV) rooms.

- ***SDOs' experience of the set-up of the YAC***

The SDOs indicated that peer educators were at the forefront in the delivery of services (a thing that is said to attract young people). The professional staff presentation and their dress code are casual but smart, therefore do not deter young people from interacting with them. The study found that the staff are trained in the provision of youth-friendly services. This is a deliberate effort to ensure that the setup is kept youth-friendly. Service providers' friendliness and the activities provided also determine whether recipients frequent the centre. According to the SDOs:

> *This is a youth-led association where we believe that for young people to be free to talk about issues concerning them, they have to be with another young person. For them, they see every figure as a mother who should remain at home and not be here, therefore the youth experiences should be different when in the*

centre. When we were employed, we were told to be conscious, we should dress smartly, but when there is an activity here in the centre we should be able to wear casual clothes.

The main reason we have a set-up that has youth up-front is that when another young person visits the centre, they are able to relate to their age mates.

We have many sports activities to choose from, such as drama, soccer, volleyball and others. Because of them being up-front, when they are given work to do, they do it wholeheartedly because they have initiated it, implemented it and hence own it. This makes the set-up of the environment to be more youth friendly.

- ***Peer educators' experience of the set-up of the YAC***

Most of the peer educators felt that the set-up of the YAC was good:

A young person, when he/she comes to the centre, the first person to meet or interact with is us peer educators. We assist them and direct them to the services they are seeking.

The centre here makes one to feel free. It is really teaching us to know ourselves as a youth and where we are going as a youth.

After receiving the training we conduct some centre talk with other youth coming to the centre and then we tell [teach] them what we have been told.

- ***Young people's experience of the set-up of the YAC***

The participants expressed satisfaction with the physical arrangement or set-up of the rooms, and the sports fields. However, they were concerned at the shortage of equipment and that damaged equipment had not been repaired or replaced. In general, the participants showed that they appreciated having the YAC and had benefited in many ways:

When you get here, there are peer educators to help you. They are great people and helpful.

Most of the time the people who work at BOFWA are our age. In certain circumstances, you find that you cannot tell your friend about your problem, but at BOFWA you meet trained people of our age. Also, there are so many things one can do, like playing football, volleyball and you can forget about unnecessary things and spend some time with our friends at BOFWA.

You also find the peer educators there who are young people. So it is very easy and is nice to communicate to people of your age or someone not too much older than you. You become free to talk out your concerns. They have those skills to help you, the more they advice you the more you got to know the good and the bad. I think that what I have gone through at BOFWA is very good.

The data indicated that the set-up at the YAC facilitated the youth friendliness of the facility. The arrangement of the rooms and furniture, and the various recreational activities catered for whatever services young people sought. The varied activities attracted young people to the centre and kept them occupied. Barnett and Schueller (2000:84) maintain that the set-up of a youth-friendly facility must ensure that young clients have privacy and implement policies that emphasise confidentiality.

Sub-category 1.3: Health education/IEC materials availability

The availability of IEC materials refers to whether adequate pamphlets, publications and posters on different topics that affect young people are displayed and available at the YAC. IEC materials are useful in assisting and guiding both the service providers and the young people. According to the SDOs, the YAC obtains IEC materials from the Kgatleng District Council through the District Health Team (DHT). The SDOs indicated that there was a shortage of materials and that there is a problem with distribution and acquisition. The DHT orders or requests IEC materials from the MOH, and then distributes to organisations/catchment areas in the district.

The development, provision and display of IEC materials or health educational materials are important in YFS as they enhance the knowledge of the target audience. All IEC materials are unique methods of communicating the message to the target group. Therefore, they are necessary in any public health education programme.

Service providers can give the materials to clients during consultation so that they learn more about their needs or problems. IEC materials can also be provided in a “self-service” way, by displaying them prominently. The self-service approach is a friendly and convenient method of distributing materials to young people because they can choose what they want for themselves. This approach increases access and utilisation. Young people are sensitive and secretive, therefore, it is important to provide them with IEC materials that they can read privately. Audio education is also highly effective, as it is visible and interactive and there is learning and entertainment. Young people like and concentrate during video sessions, which imply that there is interest and learning.

- ***SDOs’ experience of IEC material availability***

The SDOs emphasised the value of having IEC materials. According to them, the use of materials during discussions in general and with young people during consultations is important, as it allows them to go in detail and enhance their understanding. However, all the SDOs raised the problem of a shortage of IEC materials:

> *My experience dealing with young people is really interesting. They really utilise the services, they do come, they know that at BOFWA there’s information and the services are youth friendly.*
>
> *We actually have IEC materials on all topics, yet not enough for distribution purposes. For example, when you meet the youth and discuss certain issues, such as drugs and alcohol abuse, pregnancy or any other issue, they normally want to have their own copy but we fail to give them because there are not enough.*

- ***Peer educators’ experience of the availability of IEC material***

The peer educators emphasised the need to have IEC materials in discussions with the youth. The materials are very useful and necessary to assist individuals in acquiring knowledge. The peer educators pointed out that they also read the materials to better understand the topics and issues. They said the materials were put out for young people to choose and read for themselves while waiting to be helped. They could also choose to take what they want to read at home. The peer educators expressed

concern over a lack of IEC materials on certain topics, such as relationships and relating to peers of the opposite sex. According to the peer educators:

> *All these leaflets, booklets and posters play an important role when we discuss with young people. We give them even in schools.*

- ***Young people's experience of availability of IEC material***

The participants felt comfortable with the way the materials were distributed and appreciated the availability of IEC materials. However, they expressed the concern that available IEC materials did not address some topics. According to one of the participants:

> *The educational materials are helpful as they go into detail explaining. I wish more could be developed on other topics.*

The shortage of IEC or health education materials emerged as a challenge. The centre did not obtain materials directly from the Ministry of Health Headquarters in Gaborone, but through the DHT. The centre had limited access to organisations that develop and distribute materials to the districts. The shortage of IEC materials impeded access to information and privacy because their absence obliged young people to ask SDOs or peers for information. The SDOs frequently could not give young people IEC materials to read at home or in their own time because they are not adequate.

The availability and use of health education materials plays a critical role in keeping young people informed and educated on different topics. Barnett and Schueller (2000:13) found lack of knowledge and information as a barrier to good reproductive health care. Timely, appropriate and relevant IEC materials would ensure that young people have the knowledge and information they need to make informed and responsible decisions. The use of relevant and appropriate IEC materials is key to spreading awareness. Furthermore, peer educators need IEC materials in their outreach to young people.

4.5.2 Category 2: Administrative aspect of the youth friendliness of the YAC

The administrative aspect is also important in facilitating youth friendliness. Administration rules, regulations, procedures and polices greatly influence where young people seek help or whether they continue to utilise services provided. The researcher identified the following sub-categories of the administrative aspect of the youth friendliness at the YAC: shortage of SDOs; shortage of funds; polices and procedures; services and activities offered; poor communication between staff and peer educators, and hours of operation.

Sub-category 2.1: Shortage of staff

Shortage of staff is described and explored in relation to the capacity of the staff in terms of numbers, knowledge and skills needed to deliver services to young people. The shortage of both professional staff and peer educators was among the concerns raised by informants. The issue was raised only by the SDOs.

The data revealed that there is a shortage of staff, particularly in the clinic. If the nurse goes on outreach activities or has to attend any activity outside the YAC, the clinic closes. The SDOs felt that it was not good or convenient for the young people for the clinic to close when the nurse had duties outside the centre. The high turnover of peer educators was also a constraint.

- ***SDOs' experience of shortage of staff and peer educators***

The centre had a shortage of professional staff and peer educators. As a result, most of the time when peer educators did outreach activities at schools, professional staff do not accompany them. There was a high turnover of peer educators because once they were trained, many found employment or chose to seek employment in other towns. According to one SDO:

> *Another challenge is the movement of the youth. The youth are trained but they do not last in our organisation. Although it is good that they learn and the learning experience paves the way for them to get jobs, for us it's a loss.*

Sub-category 2.2: Shortage of funds

This section explored the financial situation of the YAC, how that affected the delivery of services, and what could be done to improve the situation.

All the SDOs stated that a shortage of funds was a challenge and had led to a failure to implement activities as planned. Failure to implement activities frustrated SDOs and young people as recipients of the services. Activities at the centre and outreach activities suffered due to lack of funds. In addition, not having funds to transport peer educators to areas or villages to carry out assignments denied young people in those areas access to services. The participants indicated that the government should be involved as the centre catered for the same youth that could be receiving services from public health clinics.

- ***SDOs' experience of shortage of funds***

The SDOs found the shortage of funds a challenge. Some planned activities could not be carried out because of lack of funds. Moreover, the intention had been to extend the programme to nearby villages, but a lack of funds had prevented this. According to the SDOs:

> *Major challenges include inadequate funds. We are not able to implement or achieve all our goals because of limited resources.*
>
> *Lack of funds to implement activities affects young people because they become frustrated, as you can imagine, when a planned activity is not implemented. They really get frustrated! Even we as officers get frustrated.*
>
> *The problem comes when the donors who promised to sponsor certain activities don't fulfil their promises. Maybe we as the officers understand; but the young people and the volunteers get frustrated and decide to sit back at home.*
>
> *Lack of funds hinder our intentions to extend the programme to peripheral places, the resources are limited.*

- ***Peer educators’ experience of shortage of funds***

The peer educators also found the shortage of funds an obstacle:

> *There are activities that have been cancelled because of no money. Our centre depends on donors. So sometimes there is a shortage and activities cannot be held.*
>
> *You can imagine after planning and telling people that there is an activity, and next thing it is cancelled. It is discouraging.*

- ***Young people’s experience of shortage of funds***

The participants found the shortage of funds a problem and frustrating:

> *Most of the equipment is not working and no repairs have been done. When we ask about this, we are told there is no money for repairs.*

The data revealed that a lack of or inadequate funds to implement programme activities or to expand programmes to nearby villages was a serious problem. In addition, donors sometimes withdrew their support during the year when plans had already been made and were being implemented. The cancellation of planned activities discouraged young people from coming to the centre and participating in future activities.

Sub-category 2.3: Policies and procedures

In policies and procedures, the focus was on describing how the YAC functions, what policies the programmes are anchored on, which have been beneficial, and whether there are any gaps. The YAC is anchored on the national youth policy, national population policy, national sexual and reproductive health framework, policy guidelines and service standards for the national sexual and reproductive health programme as well as the national development plan (NDP) 8-9. Policies and procedures can be an impediment in the delivery of services in some areas. Only the SDOs were asked about policies and procedures.

- ***SDOs' experience of policies and procedures***

The SDOs indicated that the policies and procedures used in the centre were useful and needed. At the same time, however, they also hindered service delivery:

> *We acquire most of the materials that we have for young people from government departments. The problem is that the procedure involves an assigned officer to order from Gaborone for us. If they fail to order in time, we therefore run out of stock here in Mochudi.*
>
> *From the ministry we are normally issued with a few copies because there are other facilities, which also share with us. To me, I think at the ministry there should be a section or unit specifically dealing with youth issues so that we could easily trace other sister facilities, which offer youth education of which we can share resources easily.*
>
> *The problem comes from the Central Medical Stores, which is the main supplier of drugs and condoms. The condoms issued by Central Medical Stores are never enough and we ask for more from NGOs, if we have shortages.*
>
> *We encourage them to condomise when they engage, but we fail to supply them with condoms.*

The SDOs frequently referred to the shortage of condoms in the YAC as an impediment to accessing services. At one point the centre had gone for a period of two months with out condoms. The SDOs blamed the DHT as it is responsible for supplying the YAC with condoms. There seemed to be problem of calculating the buffer stock.

Barnett and Schueller (2000:84) maintain that policies and programmes must not hinder youth from accessing services and information. The MOH and the DHT need to revise their IEC materials distribution policies and procedures to improve access and delivery of services.

Sub-category 2.4: Services and activities offered

This sub-category described the activities that the YAC offered young people. The outreach activities at the centre are divided into two groups, namely for youth out-of-school and for youth in school. The major activities are consultations, workshops, sport, and tournaments and minor activities are individual or group talks at the centre. The sport activities attract most young people to the centre.

The centre offers services that build, guide and empower young people to be able to make informed decisions, to act responsibly and above all to acquire skills to make them better able to know what is right and wrong, what is appropriate and, most importantly, what is safe and what is unsafe.

The facility lists the following services and activities on a notice board: clinical services (for different ailments; STI treatment; prevention of mother to-child transmission [PMTCT]; screening for cervical cancer, and others); sexual education; counselling services; basic economic skills for out-of-school; blood transfusion; library services, and recreation (table tennis, pool, volleyball, soccer etc). The educational activities include video and discussion sessions; health talks, presentations and discussion, and reading health materials to equip young people with knowledge and skills. Youth acquire knowledge on the prevention of HIV, STIs and pregnancy, and avoidance of risky behaviour such as alcohol and substance abuse.

- ***SDOs' experience of services and activities offered***

The SDOs stated that services were offered for young people aged 10 to 29 years, and if young adults over 29 years sought services they were also helped:

> *This organisation is committed to providing youth-friendly service to young people aged 10 to 29 years. They really utilise the services, they come, they know that at BOFWA there's information and the services are youth friendly. But most of the young people who come for HIV testing are negative, which is a promising thing. Among those who are HIV positive you could pick that if young people were given enough information, enough training, enough life skills, really*

the situation would be different. Also, if enough could be done, we should be able to control HIV/AIDS among young people.

We teach them about family planning, sexual related issues in a conducive environment. We have many sports activities to choose from, including drama, soccer, volleyball and others. One of the activities we do here in the centre is counselling. Other activities include blood donation.

- ***Peer educators' experience of services and activities offered***

The peer educators had positive experiences of the services and activities:

I didn't know how to use a computer and I didn't know anything about life skills. Here, in BOFWA I was taught about life skills especially HIV/AIDS. Life skills are topics like teenage pregnancy, drugs and alcohol abuse, HIV and AIDS. I didn't know anything about these topics before and was not capable of teaching others about them. When I joined the peer educators, we were taught about these topics.

Here I was taught different things like basic counselling, communication skills and quite a number of topics.

- ***Young people's experience of services and activities offered***

The participants were satisfied with and grateful for the services and activities offered:

Coming here to the centre has helped me to learn about many topics such as teenage pregnancy from peer educators.

Before I became a regular user of the centre, I used to smoke and drink but when I came here friends told me to stop and indeed I stopped. Now I play volleyball.

I heard that BOFWA guides children and teaches them good behaviour. I have learned good manners and that drinking and smoking is not good for one's health.

BOFWA is a very good place when it comes to guiding, advising, counselling people. So myself, when I have a problem I go there.

Sub-category 2.5: Poor communication between staff and peer educators

This section describes the prevailing practice of communication between the professional staff (SDOs) and the peer educators. Communication is essential and crucial in everyday life, at work and most importantly in delivery of services. Where communication is lacking, misinterpretations, misunderstandings, mistakes and disputes are likely to occur. Therefore, in every operation, facility or work situation, the lines of communication must be defined. There is a need for prompt and timely communication in work relations. The data analysis revealed problems with the way SDOs deal or interact with peer educators.

- ***Peer educators' experience of poor communication between staff and peer educators***

The peer educators raised poor communication as a major stumbling block in working relationship between themselves and professional staff. At the same time, however, it became clear that they had better working relationship with some SDOs while others did not have the expected youth friendliness in serving young people. Poor communication proved to be a combination of late notification and being harsh on young people when talking to them. In some cases they even fail to communicate at all. According to the peer educators:

I have noticed that some activities at BOFWA are delayed because of lack of communication. Some things are communicated very late and you are pressured to work faster whereas you should have been told a way back. Lack of communication is something that makes some of the activities fail. If the activity was communicated very late, it will end up not giving you good results.

People will be called for activities, but when the activity is cancelled, they are not called and people come only to be told that the activity has been cancelled.

Another challenge in our centre is poor communication, as mentioned before. You find that some activities do not succeed, they fail because of poor

communication. Some activities are planned for and people are invited. Then the activity is cancelled at the last minute and that discourages people.

- ***Young people's experience of poor communication between staff and peer educators***

The young people indicated that planned activities were sometimes cancelled and no message was sent to them. They only found out about the cancellation when they arrived at the centre.

The study found that the lack of or poor communication between SDOs and peer educators was a serious obstacle. Poor communication has a negative impact on interaction and the implementation of activities. At the YAC poor communication had deterred peer educators from coming to the facility. The peer educators stated that some of the professional staff told, instructed and shouted at them impatiently. This led some peer educators to stay away from the centre.

The cancellation of activities, in particular, was done late because of poor communication. As a result, the peer educators had to work under pressure to inform young people and ended up failing to contact all of them. This, in turn, made peer educators and young people frustrated and angry because after making the effort to go to the facility, when they got there they were told that the activity had been cancelled.

Sub-category 2.6: Hours of operation at the YAC

The YAC is open from 8:00 am to 5:00 pm on Monday to Friday. Since 2006 the clinic has been open on Saturdays from 08:00 am to 1:00 pm for consultation.

- ***SDOs' experience of hours of operation at the YAC***

All the SDOs stated that the hours of operation were suitable, particularly since flexibility is exercised in taking appointments, and serving all those who need services even if it was past closing time.

- ***Peer educators' experience of hours of operation at the YAC***

There was consensus among the peer educators that the current hours with the centre open only on weekdays during the traditional working hours of 8:00 am to 05:00 pm were unfriendly and limited access to services. The days and hours of operation were unfavourable for young people who were attending school and the working population. The peer educators felt that the days and hours of operation should be extended to include Saturdays and close after 5:00 pm. According to the peer educators:

> *Another challenge is that the centre caters for out-of-school youth only and those who are not employed. Those who are in school access the centre only a quarter of the year, as our centre opens Monday to Friday from 8:00 am to 5:00 pm, and that is when those in school are not available.*

> *The centre should be open during weekends to cater for those who are employed and in school.*

- ***Young people's experience of hours of operation at the YAC***

The participants stated that the days and hours of operation were not friendly and should be changed, as most of them were in school and could only visit the YAC after school and during the weekends. For it to close at 5:00 pm and weekends limited access to the facility as the majority of young people are school. According to the participants:

> *Limited hours affect young people because when they come and find the centre locked; they may start to go to the bars.*

> *Some people will be busy at school and when they come here after school to seek help, the centre is closed and they don't know what time it closes. There is nothing they can do. Some give up as they have low self-esteem.*

> *During weekends they do not open. They should improve on that.*

> *BOFWA should be open on Saturdays because more young people will be home and could come and get information.*

The centre should close late on Fridays, so that the students can improve their attendance and this will help people who are coming from far areas. Improvement, such as time for playing and time for teaching life skills, is necessary.

They should extend the hours of operation. We always want to play and the centre is closed. Even when the small gate is not locked, you are not allowed to come to the centre.

The data indicated that the hours of operation limited access to the centre. The hours were not convenient for young people, particularly those at school. The YAC was opened when they were in school and closed at weekends. The YAC closed at 5:00 pm, therefore, students and working young people could not access the facility during the week. Students left school at 4:00 pm and working people at 4:30 pm, which meant they could only reach the YAC after 5:00 pm.

Although the SDOs stated that since 2006 the clinic was open on Saturdays from 08:00 am to 1:00 pm for consultation, the data indicated that many young people were not aware of this change. In addition, young people would like to have the YAC fully open so that all the services offered during the week could also be accessed on Saturdays.

When asked what they would suggest for improvement, almost all the peer educators and young people said the hours of operation should be extended and the centre should also open on Saturdays. Most importantly, the young people valued and perceived the YAC as a good and safe place to go to as it offers activities that are beneficial and equip young people with life skills. The participants emphasised that the centre kept them busy, away from bars and helped them to avoid indulging in risky behaviour.

Webb (1998:11) emphasises that “a convenient location, a ‘youth-friendly’ and comfortable environment, flexible hours, a strong counselling component, specially trained providers, and comprehensive reproductive health services” are important characteristics for adolescents.

Different groups of young people access the centre and come to seek health services, to learn livelihood skills, for recreation and to volunteer their time and services as well as to participate in the activities organised.

4.5.3 Category 3: Psychological aspect of the youth friendliness of the YAC

Young people experience the psychological aspect of youth friendliness from the attitudes of service providers, peer educators and other young people. Interaction between them reflects youth friendliness. The way young people feel about the services indicates the psychological aspect of the friendliness.

The researcher identified the following sub-categories of the psychological aspect of the youth friendliness of the YAC: involvement of young people; empowerment of young people; stigmatisation of the YAC; lack of parent-child communication; SDOs' attitudes; peer educators as role models, and peer interaction.

Sub-category 3.1: Involvement and participation of young people

The involvement and participation of young people is central to the delivery of youth-friendly services. The data analysis demonstrated that the YAC has natured this element well. It became evident that they young people were involved in the planning of the YAC, even the plans for extension of the buildings. Furthermore, they played an active role in implementing activities. The centre has several ways of involving young people, including peer educators, volunteers, and working teams. Peer educators are young people selected to become staff members and given an honorarium to sustain them. They are trained and equipped with the necessary knowledge and skills to enable them to give health talks, give out condoms, facilitate discussion with peers, counsel their peers, do outreach activities to schools and do presentations and home visits, and plan and organise programme activities.

Volunteers are young people who volunteer to assist in the carrying out of planned activities. Like the peer educators, volunteers come to the centre almost daily. Volunteering keeps them busy; therefore they do not idle in the streets or go to bars because they are unemployed. At monthly meetings the professional staff, peer educators and volunteers get progress reports and updates, as well as discuss and

plan for upcoming activities. Young people are also involved in working teams, which are formed particularly when activities are carried out in the community. The teams go to schools or conduct home visits to reach out to those in need of information, knowledge and services.

There are problems, however, when the activities are not implemented as planned or changes occur due mostly to a lack or delay of funds. The peer educators are not normally involved in cancelling and rescheduling, even though they are the ones who have to pass such information on to young people for whom the activities are intended.

- ***SDOs' experience of involvement and participation of young people***

The SDOs stated that the centre encouraged the involvement and participation of young people. The SDOs said that young people were involved right from the planning stage, particularly the extension of the building, and shown the drawings and were part of the discussions. Furthermore, the peer educators and the volunteers who assist with activities at the centre on a regular basis represented young people. Some young people belonged to "working teams", which were meant to encourage participation. According to the SDOs:

> *The reason why we reach our target is that we involve them in almost everything. Even in the beginning when the house plan was approved, the volunteers were present, so we always involve them so that we get commitment from their side.*

> *This is a youth-led association where we believe that for young people to feel free to talk about issues concerning them, they have to be with other young people.*

> *Something interesting about young people is that it is very rare to see a young person coming with repeated STIs. Once you treat them and give information, guide them, the next time they come, they might come with other ailments, such as headaches. This shows that they are people who comply, they take treatment as guided and they take prevention actions.*

- ***Peer educators' experience of involvement and participation of young people***

The peer educators indicated that they were involved and participated in all activities targeted to them. They were part of the decision-making processes that took place in the centre. They also said that whenever the professional staff attended meetings in Gaborone and there were things that concerned the YAC, they were always be briefed. Examples are meetings regarding stoppage of funding, decrease of the budget ceiling, staffing and so on. According to the peer educators:

> *After receiving training we conduct centre talks with other youth coming to the centre.*

> *Every day when we are here, we are divided into different groups whereby we will be given different topics and we will discuss them. After discussion, that's when we come together, then every person will present each topic we were given.*

- ***Young people's experience of involvement and participation of young people***

The participants generally felt they were part of the process. They said that at the end of every term a workshop was organised for young people in schools, where different speakers addressed them. Furthermore, many activities took place in the centre and those who had the time assisted with the preparation. According to the participants:

> *Peer educators are important to us because they are trained and they have experience so that when you have a problem, they know how to help you solve your problem.*

> *Coming to the centre has helped me learn about many topics such as teenage pregnancy from peer educators.*

> *I have found it useful because I have developed skills. I know how to talk to other people about issues they are uncomfortable discussing.*

The data indicated that the participants were meaningfully involved and actively participated in the implementation of programme activities at the YAC. Young people appreciate being involved as it kept them occupied, and they gained skills and experience as well as confidence. Being involved had given them experience in functioning at office level, organising activities and, above all, interacting as a team. All the SDOs and peer educators valued and endorsed the involvement of young people in the operation and delivery of services as vital. Therefore, involvement is an essential characteristic of any programmes for young people.

Barnett and Schueller (2000:83) emphasise that involving young people enables service providers to better serve them. Furthermore, young people's involvement is a strategy that makes services 'youth friendly'. Involving young people actively as participants, planners, and managers is critical to the success of youth centres and projects targeted at them (Webb 1998:36).

Sub-category 3.2: Empowerment of young people

In this sub-category the SDOs, peer educators and young people described how the YAC empowered young people. Empowerment of young people is vital in facilitating change in people's lives. Empowerment is "the process by which disadvantaged people work together, to take control of the factors that determine their health and their lives" (Werner 1997:964). Therefore, empowerment is about the personal psychological growth equivalent to self-efficacy and self-esteem. When individuals increase their ability to solve problems in a participatory approach, they are enabled to understand themselves, personal, social, economic and political forces in their lives in order to take action in order to improve (UNAIDS 1999:10). Empowerment refers to equipping people with the necessary knowledge, skills and/or resource to deal with situations in their lives.

- ***SDOs' experience of empowerment of young people***

The SDOs stated that the programmes were based on the needs of young people and were therefore relevant to meet their needs. Young people were taught different subjects, helped to acquire skills and change to become better people. According to the SDOs:

They can say no to sex. They are really empowered. Initially we had a problem, as they didn't want to talk about condom use. I have been working with them for the past five years and I must say there has been a lot of growth over this period.

They really don't have stage fright. They even fight to go to school unlike before. We also have condom demonstrations here in the centre. They now know how to accurately use them nowadays because of the demonstrations. They always demonstrate to their peers. In a nutshell, BOFWA has really equipped these people and they can now decide for themselves. Their self-esteem is high now.

- ***Peer educators' experience of empowerment of young people***

The peer educators stated that the training, teaching, and their participation empowered them to be better persons as they had knowledge on sexual and reproductive issues that affect young people, had skills and were informed to take responsible actions and decisions as well as guide and encourage others. The peer educators felt that being part of the YAC benefited them in several ways:

If I stayed at home I would not have had the opportunity to be trained. I am not wasting time because every day I am getting empowered, and that P300.00 they give me for transport, I can utilise it to start something.

I think the challenges we have as peer educators are that we are empowered or informed more than others. Out there they expect us to do what we preach, to live the way we encourage them to live.

- ***Young people's experience of empowerment of young people***

The participants stated that the activities at the YAC gave them knowledge and skills and helped them to make better decisions. They added that the interaction with peers was beneficial as they learned from each other. According to the participants:

There is a boy who indulged in drugs. Since we taught him about BOFWA activities he has changed his behaviour. In the last workshop he testified that he is no longer in sin, rather he is empowered, he has got light.

Before I became a regular at the centre, I used to smoke and drink but when I came here friends told me to stop and indeed I stopped. Now I play volleyball.

Here in BOFWA I started moulding myself, getting empowered and changed my behaviour.

The study found that the YAC had empowered young people in acquiring knowledge on different subjects, communication, leadership, facilitation, computer skills, counselling and/or life skills, and making behavioural changes and gaining skills for managing their lives.. The young people asserted that using the services available at the centre had equipped them with skills and knowledge on everyday life. They were trained, taught and counselled to become better persons and make responsible decisions.

According to Faber (2002:2), a community-based project with a participatory approach similar to the YAC showed that members were empowered as they had gained knowledge and acquired skills. Matshediso (1998:9) points out that empowerment is essential in delivery of services that aim at influencing behaviour change and enabling individuals and communities to take control and make informed and responsible decisions.

Sub-category 3.3: Stigmatisation of the YAC

This section described how stigma was manifested, the implications in relation to young people's utilisation of the YAC and the support of parents and community leaders.

- ***SDOs' experience of stigmatisation of YAC***

The SDOs stated that there is stigma attached to the YAC, mainly due to parents' and community members' lack of correct knowledge about the centre. Parents with negative attitudes discouraged their children from using the centre. According to the SDOs:

They don't want to wait or to have their age mates see that they were here.

Because it is a multi-purpose centre, young people have drama groups, poetry, and other activities. With all of these we disseminate messages using different

acts and we have many activities. So, the parents hearing that the radio is there and young people are making a noise think that this is where youth can run away from home and come to do unacceptable activities.

The data indicated that stigma existed at community and facility level. The stigma at community level came from parents and impeded access to the YAC because some parents prohibited their children from using the centre. At facility level, some young people did not want their peers to know that they used the clinic services. Young people are sensitive about privacy and confidentiality and might fear that their peers could reveal that they had gone for clinical consultation.

The SDOs stated that many parents and elders had a negative attitude towards and lacked correct information about the centre. Consequently, the SDOs planned to conduct parent workshops and elder workshops.

The researcher deduced that the low utilisation of the centre could also be attributed to the stigma attached to it by some parents and community members. Young people did not want to be identified with the place and 'labelled' bad. In addition there was a lack of accurate information about the centre among parents and community leaders. Negative "labelling" or stigmatising of the centre by adults and parents affects how young people react to the centre.

Fortenberry, McFarlane, Bleakley, Bully, Martin, Grimley, Malotte and Stoner (2002:378-81) found stigma and shame a major barrier to gonorrhoea and HIV screening. Mshana, Wamoyi, Busza, Zaba, John, Kaluvya and Urassa (2006:647-657) identify stigma as a barrier to accessing antiretroviral therapy, as people fear being discriminated against. According to Emlet (2006:350-358), stigma is significantly associated with service use.

Sub-category 3.4: Lack of parent-child communication

This section examined whether poor parent-child communication affected young people's utilisation of the YAC.

➢ ***SDOs' experience of lack of parent-child communication***

The SDOs stated that culturally, parents shied away from discussing anything related to sexuality and sex with their children. This could be why parents and community leaders were not interested in the centre. The SDOs added that some parents had negative attitudes and did not want their children to use the YAC. According to the SDOs:

> *There are certain cultural aspects in our society that forbid the parents from freely communicating with their children but that can derail the youth.*
>
> *Some of the youth who are active in the YAC talk with their parents, but some do not discuss with their parents. We encourage them to open up to their parents and ask them to visit us, however, so that we can discuss issues pertaining to their children with them.*
>
> *Now we have realised that we should hold frequent seminars and talk to community leaders like chiefs and parliamentarians that during their campaign they may market our services so that we may show the parents what their children are doing.*
>
> *The challenge that we face in the day-to-day operation is lack of parents' participation. Maybe volunteering being in the centre so that young people can learn to interact with older people and know how to communicate with them better.*

The data found that a lack of parent-child communication impacted negatively on young people because they could not ask questions they had despite the need for the information and clarification. Some parents were not comfortable discussing sexual and reproductive health issues. Negative attitudes caused discomfort for the young people by knowing that the place they identified with was not acceptable to their parents. Labelling young people who utilised the services as involved in unacceptable things limited access to the YAC. Furthermore, the data revealed that parents did not visit the centre to seek clarification or enquire about what actually transpired there. Consequently, they could not advise their children to visit the centre because they did not have information about the centre.

Kirby (2003:3) found that if mothers disapproved of their teenagers having sexual relationships and their communication started early, particularly where there was a close mother-child relationship, such mother-daughter communication might delay the child's onset of sexual intercourse.

Riesch, Anderson and Krueger (2006:41) maintain that improving parent-child communication is more likely to minimise individuals' health-risk behaviour. Moreover, parent-child communication actually enhances the child's academic performance and self-esteem, and at the same time motivates the parents to modify their parenting practice and to act as models of healthy behaviour.

Sub-category* 3.5: *SDOs' attitudes at the YAC

This sub-category described and explored the attitudes of SDOs at the YAC.

➢ ***SDOs' experience of their attitudes***

All the SDOs stated that they worked well with young people. They understood young people to be vulnerable therefore they were sensitive in dealing with them. Being accepting and non-judgmental of young people is crucial in attracting young people to use services. According to the SDOs:

> *The experience that I have with young people is that they do not want to be judged, they really want to be accepted as they present their problem. Young people are very interesting, if you ask them their problem, they will really do that, as long as you are not judging them and you are willing to help them.*

> *You would find that they really need youth friendliness when you deal with them. Just make them be open and understand that you are there to assist them.*

➢ ***Peer educators' experience of SDOs' attitudes***

The peer educators indicated that they had worked with different SDOs and some had good welcoming attitudes while others did not. They even attributed the low usage rate of the YAC to the attitudes of the SDOs, which are not youth friendly. Some peer

educators stated that they sometimes absented themselves because of the prevailing attitudes at the YAC. According to the peer educators:

The other thing that is lacking in the service provider is being welcoming. I think in the YAC there should be friendly service provision and I think that is why most people are not coming to our centre. Friendliness is lacking from the professional staff. The most important thing in our centre is recreation, but the clinic has to be well, that is when we can expect to see most youth coming.

I can just go along with the previous speaker. Actually as I said before this lack of communication goes along with lack of friendliness, because if someone does not talk with you frequently to know what pleases you and what doesn't please you. They won't get a chance to know what the clients are saying. This is because she is always far or not open and lack of friendliness can't improve.

The friendliness we are talking about is not only to the clients outside there, we should be included. Sometimes you wake up and feel like coming to BOFWA to enjoy, rest and do scheduled work. What is disappointing is that when you get here at BOFWA instead of being spoken to in a friendly manner/youth friendly manner to do something, you are told in a harsh way and you end up dropping to the last degree and feel like, what did I come here for, to be pushed around or what?

- ***Young people's experience of SDOs' attitudes***

Generally, the participants felt that the SDOs had good attitudes. Most felt they got help when they needed it:

When I have a problem I go there and find my age mates. I talk to them and discuss the problem with hem. So I do not see anything wrong with BOFWA people, they are friendly.

You will also find that an older person who should be supporting young people, but when you enter, the person does not show you a welcoming face to an extent that you do not feel free to say you have a problem.

The data found that some SDOs lacked positive attitudes. The way some SDOs interacted with peer educators deterred them from coming to the centre. The reluctance of peer educators and volunteers spilled over to regular users because when they realised that the peer educators were unhappy, they were also reluctant to come.

The data indicated that peer interaction included discussions, guiding, advising, and sharing information and experience. The young people reported that during peer interaction conversation with peers helped them to learn, correct each other and advise others. In addition, they liked it when they were listened to and their advice was taken.

According to Barnett and Schueller (2000:84), implementing youth-friendly programmes calls for all staff to be aware that it is a must to treat young people with respect and dignity. Young people are sensitive but resilient, therefore, service providers should be knowledgeable on how deal with young people.

Barnett and Schueller (2000:14) highlight that judgemental attitudes towards young people deter them from using services. Respect for young people; privacy and confidentiality; adequate time for client/provider interaction, as well as continuing and active involvement of young people are among the key characteristic that reflect youth friendliness of services/programmes and staff *(*Senderowitz et al 2003:3).

According to the MOH (2002:10-11), being a role model is an in-built component of peer education. A peer educator is an individual who effects change and reinforces positive behaviour among members in the same situation(s).

Sub-category 3.6: Peer educators as role models and peer interaction

This sub-category described and explored the role of peer educators as role models and the interaction of young people with their peers. Table 4.4 lists the ages of peer educators at the YAC. Table 4.4 indicates that the age group 10 to 14 years is not represented.

Table 4.4 Frequencies of ages of peer educators at the YAC

Age group	Frequencies
10 - 14 years	0
15 - 19 years	1
20 - 24 years	9
25 - 29 years	7
TOTAL	**17**

Peer educators are seen as role models as they have been taught, given skills and know what risk behaviour is and how to prevent health problems. They are equipped with knowledge; skills in communication, counselling, presentation, facilitating teaching and discussion, and are recognised as role models in the community. The peer educators value the fact that they are regarded as role models. The SDOs said the YAC is youth-led, therefore, peer educators receive, guide and assist other young people who come to the YAC. However, being young, the peer educators stated that they face challenges, particularly in relationships. The burden is that in such situations their peers or the community expect them to be strong and perfect.

➢ ***SDOs' experience of peer educators as role models and peer interaction***

The SDOs stated that peer educators played an important role because they assisted in delivery of services. Their presence at the YAC encouraged young people to utilise the centre and interact with their peers:

> *To some extent they utilise the centre because they find other youth utilising it. The funding we got made it possible for the youth to utilise the centre, access the activities and implement them. To me, BOFWA has grown as I compare to the time when I joined the system. Now young people are coming in large numbers to utilise the facilities.*

➢ ***Peer educators' experience of peer educators as role models and peer interaction***

The peer educators valued their position and being regarded as role models. They spoke highly of peer interaction and discussion. They said that young people talked more openly to their peers and that was why they discussed the weekend's events

every Monday. Everyone shared what they did and then advised each other. They revealed that if they felt that one of them was hiding or is not freely sharing something, they normally asked the SDOs to leave and then the person will freely share. Then they discussed and advised each other and recommended what they should do. According to the participants:

> *I think the challenge we have here, as peer educators, is that we are empowered or informed a bit more than others. Out there they expect us to do what we preach, that is to live the way we encourage them to live. The other thing is that if you don't do that, it can be bad, so if you tell someone to do something that you actually don't do, it confuses people. Another thing is that our behaviour sometimes makes me feel that maybe we are the ones contributing to the decline in numbers of those coming to the centre. We have to do something that will make someone outside be interested, but then if we are the ones again who are doing bad things. It is not what someone would like to do because we have to be role models.*

> *I feel proud, but the only thing is that a lot is expected of us. We are expected to do things that are different from what others are doing.*

> *I like being a role model, but it is challenging because someone will copy what you are doing. The right way to do things is to move away from bad things like smoking and drinking.*

- ***Young people's experience of peer educators as role models and peer interaction***

The participants valued the existence of peer education and peer interaction. They liked being around the centre and interacting with other young people and being able to discuss things with peer educators:

> *As for peer educators we expect friendliness from them and that will help the centre to attract more young people.*

> *I have benefited, I learnt you could also go there and have time with peer counsellors. They advised me.*

4.6 PARTICIPANTS' SUGGESTIONS FOR IMPROVEMENT

The participants were asked what should be done to improve the delivery of and access to services at the YAC and suggested the following:

(1) Extend the hours of operation, by having the centre open until 6:00 pm.

(2) Have the centre open on Saturdays and function as during weekdays where all services are provided.

(3) The government should provide financial support for the YAC, so that if there is a shortage or abrupt withdrawal of fund by donors, the centre could request government assistance. This would address the issues of activities not being implemented because of shortage of funds.

(4) Increase service delivery officers so there are two nurses. Besides the nurse managing the clinical services, BOFWA should also hire a relief nurse. This would avoid having to close the clinic whenever the nurse had to attend to services outside the YAC.

(5) The MOH and the DHT should revise the distribution system of IEC materials.

The data analysis suggests that environment affected the participants' lives. Therefore, to build "well-rounded" young people, all the influential players must be part of the programme or intervention to empower them. The researcher used McLeroy, Bibeau, Steckler and Glanz's (1998:351-377) ecological model of health promotion to illustrate the link between individuals and their environment.

4.7 ECOLOGICAL MODEL OF HEALTH PROMOTION

The Ecological Model of Health Promotion argues that People's environment influences their behaviour. The environment is "the world around and within persons that is the source of stimuli: focal, contextual, residual, or groups" (Stanhope & Lancaster 2000:198). McLeroy et al (1998:351-377) advocate an ecological perspective on health promotion programmes. This perspective focuses on linking the physical, social,

economic and physiological environments within which individuals exist and their behaviour. McLeroy et al (1998:351-377) emphasise that individuals exist within different environments and these influence their development and ultimately their attitudes and behaviour. According to the ecological model of health promotion, people exist in different environments, namely: the individual (self); family; community; organisations/institutions and public policy.

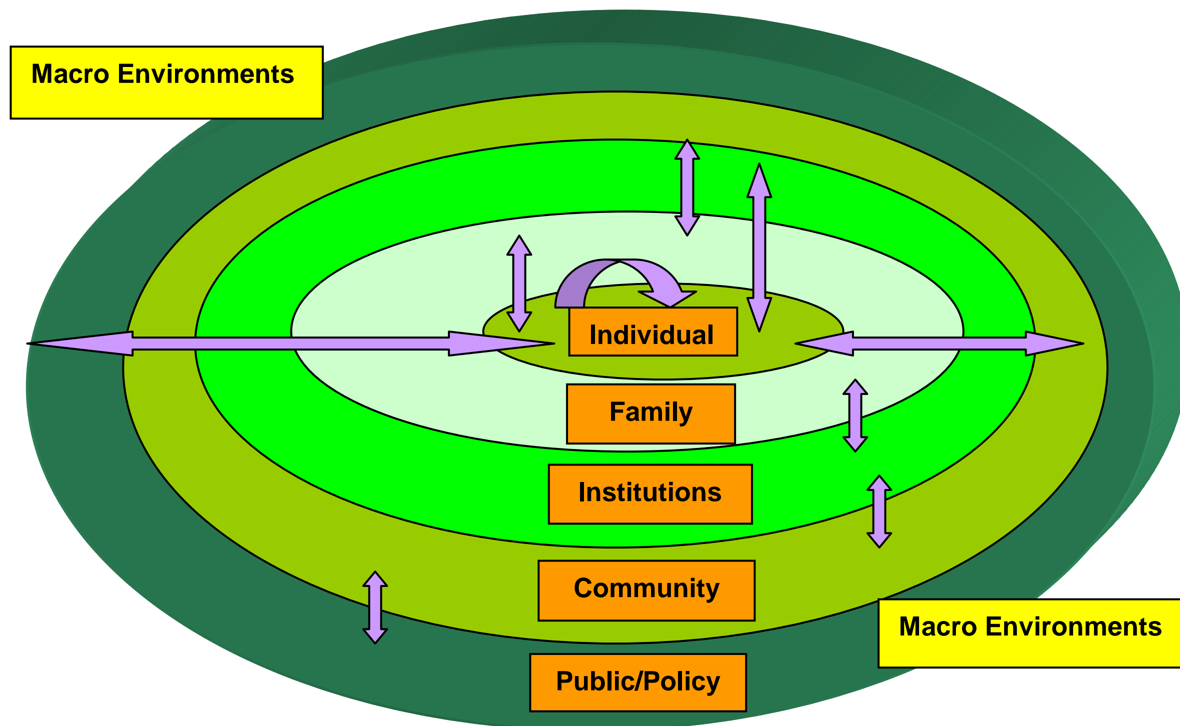


Figure 4.5: Ecological model of health promotion

Source: Adopted from UNAIDS (1999:11)

Consequently, behaviour is a result of different factors including the following (McLeroy et al 1998:351-377):

- **Individual or self:** exists in intrapersonal factors such as knowledge/skills possessed by one, attitudes, and self concept hat influence their behaviour.

- **Family:** constitutes an environment where interpersonal factors and process take place around the individuals. For example, the existence of friends, social

groups, and formal primary support groups form networks that play a role in one's development and behaviour.

- **Institutions:** which composed of such entities as: organisations, agencies, institutions, rules and regulations do influence the interactions, activities and certain cultures which ultimately determine one's behaviour and development.

- **Community:** Bears relationships between organisations and institutions which could be formal, and /or informal. Those networks do affect behaviour of those existing within such factors.

- **Public policy:** the local and national laws and policies that prevail also form factors influencing behaviour. What ever, policies, regulations, laws and polices determine the delivery of services or behaviour of people, which also in-turn is transferred or affecting the recipients.

These environments have an influence on people's development and behaviour in a certain manner. Furthermore, the environments or systems are intertwined and related. The family environment has an influence on the community and vice versa. The family has an influence on the institutions and visa versa. Likewise, the institutions, community and family have an influence on the individual hence their role in people's development. Figure 4.5 above illustrates the ecological model of health promotion. The model is employed show how the YAC influences the behaviour of young people or how it empowers young people who are utilising the YAC.

Glanz et al (2002:410) state that it is important that "health promotion interventions must address the environmental resources that may either facilitate or hinder the targeted health behaviour changes". The study found that the individuals (young people), the family, the community, the organisation (YAC) and public policies were important and influenced young people's lives because they interacted and existed with or within them.

Stanhope and Lancaster (2000:52) define health promotions as "activities that have as their goal the development of human attitudes and behaviours that maintain or enhance well-being". McLeroy et al (1998:351-377) maintain that the social environment will lead

to changes in a person and that the support of other players is imperative in implementing environmental changes. Glanz et al (2002:421) point out that the success of health promotion interventions depends on policy. For policy makers to pass legislation and approve budgets, they should have some understanding of the relevant issues.

4.8 APPLICATION OF THE ECOLOGICAL MODEL OF HEALTH PROMOTION TO THE YAC

The role of the YAC in influencing behaviour is extrapolated using the ecological model of health promotion. The YAC is an intervention created to bestow a facility that has an environment that could be positive enough to attract, services, build young people and influence their behaviour. The facilitation of the YAC should therefore take into consideration the environments to enable the YAC to be effective in empowering young people. The guidelines meant to enable operation of the YAC should be applied based on the framework and paradigm illustrated by the ecological model of health promotion.

4.9 CONCLUSION

This chapter discussed the data analysis and interpretation with reference to the literature reviewed. The overall theme that emerged from the analysis was the youth friendliness of the YAC. The YAC's youth friendliness consisted of three main categories: physical environment or location of the centre, administrative, and psychological aspects. The researcher also applied the ecological model of health promotion to the results to illustrate how young people link to the key players in their environment.

Chapter 5 presents phase 2 of the intervention designed to facilitate youth friendliness in a YAC, namely the development of guidelines for the facilitation of youth friendliness. Knowing more about what works in youth programmes and services enables managers and implementers of youth programmes to establish effective programmes to achieve the intended and desired outcomes (Adamchak et al 2000:1).

CHAPTER 5

Framework and guidelines for youth activity centres

5.1 INTRODUCTION

Chapter 4 discussed the data analysis and interpretation and findings with reference to the literature review in order to conceptualise the respondents' lived experience of the YAC. The findings indicated that facilitating youth friendliness in a YAC requires a friendly physical, administrative and psychological environment. The study identified factors that hindered young people's access to and utilisation of the YAC. Utilisation empowers young people with knowledge and skills they need for informed decision making and responsible behaviour. Empowerment should assist the target group to learn and practise what they are taught (Conger, Kanungo & Menon 2000:747-767).

This chapter covers phase 2 of the objectives, namely to formulate and describe guidelines to facilitate the youth friendliness of the YAC. The guidelines are geared towards improving young people's access to and utilisation of the YAC through facilitation of the youth friendliness of the centre. Improving the sexual health of young people "requires contextual interventions to effectively target a range of social and environmental influences for enabling and supporting protective behaviour among youth" (Collumbien, Douthwaite & Jana 2006:155 citing DiClemente & Wingood 2003). According to Chase and Aggleton (2006:94-95), if people embrace health-enhancing behaviours they will improve their health and/or maintain better health. The guidelines are specific to facilitation of the operations of the YAC offering youth friendly services (YFS). These guidelines also apply to other initiatives aimed at empowering young people to have control over their lives and environment to deal with challenges.

5.2 CONCEPTUAL FRAMEWORK

In an effort to nurture young people, the researcher developed the guidelines to facilitate the youth friendliness in the YAC. The researcher used Dickoff, James and Wiedenbach's (1968:468-499) survey list of questions as the conceptual framework

(see figure 5.1). The survey list comes from the "Theory in a Practice Discipline" which aims to guide the relation of theory to practice and aiding research (Dickoff et al 1968:468-499). In this study, the activity was facilitation of youth friendliness in YAC. Dickoff et al (1968:479) stipulate six aspects and questions regarding the activity to be undertaken. The aspects and questions are:

- **Purpose or terminus**: What is the goal of this activity?

In this study, the goal of this activity was to provide holistic and comprehensive youth-friendly services accessible to young people.

- **Agent:** Who practises this activity?

Different groups practise the activity, namely service providers or service delivery officers at YAC, including peer educators, and other partners.

- **Recipient**: Who receives this activity?

The recipients of the activity are mainly young people who are the primary targets. Family and community members are the secondary target.

- **Framework (context):** In what context does this activity take place?

The activity takes place in Kgatleng District in Mochudi BOFWA Youth Activity Centre. The context has the following environments:

Internal environment – at the YAC, service providers or service delivery officers interact with peer educators and young people, and peer educators interact with the young people in providing services.

External environment – in the community, outreach activities are carried out e.g. to schools, to homes, and community meetings. In addition, community leaders, political leaders; institutional policies, socio-cultural, socio-economic factors also form the external environment.

- **Dynamics:** What is the energy source for the activity?

The energy source or motivating factor for the activity is to empower young people to have better health and quality of life. Young people have crucial SRH needs and authorities have an obligation to provide young people with services. The Botswana Sexual and Reproductive Health programme has the ultimate goal of improving their health and quality of life. Adolescent sexual and reproductive health problems, such as teenage pregnancy, abortions, STI, HIV and AIDS, substance abuse, and rape, have increased and need to be addressed.

- **Procedure:** What is the guiding procedure, technique, or protocol for the activity?

The *guidelines on facilitating youth-friendliness in a youth activity centre* are the guiding procedure, technique, or protocol for the activity.

These guidelines are anchored on a holistic and comprehensive health promotion model encompassing the prevention of ill health, protection of health, and education about health. Botswana's National Sexual and Reproductive Health Framework and National Population Policy also form the basis for the guidelines. Botswana's National Population Policy emanated from the 1994 International Conference on Population and Development (ICPD) Plan of Action, which introduced the reorientation of Maternal and Child Health/Family Planning to Reproductive Health.

The ICPD Plan Action (UNFPA 1999:10) stipulates:

> *Unless people are empowered, educated, their health cared for, and economic opportunities created for them, ill health, poverty and other suffocating needs will occur. Therefore, it is important to invest in people by increasing educational opportunities, and expanding family planning and related health services to reduce mortality.*

Figure 5.1 represents the framework to empower young people in the area of Mochudi in Kgatleng District in Botswana. The framework addresses the needs faced by young people and how to intervene to enable the to have better health. Among the needs are information and knowledge on the biological and development of their bodies, relationships with peers of the same and opposite sex, prevention of diseases, staying healthy, and life skills or skills to take control of their environment.

5.3 GUIDELINES FOR FACILITATING YOUTH FRIENDLINESS IN A YOUTH ACTIVITY CENTRE

To curb the HIV/AIDS epidemic, a multi-sectoral approach was adopted as the most appropriate and effective strategy (NACA 2004:1). In particular, the Government in partnership with United Nations Population Fund (UNFPA), the Botswana Family Welfare Association (BOFWA), a non-governmental organisation (NGO), and the Botswana National Youth Council (BNYC) pioneered and established the YAC as an intervention to reach young people and increase their access to adolescent sexual and reproductive health services. The intention was to provide services to assist young people to prevent being infected with HIV.

To date, the experiences of young people in utilising the YAC as a facility have not been assessed or the effectiveness of the intervention in preparing, influencing and/or empowering their sexual behaviour examined. This motivated the researcher to undertake the present study.

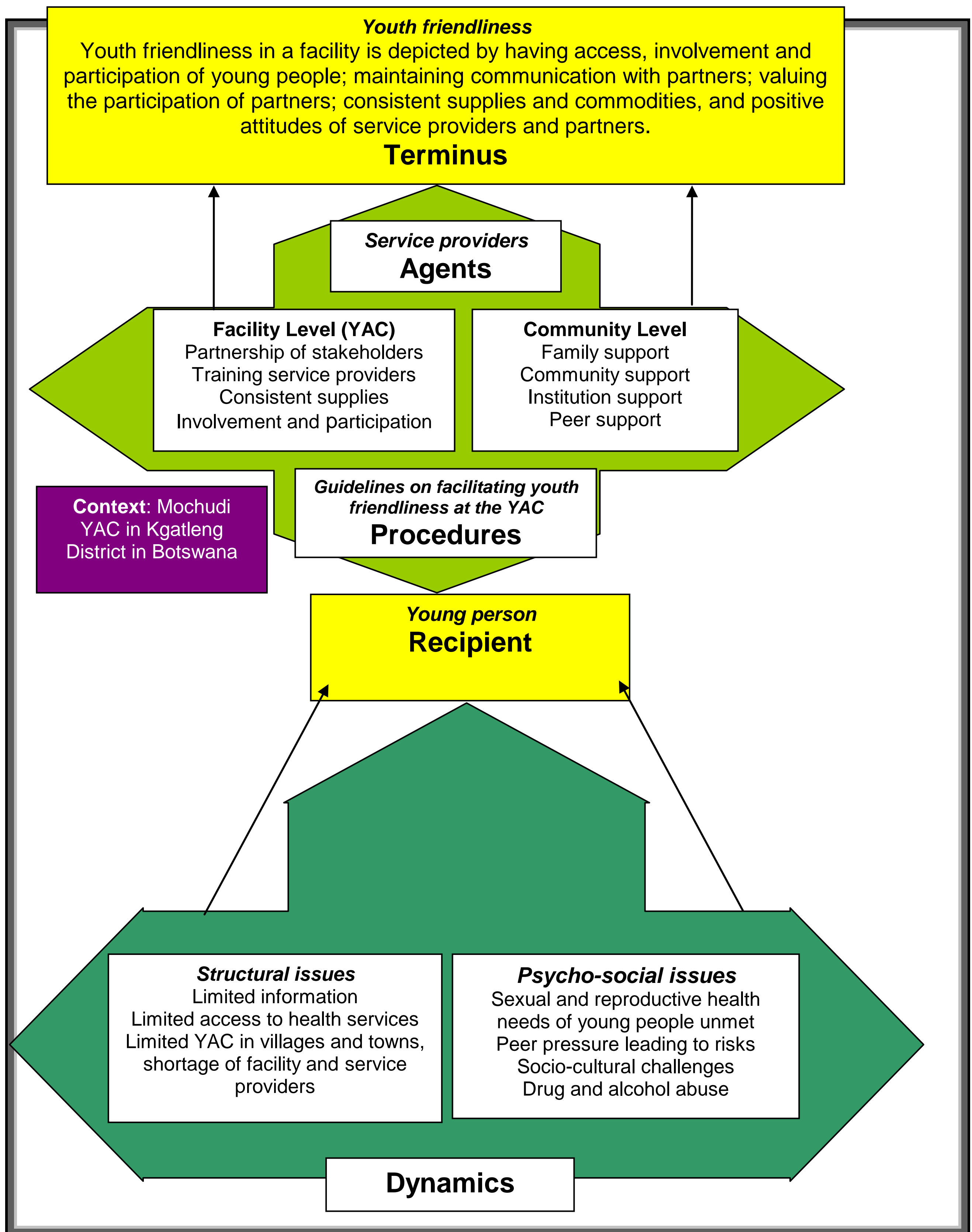


Figure 5.1 Framework for empowering young people in the Kgatleng District in Mochudi in Botswana

Adapted from Dickoff et al (1968:468-499)

The study was conducted in two phases with the following objectives:

- Phase 1: To explore and describe the experience of young people utilizing the YAC in Kgatleng District in Botswana as well as the perceptions of service providers.
- Phase 2: To develop and describe guidelines to facilitate youth friendliness of the YAC.

The key objective of the guidelines is to facilitate youth friendliness in a youth activity centre, endeavouring to reach young people with the ultimate goal of empowering them with improved knowledge and skills. The knowledge and skills are to assist them to make informed decisions and take responsibility for all aspects of their life. Powerlessness is a risk factor for disease and empowerment has the role of a health-enhancing strategy (Wallerstein 1992:197-205).

Youth friendliness can be achieved by facilitating

- access to services in the context of the location of the YAC
- access to services by creating partnership with stakeholders
- effective management of the YAC by BOFWA
- friendly policies and procedures for the YAC
- social marketing and advocacy for services and activities offered at the YAC
- meaningful involvement and participation of young people
- empowerment of young people by implementing varied participatory learning activities
- training to build positive attitudes of service delivery officers
- effective and good parent-child communication
- family and community integration

The guidelines are termed "*PATHWAYS TO EMPOWERMENT: Creating Access To Youth Friendly Services*". To have a successful YAC, the following guidelines are essential to create youth friendliness:

5.3.1 Facilitate effective management of the YAC by management

Staffing and funding emerged as major challenges that affect delivery and access to services.

- **Staffing**

The study revealed a shortage of staff as one of the major constraints to accessing services. To address the issue, the management of the YAC should explore efficient utilisation of staff available as well as introducing a relief nurse. Clinical services are greatly affected because if the SDO for the clinic has to attend a meeting, then the clinic has to close. Effective utilisation of staff includes re-examining priorities and assigning staff accordingly.

- **Funding**

A shortage of funding emerged as a serious challenge facing the YAC. In the absence of funds, activities cannot be carried out. Incidences of donors "pulled-out" assistance during the course of financial year were reported. This means that planned activities had to be put on hold. Halting the implementation of planned activities discouraged young people, as they were looking forward to and had prepared for the activities.

To address the issue of financial shortage, it is imperative to tap into Ministries mandated with development. This approach would enable stable funding for the YAC. Accordingly, the Ministry of Education and Skills Development (MOE & SD) and the Ministry of Sports, Youth and Culture and NACA (Global Fund and PEPFER Fund) as well as the Ministry of Local Government (MLG) should be approached to support certain activities. The MOH, ACHAP, and UNFPA have provided considerable and consistent support, but these key stakeholders could provide more.

5.3.2 Facilitate youth-friendly policies and procedures used by the YAC

Certain policies and procedures were identified as unfriendly thereby hindering access to services. For instance, days and hours of operation and IEC materials ordering process were identified as some policies and procedures that hampered access to

services. BOFWA Management should revise the policy on days and hours of operation, appoint a Relief Nurse, and approach institutions that develop and distribute IEC materials. To address the gap, the YAC and BOFWA management should work with stakeholders to find a more friendly way to increase access to the YAC by having facilities different from the traditional health facilities.

5.3.3 Facilitate training to build positive attitudes of service delivery officers

The study results illustrated that although initial training was done, SDOs and peer educators received no further training. In addition, the study found that some SDOs displayed negative attitudes that led several peer educators and young people to no longer utilise the services. Lack of regular training occasionally resulted in service providers' relapsing and becoming "anti-youth" (Macfarlane & McPherson 2007:138). To overcome these problems, the following can be done.

- **Training of professional staff**

Training and continued refresher courses and update sessions are essential to keep SDOs' youth friendly. According to Macfarlane and McPherson (2007:134), staff must be trained to improve their knowledge of ASRH issues and skills to communicate with young people. Webb and Elliot (2001:211) emphasise that training and monitoring and evaluation are essential for services providers to equip them with necessary skills to service young people. Young people do not easily want to discuss or disclose sexuality-related issues with adults. Therefore services providers, who are more likely to be older than the target group, should be skilled to deal with them. In addition, the staff should have skills to reach out and bring to the centre the marginalized young people who are reluctant to use traditional conventional health facilities.

Jaya and Reddy ([Sa]:3) point out that training is the cornerstone of running any successful programme because it tailors service providers to be effective and productive in executing their work. Barnett and Schueller (2000:85) maintain that training of staff is essential to give them the skills of counselling and to equip them with up-to-date information on contraceptives and other services. The FMOH-Ethiopia ([Sa]:15) emphasises that service providers must be equipped with knowledge, skills and positive attitudes for them to be efficient and effective to deliver youth-friendly

health services (YFHS). According to Brabin (2002:15), service providers need to be friendly as well as knowledgeable and have skills to offer services. Moreover, “effectiveness, appropriateness and comprehensiveness are the dimensions of quality that relate to standards of clinical practice” (Brabin 2002:15). It is imperative, therefore, to equip service providers with the necessary skills and knowledge so that they can effectively prevent problems, promote healthier life styles, and deliver clinical care services to young people.

5.3.4 Facilitate access to services in the context of the location of the YAC

The study found that the location of the YAC hinders young people from accessing services, as it is not in centre of the village. Young people have to pay taxi fare to access the YAC. This resulted in young people not coming to the centre regularly and missing activities and services they would have benefit from. The participants were not prepared on how best to derive benefits from the YAC without necessarily coming to the centre all the time. According to Webb (1998:11), convenient location, a youth-friendly comfortable environment, flexible hours, a strong counselling component, specially-trained providers, and comprehensive reproductive health services are important characteristics for adolescents.

To address the above, young people could be assisted to access services through the following:

- **Outreach activities**

Young people should be encouraged to attend outreach activities offered at both community and school levels. Outreach activities include IEC and counselling as well as recreation, where tournaments and other activities are taken to sports fields in schools and in the community. Utilising the outreach activities would reduce the visits young people have make to the YAC, while still accessing services offered by the facility. Having peer educators give health talks at the community, and forming drama groups at ward and school levels, could increase outreach activities at community level. This would increase the number of activities happening at both community and in school levels. The activities should be supported and organised by peer educators assigned to the wards or areas. Pathfinder International (2006a:5) argues that outreach activities to

the community empower members and its effects are long-lasting and become an asset resourceful to the community.

- **Information education communication (IEC) materials**

The study revealed a shortage of IEC materials at the YAC, to the extent of them not placed in the waiting room for clients to pick up. If utilised effectively and distributed prudently, IEC will fill a gap in the absence of service providers. Young people will read on specific topics or health problems and gain knowledge and make informed decisions. It is imperative that health care providers distribute IEC materials to young people, to read at their own time. In this case they will read and gain knowledge even when they are not at the centre. IEC materials facilitate access to information services while at home. If clients are given IEC materials to take home, they do not need to frequent the YAC thereby avoiding the cost of taxi fares.

- **Set-up of the YAC**

The study found that the current set-up in the facility is friendly. Young people feel comfortable. The arrangement of rooms, and sports fields allows young people to be more visible than SDOs. The fact that young people are at the forefront makes other young people who seek services to feel comfortable at the facility. It is important to continue the set-up and make it more attractive to young people.

- **Hours of operation**

The hours of operation emerged as a major impediment for young people to access services. To resolve this problem, the YAC management working with young people should revisit the hours of operation as well as the days the centre is open for clients. The YAC should be fully operational on Saturdays. Moreover, all services offered during the week should be accessible on Saturdays to provide young people unable to access services during the week an opportunity to seek them. Students and young workers cannot go to the facility because by the time they leave school or work the centre is about to close. On Saturdays young people are not in school and have ample time to utilise the facility. In addition, the YAC should change the hours of operation to open at 08:00 and close at 05:50.

5.3.5 Facilitate access to services by creating partnerships with stakeholders of the YAC

The findings indicated that the YAC was not grounded on the concept of partnership hence the lack of involvement of parents and the community, which led to rejection and stigmatisation of the YAC by some parents, community members and community leaders. There is a serious lack of parental and community support. At the conceptualisation of the YAC or other similar interventions, partnerships (joint efforts) should be facilitated from the planning stage and continue through to the implementation and evaluation of the initiative. Naidoo and Wills (2000:157) describe a partnership as joint action between partners (national and local agencies and the public).

According to the UNDP (2006:24), forming partnerships is essential in building communities because the latter have power that could be used to mobilise the community for involvement. In addition, communities can be used for resource identification as well as for social change. For this reason, members of the community should be part of the initiative from the planning to the implementation stage. Morrish (1997:1) maintains that partnering accords stakeholders the power to contribute, participate and ultimately experience change and the outcomes. Normally stakeholders have specific knowledge and expertise they can share, therefore it is vital that partners be involved. In addition, it is important that partners have common models in practice and debate sensitive issues in practice. When in partnership, all norms and cultures developed are bound to be relevant and appropriate because the parties are part of the process, represented and involved in all phases of decision making. Partnering in delivery of ASRH is of crucial, as it prevents duplication and maximises utilisation of the limited resources. For partnership to work, all the parties should be treated and benefit equally.

Robinson, Orleans, James and Sutton (1992:2) assert that in dealing with problems affecting young people, their friends, families and relevant organisations should be party to the solution. The implementation will then take a holistic approach when significant stakeholders in the environment where a young person is growing are recognised.

Accordingly, UNICEF, UNAIDS and WHO (2002:36) state that partnership is essential and the commitment to pull partners together should exist in organisations. Ruland (2003:1) argues that participation allows target groups to be part of the learning process, as they determine the needs and how to address them. This entails identifying the solutions and strategies to tackle the needs and gaps along with ameliorating the problems.

Forming partnership guards against isolation, stigma and negative attitudes that hinder access to the facility. Partnership builds partners' ownership of the facility/intervention and ensures commitment to success.

5.3.6 Facilitate meaningful involvement and participation of young people

Although involvement (being part of) and participation (taking part in) of young people is a key principle at the YAC, certain factors hindered this. For example, none of the peer educators fell in the 10-14 years old category. This hindered access to YAC by the specified age group. Other factors hindering meaningful involvement included attitudes service providers; poor communication and an imbalance of power between the professional staff and peer educators as well as between peer educators and young people, and inadequate involvement of stakeholders.

Facilitating meaningful involvement and participation of young people is central and crucial to implementation of YFS. Young people know their needs hence the imperativeness of their involvement and participation to ensure that the programmes, interventions or services are relevant and successful. Interventions targeting young people must take an approach that will involve and keep them constantly interacting with service delivery officers. This will enable sustainability of safer behaviour because of continued access to services (Sengstock 2005:29). To address issues of meaningful involvement, the following are essential:

- **Establish a peer educators' team that has all age groups representation**

For the YAC to achieve meaningful involvement and participation, the peer educators' team should be constituted of young people of all age groups in order to ensure a fair representation of the needs of all groups and enhance accessibility to services.

Peer education is a commonly used method of meaningful involvement and participation. Peer education is offered by trained people, who are members of the same group or at least fit similar criteria, such as age, educational level and similar experience or problems as the relatively homogeneous group. The key aim of peer education is to increase the acceptance of educational messages through a hierarchical situation.

Chase and Aggleton (2006:95) emphasise that promoting meaningful participation is among the five key principles central to programmes targeted to young people. The other key principles are putting young people first; gender equity; a rights-based approach, and tackling risk and vulnerability within the distinct context of the young person's life. Measor et al (2000:150) point out that it is vital to consult young people when planning programmes. Failure to do so will lead to the programmes not addressing the concerns of young people, thereby addressing the concerns of those who plan and implement the programmes instead. Health promotion emphasises consulting with target audiences because that will lead to the outcome being relevant and valuable. According to Naidoo and Wills (2005:111), involving target group "permits for identification of unmet needs, ownership is created, and satisfaction is improved". In addition, participation allows learning to happen as well as gaining skills on how to address issues in people's lives. This also makes the target group feel powerful and in control of their lives, therefore, a meaningful change is envisaged. Meaningful involvement and participation of young people builds and promotes their self-esteem and efficacy. This strengthens their belief about their capabilities to influence events that affect their lives.

The FMOH-Ethiopia ([Sa]:45) identifies the following characteristics of adolescent youth-friendly health services, namely "accessibility, equitability, acceptability, appropriateness, comprehensiveness, effectiveness and efficiency". Stone and Ingham (2006:198) maintain that health promotion interventions should use different

approaches in the implementation and delivery of messages because failure to do so may lead to the programme not achieving the change in the target group. Peer education is an important strategy in ensuring meaningful involvement and participation of young people.

- **Form a YAC advisory board consisting of young people, parents and partners (stakeholders)**

To achieve meaningful involvement and participation, stakeholders should be adequately involved through the YAC advisory board. This will ensure understanding the roles and functions of the YAC and the expectation of how to serve young people. This will also build ownership and commitment to the success of the intervention.

Inadequate involvement of stakeholders results in community leaders and others having negative attitudes towards the centre, stigmatising it and not knowing much about the YAC. Stigma and negative attitudes lead to low utilisation of the facility. A multidisciplinary advisory board composed of key stakeholders in provision of the services should be established. A YAC advisory board on youth-friendly services should be comprised of young people, parents, schools representatives; community leaders, councillors, churches, faith-based organisations, policy makers, service providers, and government representatives, such as MOH, MOE & SD, MLG, and MYSC.

Walley et al (2001:264) maintain that good public health practice should distinguish the/with wider influences on health and endeavour to modify them by working with other sectors and disciplines. Robinson, Orleans, James and Sutton (1992:2) concur as they emphasise that in dealing with problems affecting young people, their friends, families and relevant organisations should be party to the solution.

According to UNICEF, UNAIDS and WHO (2002:27), parents and community and religious leaders need to recognise the importance of their own roles in providing life-saving information and skills. Furthermore, the advisory board is an important link between the community and the facility (UNICEF, UNAIDS & WHO 2002:31). Brabin (2002:6) states that an advisory board is predestined to guide the programme, give agreement on programmatic issues and have shared understanding with service

providers. The authors mentioned above evidence the need and the role of an advisory board in delivering a programme that has stakeholders.

5.3.7 Facilitate empowerment of young people by implementing varied participatory learning activities

The main aim of the YAC is to empower young people. To achieve this, additional activities that build a young person's knowledge, decision-making skills and assertiveness should be introduced. The study found that empowerment is a good strategy to facilitate informed decision making and responsible behaviour. Introducing drama groups according to age groups, (e.g., 10-14; 15-19; 20-24 and 25-29) consisting of both peer educators and young people who utilise the YAC would increase the number of young people participating in drama as well the number of activities requiring full participation of young people. Drama is an activity that makes learners experience the situation, realise their ability, as well as gain knowledge and build their skills.

Naidoo and Wills (2000:98) describe empowerment as a "down-up" approach, which makes it possible for people to recognise their issues and develop skills and the self-assurance to "deal" with them. Empowerment makes people able to "recognise and understand their powerlessness; feel strong enough about their situation to want to change it; and feel capable of changing the situation by having information and support and life skills" (Naidoo & Wills 2000:98).

5.3.8 Facilitate effective and good parent-child communication

The study found out lack of support by parents or families to young people, as well as poor or inadequate parent-child communication as a major challenge. Most parents do not want to discuss issues related to sex with their children. In some cases, young people are discouraged to use the Centre because parents hold negative attitudes about it. Campbell and Aggleton (1999:257) point out that in families where parents openly talk to their children about sex, young people are more likely to use condoms and contraceptives. Good communication is important as it ensures that fears and questions are answered, ensures that certain good-quality services are provided, and builds trust and rapport between the users and service providers. In addition, strong

service provide-user relationships and prompt delivery of quality services are essential in youth-friendly services (WHO, UNFPA & UNHCR 1999:120-121).

According to UNICEF, UNAIDS and WHO (2002:27-28), in homes where members are free to discuss sex and related issues, young people make safer decisions on sex matters. Young people have needs, including the need for information, knowledge and skills. Parents and families have a responsibility to meet the needs of young people by educating and answering questions and allaying their fears.

According to Campbell and Aggleton (1999:257), poor communication in families or poor adult communication leads to young people finding themselves in health-related problems. Maboko and Mavundla (2006:24) concur, stating that where there is open communication between a patient [individual] and family there is love given as well as support to the individual. Moreover, the prediction of young people's sexual health behaviour is based on parental support. If mothers disapprove of their children having sexual relationships, particularly when the communication is done early and there is a close mother-child relationship, then such communication of mother-daughter may delay the child's onset of sexual intercourse (Kirby 2003:3).

Macfarlane and McPherson (2007:138) affirm that parents are important in the lives of young people. They provide for their economic, social, love, protection and information needs, therefore health source provision is also their role. For this reason, the provision of youth-friendly services should recognise the roles and the importance of parents in health service provision.

5.3.9 Facilitate family and community integration

The study found that from the YAC's inception, there was a lack of integration of family as well as community members. This resulted in some parents and community members harbouring negative attitudes about the centre and stigmatising it. Families and community members with negative attitudes discouraged their children from using the facility. Kuate-Defo (1998:356) emphasises that for education programmes to be effective and sustainable, particularly in Africa, it is imperative to educate the parents, as they are an influential entity in young people's lives. Programmes should assist parents and other adults as well as community members to have correct information, be

open to accept young people, and be free to discuss reproductive health issues (UNICEF, UNAIDS & WHO 2002:27-28).

The researcher is of the opinion that equipping parents and the community with correct information will help them shift from being didactic but rather advise and discuss with their children. Measor et al (2000:152) argues that it is essential that service providers should work with families and community leaders in conducting sex education and even training them so that they are informed. This will eliminate parents, families and communities' ambivalence about and resistance to the programme. Ethier and Orr (2007:290) found that parents' involvement in adolescent sexual interventions proved fruitful in programming. A parental bond, satisfactory parent-child relationships, parental monitoring, supervision and communication about sex in families leads to responsible sexual behaviour and less risk for sexually-transmitted infections in young people. To address these issues, the following can be done:

- **Organise parent-child days**

The YAC does not have a forum where parents are invited to the Centre to see it and relax with young people. Furthermore, the study found a lack of parental involvement and support. Organising parents' days at least twice a year would facilitate parents being informed and supportive. At the forums, parents and community members could be briefed about the activities at the YAC, and make suggestions on how to best operate the YAC. Most importantly, parents could raise issues they feel are relevant and should be discussed with young people. The opportunity would also be used to continue teaching parents and the community on ASRH.

- **Organise community leaders and stakeholders' forum**

Feedback and keeping communication open with community leaders and stakeholders was found lacking. This was revealed by a lack of involvement, participation and support of community leaders as well as their negative attitudes towards the Centre. According to Maboko and Mavundla (2006:15-16), communication is essential in every interaction, as it is a way that partners can share, agree and understand each other. Moreover, community leaders and stakeholders will feel valued and respected when there is open communication. Stratten (1999:7) points out that keeping open

communication with all partners and stakeholders is imperative in delivering of youth-friendly services.

Lack of a supportive community environment was identified as a challenge. The stigma and negative attitudes also result from a non-supportive community. Social and capital support is important in influencing community health. A multi-sectoral approach in service delivery fosters and facilitates health-enhancing behaviour (Campbell & Aggleton 1999:258). According to WHO, UNFPA and UNHCR (1999:1), involving the community is imperative and creates the acceptability, appropriateness and sustainability of interventions. This, in turn, increases the chances to achieve the desired change because of collective action in the community. Denver (1997:8) states that the community should be mobilised to actively take part. Campbell and Aggleton (1999:259) assert that a supportive environment assists individuals to discover their capability, develop self-esteem and confidence. A supportive environment is a function of initiatives and activities that aim to assist members to be part of the programme.

5.3.10 Facilitate social marketing and advocacy strategies for services and activities offered at the YAC

The data analysis revealed that the original plan did not include a social marketing and advocacy plan. The inadequate support from the community leaders, inadequate information about the YAC to the community, and limited access to information and services by young people are sign of lack of marketing and advocacy activities. Naidoo and Wills (2000:242) define marketing as "the sum of all activities (the marketing mix) designed to persuade people to adopt certain behaviours" and Lawrence and Fortenberry (2007:33) refer to social marketing as "the design, implementation, and control of programmes seeking to increase the capacity of a social idea or practice in a target group".

Webb and Elliot (2001:211) emphasise that advocacy is a component of youth-friendly services. Advocacy is a good practice in programmes reaching young people. According to Naidoo and Wills (2000:86), advocacy is "representing the interest of disadvantaged groups and may mean speaking on their behalf or lobbying to influence policy". Webb and Elliot (2001:211) contend that advocacy is important in delivering school-based programmes targeted at young people.

The researcher is of the opinion that defining the social marketing and advocacy strategy, approach or plan is an important element of a successful health promotion programme or intervention. The plan directs the service providers to prioritise the needs and wants of the target group. "Public health professionals must first find out what the consumer wants and then redefine, repackage, reposition, and reframe the product in such a way that it satisfies an existing demand among the target audience" (Siegel & Lotenberg 2007:45). Naidoo and Wills (2000:252) maintain that social marketing drives the acceptability of desired behaviour consequently emerging to be wanted and "trouble-free" to accept. Social marketing is an approach that is analogous to commercial marketing. This is where the principles of marketing are modified to be applicable to health promotion. Social marketing is applied in public for different programmes and the YAC should do the same to improve the appropriateness of the facility. At the same time, Seeman and Leinhos (2007:531-533) caution that social marketing should carefully observe ethics, because in offering services there are ethics-related issues. In addition, values are involved in efforts to change behaviours that put people at risk.

In the researcher's view, both social marketing and behavioural science should be applied to study what influences and motivates people to adopt certain behaviours in order to better design messages that succeed in influencing them to change. Health promotion practice "sells" health messages, promotes healthy behaviour to bring social change, therefore, marketing becomes core in programme and intervention implementation to place the target audience at the centre or "heart" of the initiative.

5.4 IMPLICATIONS FOR HEALTH PROMOTION PRACTICE

Watson and Platt (2002:1) identify five strategies for health promotion practice, namely building healthy public policy; creating supportive environments; strengthening community action; developing personal skills, and reorienting health services. The specific actions under the strategies include promoting social responsibility for health; increasing investment in health development; consolidating and expanding partnerships for health between partners and at all levels, and securing an infra-structure for health promotion (Watson & Platt 2002:1-2). These strategies and principles of health promotion guide the practice. Lawrence and Fortenberry (2007:33) maintain that health care providers should borrow and use social marketing in health promotion. There is a

need to maximise tools used in commercial marketing to enhance the chance of people accepting the programmes and/or messages.

Hornik (2002:13b) emphasises that health promotion/health education programmes should produce messages that directly support the desired behaviour. Furthermore, programmes should target the knowledge, beliefs, or social norms, strengthening or supporting the behaviour instead of advocating for the new behaviour. Through public health or health promotion research, such issues of knowledge, beliefs, culture as well as social norms can be known.

Coates, Petersen and Perry (1985:11) found that conflicting or contrary assumptions, professional perspectives, and research paradigms in the design and implementation of health promotion programmes for adolescents were barriers to access and utilisation thereof. Therefore, to have effective health promotion and cross fertilisation of ideas, practitioners should adopt a multidisciplinary approach in health promotion research and the formulation of programmes and interventions; apply strategies designed for specific problems to other problems, such as teenage pregnancy, and use information about young people for development and evaluation of health programmes.

5.4.1 Models of health promotion

Health promotion practitioners need to further develop health promotion models that guide the development of programmes and interventions focused on building well-informed and healthier young people.

Health promotion as a practice aims to enable people to increase control over their health and to improve it Health promotion consists of prevention of ill-health; protection of health, and education about health (Mackinnon 2007:178-179). The central principle of health promotion is empowerment through informing people how to achieve and maintain good health, motivating them to do so, and promoting environmental and lifestyle changes to help them in their objectives. This could be achieved through communication with target populations, imparting information, and increasing knowledge as well as motivating people to improve their health.

According to Kuate-Defo (1998:285), paradigms in population development and reproductive health demand a shift in intervention strategies and practice. The findings of this study concur with Kuate-Defo (1998:285) that pedagogic approaches are needed to enable all relevant disciplines to contribute to the challenge of delivering better health promotion programmes. Public health and social sciences need to recognise the inter-relationship with other fields and that health problems and social problems are intertwined. For example, teenage pregnancy is a health issue as well as a social problem. Walley et al (2001:264) contend that good public health practice should distinguish the wider influences on health and endeavour to modify them by working with other sectors and disciplines. Therefore, realising inter-relationships would lead to the development and design of programmes and interventions that are holistic and comprehensive.

5.4.2 Role of advocacy and social marketing in health promotion

Health promotion practitioners should note the role of advocacy and social marketing in bringing social change or improving and promoting the public's health (Siegel & Lotenberg 2007:39). Social marketing and behavioural science are applied to study what influences and motivates people to adopt certain behaviours in order to better design messages that succeed in influencing them to change. Kennedy, Mizumo, Seals, Myllyluoma and Weeks-Norton (2000:180-9-18) maintain that the use of social marketing and health promotion in combination would maximise the effects of messages targeted to young people.

Social marketing and advocacy are crucial in health promotion as practitioners have to compete with industries whose main aim is to sell and promote unhealthy behaviours such as smoking, substance and alcohol use, and eating unhealthy ("junk") food. Training or reorientation is necessary to deal with the following:

- Inadequate emphasis on advocacy and marketing in public health.
- Limited expertise in advocacy and marketing among the current public health practitioners.
- Inadequate training in advocacy and marketing for public health practitioners.

For the YAC and YFS to be utilised to the maximum by the target group, service providers need to approach and attract stakeholders and policy makers. Most importantly, they should market the programmes and interventions as well as facilities including health messages and desired behaviours. The target audience for advocacy and marketing include young people as the primary target group, parents, teachers, community members and leaders as the secondary target group. According to Siegel and Lotenberg (2007:46), public health, particularly health promotion practitioners, must employ the principle of marketing and advocacy to bring about the social change desired. Specifically, "marketing mix" should be applied as it aims to make "human activity directed to satisfy needs and wants through exchange process" (Siegel & Lotenberg 2007:46). In marketing the aim is to address and prioritise the needs and wants of clients. The seven marketing mix principles, or the 7 Ps, are Product, Price, Place, Promotion, People/Personnel, Partners and Process. These marketing mix principles guide and redirect programmes and interventions by having the needs and wants of clients "put at the heart" (Siegel & Lotenberg 2007:46).

5.4.3 Urgent need for health promotion programmes on ASRH

The 1994 ICPD Plan of Action (1994:26-28) makes provision for SRH services to "increase adolescents' access to reproductive health services by making services youth friendly; having service providers who are youth friendly and trained to deliver services; social marketing/advertising and commercialising services, and partnering with young people and other stakeholders. These objectives challenge practitioners and service delivery officers to shift their approaches. This calls for new perspectives for health promotion models, programmes and interventions as well as training or reorientation of service providers. According to Bauer, Davies, Pelikan, Noack, Broesskamp and Hill (2003:107-113), health promotion practice should harness systems theory, socio-ecological and other models that are public health related to enable the profession to develop a reference point for the field of public health. Public health practitioners in general have a responsibility to create or facilitate social change in complex health problems, such as HIV and AIDS, as well as chronic diseases (Siegel & Lotenberg 2007:22).

According to the African regional forum on youth reproductive health and HIV (2006:4), when designing programmes to meet young people's needs, it is essential to have a

knowledge and understanding of the environment in which they live. The planning of all development programmes should be based on theories and models and be evidence-based, as that will tailor them to address the needs of the target audience.

5.4.4 Holistic youth-friendly health promotion interventions

The practice of health promotion, in particular, should value and further explore contemporary concepts and approaches such as peer education, self-efficacy, health communication, sexual health communication, advocacy and marketing. Further studies should be conducted on how the concepts and approaches could be employed in empowering young people. Self-efficacy allows people’s beliefs about their capabilities to influence events that affect their lives. Self-efficacy beliefs determine how people feel, think, and motivate themselves and make them eager to perform the desired positive behaviour. Self-efficacy is imperative in taking control or achieving the desired behaviour.

According to Coleman, Henry and Kloep (2007:1-17), it is imperative to understand adolescent health and the adolescents themselves. In reaching to them, health communication methods should be used to inform and influence individual and community decisions that enhance health. In addition, peer education has much to offer in health promotion. This is the type of education offered by trained people, who are members of the same group (or at least fit similar criteria, such as age and educational level), and relatively homogeneous with the group they are serving. The key aim is to increase the acceptance of educational messages through a hierarchical situation. Peer education is under-utilised and where it is used there is still cultural and structural hindrance. Many contemporary adolescent issues could be addressed through peer education, particularly to enhance sexual communication with peer, parents, family and the community at large. Indeed Coleman (2007:83-104) argues that there are several challenges, needs and problems that young people are faced with and should therefore be addressed. There are individual, contextual, social and cultural influences that are important in dealing with young people (Coleman 2007:83-104).

A holistic approach in YFS allows for issues to be dealt with as a whole and not just as part of an essential element. Health promotion practice upholds its principle of

informing people how to achieve and maintain good health, motivating them to do so, and promoting environmental and lifestyle changes to help them in their objective.

Stone and Ingham (2006:198) maintain that health promotion interventions should use different approaches in implementation and delivery messages because failure to do so might lead to the programme not achieving the change in the target group. Jemmott and Jemmott (2007:243) emphasise that health promotion interventions should use relevant theoretical models and reach consensus on outcomes for them to be effective and successful in influencing behaviour.

5.5 CONCLUSION

This chapter discussed phase 2 of the objectives of the study by illustrating and explaining the conceptual framework and developing and describing the guidelines for facilitation of youth friendliness in a YAC.

The guidelines recognised the importance of the physical, administrative and psychological environment in which the YAC and YFS operates. This concept is based on a holistic approach to dealing with issues and the needs of individuals. In addition, the guidelines acknowledge the inherent reciprocity between the environment and the clients in the process of empowerment (Weis, Schank & Matheus 2006:17-24). Most importantly, the guidelines overcome the imbalance of power created by service providers having control over, hence the element of partnership, meaningful involvement and participation of the target group and others. The fact that service providers are experts and have access to information as well as having control over services offered, they are “power holders” which leads to the recipients of services feeling powerless, implicating imbalance of power between the two parties (Weis et al 2006:17-24). The guidelines therefore attempt to create a balanced power among all stakeholders.

Chapter 6 discusses the conclusions reached on the basis of the findings and makes recommendations for practice and further research.

CHAPTER 6

Conclusions, limitations and recommendations

6.1 INTRODUCTION

Chapter 5 described the guidelines for facilitating youth friendliness in a youth activity centre (YAC) and the conceptual framework utilised to support the guidelines. This chapter discusses the conclusions and limitations of the study and makes recommendations for practice and further research.

The findings of the study endorse the need for an effective and accessible YAC. In addition, the imperatives of nurturing factors that facilitate and encourage utilisation of a successful YAC in Botswana emerged. The study findings should be of considerable value to health promotion practitioners in developing and implementing youth-friendly programmes. Most importantly, the recommendations made should improve the health care provision because research is key in designing health promotion programmes (Santelli 2006:42).

6.2 CONCLUSIONS

The study utilised a qualitative design that was phenomenological, explorative, descriptive and contextual in order to understand social issues by direct inquiry from those who had lived the experience. The researcher wished to explore, describe and contextualise the lived experiences of young people utilising the YAC in the Mochudi area in Kgatleng District in Botswana. Phenomenology draws a naturalist inquiry from informants, bringing the reality, reflection and originality of their life-world and defining the meaning of the lived experiences. This approach produced credible results because the respondents' related their lived-experience and they know their own life-world.

The assumption in phenomenology is that understanding human beings and their behaviour is most achieved in the course of probing into their human experiences. Accordingly, to discern the respondents' lived experiences they were asked to relate

their interaction with others and the environment in their life-world. Descriptive phenomenology unravels the sense of how people lived their experiences and explores the meaning attached (Creswell 1994:145; Van Manen 1997:347). Phenomenology is "how people make sense of their lives, experiences and description of their structures of the world. It is descriptive in that the researcher is interested in the process, meaning, and understanding gained through words or pictures" (Creswell 1994:145).

People's experience comes from the past and present circumstances and what future possibilities are. In addition, experience is something that people exemplify in their life, hence the life-world. In reciting the experience, people actually give their observations, perceptions and discernment of and insight into what they have lived. *Collins English Dictionary* (1999:449) defines experience as "direct personal participation or observation. A particular incident, feeling etc. that a person has undergone, accumulated knowledge and in practical matters". Experience is "the state of knowing or having learnt a lot about life and the world from events that have happened to you and people you have met" (*Longman's Dictionary of Contemporary English* 1995:475), while *Oxford Advanced Learners Dictionary* (2006:513) defines experience as "the knowledge and skills that you have gained through something for a period of time".

In this study, the experiences of young people utilising the YAC were explored through assessment of their knowledge and perception of their lived experience. The main purpose was to explore and describe the experience of young people utilising the YAC in the Kgatleng District in Botswana. The key question was: What is your experience as a person who has used the youth activity centre? The young respondents were categorised into two groups, namely the regular users and peer educators. The service delivery officers at the YAC were also asked to relate their experiences. The researcher interpreted both young people and service delivery officers' knowledge and perception of the youth friendliness in the YAC to answer the research question.

In examining the youth friendliness of the YAC and its utilisation, the research revealed that there are physical, administrative and psychological aspects of the YAC affecting youth friendliness of the facility.

The findings indicated under utilisation of the YAC by young people. Some young people who should be using the centre were not; some who used to be regular users

currently seldom used it, and others had stopped visiting the YAC. At the same time, there were regular and consistent users. The respondents indicated there are physical, administrative and psychological aspects, both external and internal, that made the centre unfriendly to youth and impeded access and utilisation.

The physical aspects that proved to be stumbling blocks to access and utilisation included the YAC's location, transport to the centre, and lack of taxi fare. Barnett and Schueller (2000:14) found lack of money to pay for services and transport as a serious hindrance to accessing services. Administrative aspects, such as the days and hours of operation, unavailability of commodities particularly condoms, shortage of funds and IEC materials, poor communication between the staff and peer educators, and shortage of staff, made the facility unfriendly to young people who utilised it. Coleman et al (2007:166) emphasise that communication among SDOs and young people should be cooperative, instructive, and link the two parties in harmony rather than investigative. Investigative communication and relationship destroys the youth friendliness and acts as a deterrent to those who need services. This, in turn, might prohibit revisits for review or other services and discontinue care. Unfavourable psychological aspects, including poor communication between the staff and peer educators, SDOs' negative attitudes, stigma, and parents' and community leaders' negative attitudes, hamper utilisation of the YAC. All these deterred some young people from accessing and benefiting from the centre.

The limited number of young people that accessed the facility perceived it as a welcome intervention that provided necessary services. The YAC had empowered users with knowledge particularly on health-related topics such as teenage pregnancy, sexual transmitted infections, HIV and AIDS, and negotiation skills in relationships, preparation, organisation and facilitation of activities as well as entrepreneurial skills.

All the respondents in the study experienced a positive change in their lives. Most reported a positive change in their lives after starting to utilise the YAC. Some had, in fact, survived problems such as teenage pregnancy, being teen mothers, substance abuse and irresponsible sexual behaviour. Pathfinder International (2006b:4) asserts that young people are agents of change to themselves because they use the knowledge gained and skills acquired during interventions to shape their current lifestyle, behaviour and their future. The utilisation of the YAC developed and

empowered the respondents (young people) by equipping them with knowledge and skills to make informed decisions and behave responsibly. This was facilitated by the provision of appropriate and relevant services and the meaningful involvement as well as participation of young people in the delivery of services.

Empowerment of young people was a major benefit and achievement, according to the peer educators, young people and SDOs. Field placements in various health and social services settings allows students the opportunity to experience the sense of empowerment and accomplishment that comes from being asked to do something meaningful and doing it well. Both the peer educators and the young people said they were better people now compared to the time before they utilised the YAC. According to them, they had the knowledge and skills and were better at making responsible decisions. Some had changed their behaviour since coming to the centre. For example, they had stopped smoking, abusing alcohol and having multiple partners. According to Fako (2005:348), having multiple partners is one of the risky behaviours commonly practised by young people because they perceive it to be prestige. In addition, some indicated that they decided to delay sexual debut and child bearing. The urge to have children is a factor that exposes young people to early sex, HIV and AIDS (Fako 2005:349). The study found different levels of empowerment, namely individual, psychological, community and societal. There was a building of personal strength, sense of mastery of knowledge, skills and taking control of their situation as well as balance of power within and with people. Therefore, the empowered young person relates to the community and the society and the need to create an environment that accepts and supports the person. For this reason, then, the community and society at large should be involved in initiating interventions in order to overcome resistance, rejection and stigma, and facilitate ownership.

The credible findings assisted the researcher to formulate appropriate guidelines to facilitate youth friendliness thereby increasing access and utilisation of the YAC by young people. The design of the study, the credible findings as well as the researcher's experience contributed to the formulation of germane or relevant guidelines for operating a YAC that could successfully create access to the centre and provide services that empower young people. The researcher asked an adolescent sexual and reproductive health expert to appraise the appropriateness of the guidelines. The expert

accepted them as highly pertinent and germane or relevant to the contemporary approach of serving young people in order to empower them for better health and life.

6.3 THEORETICAL FRAMEWORK AND GUIDELINES FOR IMPLEMENTING YAC

The ecological model of health promotion was used to illustrate how individuals interact with their environment and how the latter affects young people's development and behaviour. According to Coates, Petersen and Perry (1982:2-3), there are three vital trends in adolescent or young people health promotion, namely: health promotion has become a national priority; the medical profession has recognised the unique health care needs of adolescents, and researchers have become aware of the importance of the complex interaction between behavioural and biomedical science for understanding health and disease. In this study, the ecological health promotion model was key in studying young people and developing intervention programmes to address their needs and problems.

The conceptual framework and the guidelines on facilitating youth friendliness of the YAC included all stakeholders (young people, parents and community leaders, service providers and partners) in the implementation of youth-friendly services and/or operation of the YAC. The findings indicated the necessity to involve stakeholders from the planning stage to keep them informed about the centre to the implementation and evaluation phases. It is imperative to bring partners to the centre to see it before the start of the operation. After the visit, the SDO then tasks the parents with the responsibility of telling young people about the YAC and encouraging them to visit and use it. The guidelines emphasise partnership with stakeholders and ongoing training of parents, community and staff. In addition, the need for constant sharing of information and maintaining linkages as well as creating a supportive environment at home and in the community emerged as crucial.

6.4 LIMITATIONS OF THE STUDY

The researcher identified the following limitations in the study:

- The study examined the concept of the YAC and YFS, as they are the key strategies employed to reach young people and tackle HIV/AIDS and other

sexual and reproductive health issues. However, the study was limited to the Mochudi BOFWA YAC in the Kgatleng District. The findings therefore cannot be generalised to the other YACs in Botswana or elsewhere.

- The distance between the areas where the other centres are located and a lack of financial resources prevented the researcher from extending the study.
- The researcher used purposive sampling, which, although providing credible data of the respondents' lived-world and experience of the phenomenon under study, restricts the generalisability of the findings.
- There were fewer male than female respondents among the young people and peer educators.

There were no male SDOs, as all the professional service providers were females. The findings might, therefore, have been different had there been male SDOs.

6.5 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for practice and further research. The recommendations are divided into three categories: practice in the youth activity, education of service delivery officers, and further research. Santelli (2006:42) emphasises that research has become fundamental in improving health promotion, because the knowledge gained is used to develop new health promotion programmes. Like all research, health promotion studies aim to contribute to the body of knowledge guided by the intentions of the researcher (Santelli 2006:48). Accordingly, further research on the operation of the YAC and the provision of youth-friendly services deserve special attention.

6.5.1 Practice in the youth activity centre

It is recommended that:

- The implementation of an intervention such as the YAC should based on set guidelines. Guidelines are a set of steps/procedure/strategies define by experts based on empirical evidence illustrating how such initiatives can produce intended results (*researcher's opinion*). According to WHO, PC & FHI (2006:15)

to improve interventions lessons from experience of implementations should be applied.

- The YAC should develop an inclusion and orientation plan targeting stakeholders/partners (councillors, chiefs and/or headmen, village development committees, village health committees, parent-teacher associations and other serving committees in the village, churches/faith-based organisations, parents, teachers, and other community-based structures). This would enable stakeholders to own the programme and be kept abreast of information at the YAC. In particular, Pathfinder International (2006a:18) argues that parents and family members play an influential role in the successful involvement and participation of young people in SRH activities. According to the International HIV/AIDS Alliance (2001:212), creating partnerships is a good strategy to reach more people and gain support. Measor et al (2000:152) point out that training parents as partners is essential to keep them informed of what is happening. Naidoo and Wills (2005:144-145) maintain that knowing and appreciating varying power is essential for partners. Keeping open communication shows transparency in decision making hence it is crucial in nurturing partnership.

- YAC management and service providers should reconsider the days and hours of operation to make them more suitable for young people at school and at work. The current schedule of Monday to Friday and 8:00 am to 5:00 is unsuitable for many young people. The YAC should explore the following options:

    - If there is no relief nurse, either operate full day (8:00 am to 5:30 pm) from Monday to Saturday, or operate from 8:00 am to 5:30 pm from Tuesday to Saturday, and have Sunday and Monday as their weekends.
    - If there is a relief nurse, operate half-day (8.00 am to 1.00 pm) on Mondays and full day (8:00 am to 5:30 pm) from Tuesday to Saturday – with the clinical staff, including the relief nurse, rotating Saturday duty.

- Saturday should be a fully operational day because that is when young people are not in school and can freely visit the centre. Working youth would also benefit, because those who work on Saturdays would have the afternoon to access the centre.

- The BOFWA must recruit a relief nurse to avoid the current gap where the clinic closes because the SDO for the clinic has to attend an outside activity.

- SDOs should strengthen their supervision to ensure that good working relationships between peer educators, volunteers and young people themselves. An environment of possessive peer educators destroys the spirit of volunteerism among young people and friendliness in the YAC. According to Pathfinder International (2006a:31), supervision of peer educators and volunteers is necessary to ensure they perform well and are comfortable. He also, mention technical support such as sending people on exchange visit and study tours are essential in training or build capacity of staff.

- The shortage of condoms should be dealt with by obtaining condoms from the ACHAP, the Red Cross and other institutions that supply condoms. The YAC should also increase female condom supply and improve social marketing of the commodity. Shelton and Johnston (2001:181) emphasise that Botswana, South Africa, Zimbabwe, Togo, Congo and Kenya should maintain the standard of a high provision rate of condoms per individual per year.

- SDOs should develop a schedule for utilisation of the computers and ensure strict adherence to the schedule.

- The YAC management should define the lines of communication between SDOs, peer educators, volunteers and young people. Maboko and Mavundla (2006:15-30) point out that communication keeps groups or parties together. Communication is a means of education between service providers and clients and should therefore be maintained.

- For the programme to remain relevant to young people, their needs, concerns and suggestions should be canvassed. The facility should provide annual reports, including any health problems, so that the plans for the following year could address the identified problems.

6.5.2 Education of service delivery officers

With regard to SDOs' education:

- SDOs should hold a diploma or Bachelors degree in Nursing or a profession that provides clinical service. In addition, they should be taught and be guided on communication, behavioural change activities and methods, and counselling skills.

- SDOs must be trained in the delivery of YFS. SDOs whose attitudes and style of management hinder access to the YAC are a serious impediment to improving and promoting young people's health.

- SDO should undergo a course on ASRH, and programme planning and implementation. Muller, Niego and Mince (2008:111) point out that training is a cornerstone in implementing successful programmes. Service providers should be trained in adolescent psychology and development, and protocol administration.

6.5.3 Further research

Further studies should explore the following:

- The roles of parents, community leaders and service providers (health care workers and teachers) in adolescents' development.

- Programmes to assist partners to fulfil their role and responsibility in nurturing, guiding and empowering young people.
- An assessment and comparison of the effectiveness of the YAC and other programmes (approaches) to empower young people for better health.

- A quantitative assessment of adolescents' perceptions of utilisation of YACs in Botswana.

6.6 CONCLUSION

This chapter discussed the findings, conclusions and limitations of the study and made recommendations for practice and future research. Barnett and Schueller (2000:85) maintain that continual update of service providers is crucial to ensure and maintain the provision of quality health services. Walley et al (2001:264) state that good public health practice should distinguish the wider influences on health and endeavour to modify them by working with other sectors and disciplines. The challenge is for health promotion practitioners to recognise that health and social problems are intertwined.

In order to achieve an "HIV-free generation", further research on health promotion programmes and interventions is critical to address contemporary multifaceted and complex health problems. According to Hornik (2002b:13), messages produced by health promotion and health education programmes should directly support the desired behaviour. Therefore, programmes should target the knowledge, beliefs, or social norms to strengthen or support the behaviour instead of advocating new behaviour.

The study contributes to the knowledge available on YACs in Botswana. The findings of the study emphasise the need for more financial support to be able to implement plans and expand the outreach activities of the programme. In spite of its limitations, the results should benefit the field of health promotion in the design and implementation of programmes aimed at reaching young people through the provision of youth-friendly services. The guidelines improve the operation of the YAC, strengthen youth friendliness and improve access to the centre.

ANNEXURE A

Clearance certificate from Unisa

ANNEXURE B

Application for approval of Human Research

Request for permission to conduct research

Request for renewal of the research permit

ANNEXURE C

Permission granted from the Ministry of Health, Botswana to conduct the study

Continuing permission granted from the Ministry of Health, Botswana to conduct the study

ANNEXURE D

Consent letter for participants

ANNEXURE E

Bio-data form/Demographic characteristic of participants

ANNEXURE F

Sample of unstructured individual in-depth interview: Service delivery officer – youth coordinator

ANNEXURE G

Sample of focus group discussion with peer educators

ANNEXURE H

Sample of focus group discussions with young people

UNISA | university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee (HSREC)
College of Human Sciences

CLEARANCE CERTIFICATE

Date of meeting: **3 November 2006** Project No: **34965572**

Project Title**: The facilitation of youth friendliness in a youth activity centre (YAC) in Botswana**

Researcher**: Ms EM Matshediso**

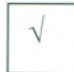
Supervisor/Promoter**: Prof TR Mavundla**

Joint Supervisor/Joint Promoter**:**

Department: **Health Studies**

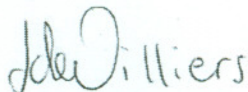
Degree: **D Litt et Phil**

DECISION OF COMMITTEE

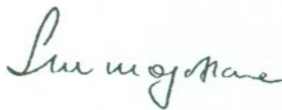
Approved 

Conditionally Approved

Date: **30 October 2006**



Prof L de Villiers
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES



Prof SM Mogotlane
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Ministry of Health

Republic of Botswana

Application for Approval of Human Research

Section A: Instructions

1. ***Fill and complete the research application form and make appropriate copies depending on the number of proposals submitted.***
2. ***Attach:***
   i. ***14 (non-academic or PHD students), 1 (academic except for PHD student) copy(s) of the study proposal.***
   ii. ***Copy of the consent/authorization form or a request for waiver of consent/authorization.***
   iii. ***Copy of the tools to be used.***
   iv. ***Curriculum vitae/ resume of the Principal investigator(s).***
   v. ***Any other supporting materials.***

Section B: Application Details

<table>
<tr><td colspan="2">1. Study Title: The Experience and Sexual Behavior of Utilising a Youth Activity Center by Young People in Mochudi</td></tr>
<tr><td>2. Date: 8 – 19 August 2005</td><td>FOR OFFICIAL USE ONLY
Proposal Review Number:</td></tr>
<tr><td>3. Type of Research:
i. Basic Science ( )
ii. Public Health (X)
iii. Clinical Research ( )
iv. Human Biology ( )
v. Other________________________</td><td>Review Body:
i. Health Research and Development Committee ( )
ii. Health Research Unit ( )</td></tr>
<tr><td colspan="2">4. Type of Review Requested:
i. Full Review ( )
ii. Expedited Review (X)
iii. Review of Exemption Status ( )</td></tr>
</table>

5. Principal Investigator*(Name & Degree)*: Elah M. Matshediso, MPH. PhD Candidate	**5(i). Contact Person *(if different)*:**
Postal Address: University of Botswana Department of Population studies P/Bag 00705 Gaborone	**Postal Address:**
Phone Number: 3552230 / 3923513	**Phone Number:**
E mail Address: matshedisoem@mopipi.ub.bw elahma@botsnet.bw	**E mail Address:**
Name of affiliate Institution/Organization: University of South Africa	**Name of Institution/Organization:**
Department *(If Government)*: Health Studies	**Department:**

6. Other Investigators			
Name:	**Organization:**	**Email:**	**Telephone Number:**
N/A	N/A		

7. Key Personnel:			
Name:	**Organization:**	**Email:**	**Telephone Number:**
Prof. T.R. Mavundla	**University of South Africa**	**mavuntr@inisa.ac.za**	**0027- 11- 429 6769**

8. List any Institutions, other than Health Research Unit that are involved with the proposed study.

Institution /Organization :	University of South Africa	
Federal Wide Assurance No.		
IRB Review Required:	Y ( ) N (X)	Y ( ) N ( )
Approval Attached:	Y ( ) N ( )	Y ( ) N ( )

Section C: Description of Research

1. Brief Description of Study

The study will examine the effectiveness the Youth Activity Center as an intervention by establishing the experience of young people who are the target group. The study will yield information on whether the intervention has benefited the users by influencing their sexual behavior and identify gaps if any exist. The study will utilise a qualitative paradigm where focus group discussions with young people will be conducted and unstructured interviews with services providers in the youth activity center and if any those at the immediately referral facility. The respondents who young people are both in-and-out-of school. The study will be carried out at the Youth Center in Mochudi village of the Kgatleng District which has been in operation since 1998.

Youth activity Center (YAC) in the context of the study refers to a facility that offers youth friendly services targeted specifically to young people of ages 10 to 29 years, providing sexual and reproductive health services and other related activities.

2. Rationale/Justification ***(Why the need to carry out this study)*:**

The government has employed varied interventions programs and strategies to deal with the HIV/AIDS predicament. In particular programmes have been instituted to create environment that could influence young people to change their sexual behavior to avert HIV infection. There are health facilities; Youth Activity Centers, Tebelopele Volunteer Counseling and Testing Centers, and educational institutions which are in place to facilitate access to HIV/AIDS prevention information and services.

However, no efforts have been made to evaluate or determine how effective these strategies are influencing sexual behavior and ultimately the reducing the infection rate.

3. Study Objectives ***(Both General and Specific)*:**

General Objective:

To establish the experience of young people in utilising a Youth Activity Center / Youth Friendly Services and determine their sexual behaviour.

Specific Objectives:

1). To explore the experiences of young people who utilize the Youth Activity Center

2). To establish sexual behavior of young people who Youth Activity Center.

3). To identify the gaps in the delivery of the Youth Activity Center / Youth Friendly services

4). To recommend how to improve the services to make the YAC more beneficial to young people.

4. Expected Results ***(Both Primary and Secondary endpoints)*:**

The experiences with the intervention and the sexual behavior of young people using the YAC will be established. Gaps of the programmes will be identified. Result could be used to improve on the YAC/ YFS programmes to make them more beneficial to the target group.

5. Subject Population(s) (Clinical condition, Gender, age, and other relevant Characteristics):

Young people of ages 10 – 29 years is the study population. This included both in-and-out of school youth utilising the activity center. Since the center targets the 10 to 29 years the study therefore covers all ages served by the center

7. Methodology ***((Describe all proposed procedures or interventions and how the data obtained will be handled)*:**

The target population will consist of young people you are utilising the Youth Activity Center and the service providers at the center and gatekeepers particularly those at the District Health Team and the Tribal Authority. A qualitative paradigm will be used, where Focus Group Discussions will be held of young people and in-depth interviews with the service providers.

Data will compiled and analysed using SPSS. After which the report will be compiled and send to the University of South Africa. The report will be sent to South Africa because this study is done to fulfill my doctoral studies which I have enrolled in at the University of South Africa, in South Africa.

8. Sampling and Sample size*(The number of subjects to be involved in the study and how these subjects will be selected from the population)***:**

The participants will be randomly selected in to focus group discussion and the in-depth interviews. The respondents for the focus group discussion will be young people who utilise the YAC. A total of 2 focus group discussions will be conducted at each facility. Each focus group discussion will have a minimum of 8 and a maximum of 12 respondents. For in-depth interviews a minimum of six (6) interviews will be done with services provides and gatekeepers per youth activity center.

9. Protection of Subjects *(Describe measures to protect subjects from and minimize possible risk of harm, discomfort, or inconvenience)***:**

The respondents' participation in the study in voluntary. Their participation in the study will remain anonymous, no names will be used nor places where the information is being collected. Even though, there will be audio-tapping, upon completion of the transcribing and verification by the independent qualitative research expert the tapes will be erased to ensured that confidentiality is maintained.

10. Subject Recruitment *(Explain all procedures in detail)***:**

Young people who visit the youth activity center of the selected days will be randomly selected to participate in the focus group discussions

11. Study sites *(Districts, Towns and Villages)***:**

Kgatleng District in Mochudi

12. Approximate Date Study Recruitment will begin: 19th December 2005

13. Estimated Duration of entire study: 2 Months

Section D: Subject Information

1. Inclusion Criteria

Young people who are utilizing the youth activity center are the ones to be included on the study.

2. Exclusion Criteria:

No one who has never used the facility will be excluded.

3. Does the study involve Vulnerable Groups? *(Tick all that Apply)***?**

Children ( )

Pregnant women, fetuses, or neonates of uncertain viability or nonviable ( )
Prisoners ( )
Decisionally impaired Persons ( )
Minority and indigenous groups ( )
Low Literacy ( )
Economically Disadvantaged ( )
Persons with Stigmatized Health Conditions ( )
Other____
N/A (X)

4. Does this study involve any use of a drug? No (X) Yes ( ). If yes, is the drug approved and registered by the Drug Regulatory Unit in Botswana? ***(Attach proof)***________________________

5. Reasonably foreseeable risk or discomforts to the subjects (*list in detail)*:

None

6. Who will cover Subject Injury-Related Costs?

i. **Sponsor ( )**
ii. **Third-Party Payers ( )**
iii. **Subjects ( )**
iv. **N/A (X)**

7. Potential benefits to society and to subjects *(do not include compensation)*:
The study results will benefit the Botswana Family Welfare Association, Botswana National Youth Council and United Nations and Population Fund as well as other organisations which have embarked on youth friendly services as a strategy of reaching young people. The results of the study would be by the organization to strengthen YAC or YFS programs. The subject will give have opportunity to relate their experience, express your feelings, ideas and suggestions for improvement of the programme.

8. Give details of Botswana based personnel that will be involved *(Name, functions and qualifications)*:

E.M. Matshediso (Principal Researcher), B Ed, MPH

9. Any compensation to Financial Costs incurred by subjects? Yes (X) No ( ). If yes, specify:
I will give them transport fee and refreshments.

Section E: Data Sources

1. Sources of Data

i. **Focus Group(s) (X)**
ii. **Interviews (X)**
iii. **Questionnaires/Surveys ( )**
iv. **Census/Public Records ( )**
v. **Human Biological Specimen**
( ) Archive ( ) Prospectively Colleted ( ) Discharged
vi. **Medical Records ( )**
vii. **Registers** ***(eg. TB register and Cancer register)*** **( )**
viii. **Other** ____

Section F: Sponsor Information

1. Name of Sponsor: Elah Matshediso - Self sponsored Ph. D research.

2. Type of Sponsor:

i.	**Government**	( )
ii.	**Private Foundation**	( )
iii.	**Industry**	( )
iv.	**Internal**	( )
v.	**Other**	(X)

3. Sponsor Contact Person: Not Applicable

4. Sponsor Contact Telephone: Not applicable

Section G: Contact Information:

PI or other researchers for answers to questions about the study or research-related injuries*(You must offer at least two contacts)*:	**The HRDC representative who can answer questions about their rights as research subjects**
i). Elah Matshediso – PI, Tel 3552230 **ii).** Prof. Thandisizwe Mavundla– Surpervisor, Tel: 0027 -11- 429 6769	**Name**__________________________ **Head of Health Research Unit** **Ministry of Health** **Private Bag 0038** **Botswana** **Tel: (+267) 3914467** **Fax: (+267) 3914697**

Section H: Investigator's Statement

INVESTIGATOR'S STATEMENT OF ASSURANCE

I promise to abide with existing relevant International Declarations and National procedures and guidelines when undertaking research involving human subjects within the Republic of Botswana and agree to:

1. Ensure that all studies conducted on human participants are designed and conducted according to sound scientific and ethical standards within the framework of good clinical practice.

2. Report to the Health Research and Development Committee any information requested, serious or unexpected adverse events and any information related to national programs.

3. Obtain prior approval from the board before amending or altering the scope of the project or implementing changes in the approved consent form(s).

4. Submit progress reports as required by the HRDC

5. Maintain all documentation including consent forms and progress reports.

Principal Investigator's Name: Elah M. Matshediso

Principal investigator's Signature: **Date:** 22/11/05

Principal Investigator's Position: PhD Student

After Completion

An electronic and hard copy of the report should be submitted to the Health Research Unit, Ministry of Health as well as other relevant Institutions/Organizations.

P/Bag UB O705
Gaborone.

10th August, 2005

Chief Research Officer
Health Research & Development Unit
Ministry of Health
Private Bag 0038
Gaborone

<u>RE: Request for Permission to Conduct Research</u>

I kindly request for permission to conduct a study evaluating youth activity centers in Botswana. The BOFWA Youth Activity Center in Mochudi has been sampled for the study. The aim is to establish the experiences of young people and the effectiveness of the intervention in influencing sexual behaviour of young people in order for them to avert HIV/AIDS.

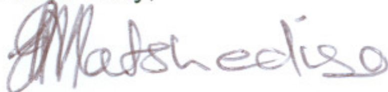
I am enrolled with the University of South Africa for a doctoral programme. For me to complete my programme I need to conduct research which is the key requirement for completion of the programme. My research topic is "The Experience of Utilizing a Youth Activity Center in Botswana". The study will identify what needs to be improved to make youth activity center or youth friendly services (YFS) more beneficial and increase access to sexual and reproductive health services young people.

Please see the attached completed form entilted "**Application for Approval of Human Research"** which was supplied to me by your office.

I thank your office for the cooperation in this matter. my mother passed

Thank you.

Yours Truly,



Ellah M Matshediso
Principal Investigator
Student - PhD Health Studies - Public Health

P.O. Box 47
Moshupa,

7th August, 2008

Mr. P. Kulumane, Chief Research Officer
Health Research & Development Unit
Ministry of Health
Private Bag 0038
Gaborone

RE: Request for Renewal of the Research Permit

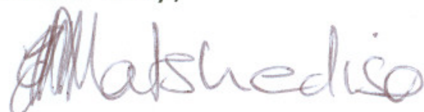
May I refer you to the Research Permit granted to me in 2005 by your office to conduct the study entitled "The Experience of Utilizing a Youth Activity Center in Botswana".

I kindly request for renewal of the permit as it has expired. I am at the stage of finalisation of the analysis and completion of the report. May I also request a modification of the title to "The Facilitation of Youth Friendliness in a Youth Activity Center in Botswana". The request follows a discussion and recommendation by University of South Africa. Please see the attached Research Permit from the University of South Africa.

I thank your office for the cooperation and the insistent attention given to the request.

Thank you.

Yours Truly,



Ellah M Matshediso
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TELEPHONE: 3914467
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HEALTH RESEARCH UNIT
PRIVATE BAG 0038
GABORONE
BOTSWANA

REPUBLIC OF BOTSWANA
MINISTRY OF HEALTH

REFERENCE No: PPME-13/18/1 Vol I (39) 23 December, 2005

Ella M. Matshediso
P.O. Box 47
Moshupa.

Dear Ms. Mathediso

Permit: The Experience of Utilizing a Youth Activity Center in Botswana.

Your application for a research permit for the above stated research protocol refers. We note that you have satisfactorily revised the protocol as per our suggestions.

Permission is therefore granted to conduct the above mentioned study. This approval is valid for a period of 1 year effective December 2005.

The permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research and Development Division, Ministry of Health within 3 months of completion of the study. Copies should also be submitted to all other relevant authorities.

Yours sincerely

P. Khulumani
For/Permanent Secretary

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MINISTRY OF HEALTH

REFERENCE No: PPME-13/18/1 Vol III (298) 8 August, 2008

Ella M. Matshediso
P.O. Box 47
Moshupa.

Dear Ms. Matshediso

Re: Continuing Review Permit: "The Facilitation of Youth Friendliness in a Youth Activity Center in Botswana".

Thank you for submitting a request for approval of an amendment and a continuing review of the above protocol. The HRDC granted permission for continuing review on an expedited basis to allow for data analysis and report writing. Amendment of the title from **"The Experience of Utilizing a Youth Activity Center in Botswana"** to the above mentioned title was also approved as it was not causing any major changes to the study protocol.

Permission is therefore granted to conduct the above mentioned study. This approval is valid for a period of 1 year effective 8th August, 2008.

Please note that conditions stipulated in the initial letter still stand.

Yours sincerely

P. Khulumani
For/Permanent Secretary

ANNEXURE D

CONSENT LETTER FOR PARTICIPANTS

University of South Africa
Faculty of Humanities and Social Sciences
Department of Human Studies

Dear Sir/Madam

REQUEST FOR CONSENT TO PARTICIPATE IN A RESEARCH STUDY

I am a Doctor of Philosophy & Literature (PhD et Litt) student at the University of South Africa. Currently engaged in my dissertation and my research topic is "The Experience of Utilizing a Youth Activity Center in Botswana". The study aims at getting experience of young people in using the Youth Activity Center (YAC). I am carrying out the study under the supervision of Prof. TR Mavundla of the Department of Health Studies at the aforementioned university.

The purpose of the study is to find out if a youth activity center is effective in influencing sexual behavior of young people and determine what needs to be improved to make youth activity center or youth friendly services (YFS) more beneficial and increase access to sexual and reproductive health services young people.

For me to complete the study I need to conduct focus group discussion with young people and in-depth interviews with staff of the YAC and/or the immediate referral facility. The discussions and interviews will be audio-taped for the purposes of verification of the findings by the independent expert in qualitative research. Your participation in the study will remain anonymous, no names will be used nor places where the information is being collected. In addition, upon completion of the transcribing and verification by the independent qualitative research expert the tapes will be erased to ensured that confidentiality is maintained. The consent that you are giving is for the above mentioned proceedings. Your participation in the study in voluntary.

Participating in this study will give you an opportunity to relate your experience, express your feelings, ideas and suggestions for improvement of the programme. The results of the study will be availed to you on request. If the need arises to contact the researcher, please use the following address:

Miss E. M. Matshediso
University of Botswana
Faculty of Social Science
P/Bag UB 0705
Gaborone

Tel: 3552230 (O) or 3923513 (H)
Cell: 71310854

E-mail: HYPERLINK "mailto:Matshedisoem@mopipi.ub.bw" Matshedisoem@mopipi.ub.bw or HYPERLINK "mailto:elahma@botsnet.bw" elahma@botsnet.bw

I thank you cooperation.

……………………………...   ………/………/………
(Participant)   **Date**

……………………………..   ………/………/……….
E. Matshediso   **Date**

Researcher: Health Education Specialist, MPH

……………………………

T.R. Mavundla, RN; Ph.D

Supervisor

ANNEXURE E

BIO-DATA FORM/DEMOGRAPHIC CHARACTERISTIC OF PARTICIPANTS

BIO-DATA FORM/DEMOGRAPHIC CHARACTERISTIC OF PARTICIPANTS	
Name of Organisation Represented	
Name of Respondent:	
Age:	
Sex:	
Highest Educational Attainment:	
Employment Status:	
Occupation:	
Grounded Expert Area:	
Position:	
How Long in this Position:	
Place of Interview:	

ANNEXURE F

SAMPLE OF UNSTRUCTURED INDIVIDUAL IN-DEPTH INTERVIEW: SERVICE DELIVERY OFFICER – YOUTH COORDINATOR

This research is done for fulfillment of Doctoral programme which I am enrolled for with the University of South Africa. My research interest topics include adolescent sexual and reproductive health. Your Organization BOFWA is very important as it has been offering services to the youth for a very long time. This approach of Youth Activity Centre is a new one and not which has been done on it even outside the country. Probably it is time we get the experience of the young people. I therefore, request you to freely share whatever information or knowledge you have. Please note that the findings will benefit your organization.

QUESTION: What are your experiences as service provider regarding the use of Youth Activity Center by young people?

RESPONSE: There is improvement in terms of the accessibility of the centre to the youth. It only started as a building which was a clinic. However, with time other buildings were constructed with funds from donors. Then there was no equipment of which we sourced for funds from ACHAP (African Comprehensive HIV/AIDS Partnership. That is why we see a reasonable number of the youth here at the centre interacting with one another. There are certain cultural aspects in our society that forbids the parents from freely communicating with their children. The center has bridged that gap. The youth do come and to some extent they utilize the centre because they find other young utilizing it. The funding we got made it possible for the youth to have such center to utilize.

To me BOFWA has grown as I compare to the time when I joined the system. Now the young people are coming in large numbers to utilize the facilities. I also want to believe that it has therefore made a tremendous improvement to the lives

of the youth because they would come to the centre and find their peers and discuss their youthful problems.

QUESTION: How do the activities improve the lives of young people?

RESPONSE: The kind of information that we deliver to the youth at this centre, is that one that they will use it to shape their lives, to know where they are going and that one that they will always be accountable to anything they do in their lives. One of the activities we do here in the centre is counseling. In counseling we discuss with the youth issues that they face and coming up wit solutions to the problems they might face. Other activities include blood donation. This goes beyond sexual reproduction health. It touches the life of a young person in the sense that they know that, whatever they do the do it because it is worth doing. The life skill that we them with the hope that they will have vision, have power to resist temptation.

We are an environment that promotes condom use so as to prevent HIV/Aids infections. Depending on the age we categorise the people who come here and hence the information delivered differs. The peer educators, who are found at the centre every day, teach the youth on who to use a condom continuously and properly before they can issue such condoms. In as much as we encourage the use of condoms, we also want them to take responsibility of their lives. We teach them about family planning, sexual related issues in a conducive environment. We do acknowledge the fact that being a youth you are faced up with certain challenges such as sexual involvement, boyfriend, girlfriend relations, but when equipped with information, they carry it along and use it. They hence differentiate what is good and bad. What I we do in the centre is that we try to make the young people appreciate their being and grow up responsibly, not only that but also to be looked up to by others young than them.

QUESTION: You mentioned that when the clientele come to the centre, they have to see young people in the forefront. Why is that important?

RESPONSE: This is a youth led association, where we believe that for a young person to be free and talk about issues concerning them, they have to be with another young person. For them, they see every figure as a mother figure that should remain at home. When we were employed we were told to be conscious, we should dress smart but when there is an activity here in the centre we should be able to wear casual clothes.

The reasons we have the youth at the up front includes the fact that when another young person visit the centre, they are able to relate to their age mates. We have many sports activities to choose from. These include drama, soccer, volleyball and others. Because of them being upfront, when given work to do, they do it whole heartedly because they would have initiate, implemented by them and hence own it.

QUESTION: Do you reach to other group out there in the community, institutions or school leavers? If you do, what activities do you do there?

RESPONSE: Amongst activities that we do are: workmate assistance and institutions visits. At the beginnings of the year we write letters to the institutions requesting them to slot us into their schedule where we can address the youth. Once every month we are invited to talk to the youth about sexual reproductive issues. At one point we even went to the University of Botswana where the Department pf Social Work invited us to talk to the students who had ventured into social work as a career. In most cases we are invited at secondary schools. We reach brigades too where see more males than females. As you know culturally males hardly go to clinics or hospitals. But now time has come for the

men to appreciate modern medicine and seek for medical intervention whenever sick.

QUESTION: What are the challenges/unpleasant experiences that you would say hinder delivery of services?

RESPONSE: Major challenges include inadequate funds. We are not able to implement or achieve all our goals because of limited services. The other challenge is concerns the movement of the youth. The youth are trained but they do not last in our organization. Though it is good that they learn and the learning experience paves way for them to get jobs but for us it's a loss. In addition, Our centre set-up is not accessible to everyone. It is not in the centre and hence makes it difficult for other children to access it because they will need transport fares. Remember this is a village set-up and hence not every parent is working. We can go out there and tell them about us [the YAC] but they will never get back to the centre even the institutions and schools our is center is far.

QUESTION: Is there any concern regarding access in addition to transport fares?

RESPONSE: We have talked about the hours of operation, across the country in all over centres (four of them) we operate up to Saturday. Even Sunday though with appointments our nurses are flexible enough to attend to clients even up to 8 pm. We however do not encourage them to access the centre after 8pm for security reasons. Saturday its from 8am to 1pm. However it could be till 5pm with appointments. During the week its from 8am till 5/6pm. From 430 to 6 its recreation.

QUESTION: What are your suggestions for improvement in terms of accessibility for the centre?

RESPONSE: We have decided that we take the services to the people because we now have the resources. She is traveling around the districts talking about many issues such as voluntary counseling and testing. Basically taking services to them as it is not accessible to all.

In the absence of any additions, I wish to thank you for sharing the information and for your time.

THANK YOU.

ANNEXURE G

SAMPLE OF FOCUS GROUP DISCUSSIONS WITH PEER EDUCATORS

I am conducting this research as a fulfillment for my Doctorial studies. My area of interest is adolescent sexual and reproductive health. Therefore, my research topic is dealings with evaluation of youth activity center. You have been utilising this center, and I would like you tell me about your experiences. Please feel free, as I already said the information will be treated with confidence.

Question: Please share with me the experiences that you have as young people. You are peer educators and you have also been utilizers of the services for some time.

Person No. 3

Actually I have been in BOFWA for about 12 months. Up to now I have experience of how to work people, I socialise with them, which improves my communication skills and facilitation skills.

Person No. 5

What I can say is that, I have learned a lot since I came here, before I came here I didn’t know many things including topics such as teenage pregnancy but now I know everything, I can advice other youth.

Question: How did you learned about those topics?

Person No. 3

Before I came here in BOFWA I was a peer educator somewhere, actually there I wasn’t the same as I’m right now, I was trained but not as of quality as I’m right now. I have learned so many things. Here in BOFWA, you get to interact with different people which gives me a challenge that would make me talk to them and interact.

Question: You talked about challenge why do say it's a challenge?

<u>Person No. 3</u>

I can say is a challenge because first of all I was not used to talking many people. Nowadays I can just say I'm getting to know many people, and that is kind of challenge because that's new thing in my life.

Question: You said you have been trained before but the training that you received here is of quality. W hat kind of training did you go through and what were you taught?

<u>Person No. 3</u>

Here I was taught different things like basic counselling, communication skills and quite a number of topics.

Question: Person number 5, you said that you learned a lot including teenage pregnancy? Can you share with us, how did you learn about those topics?

<u>Person No. 5</u>

Everyday when we were here, we were divided into different groups whereby we will be given different topics, we will discuss them after discussion that's when we come together, then every person will present each topic we were given.

Question: Please share your experience.

<u>Person No. 4</u>

I can say that the experience that I have is good communication skills and I know how to work with youth and communicate with them. And I have knowledge, I have been trained on teenage pregnancy because I did not knowing more about that.

Question: How long was the training?

<u>Person No. 4</u>
The training was one week.

Question: Who facilitated in that training?

<u>Person No. 4</u>
Our youth officer and nurses from the different centers.

Question: How do you use the information or the knowledge that you acquire from the training?

<u>Person No. 4</u>
After receiving the training we conduct some centre talk with other youth and coming to the centre and then we tell them what we have been told.

Question: What else can you share regarding people coming to the centre?

<u>Person No. 4</u>
I can say that youth come with different problems. We try and help them and see how we can handle that problem.

Question: How do they find the reception and interaction that you give to them?

<u>Person No. 4</u>
They tell us that they were getting good help and they will keep on coming to us and that shows interest and that they like here.

Question: Please share your experience with us.

Person No. 1

The experience that I have learned here is talking freely. I can just go to people and talk. I have learned a lot here about myself, about other youth. The centre here makes one to feel free it is really teaching us to know yourself as a youth and where we are going as a youth.

Question: You said that you have learned a lot and that the centre is making you to feel free. How does the centre make you to feel free when you are here?

Person No. 1

The youth officers here they teach us how to be free and life skills. We are taught to be assertive.

Question: How do you interact with young people here and also how do you find your interaction with service provider?

Person No. 1

We exchange knowledge here, mostly through discuss. I come up with an issue and so does the other youth come then we discuss and maybe in centre visits or centre talks.

Question: How often do you have centre talks?

Person No. 1

It depends, it can be everyday, and what to talk about depend on those who we attend to.

Question: Please share your experience.

Person No. 6

I will say I have learned a lot since I came here, two and half years back. The more you talk to people is the more you learn, you meet people with different calibre and at the end of the day you can handle issues that you never thought you could. For example, if somebody comes with a problem and you have met a case like that one before, it gets easy for you to understand how to handle the situation.

With youth coming to the centre is actually nice because you know sometimes if you talk to people and they leave the place happy and you can see the change and they always tell that they have changed, is nice because you can see that you are doing something for the community, as well you feel like volunteering is good to do especially if you don't have anything to do at home, at least when you come around you can share with others what ever the knowledge you have, because someone can have knowledge but if you don't use it you will never know what you are able to do up until you explore it.

Question: You said that interacting with people will make you handle the situations that thought you could not, you mentioned counselling, what else do want to share with us about coming to the centre?

Person No. 6

Being able to speak up, being assertive, sometimes you have a problem of your own and feel if you tell someone maybe he will not understand. Knowing people better and telling them about your life can help you out and end up realising that you are not actually the only person having the problem. We are so many, we sit down talk it out and we can solve it.

Question: What is your experience?

<u>Person No. 2</u>

I have learned a lot, is two years back, I have learned a lot in terms of inter-personal skills, communication skills, and life skills. I can see that I have learned a lot because before I came here I was self-centred, shy and couldn't express myself.

Question: Could you define life skills and what it entails?

<u>Person No. 2</u>

Life skills are the skills you need in life, so I can say I have learned a lot. Life skills includes assertiveness, self-esteem, self-image.

Question: What else will people like to add in relation to your experience as a peer educator?

<u>Person No. 3</u>

I have noticed that some activities at BOFWA are delayed because of lack of communication. Some things are communicated very late and you are pressed to work faster where's you could be told way back. Lack of communication is something that makes some of the activities to fail.

Question: Why lack of communication? Communication between who?

<u>Person No. 3</u>

Communication between officers and peer educators.

Question: If there is a delay in an activity, how does it affect recipients of the activities?

Person No. 3

Sometimes you get not good results. If the activity was communicated very late, it will end not giving you good results.

Question: What is Good results, give an example?

Person No. 3

I can just talk about blood drive, an activity which you need to contact people well in time so that they can put in their schedule that on this day I m going to this activity. Sometimes you will be informed in a week or less than a week, so that will make activity suffer.

Question: What happens in a blood drive?

Person No. 3

A blood drive is a blood donation campaign.

Question: Person 1, is there anything you would like to add regarding your experiences?

Person No. 1

The location of our centre, I think the youth are not using it because is very far from them, for you to come here you have to pay transport and lunch. The centre is outside the village.

Question: Anything else that you would like to share?

Person No. 2

The youth do not come in large numbers, as compared when there are some activities, the activities are the major things that contribute to attracting youth to the centre. When there is an activity we record a large number of attendance. But otherwise they come but it is not enough maybe because of the location of the centre.

Question: The centre operates everyday. What do you mean when you say “when there is an activity”.

Person No. 2

Okay, when I say an activity, in the centre there are some activities that we consider major and minor. Major activities include sports tournament, workshops, minor includes centre talks because the youth do not come in large numbers, but our sporting activities score a large number of people.

Question: Who are these young people, in-school or out-of-school?

Person No. 2

Normally our activities are divided into two. There are activities for out-of- school youth and youth in-school. The “major” activities draw a large number of people to the centre.

Question: Let’s go back to the issue of transport which you mentioned. How many times does a person have to change transport to get here? Is it the majority that has to reach the centre by transport?

Person No. 1

I think the majority have to come here by transport.

Question: Person number 2 do you have something to add?

Person No. 2

Yes, I have something to add, most people who come here they need transport like it has already been mentioned. The centre is located on the end of the village, most who come here from the different wards in Mochudi, need transport.

Question: What are your hours of operations?

Person No. 4

Hours of operation, we open at 8 am and close at 5 and we don't open on weekends.

Question: Do you have anything you would like to share?

Person No. 6

I think the challenges we have here as peer educators as we are empowered or informed a bit than others, out there they expect us to do what we preach, to live the way we encourage them to live. The other thing is that if you don't do that it can be bad, so if you tell someone to do something that you actually don't do, it confuses other people. That is why sometimes people think we are here in the centre to waste time and they don't even see the results of that. I think maybe that's the other problem that harm.

The other thing as I said, our behaviour sometimes make me feel that maybe we are the ones that again contributing to drop in going to the centre, we have to do something that will make someone outside be interested, but then if we are the ones again who are doing bad things. Is not what someone will like to do because we have to be kind of role model

Question: How do you feel about being a role model?

Person No. 3

I feel good, but it gives me encourage when somebody get to take you as a superior person, you will get attention, when you say something, they know that the one talking is positive. Unlike before I came to BOFWA, when I talk something people wouldn't take me into consideration because I was talking as an ordinary person, but now because they know I'm at BOFWA and well informed than them. They know they can learn from me knowing that this guy is talking something which is good.

Question: How do you feel to be a role model? Can give examples to the things that you sometime find yourself engaged in, that are against or contrary to what you are teaching young people?

Person No. 6

I will start with that one of role model, it is actually a nice thing to be a role model, you know the status, that you have, somebody is looking up to you. Everybody expect a lot from you and everybody knows, whatever they need, information, help, you are recognised in the community. It counts a lot, it puts me in a good mood to see that I'm a role model. The challenges that we face is that when you go around teaching people, they expect a lot from you. Yes, we are young, we youth sometimes when there is that thing, we are youth we need to participate in, we have relationship. I have one right now. We always teach people and counsel a lot having problems in their relationships. We always advice people on their relationships and stay like that about being careful during dating and whatever, We also have of problems of that, but now people expect that if she can help me, with my problems, with my relationship problems this means hers is perfect, but seeing you again having problems with your boy-friend, is like aah!! it happens to her also. Then you know sometimes you can even decide to at least stay away from it. They wouldn't expect us to go to night clubs/bars and staff like that for leisure things. Somebody feels like what? Is she the one around here? I mean those places everybody goes to, it depends on how somebody behaves after whatever.

Question: Person number 2, do you have anything to add? How do you feel as a role model or being a peer educator?

<u>Person No. 2</u>

Yes, I feel good but it also comes with challenges like the previous speaker said they expect us to be like angels, they expect us to have no problems, challenges because we teach them and help them to solve their problem.

Question: How do feel about being a model?

<u>Person No. 5</u>

It improve my status.

Question: How do feel about being a model?

<u>Person No. 1</u>

I think the people out there they appreciate what we are doing and I am very proud and they are encouraging us to do a lot.

Question: How do feel about being a model?

<u>Person No. 4</u>

I'm feeling good, but only thing is that a lot is expected from you and you are expected to do things that are different from what other are doing.

Question: Anything else?

<u>Person No. 2</u>

Another challenge in our centre has poor communication as mentioned before. You find that some activities do not succeed or fail because of poor communication. Some

activities are planned and people are invited and cancelled at the last minute and that discourages people.

Question: How do we define late?

Person No. 2

I mean we are told a week before an activity looking at the scope of the activity, you find that you should have been told in advance about the activity to prepare for that activity to be successful.

Question: What does cancellation of activities do to participants?

Person No. 4

It really discourages them. Next time when you call them for an activity they comment that you are doing the same thing like last time, and they say, myself I'm not coming.

Question: Person 2 you have something thing?

Person No. 2

It discourages and upset the participants and they lose faith in us. More so that if you plan another activity they will come in small numbers.

Question: Person 5 what do you have to say?

Person No. 5

I'm worried about the activities that are lead by us. When they are changed the youth officers we are the ones to announce the cancellation but people take us as liars.

Question: Person 6 you want to add?

Person No. 6

Sometimes, money is used to buy airtime and people will be called but when the activity is cancelled they don't call people and people will come and be told that it is cancelled. They communicate when there is something to be done but when the activity is cancelled they do not communicate.

The other thing that is lacking in the service providers is being welcoming. I think in our center there should be friendly service provision and I think that is why most people are not coming to our centre. This is lacking from the professional staff. The most important thing in our centre is recreation, but the clinic has to be well, that is when we will expect to see most youth coming.

When most youth are ill and they want to visit the government clinic, like they fear BOFWA as is not welcoming. I think the other thing is that we never have a suggestion box, maybe we should have known this sometime back. If someone from outside brings a client to the clinic then the client and is not taken care off well she will end up telling me that, you tell me to come to the clinic, the next thing this happen to me, so I will not come anymore. We are pushed from the centre to bring more clients.

Question: How can we define the friendliness in the centre?

Person No. 3

I can just go along side with the previous speaker No: 6. Actually as I said before, lack of communication goes along with lack of friendliness, because if somebody does not talk with you frequently to know what please you and what doesn't please you they won't get a chance to know or to tell her what the clients are saying. This is because she is always far or not open and lack of friendliness can't improve.

Question: Friendliness, what can you say about it?

Person No. 2

Friendliness is an issues, yes is a challenge. The clinic is suppose to be friendly, but from the way things are, is not youth friendly because of the officer there. The officer is not friendly.

Question: Person Number 1 do have a comment?

Person No. 1

As they have already said it is like that, there is no youth friendliness in our centre.

Question: Person Number 3 what do you have to say about friendliness?

Person No. 3

The friendliness we are talking about is not only to the clients outside there, sometimes when you wake up and feel like coming to BOFWA to enjoy the rest and do scheduled work, when you get here at BOFWA instead of being spoken to in a friendly manner/youth friendly manner to do something politely you are told in a harsh way and you end up dropping to the last degree and feel like what did I come here for, to be pushed around or what?

Question: Person Number 6 what do you have to say about friendliness?

Person No. 6

I think the confusion is that being a supervisor and a boss, because if you work with youth you really have to be youthful as well and don't have to take them like they are dull. You have to respect them they will respect you. You communicate well, they communicate well to you. Sometimes when she is sitting down we don't go to her. At the end of every month we are expected to write a report, then most time we have a

problem with the report, because they will think we did not do some things just because we did not invite her to interact with us knowing we won't call her.

Question: Person Number 2 what do you have to say about friendliness?

Person No. 2

Another challenge is that our centre caters for out of school youth only and those who are not employed. Those who are in-school access the centre only a quarter of the year, as our centre opens Monday to Friday from 8:00 am to 5:00 pm, and that is when the in-school are not available.

Question: What are your suggestions for improvements?

Person No. 4

The centre should be opened during weekend so that it caters for those who are employed and those in-school.

Question: What are your suggestions for improvements?

Person No. 3

A meeting for both the staff and peer educators, where they can just sit down and discuss their obstacles, that will make the centre improve.

Question: What are your suggestions for improvements?

Person No. 6

I think the other thing is that we have to learn to listen to others, to talk and respect what the other person is saying. Maybe in that way as a youth we can help with ideas that youth like. The other thing is that we will plan an activity that we know will bring the youth to the centre but then because BOFWA is run by old people they will just ignore what we are doing but from experience we know what works for youth. We think we

should be given the “floor”, the time and opportunity to do what we know and to take decisions.

In the absence of further contributions, I take this opportunity to thank you all for the information you have shared’.

ANNEXURE H

SAMPLE OF FOCUS GROUP DISCUSSIONS WITH YOUNG PEOPLE

I am conducting this research as a fulfillment for my Doctorial studies. My area of interest is adolescent sexual and reproductive health. Therefore, my research topic is dealings with evaluation of youth activity center. You have been utilising this center, and I would like you to tell me about your experiences. Please feel free, as I have already said the information will be treated with confidence.

QUESTION: What are your experiences as young people utilizing Mochudi BOFWA centre?

Person No. 3

I have learnt so many things at BOFWA, we were taught about STIs, AIDS, how to take care of ourselves and stay away from bad behaviour and how to encourage our age mates to play it safe. We were also taught that we can volunteer to BOFWA and help the Peer Educators and also to encourage people from the village to use the centre.

QUESTION: You said you were taught who was teaching you and who were you interacting with when you were at the centre?

Person No. 3

Most of the time I consulted and interacted with the nurse and the peer educators.

QUESTION: What are your experiences as young people utilizing Mochudi BOFWA centre?

Person No. 4

I have learned so many things at BOFWA. BOFWA is serving young people. There are things such as sports, blood donation and games used by young people.

QUESTION: What was your role or what part did you play in blood donation activity?

Person No. 4

I was part of the people who donated blood and I play football. Sports and other games are meant to attract people. BOFWA organized tournament for teams in Mochudi so that the can reach the number of people targeted.

QUESTION: How did you get to know about BOFWA ?

Person No. 4

I met one educator, whom we played football with and he told us that these is BOFWA and he told us what BOFWA does and that is for young people. We were interested in knowing about BOFWA because as young people we needed advises from BOFWA. I think it is good for a young person to visit BOFWA and get information, counselling and one can talk openly because there will be no intimidation with your age mates.

QUESTION: One of the interesting things that you said is that you found it beneficial to use BOFWA services. Why do you say as young people you need to be advised?

Person No. 4

Because as young people we do a lot of things, like going to parties, but we do not know the danger of doing that, we also drink beer and at the end of the day we do things that are not accepted to the society. At BOFWA you can get advise that when you go out partying you must behave properly.

QUESTION: Person No. 5 what is your experience?

<u>Person No. 5</u>

I think at BOFWA, we can share ideas with other young people and peer educators. Most of the time the people who work at BOFWA are our age-mates, and an older person is there. In certain circumstances you find that you cannot tell your friend about your problems, but at BOFWA you will find older person to tell her/him your problems. At BOFWA you can do many things like paying football, volleyball and you can forget about doing other unnecessary things just by being with our friends at BOFWA.

QUESTION: What are things that make young people to get into problems?

<u>Person No. 4</u>

At BOFWA we have pool to play for free, but if you go to the bar then you pay or use your money and most of time if you are drank you end doing things that will destroy your life. People are concerned that young people engage in risky behaviour when they are drank and some end up being abused, so most of the time that we spend at BOFWA help us to stay away from risky behaviour.

QUESTION: Both of you, person 4 and person 5 you talked about being free to discuss your problems with your peer educators. What can you say about having peer educators?

<u>Person No. 4</u>

Peer Educators are important to us because they are trained and they have experience. If you have a problem they know how to help you to solve your it.

<u>Person No. 5</u>

Peer Educator is a person who is in a position to solve your problems and if she/he cannot solve the problem he/she can refer you they are trained and you can speak openly when you are with them.

QUESTION: What is your experience as a young person using the center?

Person No. 1

We get some ideas from BOFWA. There are playgrounds where we exercise. If one feels lonely, at times you feel that as a young person you are stressed and one can exercise at BOFWA and relief stress. You also find the peer educators there who are young people so is very easy and is nice to communicate to people of your age or someone not too much older than you. You become free to talk out your concerns. They have those skills to help you, the more the advice you the more you got to know the good and the bad. I think that what I have gone through at BOFWA is very good.

QUESTION: You mention that as a young people you do have experience on stress at times, what are the issues that will cause stress for young people?

Person No. 7

As young people we go through [experience] changes as we are growing. You might find out that at times we are indulge in relationships and at times you find the relationship is not going properly. Social problems at times and havig problems with friends can end up causing stress which is not good for our health. So if you are in this problem you can go to BOFWA and find peer educators and talk to them and they will advice you because they know what they are do.

QUESTION: What is your experience?

Person No. 8

BOFWA is a very good place when it comes to guiding advising, and counselling people. Myself as a young person if I have a problem I will go there. I normally find my age mate, talk to them and discuss the problem with them. I don't see anything wrong with BOFWA people they are friendly.

QUESTION: You brought up a very important issue of being friendly, can you elaborate the friendliness in relation to your interaction young people, peer educators and service providers? Do you experience the friendliness?

Person No. 8

I would say they are friendly. When I talk to them and the way they respond is friendly.

QUESTION: What can you say about friendliness at the center?

Person No. 7

The good part of it is that the peer educators they are friendly and they have patience when you talk to them. A person can become free and be able to raise his/her opinion, more so that both of them would have gone though the problems. The centre has so many things like, playgrounds, pools, and games. So instead of roaming around the village or using drugs with friends, it is good for a young person to be at BOFWA and have fun.

There is a problem when you find that there is an older person who should be supporting young people and is not. When you enter room and the elder [professional staff] does not show you a welcoming face to an extent that you cannot be free and say what your problem is. Sometimes you are told, wait I am coming ,and never returned as if he/she has a problem. If you have come to test for HIV and the person does that you, it will take time for you to come back again. The elders there are not welcoming and are not supporting the peer educators.

QUESTION: Person 7 can you explain further the waiting time, general what is the waiting time before one can be seen and also go further to explain when people are made to wait, is there any explanation why they are made to wait?

Person No. 7

When you enter the centre you will find a young person/peer educator, whom you tell you want to see the nurse. Then she/he will tell the nurse and the nurse may say that she is busy and you should wait for 2 minutes, she will be with you, you will wait and wait until they close.

QUESTION: What does the waiting time and unwelcoming or friendliness attitudes do to you as a young person?

Person No. 7

As a young person you tell yourself that I want to go and get help and you take your time to think about all that you want to do. For example, if I want to go and test for HIV and when I get there people are not welcoming you feel hopeless, and all the energy that you had will disappear and the love that you had will also go and you will lose control and end up indulging in bad behaviour because you want to change and people have failed to assist you.

QUESTION: What experience can you share?

Person No. 2

My first experience is that I heard about BOFWA from a friend, my neighbour and a peer educator at BOFWA. The first time I went to BOFWA was during school sports activities at Maranyane. I was unfortunate because, first, I was told that they will reveal your test results and secondly discuss them with others. So my first visit a was quiet because I felt that they will discuss with me and I was just watching how people interact. My second visit I interacted with girls and I felt that the people were good and one can talk with them and share stories.

QUESTION: What would you say your benefited as a young person, you talked about chatting and sharing with peers but what would you say as young person you benefited from BOFWA?

Person No. 2

I have benefited, I learnt that you can also go to the center and discuss peer counselors. I have learnt a lot their advised.

QUESTION: What is your experience and share with me?

Person No. 6

I have learned that through BOFWA we can stay away from bad behaviour. We can go to BOFWA and play soccer, tennis and other sports games, test for HIV and chatting.

QUESTION: Can you tell me about the occasion where you attended an educational activities/teaching sessions?

Person No. 6

The chatting was all about how to play safe sex and they taught us about the bad things of going to the bars and roaming in the street you may end up committing crime.

QUESTION: On average, what you would say is the waiting time that a young person goes through before they are helped?

Person No. 8

When I want to be helped I always find people available. I do not think there is waiting period.

QUESTION: On average, what you would say is the waiting time that a young person goes through before they are helped?

Person No. 3

I have not waited, but I know that it happens, more so, when we started using the facility there was a new person at BOFWA. Since the person came, she is always busy and there has been a waiting time of about 30 minutes. The person was not friendly. If you tell your friends that I want to go and test and you get there and you have to wait a long time you may become demoralized and you can end up going back without testing.

QUESTION: When you are demoralized by the attitudes you receive as a young person what does it do to the young person?

Person No. 3

It makes you to lose hope in everything, you don't have hope and you feel that when test for HIV you are not save whether you will get proper counselling and help and you will never trust the centre.

QUESTION: What do you have to say?

Person No. 5

Since I started using BOFWA, they are so many peer educators and so many activities that we can do and you cannot find a person to chat with. You can also play games and feel free to test for HIV.

QUESTION: Tell me, what do you understand the youth activity centre to be? When going there what expectation to you have when you get to the center?

Person No. 2

I expected the youth centre services to be friendly since is for the youth.

QUESTION: What expectation to you have when you get to the center?

<u>Person No. 6</u>

I expected user to be friendly. They are not youth friendly because I have disagree with one person at the centre. I am a user the centre.

QUESTION: What expectation to you have when you get to the center?

<u>Person No. 1</u>

When you get there you expected people who can help you and you need their kindness. The people who are at the centre are youth and we expect them to assist you more so that some of them may face the same problem or may have experienced them in the past, They are still growing and we expect so many things. Like you go to the centre you can go there to do pregnancy test or get advice or method of contraceptives and when you go there and tell a person about your problem the person must be friendly and being able to advise you accordingly on the method that you can use.

QUESTION: What expectation to you have when you get to the center?

<u>Person No. 4</u>

As for peer educators we expect friendliness from them and that will help the centre to attract more young people. When we tell our friends to go there and are not treated well it is not good. It is dangerous to work with young people, for example if you test your self people can reveal your status to other people. They should keep things confidential.

QUESTION: You brought up the issue of confidentiality. Are there anyincidences where it has been tempered with?

<u>Person No. 7</u>

Peer educators they are people like us, yes, they have been trained but there are mistakes that they make they cannot be 100 percent.

QUESTION: The issue of confidentiality. Are there any incidences where it has tempered with?

Person No. 5

People always quarrel since the introduction of playgrounds, people are called and the issue was solved, but young people being themselves you never know if the will not talk about your problems.

QUESTION: The issue of confidentiality. Are there any incidences where it has tempered with?

Person No. 4

Peer educators volunteer and they can end up feeling tired and they may want something in return. So they may make mistakes. The numbers of peer educators have decreased.

QUESTION: What do you think is the proper way of facilitating peer educators or assisting them to work effectively?

Person No. 5

About transport, the peer educators are given bicycle. I do not agree that they are tired, I feel that they should always be there to assist us and we do not expect a person who has choosen to volunteer to be tired.

QUESTION: What do you think is the proper way of facilitating peer educators or assisting them to work effectively?

Person No. 1

They must be a way of motivating them so that they can do they work effectively. If they feels that the bicycle are not good, there is a mini-bus to transport them. The peer

educators go to BOFWA because they are unemployed and come from the hardships. The peer educators must be given time to volunteer and they must sign a contract. This is important because we may end up losing vulnerable people at BOFWA who were doing a good job. People are not the same, people will have different opinion on the time frame.

QUESTION: What do you think is the proper way of facilitating peer educators or assisting them to work effectively?

Person No. 8

I think the peer educators should decide whether they want to work there or not. If they are fired they should go, allow others to come in.

QUESTION: What do you think is the proper way of facilitating peer educators or assisting them to work effectively?

Person No. 7

The should be a contract. Some of them are from the villages, some of these person have issues that cannot keep aside, they are not professionals. May be they can work up to 3 years and new faces can be brought in before.

QUESTION: Any suggestions on how we could improve operation at the youth Centre?

Person No. 5

We can be given a chance to do traditional dance as one of the activities such. For example there is sports and games. So traditional dance should be considered,

QUESTION: Any suggestions?

Person No. 4

Peer educators must always give people a chance to use the facilities, such as the computers, we must have a chance to use them.

QUESTION: Should the Center create specific days for young people and peer educators to avoid that problem?

Person No. 4

Yes we must create days and time for different people to have chance to use the facilities.

QUESTION: Should the Center create schedule for young people and peer educators to avoid that problem?

Person No. 1

These must be a schedule for the computers to be used by different people. They should be suggestion box and the suggestions should be taken care of.

QUESTION: Anything else that you would like to add?

Person No. 1

I think we come from different places and the centre is not located properly. It is more of the outsider of the village.

QUESTION: Anything else that you would like to add?

Person No. 5

The centre is not in the centre of the village. BOFWA should transport young people so that it can be easy for them to use it.

In the absence of further contributions, I take this opportunity to thank you all for the information you have shared.   Thank you.