AN ASSESSMENT OF THE DELIVERY OF YOUTH FRIENDLY HEALTH SERVICES IN THE NORTHERN CAPE

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Submission as a full dissertation in partial fulfillment of the requirements for the degree of

MASTERS IN NURSING

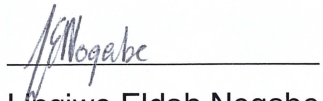
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DECLARATION

I hereby declare that work presented in this dissertation was done by the author under the supervision of Professor A. Joubert and that inputs from others have been acknowledged and referenced.



Lingiwe Eldah Nogabe

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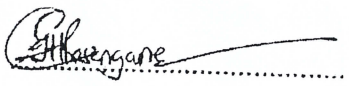
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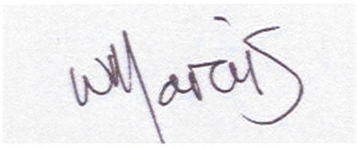
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ABSTRACT

Literature indicates that structural as well as functional accessibility and acceptability of Primary Health Care (PHC) services is a challenge facing the delivery of youth-friendly services in South Africa. Therefore, the aim of this study was to assess the delivery of youth-friendly services in the Northern Cape. A quantitative methodology using a descriptive design was selected for this purpose. Two hundred and fifty six (256) high school-going females and males aged 13-21 who were selected conveniently from six high schools in Kimberley, completed a self-report questionnaire. The results revealed conflicting perceptions about structural and functional accessibility and acceptability.

The positive feedback focused on counselling and testing, communication, and attitude. With regard to the range of services offered to the youth, 51.9% (n=133) felt strongly about the provision of HIV counselling and testing, and acknowledged that the services were available to them. Although not conclusive, some respondents stated that the health care workers communicate well (n=18/12.5%), and that health care workers understand when they (the respondents) talk to them. The nurses were further described as good to very good listeners (55%), friendly (59.74%), competent (54.38%), respectful (50.87%), caring (46.53%) and lastly that they are helpful (61.20%). More than half of the respondents (64.3%) were of the opinion that the nursing staff at the clinic understand their needs.

The negative feedback focused on operating hours, waiting time, treatment, and the attitude of health care workers. Eighty (34.2%) of the respondents said that they never find the clinics open, opposed to sixty-six (28.2%) that indicated that they seldom find the clinics open. Several respondents (n=24/19.5%) stated their dissatisfaction with the treatment offered to them. Nineteen respondents (15.4%) consulted a private practitioner for a second opinion after they have been treated at the clinic. Thirty-two (26%) described nurses as unfriendly, rude and judgemental.

Respondents, 138 (55%) and 49 (19.5%) respectively, recommended longer operating times ranging from 13-24 hours. Some 141 (56.6%) requested services to be available

from Monday to Saturday, while fifty-four (21.7%) suggested that services be rendered Sunday to Saturday. Twenty-two (20.5%) experienced problems with waiting areas.

The structural and functional accessibility and acceptability of PHC services, especially with regard to the needs of the youth must be addressed. This conclusion is, for example, based on the fact that no positive responses obtained the support of more than 60% of the respondents, while problems with nurses was indicated by 69 (64.5%) of the respondents. High levels (>90%) of satisfaction on any issue addressed in the study, were not expressed. It is also recommended the school going youth be accommodated as a one-stop service, services be extended to public holidays and that health care workers include the youth when planning health care programmes. It is suggested that further research be done on the delivery of youth services, where the younger ages of 10-13 years are included, and the research be conducted in other areas within the Northern Cape. The training of health care workers on youth-friendly services should be included in the curricula and such training should be extended to other provinces.

OPSOMMING

Volgens die literatuur is strukturele en funksionele toeganklikheid en aanvaarbaarheid van primêre gesondheidsorg- (PGS) dienste 'n uitdaging wat jeugvriendelike dienslewering in Suid-Afrika in die gesig staar. Dus is die doel van die studie om jeugvriendelike dienslewering in die Noord-Kaap te assesseer. 'n Kwantitatiewe metodologie, wat 'n beskrywende ontwerp volg, is vir hierdie doel gekies. Twee honderd ses en vyftig (256) skoolgaande meisies en seuns, ouderdom 13-21, is deur middel van gerieflikheidsteekproefneming uit ses hoërskole in Kimberley gekies. Hulle het 'n selfrapporteringsvraelys voltooi. Die resultate het teenstrydige persepsies oor strukturele en funksionele toeganklikheid en aanvaarbaarheid getoon.

Die positiewe terugvoer het op berading en toetsing, kommunikasie en houding gefokus. Met betrekking tot die reeks dienste wat aan die jeug gebied word, het 51,9% (n=133) sterk gevoel oor die verskaffing van MIV-berading en toetsing en erken dat hierdie dienste aan hulle beskikbaar is. Alhoewel nie beslissend nie, het sommige respondente genoem dat die gesondheidsorgwerkers goed kommunikeer (n=18/12,5%) en dat gesondheidsorgwerkers verstaan wanneer hulle (die respondente) met hulle praat. Die verpleegkundiges is verder beskryf as goeie tot baie goeie luisteraars (55%), vriendelik (59,74%), bevoeg (54,38%), respekvol (50,87%), besorg (46,53%) en behulpsaam (61,20%). Meer as die helfte van die respondente (64,3%) was van mening dat die verpleegpersoneel by die kliniek hulle behoeftes verstaan.

Die negatiewe terugvoer het op werksure, wagtyd, behandeling en die houdings van die gesondheidsorgwerkers gefokus. Tagtig (34,2%) van die respondente het gesê dat hulle nooit die klinieke oop vind nie, teenoor 66 (28,2%) wat aangedui het dat hulle die kliniek selde oop vind. Verskeie respondente (n=24/19,5%) het hulle ontevredenheid met die behandeling wat hulle ontvang het, genoem. Negentien respondente (15,4%) het 'n privaat praktisyn vir 'n tweede opinie geraadpleeg nadat hulle by die kliniek behandel is. Twee en dertig (26%) het die verpleegkundiges as onvriendelik, onbeskof en veroordelend beskryf.

'n Totaal van onderskeidelik 133 (55%) en 49% (19,5%) respondente het langer werksure wat van 13-24 uur strek, aanbeveel. Sommige, naamlik 11 (56,6%), het versoek dat dienste van Maandag tot Saterdag beskikbaar is, terwyl 54 (21,7%) voorgestel het dat dienste van Sondag tot Saterdag gelewer word. Twee en twintig (20,5%) het probleme met wagareas ervaar.

Dit blyk duidelik uit die resultate dat die strukturele en funksionele toeganklikheid en aanvaarbaarheid van PGS-dienste, veral met betrekking tot die behoeftes van die jeug, aangeroer moet word. Hierdie gevolgtrekking is gegrond op die feit dat byvoorbeeld geen positiewe response die ondersteuning van meer as 60% van die respondente gekry het nie, terwyl probleme met verpleegkundiges deur 69 (64,5%) van die respondente aangedui is. Hoë vlakke (>90%) van bevrediging oor enige saak wat in die studie aangeroer is, is nie uitgedruk nie. Die aanbeveling word ook gemaak dat 'n eenstopdiens in die behoeftes van skoolgaande jeug voorsien, dat dienste tot openbare vakansiedae uitgebrei word en dat gesondheidsorgwerkers die jeug insluit wanneer gesondheidsorgprogramme beplan word. Die voorstel word gemaak dat verdere navorsing gedoen word oor jeugdienslewering waar die jonger ouderdomme van 10-13 jaar ingesluit word en dat navorsing in ander gebiede binne die Noord-Kaap gedoen word. Die opleiding van gesondheidsorgwerkers in jeugvriendelike dienste moet in kurrikula ingesluit word en sodanige opleiding moet na ander provinsies uitgebrei word.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
DoH	Department of Health
DoE	Department of Education
HIV	Human Immune Virus
HCWs	Health Care Workers
IPPF	International Planned Parenthood Federation
MCWH	Maternal, Child and Women's Health
MEC	Member of the Executive Committee
PHC	Primary Health Care
SA	South Africa
STIs	Sexually Transmitted Infections
TOP	Termination of pregnancy
UNAIDS.	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nation Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organisation

CHAPTER 1
ORIENTATION TO THE STUDY

The reproductive health of young South Africans is in jeopardy. This has been revealed by an analysis of relevant literature indicating that young people in this country are at risk from a broad spectrum of health related problems, especially sexual and reproductive ones. Statistics on the presence of Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), Sexually Transmitted Infections (STIs), and teenage pregnancies among young people are numerous and distressing (Africa, Van Deventer & Barnard, 2008: 473, S.A. Department of Health, 2009: Online).

There are diverse explanations for the increasing sexual health problems affecting the youth. These include factors such as the socio-economic decline, the cultural practice of entitlement, and lack of education with resultant ignorance concerning reproductive health and sexual practices. Among the factors influencing the reproductive health of young South Africans would certainly be the quality of health care services they receive (Muller, 2004: 54).

The services rendered by the public health care system have an extensive effect on the health of youth since this system offers the only opportunity for young people from disadvantaged communities to seek health care, counselling, and/or advice. Services can be either constructive and health promoting, thus preventing health problems among the youth, or destructive by offering services that do not respect young people as human beings, are less informative, and not understanding to this particular age group and their problems. The latter makes services less attractive to the youth (Mabiletsa, 2009: Online).

The DoH (SA) as the main provider for public health services strives to promote access to comprehensive and high quality sexual and reproductive health care, including "Youth Friendly Services", but does not seem to be focusing on the youth,

and subsequently overlooks their needs as a group (Van Rensburg, 1992:61 in Dennill, King & Swanepoel, 2000:34.

In order to determine and understand the underlying reasons and to describe the services delivered to the young South Africans, we need to be aware of the history and the framework of legislation wherein health lies.

1.1 BACKGROUND TO THE PROBLEM

Kautzky & Tollman (n.d: Online) state that many countries in the world were confronted with services which were fragmented and focused on the provision of expensive, curative (hospital-based) health care services; which were often only geographically or financially accessible to the elite. The authors though did not specify these countries and continued by stating that the majority of populations was denied adequate preventive and basic health care services (Kautzky & Tollman, n.d: Online).

In South Africa the legislation recommended and enforced by the Apartheid era after 1948 segregated and determined the health care services according to race, income, and location. The Gluckman Commission of 1944, which called for a "...single, national health department that would serve all sections of the population, according to their need, irrespective of race, colour, means or station in life", was ignored, thus placing South Africa in the same situation mentioned above (Van Rensburg, 1992:61 in Dennill, King & Swanepoel, 2000:34, Kautzky & Tollman [n.d: Online].

In addition, South African health care consumers were classified into two different age groups. Every person below the age of 14 was classified as a paediatric health care consumer while everybody above 15 years was classified as an adult and treated as such. Young people were evidently discriminated against according to age as they received services that suited adults. In addition, health services were rendered according to income and because the youth are legally unemployable they were further disadvantaged. Services were also rendered according to location, and

because the youth's residential location is determined and decided on by the parents they were still disadvantaged. In short, services were not youth-friendly.

Privatisation of health care in South Africa the late 1970s, resulted in the provision of expensive services and this led to turmoil. The private services were not financially accessible to all citizens, including youth. This financial inaccessibility of services situation started to change in 1978, when the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) sponsored the first international conference to conceptualized Primary Health Care (PHC). PHC would ensure the provision of health care to the entire population, which included the youth. Emphasis was on universal accessibility and affordability of health care services. Such services would be based on "...practical, scientifically sound, and socially acceptable methods and technology that is universally accessible to individuals and families, at a cost that is affordable to the community and the country" (Taylor, Lillis & Le Mone, 2005:54).

1.2 THE PROBLEM STATEMENT

The concept "youth" as a separate and distinct stage of life is of recent origin, as in the medieval societies one passed from childhood to adulthood as soon as one reached physical maturity (Biddle, 1983:153). A part of the reason is also that "...young people have been regarded as a healthy age group who do not need priority action since the mortality and morbidity rates were generally lower for youth than for infants as well as young children under the age of five or childbearing woman" (World Health Organisation, 2002:1). Unfortunately, this belief has led to a situation where the health needs of the youth and adolescents are overlooked, and the other groups are given priority to services, especially in places where resources are limited (Motlomelo & Sebatane, 1999:2) cited in Moletsane (2003:5).

Although Naude and Setswe (2000:4) are of the opinion that South Africa has adopted a system of equality; and one through which "...every person's health is seen as important, and every person receives the health care that he or she needs", it seems that many people, especially the youth, fell through the system. It could also

be because youth are not regarded and treated as a separate group with unique emotional and social developmental phases and problems. Yet, it is precisely these developmental problems that are fundamental to the causes of the high incidence of sexual health problems (Biddle, 1983:153; Dennill et al., 2000:184; SA Department of Health, 2001:6).

The new democratic government of South Africa that came into effect in 1994 tried to redress the inequities of the past including health care. This government sought to eliminate the "fragmentation" and "duplication" of services thereby integrating all health services under a single Ministry of Health (Kautzky and Tollman, n.d: Online). Hence the White Paper for the Transformation of Health Systems (1997) provided for youth and adolescents health within Maternal, Child and Women's Health (MCWH) care.

As the name implies, MCWH is a cluster that concentrates mainly on mothers and children under the age of five years. Kautzky and Tollman [n.d: Online] specified "mandatory immunisations, schools feeding schemes, the establishment of community food gardens, child-growth monitoring, breast-feeding and family planning" as priority areas. Naude and Setswe (2000:143) summarised the services provided within MCWH at public health clinics as follows (refer Table 1.1).

TABLE 1.1: SERVICES WITHIN MCWH CLINICS

Maternity health services	Child health services	Women's health services
Antenatal	Growth monitoring	Family planning
Delivery	Immunisation	Pap smear
Postnatal	Health education	Health education

Considering the above-mentioned services, youth and adolescents are accommodated within two of the three namely, maternity and women's health. However, the reproductive health risks namely, HIV and AIDS, STIs, and unwanted pregnancies are not a priority whereas "4,981,721 (11%) South Africans are young people aged 15 to 19 years" (Statistics South Africa, 2010: Online).

Furthermore, it is worrying enough that HIV infections among women (15 – 49 years) increased by 11% in five years from 9% in 2001 to 20% in 2006 (Statistics South Africa, 2006: Online). In another survey on HIV and AIDS conducted by the DoH among antenatal attendees in the nine provinces, 29.4% of pregnant women aged 15 to 49 were living with HIV (S. A. Department of Health, 2009: Online). According to Harrison (2010:315), the latter is possible seeing that less than 10% of sexually active youth aged 15 to 19, who reported using contraceptives used condoms as contraception.

The mid-2006 census indicated that "...the population of South Africa comprises of 47 390 900 people, and the Northern Cape being the smallest province accommodated 900 427 (1.9%) thereof; with 255 500 (28%) young people between 10 and 24 years (Statistics South Africa, 2006:10). In mid-2010, the estimates published by Statistics South Africa indicated that the country's population was 49 991 300 and that the Northern Cape had 1 103 900 (2.2%) thereof (Statistics South Africa, 2010: Online).

Reflecting on teenage pregnancy only, the WHO (2006:11) indicated that 30% to 60% of adolescent pregnancies end in abortion because teenage pregnancies are not merely unplanned, but also unwanted. The WHO (2002: Online) estimated that about a million to 4.4 million pregnancies occurring worldwide, were terminated annually by young women aged 10 to 24 years and that most of these were performed illegally.

In 2000, approximately 18.9 million new cases of STIs were reported, of which 9.1 million (48%) were among young people aged 15 to 24 years. Seventy-five percent of these infections were HIV contracted through sexual intercourse (Weinstock, Berman & Cates, 2004: Online). Furthermore, these authors estimated that the prevalence of HIV and AIDS would reach about 27% of the sexually active population in South Africa by the year 2010. According to the DoH, Northern Cape (2010:1) the prevalence rate of HIV among woman aged 15 to 24 years was 11.8% in 2002 and 3.9 % in 2008. In addition and as a reason for the decrease in HIV infection, the department indicated that condom use among people 15 years and older increased from 16.9% in 2002 to 52.6% in 2008.

In agreement with the prevalence estimated for 2010, the National DoH in South Africa (2000) cited in Stadler and Hlongwa (2002: 365) confirmed that 4.7 million South Africans are HIV infected. The department also projected an increase of up to 10 million for the next eight to ten years. Reflecting on pregnant teenagers aged 15 to 19 only, Van Rensburg, et al (2002:53) indicated that nearly 13% of respondents were found to be HIV positive and that 9.5%, had become infected before they had reached the age of 15; yet, the South African public health care facilities are failing to provide youth friendly health services because adolescents are not seen as individuals with particular needs that determine the service provided to them (Mabiletsa, 2009: Online).

Given the fact that their health needs are different and very unique, especially with regard to exposure to reproductive health risks, as well as the growing recognition among reproductive health providers throughout the world for the need to provide youth friendly health care services, one would expect that this group be provided for separately in all health care programmes. Services should be able to effectively attract young people, meet their needs, and succeed in retaining them for continuing care (Senderowitz, 1999:1; Dennill et al., 2000:184; SA Department of Health, 2001:6).

It was only in 2002 that the South African Minister of Health (Dr Manto Tshabalala-Msimang, later referred to as the Minister) announced that the "...traditional approach to the prevention and the management of health problems affecting adults and children is not always effective when dealing with the problems of the youth and adolescents". The minister also described this era as the time to dedicate resources to adolescent and youth health (SA DoH, 2001: 6). As such, the first two policy guidelines aimed at contraception, and youth and adolescent health were launched.

The DoH, in response to the guidelines, initiated the training of health care workers towards the provision of youth friendly services. The DoH (2001:24) also advised that the services provided to youth and adolescents should be tailored to ensure a holistic approach with emphasis on their special needs, that health care services should be youth friendly and effective in dealing with the problems of the youth, and

that youth services should comply with more than the community-based philosophy, that emphasises accessibility and affordability. Most importantly service delivery to the youth should be provided by HCWs who are trained on youth health. Young people were seen as actively involved in both the design and implementation of programs (UNFPA, 2003: Online).

To implement the vision trained HCWs rendering a service to youth, universities in South Africa were invited to participate via a tender process. Eventually the tender for training of HCWs was awarded to the University of the Free State. To pilot the training, the Northern Cape was according to Botma, Alexander, Gopane, Kgakatsi, Magwaca, Mokonotela, Molefi and Nkhobo (2001), the lowest populated province with wide geographic spaces between towns, a situation that made it difficult to provide comprehensive care. The School of Nursing piloted the training in the Frances Baard district in 2001. A pre- and post-test research survey (not published) was conducted by Botma, Alexander, Gopane, Kgakatsi, Magwaca, Mokonotela, Molefi and Nkhobo titled, *"Assessing the attitudinal impact and outcomes of training health care workers to deliver a Youth Friendly Service in PHC clinics".* The researcher chose to implement one of the recommendations from the study by Bothma and others, to assess the delivery of youth friendly services in the Northern Cape.

This study will focus on two important issues identified by the researcher, namely, the accessibility and acceptability of PHC services to the school going youth in the Northern Cape.

1.3 AIM OF THE STUDY

The primary aim of this study was to assess the delivery of youth friendly services in the Northern Cape.

1.4 OBJECTIVES OF THE STUDY

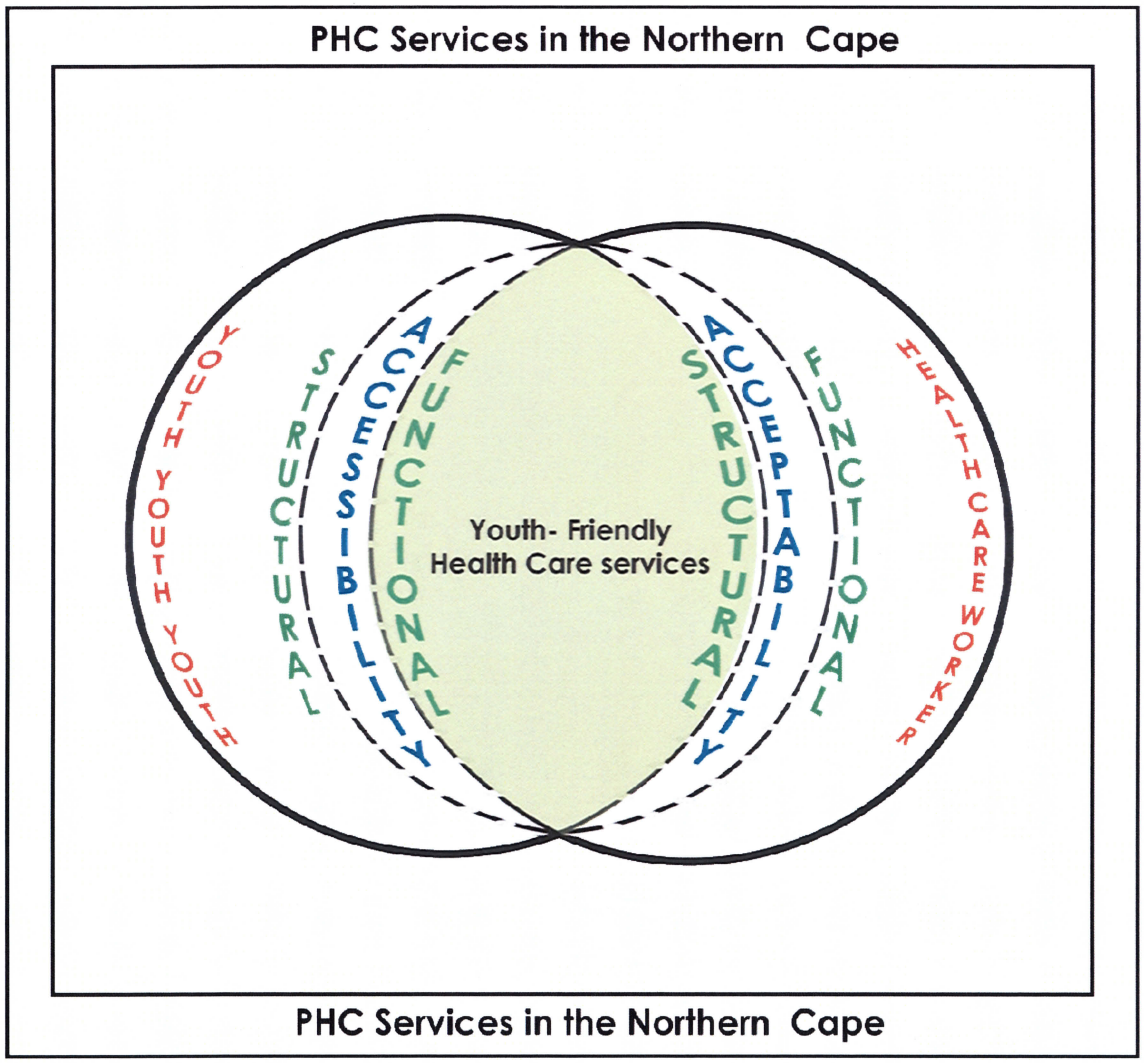
The objectives of this study were to assess the delivery of youth friendly services by:

- determining the accessibility and acceptability of PHC services to the school going youth in the northern Cape;
- measuring the utilisation of primary health care services;
- describing how the services are perceived by the school going youth in the Northern Cape; and
- highlighting the suggestions offered by the youth on how to improve existing health care services.

1.5 CONCEPTUAL FRAMEWORK FOR YOUTH FRIENDLY SERVICES

The basis of the conceptual framework developed by the researcher, was the definition of PHC which specifies that care should be based on "...practical, scientifically sound, and socially acceptable methods and technology that is universally accessible to individuals and families, at a cost that is affordable to the community and the country" (Taylor et al., 2005:54); as well as the definition of youth friendly services that "attracts young people, meets their sexual and reproductive health needs and are accessible and acceptable to a diversity of young people" (The International Planned Parenthood Federation, 1999:1). Both definitions focus on the accessibility and acceptability of services. Eventually the literature referred to in chapter 2 was used to finalise the framework.

Figure 1.2 Relationship of the concepts guiding the study



The figure above illustrates that youth friendly services are central to service delivery. Further that for the PHC services delivered by HCWs to be youth friendly, they should be structurally as well as functionally accessible and acceptable to the youth. The broken lines indicate that no barriers should hamper the youth from accessing and participating in the service provided to them, nor prevent the HCWs from delivering the services; thus making them unacceptable to the youth.

The framework influenced and guided the construction of the chapter on literature by determining flow of thoughts and arguments. It also directed the choice and formulation of questions used in the development of the questionnaire.

1.5.1 Operational definitions

The following definitions will be used in the study:

Assessment

The South African Concise Oxford Dictionary (2002:64) refers to an assessment as a process that enables the "evaluation or estimation of the nature, value or quality at a specific level" Assessment is further distinguish from evaluation by indicating that it not only involves the gathering, summarising and interpretation of data, but also involves deciding on a course of action.

In this study, the latter was of utmost importance in that the results of the assessment lead to conclusions and recommendations to structures such as departments of health, hospitals, and clinics.

Accessibility

The WHO (1981:27 cited in Dreyer, Hattingh & Lock, 2000:156) defined accessibility as the number or portion of a given population that can be expected to use a specific facility or service, with the assumption that certain barriers may exist. Hattingh, Dreyer and Roos (2006:121) defined accessibility from within PHC as "the continuing and organised supply of an equitable level of care that is within easy reach of all citizens geographically, functionally and financially".

Acceptability

In terms of PHC, acceptability is defined as a level of health and health care that is acceptable to both the health care provider and the health care consumer in terms of local needs or constraints. It is said to be determined by factors such as culture, types of services provided, the cost of services, the distance travelled, the attitude of consumers towards health and health care as well as the attitude of the health care providers (Hattingh et al., 2006:112).

In this study, acceptability would refer to the willingness of the youth to receive health care services from HCWs without being judged and expressing their feelings, perceptions, and experiences without fear of being criticised.

In this study, acceptability refers to the assessment of youth regarding the type of service, whether their needs were met, the attitude of the HWCs towards them, and problems encountered by young customers who have consulted clinics in Kimberley.

Delivery of services

According to Strydom (2008:4), the term service originates from the business world and is related to work done. It is described as an intangible part of work which one cannot feel or touch. Only products (goods produced) can be touched. Delivery is referred to the production and/or distribution of the goods. As part of the business for the DoH, the vision for the Northern Cape DoH is "an excellent, holistic, people-centred and affordable healthcare service for all" in the province (Northern Cape Business, 2009: Online).

In this study, service delivery refers to activities undertaken by health care workers during their interaction with health care consumers.

Health Care Worker (HCW)

According to Verow, Blair and Lees (2004: 4-5), a Health Care Worker includes "…all individuals who routinely have contact with patients, with or without hands-on patient responsibilities in health care facilities. This definition includes administrative staff, chaplains, social workers, pharmacists, occupational and rehabilitative therapists, volunteers as well as health aides." In addition, three categories of health care workers were defined:

- Clinical staff, which includes service providers who have direct contact with service consumers such as doctors, nurses, dentists, and paramedics.
- Laboratory staff and others who may not have direct contact with patients but complement the service of clinical staff in other areas of the facilities.
- Non-clinical ancillary staff such as clerical, security, and maintenance or cleaning services.

In short, health care workers are all people whose activities involve contact with patients in health care facilities.

In this study, however, a HCW refers to any person delivering health care to the youth from primary health care clinics in the Northern Cape. In addition to the definitions mentioned above, a HCW will include any person who renders a necessary service from the entry to a health care clinic to the exit point of the clinic. Therefore, HCW will include the security guards and support group members as well.

The Northern Cape

The Northern Cape is the largest but most sparsely populated province in South Africa. It came into existence in 1994 when the Cape Province was split into three areas. The Northern Cape is divided into five districts namely, Kgalagadi, Namakwa, Karoo, Siyanda, and Frances Baard where its capital city, Kimberley, a predominantly diamond mining town, is situated (Bradshow, Laubscher, Groenewald, Joubert, Nojilana, Norman, Pieterse & Schneider, 2000: Online). In 2009, the total population in the Northern Cape was 1 147 600 and 39 502 were below 18 years (Yezingane Network, 2010: Online).

Primary Health Care Clinic

A Primary Health Care Clinic is "a health facility in which care is rendered at community level, and addresses the needs of the community it serves" (Naude & Setswe, 2000:3). The National DoH (2007:13) and Fraser, Cooper and Nolte (2010: 978) refer to a clinic as a unit that normally functions on working hours during the week excluding week-ends. This unit is staffed with nurses, community health workers, and a visiting doctor.

For the purpose of this study, a Primary Health Care C defined clinic refers to any provincial or municipal clinic in the Northern Cape, which offers general primary health care services at community level, (not pertaining to specialised clinics or health care centres), which are used by the youth for service, information on health, and/or health related issues.

Youth and adolescence

The WHO (1999:18) and Harrison (2010:306) define the 10-19 year old persons as adolescents and those aged 10-24 as the youth. Pilliteri (2003:905) in turn describes adolescence as the time period between 13 years and 18 to 20 years.

In this study, the term youth will be used to designate persons aged 13 to 21 years, who have consulted a primary health care clinic for treatment or health related information as well as those who, for reasons identified in the study, do not make use of the services anymore. This specific age group is found predominantly in high schools, hence the researcher chose high school going youth as the target population for the study.

Youth Friendly Health Care Service

The International Planned Parenthood Federation (2001:1) defines a youth friendly health service as one that "attracts young people, meets their sexual and reproductive health needs and is accessible and acceptable to a diversity of young people". According to Senderowitz (1999:11) and the African Youth Alliance (2001:4), youth friendly services should not only attract young people, but also provide a comfortable and appropriate setting for serving youth, and succeed in retaining those young clients for continuing care.

For the purpose of this study, youth friendly services is defined as health care services that are accessible and acceptable to the youth in the Northern Cape as assessed by means of a structured questionnaire designed for this purpose.

1.6 RESEARCH METHOD, DESIGN AND TECHNIQUES

The study adopted a quantitative, non-experimental, descriptive design to describe the assessment of youth friendly services.

1.6.1 Population and sampling

1.6.1.1 Population

Burns and Grove (2005:336) and Brink (2006: 136) describe the population of a study as the entire set of individuals or elements defined by the sampling criteria established for the study.

In this study, the population will include young people who had consulted PHC clinics in the Northern Cape for service or health related information.

1.6.1.2 Sampling

The researcher will use both the probability and the non-probability sampling methods in the study. The geographic size of the province would be too wide and diverse for the study. Therefore, the capital area was more accessible and also affordable for the researcher. Hence the study will be conducted in Kimberley in the Frances Baard district.

1.6.1.3 Probability sampling

A probability or random sampling method will be applied to select a sample of high schools. The names of all 16 high schools situated in Kimberley both public and private were placed in a container and the required number (6), were selected randomly. However, their inclusion and participation in the study is voluntary and depends on their willingness.

1.6.1.4 Non-probability sampling

The convenience or accidental (non-probability) sampling method will be used to select a sample of respondents for this study. This method includes subjects into a study because they happen to be in the right place at the right time, and are accessible to the researcher. Available subjects are added into the study until the researcher is satisfied that the desired sample size is reached (Burns & Grove, 2005:374).

A set of criteria for inclusion into the sample must be stipulated, and one for this study will include young people, of any race or gender, aged 13 to 21, who will be attending one of the high schools participating in the study. The person must have attended a PHC facility in Kimberley and volunteer to participate in the study. For those learners who were younger than 18 years, permission for inclusion must be granted by a parent or guardian (refer Annexures D & E).

1.6.2 Research technique

The measuring instrument is an adjusted version of an existing questionnaire developed, piloted and used by Botma et al., in 2001 to assess the impact of attitudinal change among HCWs towards the provision of youth friendly health care services within the Frances Baard district in the Northern Cape. The new version will be adapted based on an extensive literature review and structured to suit the purpose of this study. The initial instrument was not a self-administered questionnaire: field workers collected data by interviewing both the HCWs providing service and youth on their exit from the clinics.

In this study a self-administered questionnaire will be completed by youth at a high school away from the clinic, on a different day than the one they may have consulted to the clinic. The self-administered questionnaire consists of 13 close-ended questions and nineteen open-ended questions. Three of the questions explored qualitative data regarding the experiences of youth as health service consumers while all others are quantitative in nature.

1.6.3 Pilot study

The adjusted version of the questionnaire was piloted on 25 learners from a high school in Bloemfontein. Learners were expected to complete the questionnaire in at least one hour, but most of them ignored the instructions provided for completing the questionnaire. Most of the younger respondents, 13 to 15 years, did not provide answers to the open-ended questions.

To address this problem, the researcher read the instructions to all respondents before the process of data collection had started, and emphasised the value of providing one's own ideas by responding to the open-ended questions. Some of the questions were rephrased so that even the younger learners could understand them. All instructions that need to be adhered to were put in bold to draw the respondents' attention.

1.6.4 Data collection

The researcher will collect data from a convenient sample of high school going youth in Kimberley within six months of the pilot study. The researcher plans to collect the

data from all six schools on the same day at different times that will suit the different schools. This will prevent learners from informing friends from the other schools about the research and thereby creating bias.

1.6.5 Data analysis

The data collected will be coded by the researcher and analysed by a data analyst who is staff member of the Department of Bio-statistics at the University of the Free State using the Statistical Package for Social Sciences (SPSS) for Windows software. It is a standard procedure in the faculty that statistical analyses of data be done by a biostatistician within the faculty. Standard descriptive techniques were used to identify the experiences of the youth who utilized the PHC services, and also of those who will have decided not to use the services anymore.

The reasons that made them go to the clinics as well as those that prevented them from doing so will be explored. Finally, the services provided by the clinics they consulted will be compared to those they wish to be offered by youth friendly services. The impact of the experiences on future use of the clinics will be looked into and suggestions for improving utilisation of available services will be highlighted.

1.7 RELIABILITY AND VALIDITY

The questionnaire was piloted and adjusted to improve face and content validity and reliability. The questionnaire was purported to be reliable and valid as it had been examined by experts in the field of PHC. The researcher monitored that the data gathering was done according to the ethical considerations stipulated and that such considerations were adhered to.

1.8 ETHICAL CONSIDERATIONS

There were two ethical considerations that were paramount to this study namely, informed consent and anonymity. To ensure that informed consent was given, permission was requested from the Provincial DoE (Northern Cape), parents, or guardians of the learners as well as voluntary participation of the respondents. An additional measure was that the researcher communicated information in the

respondents' chosen language, which included Tswana, English, or Afrikaans to ensure that the content of the consent form was correctly understood.

The second aspect was optimum confidentiality through the confidential use of the data collected, as well as ensuring partial anonymity of respondents by not requiring any personal information from them. Partial anonymity implies that although the researcher has face-to-face contact with the respondents, in this case the high schools and/or learners that participated, no identifying information would be included in the research. Numbers were used to be able to identify the questionnaires from the different high schools.

The respondents were also informed that their participation was voluntary and that they had the right to withdraw from the study at any time, without being discriminated against. Permission to conduct this study was obtained from the Ethics Committee of the University of the Free State (UFS), the Ministry of Education in Northern Cape, and the principals of the selected schools as indicated. A letter of reminder was also forwarded to the Director of Health Services although an agreement was already entered into with the UFS.

1.9 VALUE OF THE STUDY AND CONCLUSION

The literature indicates that the reproductive health and the specific needs of youth and adolescents are not fully accommodated within the South African health care system. It also states that the health of young South Africans, particularly their reproductive health, will not improve unless the services become youth friendly, and young people are seen and treated as a unique group with special needs. The findings of the study suggest a need for improving existing PHC services towards the provision of youth friendly services.

As such, problems identified with regard to the accessibility and/or the acceptability of PHC clinics by the youth, as well as suggestions made by respondents, formed the basis of the recommendations that will be submitted to the DoH in the Northern Cape. Hopefully these recommendations will pave the way for the development of necessary strategies to address identified problems. The recommendations may also

help in the design of training programmes and in the formulation of standards regarding care in the future.

1.10 CHAPTER ALLOCATION

This section illustrates the arrangement of chapters in the dissertation.

Chapters	*Content*
Chapter 1	Problem statement, its background and significance The aim and objectives of the study as well as the theoretical foundation thereof
Chapter 2	Literature review
Chapter 3	Research design and methods
Chapter 4	Presentation of results and discussions
Chapter 5	Conclusions and recommendations

CHAPTER 2
LITERATURE REVIEW

The historical background of the health care system in South Africa described in the previous chapter was marked for its continuous change that originated both national and international.

Internationally, the history reflected back on the Gluckman commission of 1944 that aimed at the development of a single health care system, which seemed not to have succeeded in all countries including South Africa; as some continued with fragmented service provision. A global awareness came about in 1997 that the majority of the people around the world, including in South Africa, had inadequate access to basic services, including health. It could been due to such awareness that the WHO and Unicef sponsored the Alma Ata conference that conceptualized PHC, and was aimed at achieving "Health for All" in the 21st century in 1978. PHC is said to have commenced as early as 1975 following an urgent need for a new approach to health in developing countries where a lot of people suffered and died from preventable diseases such as malnutrition (Hattingh et al., 2006:151). The WHO focused on good quality PHC that is affordable, accessible, available and acceptable to all citizens (Hattingh et al., 2006:83). To ensure availability, clinics were built in communities while affordability was addressed by providing all PHC services including the medication prescribed, free of charge. Therefore, issues addressing the accessibility and acceptability of the services become crucial.

All countries that participated in the Alma Ata conference endorsed PHC both as "a philosophy and an approach or a strategy to provide health care" (Hattingh et al., 2006:83). Philosophically, it refers to the political demand for radical change regarding the conventional model of health care, while viewed as an integral part of the entire social and economic development (Van Rensburg, Benetar, S.R.,

Dohentry, Heunis, McIntyre, Ngwena, Pelser, Pretorius, Redelinghuys, & Summerton, 2004: 413).

This chapter was an effort to describe the historical background with regard to primary health care services in South Africa, and eventually address the provision of youth friendly health care services.

2.1 HISTORICAL BACKGROUND TO PRIMARY HEALTH CARE SERVICES IN SOUTH AFRICA

In South Africa, the provincial departments rendered PHC services in the rural magisterial districts under the section 30 of the Health Act, No. 63 of 1977. This implies that PHC services existed in South Africa before the Alma Ata conference held in 1978. Therefore, it was hoped that the integration of PHC into the entire health care system would lead to the enforcement of the systems (Frenk, 2009: 170).

A literature review regarding health services delivered to the youth in South Africa presents conflicting results. On the one hand, government has set out policies directing health care services to be accommodating to the youth yet the statistics on the prevalence of diseases related to reproductive health presents a bleak picture. For example, PHC services are available and provided freely in South Africa, but statistics around teenage pregnancy and STIs including HIV and AIDS suggest that services might not be sensitive enough to the youth and are therefore unfriendly to this group.

The new national health plan came about when South Africa implemented a drastic political change in 1994. This new government inherited a number of inequities related to service provision, including health, which the government committed to address (Myburgh, Solanki, Smith & Lalloo, 2005: Online).

The national health plan was based on the Reconstruction and Development Programme (RDP) of the government and its approach involved a complete transformation of the entire service delivery system, including health. It embodied the concepts of community development and community participation, both of which

demanded that communities should be actively involved in the planning, provision, control as well as monitoring of services.

Up to the National Whitepaper on the Transformation of Health System in South Africa (1997) focused on integration of fragmented health care services which came as a result of the Apartheid system. The latter provided racial and social fragmented services, whereas the ANC led Democratic government that commenced in 1994 used the PHC as well as the District health systems as vehicles to enhance the provision of comprehensive and integrated PHC services that are within reach of the communities (Denhill, 2009: 16).

South African health authorities adopted and applied the recommendations by the WHO (2003: Online) that health services provided to the youth must be confidential, accessible, free from judgment, and offer a complete range of services. In addition to that, According to Finger (2000: Online), in a study aimed at encouraging youth friendly clinics, the Family Health International suggested that the services should ensure privacy and have sensitive service providers.

More than 30% of existing PHC facilities was built just after 1994, at a time when youth were not viewed as priority for health care compared to mothers, children, and women. The South African Patients' Rights Charter (2002: Online), asserts access to a full range of affordable health services as well as treatment by trained and knowledgeable people is a constitutional right afforded to all service consumers. Despite this and regardless of evident escalation of the reproductive health problems affecting youth, minimal health care services are specifically aimed at youth and adolescents. Young people reflect that health services are for adults, mothers, and small children; and that unmarried adolescents do not visit them because services are hostile to adolescents and young people (Plan, 2009: Online).

Literature used in the problem statement has indicated that adolescence is a stage where reproductive maturity commence, and also that most of the problems affecting youth for example unwanted pregnancies, STIs including HIV and AIDS were reproductive in nature. It was further indicated that these problems have put the health of South African youth in jeopardy. Taking these factors into consideration

and also noting the perceptions of consumers regarding the services, and also the fact that it is clear that the reproductive health services need special attention.

2.2 REPRODUCTIVE HEALTH SERVICES

The majority of reproductive health care services in South Africa are provided from PHC clinics. For example, most of the clinics operate from seven in the morning until four or five in the afternoon, five days a week – when most youth are at school. As such, the youth receive a type of service that is not geared towards their needs as a group and clinic services are not adequately accessible to the youth and adolescents (Reagon, Irlam & Levin, 2004: Online).

According to Botes & Poggenpoel (2000:27), much as the knowledge on modern contraceptives among the youth is high, and problems around reproductive health are increasing, little attention is directed to the reproductive needs of youth. For the past 50 years, the need for sexual and reproductive health services for adolescents has become critical for the entire world, but particularly South Africa, where statistics shows an enormous increase of STIs and pregnancy among the youth (Foy & Dickson-Tetteh, 2001:3).

2.3 PROBLEMS EXPERIENCED BY YOUTH

Adolescence is regarded as a relatively healthy period, but concern about an increase of youth engaging in behaviours that put their health at risk is increasing. The risks are diverse and linked to the physical, psychological and social development of young people. Among others, Physical development includes the onset of puberty were young people enters in reproductive maturity. Psychologically, young people enters into a transition from childhood into adulthood and they need to identify with others so as to develop their own identity. Socially, the peer group becomes more important than the family (WHO, 2002 2:4). The author further indicated that the development process have positive and negative outcomes which determines and also influence the type of services needed by youth.

Young people do experience other health issues, for example nutritional disorders such as anaemia and obesity, substance abuse such as smoking, and psychological and behavioural disorders, but, this study will only focus on reproductive health problems because these seem to be most pressing. Among negative outcomes are risks behaviour such as unsafe sexual relationships which result in acquiring STIs, HIV and AIDS as well as unwanted pregnancies are most pressing (WHO, 2002:4).

2.3.1 Unwanted pregnancies

There are several reasons why unwanted pregnancies occur, much as there are many reasons for their termination. According to Barnett (2000: Online), abandonment by the parents and/or the partner, extension or even expulsion from school, or loss of a job as some of the severe consequences leading to the termination of an unplanned pregnancy for adolescent girls. Adolescent sexual behaviour, especially experimentation and risk-taking such as wanting to please others or providing sexual favours in exchange of personal needs, makes this group more vulnerable to pregnancy (Senderowitz, 1999:4). In the Northern Cape, almost one in every five pregnant women is aged between 15 and 19 years. To address the teenage pregnancy and related reproductive problems two youth centers were opened in Kimberley and Upington in 1997 (Thom, 2004: Online).

The number of pregnancies terminated in the smallest province in the country (the Free State) from January to December was 8 343 in 2004 and 8 954 in 2005. Of the 8 343 pregnancies terminated in 2004, 1 023 (12.3%) were terminated by young mothers below the age of 18 years and 5 367 (64%) of them were terminated before 13 weeks of gestation, meaning before the pregnancy became visible. The black teenager accounted for 7 864 of the terminations. One should not lose sight of the fact that these are only the reported cases. This might also be an indication that young people do not want to be pregnant; hence they are using abortion as contraception (WHO, 2002:4).

Reflecting on teenage pregnancies only, teenagers believe that the prevalence of teenage pregnancies has not increased beyond what it used to be in the past. They argue that teenage girls were getting married at an earlier age, but now the age at which young people get married has moved up. As a result, sexual activities and the

resultant pregnancies that could have occurred within a marriage are now occurring before marriage (Dailard & Richardson, 2005: Online). It should be noted that termination of pregnancy is every person's constitutional right and that every person should receive it without judgment or consent from the next party (Botes & Poggenpoel, 2000:27).

2.3.2 STIs and HIV and AIDS

Factors that put young people at risk of sexually transmitted infections are many, interrelated, complex, and not easy to change. These factors include poor education, unemployment, and poverty, amongst others (Best, 2000: Online).

The results of the study conducted by Van Rensburg, et al (2002:53) confirm that among 206 first-year students from the University of the North in South Africa, 60 (29.2%) reported that they had never used condoms while 8.5% had used condoms irregularly in the previous three months. The situation is specifically highlighted because the general expectation is that young people, who were at university in 2001 when HIV and AIDS was under the spotlight, should be better informed and cautious about sexual behaviour. The majority of the students included in the study perceived the use of condoms as unsafe or an encouragement of promiscuity.

The department also projected an increase of up to 10 million for the next eight to ten years. Referring to a study on pregnant teenagers aged 15 to 19, Van Rensburg, et al (2002:53) indicated that nearly 13% of respondents were found to be HIV positive, and that 9.5%, had become infected before they had reached the age of 15.

Pelzer focused on condom use because it forms an integral part of the prevention of STIs including HIV and AIDS. According to the WHO, as quoted by Van Rensburg, et al (2002:53), condom promotion has received considerable attention in sub-Saharan Africa where HIV transmission is mainly through sexual contact. Unfortunately, condom use is the most difficult issue to address in the programmes designed to reduce the STI and HIV and AIDS epidemic in Africa.

Mfono (1998:2) states that, for example, the use of contraceptives, with the condoms as an example thereof, is constrained by attitudes which associate contraceptives

with marital commitments or stable relationships. None of which is characteristic of teenage relationships.

The statistical estimations mentioned above are an indication that the National DoH is confronted with the challenge of making reproductive health services more accessible and more youth friendly and with staff that can talk openly and honestly to young about issues that affect their lives (Foy & Dickson-Tetteh, 2001:15).

The accessibility of health care services to the youth will be looked into with regard to the structural and functional factors.

2.4 DEFINITION OF YOUTH FRIENDLY SERVICE

It was indicated that this study refers to a youth friendly service as one that attracts young people, meets their sexual and reproductive health needs, and is accessible and acceptable to a diversity of young people. There are, however, still many questions about how to put this into practice. Characteristics of youth friendly services will be looked at from the three areas namely, service providers, the facilities, and the youth as service consumers.

2.4.1 Service provider

Service providers rendering youth friendly services are expected to be technically competent. This can be achieved if staff working with young people provide services that will promote care and prevent illnesses affecting youth. (Burns & Grove, 2005:231). They should promote youth friendly services by communicating well, motivating, and supporting youth without being judgmental (WHO, 2002:27; Moya, 2002: Online).

2.4.2 Health facilities/services

Health services must ensure that they respond to the needs of all young people, whatever their age, sex, ability, beliefs, religion, and sexual lifestyle. Most importantly, services should encourage young people to access services and become involved by removing the obstacles that make young people feel uncomfortable about using the services. Services must be confidential, ensure

privacy, and be accessible to all young people by operating during hours convenient for young people such as late afternoons (after school), evenings, and weekends.

Services should not overlook but involve parents, guardians, churches, and schools as they are significant in the lives of young people in the community (International Planned Parenthood Federation (1999: Online).

2.5 CRITERIA FOR YOUTH FRIENDLY SERVICES

2.5.1 Affordability

Youth friendly services should be affordable to the youth but, as indicated in the previous chapter, all services provided from PHC clinics in South Africa, including the Northern Cape, are free. Therefore, this study will not look into the affordability of clinics.

2.5.2 Availability

It was indicated that PHC services are mostly provided from clinics situated within communities and that the accepted distance should be at least 5 km from the residential areas. Therefore, services are regarded as available to the youth.

2.5.3 Accessibility

The WHO (1981:27 cited by Dreyer et al., 2000:156) defines accessibility as the number or portion of a given population that can be expected to use a specific facility or service, with the assumption that certain barriers may exist. Hatting et al. (2006: 121) further define accessibility within PHC as the continuing and organized supply of an equitable level of health care within easy reach of all citizens at the right time and at the right price or free.

Accessibility to health services is one of the intervention strategies specified in the policy guidelines for youth and adolescents. The DoH's commitment to the following forms the basis of choosing accessibility as an important part of this study: A commitment to:

- the integration of sexual and reproductive health services at all levels of health care namely the primary, secondary, and tertiary;

- the improvement of the training of all categories of health care providers involved in the provision of health care, with regard to positive, empathetic, and respectful responses to the needs of youth and adolescents, and the maintenance of confidentiality;
- ensure that sexual and reproductive health services constitute the central component of youth-friendly health facilities, and that the satisfaction of youth with reproductive health services is one of the indicators; and
- ensure that reproductive health services are accessible to the poorest of the poor.

Total accessibility implies that several components of the PHC services should be in place. These components are structural, such as physical or geographical settings, i.e. being located within walking distance of the community or being financially accessible, and functional, such as having the needed services and treatments available, having convenient operating hours, and showing cultural sensitivity when working with young clients.

2.5.3.1 Structural accessibility

The structural accessibility of services is directly associated to their availability. The location of a structure is assessed in relation to its geographic allocation from the people as indicated under physical or geographic accessibility below.

2.5.3.2 Physical/geographic accessibility

Physical accessibility is commonly described in terms of the distance from the residence or home to a clinic. It also considers the time taken to reach the service, including the means of transport (Hattingh et al., 2006:121). The physical environment (structure) of the clinics has an influence on clinic attendance by young clients.

The NAFCI outlined that the physical environment forms the basis to the provision of adolescent friendly health services, and that it influences the perceptions of youth about the service. The WHO (2004:27) states that youth friendly services should be provided in safe environments that offer privacy and avoid stigma, while in a

convenient place. It refers, for example, to services provided from schools or recreational facilities as youth friendly.

In urban areas, most of services are within walking distance, but not necessarily in places that are familiar to all people. In many towns, only hospitals and police services have sign boards placed on the road and not clinics. Young people who may not be residents in the area, who are only attending school in the said area, have to ask where the clinic is, thereby exposing their intended visit to the clinic even if they would have wanted to keep that to themselves; particularly if no signs of illness are obvious. Youth claim that they have to pretend to be ill so as to prevent embarrassment, which compromises accessibility (WHO, 2002: 24).

In addition to the distance, Dreyer et al. (2000:157), and Hatting et al. (2006:121) consider that the time needed to travel and means of transport ought to be suitable for the community being served. For example, in some countries it may mean one hour's walking distance, while in another it may be half an hour by ox cart. It is therefore necessary to define geographical accessibility in terms of a specific country, town, or even location (Dreyer et al., 2000:132).

South Africa has accepted that a PHC service should be within a radius of 5 km from the residential area to be regarded as being accessible to the community. However, the said radius does not take the topographic layout of land or the networks of paths and roads into consideration (Brabyn & Skelly, 2002:3). Senderowitz (1999:28) states that services would be more geographically accessible to youth if they are provided in places that young people can reach.

The following are examples of efforts that were made to improve on the accessibility of services:

- The Child Hope in the Philippines trains street educators in Metro Manila to improve access to services for other street children. The programme trains children aged 11 to 15 years to provide street children with health information and support as well as an opportunity to go for treatment. These junior health workers are themselves living on the streets and the HCWs have very little control over the latter. Residents of the homelands could not be

served in urban areas without a valid permit or referral letter. This resulted in limited access or no access at all to basic services, particularly health care (Dreyer et al., 2000:157). The situation changed only after 1994 when sanctions were lifted by the government of the day, and informal settlements mushroomed in all spheres of the country as a result of uncontrolled urbanisation.

According to the Member of the Executive Committee (MEC) for Health in the Northern Cape, Selao, in his speech on 7 June 2006, the provincial health plan for 2014 includes among others, building five clinics which will be 50 km from the nearest hospital and also introduction of electronic management of patients records to reduce travelling and time of service delivery. Such improvements will have a positive impact on the geographic as well as the financial accessibility of services. The distance will be shorter and other people who were paying for transport may be able to walk to clinics and have more access to clinics at a lower cost.

2.5.3.3 Financial accessibility

Financial accessibility refers to an individual's ability to meet the cost of available health care (Dreyer et al., 2000:157). Financially accessible (affordability) describes services which both the community and the country providing the service can afford, considering factors such as fees charged for the services, money paid for transport, payments towards medication as well as any financial loss the service consumers will lose for staying away from work (Hattingh et al., 2006:121). Accessibility implies that the location and operational hours should consider the situations of the youth with regard to travelling facilities and finances involved.

In South Africa, all services provided at a community level have been free of charge since 1975. Thus, all services provided from governmental services are free (Kautzky & Tollman, nd: Online). This non-payment only includes physical care and treatment provided at the clinics and excludes transport and any other financial loss incurred.

2.5.3.4 Functional accessibility

Dreyer et al. (2001:132) and Hattingh et al. (2006:121) refer to functional accessibility as a situation where an appropriate type of care is made available to individuals who need it and if it is available at the right time. According to the International Planned Parenthood Federation (IPPF) (1999:3-6), services attempting to become functionally accessible should meet the needs of all people whatever their age, sex, ability beliefs, religion, and sexual lifestyle. Some services may be inaccessible simply because of the type/range of services or programmes provided. For example, not all PHC services provide antiretroviral treatment, termination of pregnancy, or delivery services.

- **Range of services**

The WHO (2001:9) states that adolescents should have access to promotive, preventive as well as curative services. Such services should meet the needs of the different age groups. The services are also determined by the needs of the individuals. According to the WHO (2002: 24), it is also essential that PHC realise that young people need facilities with a range of services. For example, some may need information, while others could need physical care or emotional support. The availability of different services would prevent them from being asked to come back or be referred elsewhere.

- **Operating hours**

One of the key determinants of accessibility to services is operating times. According to the National DoH (2007:13), clinics normally function on working hours (07h00 to 16h00 or 08h00 to 17h00) during the week, excluding weekend. Young people may encounter logistical barriers or non-technical aspects of service such as administrative barriers, for example days of the week and hours during which the service is opened. An example of this is that most PHC operate during weekdays when young people are at school. The services are closed during weekends and public holidays. In most cases they stop taking patients by midday and use the afternoon for administrative work and to clean the facility (Erulkar, Beksinskar & Cebekhulu (2001: Online). According to these authors, Thlokomelo Youth Centre was the only facility that is opens over a weekend in Kimberley.

Due to school hours which have extended to 15:00 in most provinces, young people can only access clinics from 16:00. By this time, nurses are overwhelmed with a sudden patient load and little time is available for clients seeking advice or information. Some teenagers therefore prefer services provided by general practitioners to that of clinics, as the former service is more convenient. This also leads to a delay in seeking treatment or to self-medication (Senderowitz, 1999:28). In some places in United States, clinical staff and students take turns to do duty in the evenings or over weekends when young people are not at school, college, or working as a strategy to narrow the gap between school hours and service provision.

In addition, working youth usually find it difficult to ask for time off work to seek treatment. Programme planning should explore ways in which services can overcome such difficulties. Added to these requirements for a PHC facility to be regarded as accessible is the fact that the staff of the facility should be culturally sensitive.

2.5.4 Acceptability

Acceptability implies that there should be no emotional barriers regarding the service that would discourage youth from visiting the clinic as was indicated in the conceptual framework designed for this study. According to the WHO, (2002: 18) services must be planned in such a way that they are appropriate, effective, affordable, acceptable, and accessible to the community as a whole. Thus, the location, the staff, and the environment where the services are provided should be acceptable to the youth and make them feel at ease, accepted, and respected.

2.5.4.1 Structural acceptability

Structural acceptability consists of the physical appearance of a facility and includes, amongst others, the service environment, including the layout of a facility and its impact on privacy (WHO, 2002:28).

- **Physical**

The term physical refers to the body or structure where interaction takes place. In this case, the physical environment refers to the building within which health care is provided. It would include the size and placement of the rooms and what each area

is used for. The physical appearance of clinics must attract young clients from a distance (Creel & Perry, 2002:3). Attention should be paid to the paintwork, posters on the wall, cleanliness of the surroundings as well as audio-visual material available at the clinic. The paintings, information, and sign boards must be in bright colours and have pictures of young people. Young people need entertaining information and not environments that duplicate quiet school settings. It is therefore important that the young be part of the planning of services aimed to meet their needs (WHO (2002: 28).

- **Waiting areas**

One of the most important problems faced by youth with regard to clinic use is anxiety about elder clients' perception of them. The anxiety results from public speculation by older woman that teenagers attend clinics because they are sexually active (Creel & Perry, 2002:3). This makes the young people feel unhappy and ashamed to be seen in clinics. Several teenagers mentioned that they would never stay in a clinic waiting room if there was a neighbor or church member, as they were sure that they would have to answer questions such as *"what brings you here"* or *"does your mother know you're here?"* As a result they would be forced to leave immediately to avoid embarrassment (Creel & Perry, 2002:3). Hence, young people are embarrassed to be seen at clinics and claim that there is limited or lack of privacy and confidentiality.

- **Privacy and confidentiality**

Most of the clinics have limited physical infrastructure. As such, even if the clients cannot be seen by others during a consultation, there is a possibility of the conversation being overheard by others (Ndhlovu et al., 2003:18). Usually consumers would not allow a health care provider to either disclose or transmit information to any other party not directly involved in the health care delivery process as it is private.

Teenagers proposed that a separate time and room be allocated for adolescents, but health care workers felt that separate areas will draw the attention of adults to what could be happening on the other side and further create the suspicion that

nurses are promoting sexual activity among youth by providing contraceptives against the parents' wish (Creel & Perry, 2002:3).

Youth also Northern Cape, the North West and the Northern Province wanted younger or at least middle-aged, rather than 'old', nurses to advise them on contraceptives. They preferred to be served by nurses who are preferably from a different area and therefore unknown to them. In turn, health care workers agreed that it was a good idea and would enable nurses to provide relevant information and advice to teenagers, without being intimidated by adult clients.

Boonstra and Nash (2000:Online) state that lack of privacy and confidentiality adds to the psychological problems experienced by young people as a result of pregnancy and STIs, most of which are not accepted by parents, communities, and service providers.

2.5.4.2 Functional acceptability

Functional obstacles to using services also include long waiting times and inconvenient hours. Functional acceptability, on the other hand, includes administration, the programmes provided, and other issues that enable service provision. Young people expressed the need for consultations with or without an appointment and indicated that health services linked to or located in schools would address the issue of inconvenient hours (WHO, 2002:24, DoH, 2002: Online).

- **Provider-client relationship**

This is a process whereby a health professional attends to a patient physically, verbally, and non-verbally with the aim of addressing a patient's need. It involves a positive attitude and language. The challenge, however, is to get the message across and be able to interpret the response (Hattingh et al., 2006:174).

The relationship refers to the interaction between the service provider and the young person as recipient of the service. This can be physical such as examining a person or verbal such as taking history about the illness or giving information. The youth perceive their interaction with health care workers as negative, disrespectful, and without any commitment from the side of the health care providers (Diale & Roos,

2000:138). Unfortunately, poor relationship between the youth and service providers have a negative influence on the extent to which services are accessible or acceptable to the youth as service consumers (Foy and Dickson-Tetteh,2001:15).

- **Communication**

Communication is a process that enables one person to get the message across to a recipient and be able to interpret the response. Communication should suit the audience for which it is intended. (Hattingh et al., 2006:174). The problems between the service providers and the youth are not recent. *"Mothers deliver without support and they leave us alone and go to sleep." A teenage mother said, "I choose to give birth at home because at the hospital or clinic, we teenagers are treated very badly. They hit us and insult us. So, it is better at home because my mother won't scold me." (Varkey, 2000: 0nline).*

The young people expressed the need to have a relationship based on active listening and communication which is on a more equal footing than what they often find at school or at home. Where necessary, training of health workers should improve communication skills, especially regarding sensitive issues, that form a basis for caring for adolescents (Foy & Dickson-Tetteh, 2001:15).

- **Attitudes**

It is every person's constitutional right to decide on a service and to receive it without having to reach consensus with other parties as ethical decision-making requires empathy, respect for human rights, and unconditional acceptance of a person. Prejudiced health care workers who are of the opinion that the youth should not be sexually active are perceived to be judgmental. It is evident then that the judgmental attitudes experienced by the youth are unethical and need to be changed (Botes & Poggenpoel, 2000:27). Such perceived judgmental attitude has detrimental results such as shame, unhappiness, and fear.

- **Authoritative care**

A major obstacle to developing adult-youth partnerships occurs when adolescents feel that an adult, oblivious to their need to be "somebody", is patronising them (Rajani, 1995: cited in Lehana, 2000:31). Adolescents report that they often experience treatment by adults that seems to suggest that they really do not matter. This issue is fundamentally a question of power, whereby adults, including health care workers, parents, and teachers, seek to maintain control. The authors quoted this as an impression expressed by an adolescent:

"The power imposed by adults on us causes resentment, because young people want to be taken seriously. Asking adults to think about their own experiences at 14, how did the adults in their lives relate to and treat them, what was helpful and what was difficult and to recall how it felt to be young can also be beneficial."

Some (21%) of the respondents in the above study stated that they considered not going back to the clinic because of the nurses' behaviour. Some clinics were perceived to be a place where health workers' authority was paramount and unchallengeable. Female and male youth claimed that they were afraid of asking clinic staff for advice about condoms and contraception, particularly between 15 and 16 years. The service providers usually complained that they were underage and would refuse condoms and contraception (Lehana, 2000: 48).

- **Participation**

Hattingh et al. *(*2006:123) suggest that community participation can be enhanced when both communities and health care service providers are involved when decisions are made about health and health care needs. However, Creel and Perry (2002:4) are of the opinion that adolescents are often excluded from the planning of health programmes either because the adult professionals who are implementing such programmes want to discourage adolescent sexual activity, or because adolescents have been overlooked in the planning process. Involving young people in developing, implementing, and evaluating programmes which address their needs or problems can help ensure that their needs are met in a way that will be suitable and thus acceptable to them (Creel & Perry, 2002:5).

The WHO (1999:13) cited in Creel & Perry (2002:6) states that approaches which were traditionally used to prevent and manage health problems affecting adults and children were not always effective when dealing with the problems of the youth and adolescents. Furthermore, involving young people when adults are planning programmes may assist the youth in gaining a better understanding of the perspective of others, and of their own issues and concerns.

PHC services were described as functionally unacceptable to teenagers because they do not receive appropriate care for their needs due to their exclusion from programmes planned for them (Diale & Roos, 2000:193).

- **Confidentiality**

Adolescents fear that their problems will not be kept confidential in many community clinics where there is not sufficient space to guarantee privacy. In such clinics, it is easy for the conversation between a nurse and her client to be overheard. According to Creel and Perry (2002:5), because of lack of confidentiality, young people in the developing world prefer to use private-sector pharmacies, kiosks, and retail stores when seeking contraceptives because they can obtain the supplies more anonymously.

Diale and Ross (2000:136) state that fear of being seen while seeking reproductive health or fear of being seen as already sexual active among South African youth as originating from lack of privacy.

2.6 EFFORTS TO ADDRESS THE DELIVERY OF YOUTH FRIENDLY SERVICES

2.6.1 Comprehensive care

The WHO, in partnership with UNICEF and UNFPA, was said to be advocating for a comprehensive health care approach, which will be effective enough to enable adolescents and the youth to develop to their full potential and be healthy (Foy & Dickson-Tetteh, 2001:15). The comprehensive approach must address young people's diverse health and developmental needs, considering that their needs will

change over time and may differ according to gender and circumstances. At various times they may need information, skills, counselling, or various health services.

2.6.2 Programmes

A National Life Skills Project Committee was established in 1995, and life skills programmes aimed at school-going youth were implemented. By the end of 1998, two teachers in every secondary school throughout the country were trained in life skills including, among others, sexuality. As the need increased, the focus changed to include primary schools (Adler & Qulo, 1999:307). However, it is known from the implementation reports that making youth aware of their health needs created a greater demand for youth-orientated health services due to the change it brought about in their health seeking behaviour.

2.6.3 Standards

The NAFCI has also set standards for adolescent friendly clinics among which the seventh is to put in place a system to train clinic staff towards the provision of adolescent friendly services. The standards emphasized:

- the availability of drugs, supplies and equipment necessary for providing service;
- information, education and communication consistent with the essential service package;
- the availability of systems to train personnel to provide adolescent-friendly services effectively;
- the management systems which support effective provision of adolescent-friendly health services based on policies and process that support the rights of adolescents; and
- those adolescents receive individualised and adequate psychosocial care based on standard care management guidelines.

2.7 CONCLUSION

Although PHC is defined as being acceptable, accessible, and available as well as affordable to the country and the entire population, there is a clearly established

need for improving health services provided from PHC clinics to become youth friendly. Researchers have pointed to a collection of barriers that prevent or deter the youth from gaining access to the services. The most important amongst the barriers seems to be the attitude of health care workers that render the services that are unacceptable to the youth. As a result, preventable reproductive problems are escalating, regardless of the free services and the increasing knowledge on contraceptives. It is evident that both the staff and young clients should help each other in making the service more youth friendly, accessible, and acceptable.

CHAPTER 3
RESEARCH METHODOLOGY

The previous chapter cited information revealed by researching the literature pertaining to the delivery of health care services to the youth in South Africa and internationally. It was indicated that the health care services delivered to the young South Africans have not been well researched.

This chapter will focus on the method applied in fulfilling the aim of the study to assess the delivery of youth friendly services in the Northern Cape. This will entail describing the research design, the sampling method, and the process of data collection as well as the process of data analysis. The ethical considerations, the value of the study, and the problems encountered during data collection will also be discussed.

3.1 RESEARCH DESIGN AND TECHNIQUES

3.1.1 Research design

"A research design is the overall plan for obtaining answers to the questions being studied" (Polit & Beck, 2004:49). It can also be referred to as "a plan or blue print "of a research (Mouton, 2001:55 cited in De Vos, Strydom, Fouché & Delport, 2005:132; Babbie and Mouton, 2001:74). In addition to that, Burns and Grove (2005:211) add that the design "maximizes control over factors that could interfere with the validity of the findings". Uys and Basson (2000:38) refer to the research design as "the structural framework" of a study. Furthermore, Hofstee (2006:113) considers it to be anything a researcher uses to collect data.

In order to select an appropriate research design, each researcher is guided by one overarching consideration, namely, the extent to which the design will provide trustworthy answers to the research question (Babbie & Mouton, 2001:74; Polit & Beck, 2004:209). According to Babbie and Mouton (2001:74), the researcher must be

as specific as possible about "...what he or she wants to find out", and also about "...the best way to do it".

This study used a quantitative, non-experimental, descriptive, survey type of research design. Moreover, this choice was made because literature showed that youth friendly services are a new concept in South Africa which has not been adequately researched.

Quantitative research

A quantitative research method is a formal, objective and systematic process for obtaining quantifiable information about the world. The information is presented numerically and analysed through the use of statistics suitable for the aim of the study (Cormack, 2000:19; Burns & Grove, 2005:23). The goal of quantitative methods is to determine whether the predictive generalisations of a theory hold true (Cormack, 2000:19).

Furthermore, a quantitative method is used to describe variables, identify relationships among variables, and to examine cause-and-effect relationships. It is an inquiry into an identified problem, based on testing a theory, measured with numbers and analysed using statistical techniques (Polit & Beck, 2004:16). Since this study used a questionnaire where attributive variables (attitudes and experiences) were measured numerically and analysed statistically, it is clear that the obvious method for this study was quantitative.

Basically, quantitative research is divided into experimental and non-experimental research designs (Burns & Grove, 2005:26). In experimental research, an intervention or treatment is introduced, whereas in non-experimental research, data is collected without introducing any change or treatment (Polit & Beck, 2004:46; Burns & Grove, 2005:231). The 'non-experimental' research design was applicable to this study, as the human characteristics under study accessibility and acceptability cannot be studied experimentally.

Non-experimental research

Non-experimental research proposes the research of phenomena as they exist in reality. Non-experimental methods are especially applicable to most forms of research where the variables studied are attributive human characteristics as is the case with this intended study. Non-experimental research also implies that the natural situation is not manipulated and no planned intervention is implemented at any stage.

A further breakdown of research types indicates that research can either be comparative or descriptive. Comparative research proposes the comparison of groups in terms of the variable which is being studied and the application of inferential statistics, whereas descriptive studies provide in-depth descriptions of a single group regarding the variable that is being studied (McMillan & Schumacher, 2001:287).

The application of a comparative study was compromised by the fact that the literature research indicated the existence of multiple extraneous factors that influence youth perceptions and experiences regarding acceptability and accessibility of PHC clinics. This would implicate internal validity in the execution of comparative inferential design.

Conversely, descriptive studies are indicated where little research has been done in a topic as was the case in this study. The literature study revealed that the nature of health care services delivered to young South Africans has been sparsely researched. This indicated a preference for a descriptive design. Burns and Grove (2005:336) state that descriptive designs are the types of research that describe what exists and help to uncover new facts and meaning. A non-experimental design of a descriptive nature be used to generate knowledge about topics that have been limitedly or not researched at all (Cormack, 2000:20).

A survey is an empirical and logical investigation which involves a systematic and impartial collection of data from a sample of cases, after which the findings are analysed statistically (Uys & Basson, 2000:47). In health related studies, surveys are commonly used to describe existing or current situations in order to determine its

cause and contributory factors. Neuman (2007:167) recommends surveys when self-reported beliefs and behaviours are explored. A researcher using a survey "selects a sample of respondents and administers a questionnaire or conducts interviews to collect the desired information" (McMillan & Schumacher, 2001:287).

When using a survey, the researcher allows the respondents to simply answer questions from the questionnaire (mailed or personally handed to people) without manipulating any situation or condition (Neuman, 2007:31). Most surveys are used to describe the incidence, frequency, and the distribution of selected characteristics in an identified population (McMillan & Schumacher, 2001:304).

In descriptive surveys, researchers ask questions which assist them to determine the attitudes or characteristics of the population and then provide descriptions of these variables in the form of averages or percentages. Alternatively, surveys can also be used to "explore relationships between variables" (McMillan & Schumacher, 2001:304; Uys & Basson, 2000:48).

The most important methodological consideration in respect of descriptive surveys is the collection of accurate data on the domain phenomenon to be studied. Surveys are frequently used because accurate information can be obtained for a large population by means of a small sample (McMillan & Schumacher, 2001:304). The design was decided on after a detailed analysis of the characteristics and applicability of a quantitative research design.

3.2 POPULATION AND SAMPLING

3.2.1 Population

Uys and Basson (2000:86) as well as Burns and Grove (2005:336) describe the population of a study as the entire set of individuals, units, or elements defined by the distinguishing sampling criteria established for the study, whereas Babbie and Mouton (2001:174) describe it as "an aggregation of elements or cases from which the sample is actually selected". According to McMillan and Schumacher (2001:304), the intention of identifying a population is "to generalize the results of a research".

In the broad sense of the word, the population for the study would have been all young people who have consulted PHC services in the Northern Cape. However, this population would have been too wide for any research study. An alternative was to define the term population in its narrow connotation, which refers only to "those cases or elements that are potentially accessible to the researcher". Such a group is referred to as the "target population" (Uys & Basson, 2000:86). To ensure geographic convenience and affordability, the population for the study was narrowed to learners in high schools. According to Northern Cape Provincial government (2009: 26) the total number of learners enrolled in the province for 2003 was 193 335, of which 31 009 was for the 17 high schools situated in Kimberly as confirmed by Mr Ganief (senior finance clerk for the Northern Cape DoE). The target population for this study will be as described below.

3.2.1.1 Target population

The term target population refers to "the specific pool of cases" that the researcher wants to study (Neuman, 2007:203, Uys & Basson, 2000:86; McMillan & Schumacher, 2001:169; Moule & Goodman, 2009:265). McMillan and Schumacher (2001:169) argue that, "the target population is often different from the list of elements from which the sample is actually selected, referred to as the survey population or sampling frame". They also suggest that "the researcher should carefully and completely define both the target population and the sampling frame".

The target population in this study was school going youth, males and females of all races who were between 13 and 21 years and had consulted the PHC services within the geographic boundaries of Kimberley for information or treatment. This population was specifically targeted because HCWs in Kimberley received training on the provision of youth friendly services in March 2001.

The school going youth was chosen because not all young people would be equally accessible to the researcher in that young people of this age can be in different areas such as school, prisons, or on the streets. As a result, the researcher had to select an area where the population could be easily accessed. Usually, schools would be the best place to afford a researcher an opportunity to reach a large number of the youth. Hence school going youth was targeted.

3.2.1.2 Accessible population

Moule and Goodman, (2009:265), Burns and Grove (2005:342) and Uys and Basson (2000:86) define an accessible population more or less as the portion or section of the target population to which the researcher has reasonable access. According to information from the DoE in Bloemfontein, the majority of children between 13 and 18 (in the White and Indian communities) and 13 to 20 or even 21 years (in Black communities) are usually in high schools.

Schools were targeted because the majority of youth – 83% to 97% – attend school. In addition, schools are in a better position than health care facilities to address issues of health care due to the fact that large numbers of adolescents are within their reach (DoH (2001: 30; Harrison, 2010:32). Also, there is consistency in getting almost the same number of learners in a school on daily basis unlike in health care facilities.

Thus, the sample frame for this study was all high schools within Kimberley. The accessible population was all high school going young people between the ages of 13 to 21 years which according to the DoE was 1200 and 980 learners, from all races and both genders who had consulted PHC services within the geographic boundaries of Kimberley for health information or treatment recently (meaning a period of one year prior to the implementation of this study).

3.3 SAMPLING

Sampling is a process of selecting subjects that are representative of the population being studied (Moule & Goodman, 2009:266). If sampling is carried out correctly, the data can be of more value and the procedures "less time-consuming", "cost-effective", and serve as a "mechanism for control" within a quantitative study (Uys & Basson, 2000:89; Burns & Groove, 2005:47).

Basically, two methods, the probability- and non- probability sampling, can be used to obtain a representative sample (Uys & Basson, 2000:89; Polit & Beck, 2004; 50; Burns & Groove, 2005:47). However, McMillan and Schumacher (2001:306) suggest

that the researcher must make a decision based on the amount of time, money, and personnel available before designing the methodology to collect data.

3.3.1 Probability sampling

The term probability sampling refers to the fact that "every member (subject or element) of the population has a probability higher than zero" (Burns & Groove, 2005:209; Moule & Goodman, 2009:268) or an "equal probability" of being included in the sample (Polit & Beck, 2004:50). Probability sampling is further classified as "simple random sampling", "stratified random sampling", "cluster sampling", and "systematic sampling" (Polit & Beck, 2004:295-299). Strydom (cited in De Vos, Strydom, Fouché & Delport, 2005:201) adds a fifth category, namely, "panel sampling".

Simple random sampling subjects are selected from the population so that "all the members of the population have the same probability of being chosen" (McMillan & Schumacher, 2001:170). In stratified random sampling, the researcher is supposed to divide the population into different sub-groups or strata (McMillan & Schumacher, 2001:172; Polit & Beck, 2004:297).

Cluster sampling can be compared to stratified random sampling. The population is divided into groups and research subjects are selected from each group or cluster before the sample is selected (McMillan & Schumacher, 2001:172). Systematic sampling means that "all subsequent cases are selected according to a particular interval". In a panel sample, a set panel of subjects is selected from the population (De Vos et al., 2005:200-201).

3.3.2 Non-probability sampling

Uys and Basson (2000:93) describe the non-probability sampling as "one in which there is no way of estimating the probability that each element has of being included in a sample, and one in which there is no assurance that every element does have a chance to be included". De Vos et al. (2005:201) added that "...the odds of selecting the particular individuals are not known because the researcher does not know the population or the members of the population".

Non-probability sampling includes convenience, purposive, and quota sampling (McMillan & Schumacher, 2001:175-176; Polit & Beck, 2004:292-294; Moule & Goodman, 2009:272). As in the case of probability sampling, De Vos et al. (2005:202-203) states four other methods, namely, "dimensional", "target", "snowball" and "spatial" sampling.

Convenience sampling, also known as accidental sampling, entails using the most conveniently available or accessible people as study respondents (McMillan & Schumacher, 2001:175; Polit & Beck, 2004:292; Burns & Groove, 2005:303; Moule & Goodman, 2009:272). According to De Vos et al. (2005:202), convenience sampling implies that "Any case which happen to cross the researcher's path and has anything to do with the phenomenon can be included in the sample until the desired number is obtained".

Unlike convenience sampling, purposive sampling, also referred to as "judgment or judgmental", does not take place accidentally (McMillan & Schumacher, 2001:175). It depends completely on the judgment of the researcher and the characteristics and typical attributes of the population (De Vos et al., 2005:202).

In quota sampling, the main purpose is to get a sample that is as close to a replica of the population as possible, whereas the dimensional sampling strives to include at least one representative of each dimension in the sample (Polit & Beck, 2004:292; De Vos et al., 2005:202). Polit and Beck (2004:292) add that quota sampling is used "when the researcher is unable to use probability sampling but is still able to select subjects on the basis of characteristics of the population".

Target sampling requires controlled lists of specified populations in an area and designs detailed plans for recruiting the desired sample from those lists (McMillan & Schumacher, 2001:306). On the other hand, the snowball method, also known as "network or chain" sampling, uses only one case that is involved in the investigation to gain information on other similar persons (Polit & Beck, 2004: 292). Finally, spatial sampling uses very temporary populations such as people in the scene of an accident, where the researcher will have decided beforehand how they will be

approached. This method is complemented by keen observation (De Vos et al., 2005:202).

In this study, both probability and non-probability sampling methods were used. A random probability sampling method was used for the purpose of selecting the schools, whereas a convenience non-probability sampling method was used for selecting respondents (youth).

Although Polit, Hungler and Beck (2001:236) state that convenience sampling is the weakest sampling method because the available subjects might not necessarily be typical representatives of the population, and also that self-selection may lead to bias; this was the best suitable sampling method for the study. The researcher was not in a position to predict which parents would agree that their children be included in the study or which learners would be willing to participate.

3.3.3 Sample selection

The first stage of sample selection after having defined a study population is to obtain a list of all individuals in that population from which the sample is chosen (Moule & Goodman, 2009:268). This list is known as the "sample frame" (Cormack, 2000:266). The researcher usually hopes that the sample frame will at least be a reasonable approximation of the population as it is unfeasible to study the entire population or all potential cases (Yedigis & Weinbach, 2002:180).

Sampling must be fair and relate directly to the purpose of the research study, prevent any exploitation of participants, and ensure that participants are not included simply because they are readily accessible (Botma, Greeff, Mulaudzi & Wright, 2010:13). As indicated by Newman (2007:203), listing the elements in a population may sound simpler than it is. In the case of this study, it was not simple at all.

For the purpose of this study, the sample frame consisted of a list of all high schools within Kimberley. This proved to be quite difficult to obtain from the Provincial DoE (Northern Cape) because of administrative red tape.

- **The process to select a random sample of schools**

A list of the schools was obtained from the Provincial DoE (Northern Cape), but only 16 high schools were situated in Kimberley. The names of these schools public and private, were placed in a container and six were selected randomly, as 10% thereof would only have been two (schools, which would have been too small and not representative of the population.

Letters requesting permission to conduct the study were written to the selected schools five months before the main study was implemented. Feedback from the schools was unsatisfactory and the researcher decided to follow-up telephonically. During this follow-up session, one school, which was a girls' multiracial school, opted not to participate. Such a decline affected the selection process negatively because this was one of the only two schools that had a multiracial but predominantly white population, a requirement stipulated in the sample.

Dates for data collection were agreed upon with the principals of the remaining five schools. It was unfortunate that at this stage the second multiracial school, the only Afrikaans medium of instruction, also withdrew, leaving the researcher with a sample size of four schools. The reason cited by the Afrikaans medium school was that the majority of learners claimed not to have consulted PHC services because their parents are members of medical aid schemes. These learners would not have met the stated inclusion criteria as they would not have consulted any PHC service.

In an attempt to retain the sample size and to increase the representativity of the schools, two extra schools were selected from a container as done initially. The principals of both schools were phoned and both of them granted permission, and both were conveniently included in the study. The sample size of schools was then six as initially planned.

- **The process to select a convenience sample of learners**

The second step of the sampling process is the identification of the population from which the sample will be drawn, after which a sample plan is developed to increase representativeness (Burns & Groove, 2005:369-370). The authors state that in most cases a 10% sample should be sufficient for controlling possible sampling errors.

The sample of learners was selected from an accessible population by means of convenience sampling. Initially, the researcher had planned to implement random sampling, but due to practical problems discussed below this was not possible.

Accessibility would be determined by practical factors pertaining to ethical and consent issues. Selecting a sample for this study proved to be very problematic because of a number of gatekeepers involved. For example, including learners as respondents in the study did not only depend on permission granted by the department, the schools, or parents but was completely dependent on each individual respondent's willingness to participate.

In some cases this willingness was compromised. One of the schools that had predominantly white learners withdrew from the study because the majority of learners in that school claimed that they have medical aid schemes and visit private practitioners. In addition, some respondents also withdrew during the process of data collection because they claimed not to have consulted clinics in Kimberley.

With the occurrence of such issues, the only possible method of sampling that could be executed was convenience sampling.

With this fact in mind, and in the light of the practical problems mentioned below, convenience sampling was still regarded as the most appropriate method of sampling, but because this was not a random sampling method generalising would be compromised.

The sample frame requested from all the selected high schools included the number of learners in each grade as divided into classes. The number of learners per school differed from but all six schools had between 1200 and 980 learners. This list assisted the researcher in finalising the sample size, which in this case was of 20 learners per grade and 100 learners per school. This sample size was more or less 10% of 1 200 or 980 and was acceptable to the expert and research committees and confirmed by the biostatistician.

- **Inclusion criteria**

Although this was a convenience sample, the set criteria for inclusion was adhered to, as the researcher ensured that the respondents were:

- attending any of the schools that participate in the study;
- between the ages of 13 and 21;
- males and females; and
- of any race.

The researcher also ensured that the respondents:

- had attended a PHC facility in the Kimberley area;
- had obtained the consent from their parents to participate, if under 18 years; and
- had given their consent to participate in the study.

3.3.4 Sample size

Sample size refers to the number of subjects that are available and included in a sample (Polit et al., 2001:244). Burns and Grove (2005:358) indicate that the sample size and sampling plan are determined by the purpose of the study, meaning that they are determined by the depth of information that is needed to gain insight into a phenomenon. Quantitative studies use large samples that will enable researchers to identify relationships among variables or to determine differences between groups (Burns & Grove, 2005:358; Moule & Goodman, 2009:267).

In most cases a sample size which presents 10% of the population should be a sufficient sample size for controlling possible sampling errors. Although this formula is given as a general rule of thumb for research projects, researchers using quantitative methods are advised to select the largest sample possible (Polit et al., 2001:244). Contrary to this, McMillan and Schumacher (2001:306) are of the opinion that "It is better to use a small study well than a large study poorly".

In all research, the selection of individuals to partake in a study entails ethical measures pertaining to consent and willingness to partake in the study. The initial envisaged sample size for this study was 500 high school going youth, meaning that

at least 80 - 100 youths from each of the five selected high schools of which 10 males and 10 females would be selected from each grade to ensure gender, age, and racial representativeness.

3.4 RESEARCH TECHNIQUE

Techniques used in qualitative data collection include experiments, surveys, content analyses, and existing statistics (Neuman, 2007:20) In a survey, researchers usually use interviews (face-to-face or telephonic) as well as written questionnaires which may be mailed or handed to people (Leedy & Ormrod, 2005:184; Neuman, 2007:20).

According to Burns & Groove (2005:35) quantitative researchers believe that all human behaviour is objective, purposeful, and measurable and that the researcher needs only to find or develop the "right" instrument so as to measure and describe the behaviour carefully and accurately.

Construction of the questionnaires

Burns and Grove (2005:398) define a questionnaire as "a printed self-report form designed to elicit information that can be obtained through the written responses of the subjects", whereas Polit and Beck (2004:730) refer to it as "a method of gathering self-report information from respondents".

According to De Vos (2005:152) and Maree (2007:159), a questionnaire is a set of questions on a form, which is completed by the respondents in respect of a research project. Questionnaires can be applied in various ways and should therefore not be confused with the interviews used in the qualitative approach. Generally, a questionnaire is said to be a more superficial instrument than the interview but is always structured. They are cheaper and have the advantage of being distributed to more respondents than interviews (Uys & Basson, 2000:65).

According to Uys and Basson (2000:75), a data-collecting instrument should comprise of certain basic characteristics, namely, reliability, validity, sensitivity, appropriateness and suitability, objectivity, and feasibility.

Neuman (2007:233) and Leedy and Ormrod (2005:188) specify the following principles to be implemented when constructing a reliable and a valid questionnaire:

- Jargon, slang, and abbreviations should be avoided because respondents may understand their meaning differently.
- Ambiguity and vagueness may lead to misinterpretation of the question.
- Emotional language and prestige biased words with strong emotional connotations should be avoided and natural language should be used.
- Double-barreled questions should be minimised, meaning that each question must be restricted to a single idea, and that only one question should be asked at a time so as to get specific answers.
- Questions that are beyond respondents capabilities should be avoided.
- Controversial questions must be saved for the latter part of the interview.
- Questions that will elicit qualitative information should also be considered.

Although a good questionnaire should be complete, thereby getting the entire data one needs, yet be short enough so as not to abuse the respondent's time or concentration; "a short questionnaire of 3 to 4 pages is appropriate for the general population" (Neuman, 2007:181). To ensure this, the instrument should ask clear, precise, unambiguous, relevant, and understandable questions. Leedy and Ormrod (2005:188) add that the researcher must at the same time consider how each response will be quantified and that the questions should be modified accordingly. According to Maree (2007:159), clear instructions, neat and legible instructions are aspects that encourage participants to complete a questionnaire.

Initially, the questionnaire designed for the study conducted by Botma and co-researchers was meant for exit interviews at the clinics, meaning that only those young people who had consulted the clinics on that specific day were interviewed. That instrument was chosen as the current study was planned as a follow-up survey that would target youth who may not have been to the clinics during the initial survey in 2001. Secondly, the study was also aimed at getting the respondents from a neutral place either than the clinics. The reason for that was to ensure that the young people do not necessarily reflect on the situation or experience of that specific day, which may be a once off issue.

The age of the respondents was changed to suit the age of high school going youth as recommended by the DoE (13 to 21 years). The questionnaire would also be self-administered and not an interview by fieldworkers. The construction thereof was a team effort amongst members of the school who were in the project, the researcher being one of the neophytes. The newly developed questionnaire to be used in this study was developed based on an extensive literature review.

Validity and reliability of the questionnaire

The validity of an instrument is regarded as its ability to measure that which it purports to measure or to test what it is supposed to measure. Burns and Grove (2007:365) are of the opinion that no instrument will be completely valid, as validity varies from sample to sample and also from situation to situation. In other words, an instrument may be valid in one situation but not in another. Validity is not used to evaluate the instrument. It is the use of the instrument for a specific group or purpose which is validated. The validity of an instrument determines how well it reflects what is being examined. Therefore, reliability testing was done on each of the instruments, although it was previously used in a study. The pilot study was used as a measure to ensure that the questionnaire will be suitable in the different environment and for the younger age group.

Reliability, on the other hand, is defined as the ability of the data gathering device to obtain consistent results (Uys and Basson, 2000:75); or as the degree of consistency or accuracy within which an instrument measures the attribute it is designed to measure (Burns and Grove, 2007: 364). These researchers further explain that the reliability of a questionnaire relates to the accuracy of the instruments' measurement.

Cowan (2009: Online) refer to reliability as consistency or dependability of an instrument that can either be reflected when two or more assessor reaches the same interpretation (inter-rater reliability), or when an individual assessor comes up with the same interpretation in two different assessments (intra-rater reliability)

To meet the criteria stated above, the validity and reliability of the questionnaire was, for example, increased by means of the following strategies:

- The questionnaires' content validity was based on the grounds that questions were derived from an in-depth literature review, and in the attempts made to compare and contrast the findings of this research with those of the other researchers reported in the studied literature. The reliability of the previously used questionnaire would also be proven based on the results provided in that study, which the researcher has been referring to as part of the literature review. The face and content validity was obtained by subjecting the questionnaires to the scrutiny of experienced researchers and a bio-statistician who were part of the expert and research committees at the Faculty of Health Sciences at the University of the Free State. The reliability and validity were not statistically calculated.
- Modifications were made, based on suggestions from the experts, research and ethical committees. The committees agreed that the instrument adequately measured components of accessibility and acceptability of PHC clinics to the youth. To finally confirm this, a pilot study was undertaken at a High School in Bloemfontein (refer Pilot Study).

Other criteria regarding the construction of a questionnaire that were also considered include suitability, feasibility, cost and time:

- *Suitability*

Suitability implies that the instrument used to collect the data enable the researcher to meet the research objectives. Stated differently, an instrument should be suitable for the purpose intended (Uys & Basson, 2000:83). In this study, the questionnaire was tested on school going youth, and it was adjusted according to the problems identified in the pilot study. As indicated earlier, the time allocated for data collection was increased by 30 minutes.

One of the questions was rephrased for the younger school going respondents to understand. For example, one question was omitted "what contraceptive methods

are you using if any?" the reason for the omission was because perhaps not all 13 or 14 year old may have started on contraception or may not be familiar with such.

- *Sensitivity*

An instrument's sensitivity is determined by its capability of making fine enough distinctions, for example, a stopwatch which can measure a hundredth of a second is more sensitive than a stopwatch which can measure a tenth of a second; in nursing research, a seven point scale is more sensitive than a three point scale. It must be kept in mind though that human behaviour is not as easily (thus sensitively) measured as physical phenomena. Nevertheless, the aim is to refine one's instruments constantly (Uys & Basson, 2000:83).

In this case, the researcher was the facilitator and also in control of the satiation. For example a respondent needed clarity on the questionnaire, the researchers would be there to simplify the question without changing its meaning or purpose.

- *Feasibility*

Feasibility encompasses a variety of considerations, particularly in relation to the skills, costs, and time. The instrument also forms a great part of the research as the instruments may be inappropriate for either the researcher or the respondents (Uys & Basson, 2000:84).

The researcher received some training to effectively manage the instrument before the piloting took place, and all respondents possessed the necessary reading and writing skills. But, the researcher was present to transmit such skills to the youth if need be.

Regarding time, an instrument must be accomplished within the scheduled time regardless of its form. As indicated earlier, the questionnaire was shortened after the pilot study so that it would take 45 minutes at the most.

3.4.1 Pilot study

According to Singleton, Straits, Straits and McAllister (1988:290 cited in De Vos, 2005:178), the concept is described as the pre-testing of a measuring instrument or

the "dress rehearsal" of the main investigation. It is a small-scale study in which a small sample of the population, different from the group who will eventually form part of the sample group, is used (Uys & Basson, 2000:103; Moule & Goodman, 2009:296).

The purpose of the pilot study is to provide a miniature trial run of the methodology, and an opportunity to refine and adjust methods or techniques to acquaint field workers with the instruments and respondents (Uys & Basson, 2000:103). Huysamen (1993:205 cited in De Vos, 2005:179) and Leedy and Ormrod (2005:188) state that a pilot study also investigates the feasibility of the planned project or brings possible deficiencies in the measurement procedure to the fore, thereby enabling the researcher to fine tune the questions before data collection commences.

In order to establish the accuracy of the measuring instruments used in measuring youth friendliness, a pre-test was conducted on a group of 25 youth attending a High School in Bloemfontein, whose characteristics (that both male and females were involved, aged 13 to 21 years, in a high school, and that they had all consulted a PHC clinic for information, advice, and service) corresponded with those of the target populations, but who did not form part of the research populations.

Although the pilot group reported no difficulty in understanding and responding to the questions, the following aspects were also established:

- The time required completing the questionnaires was more than the envisaged hour
- The instructions were not clear especially to the younger respondents. For example, even those that only attended one clinic, who should not answer questions 3.3 and 3.4, did answer it.
- The ability of the respondents to understand the questions.

Based on the results of the pilot study, the following changes were made:

- The instructions were bolded and the researcher read the instructions to the respondents after the questionnaires are distributed.

- The questionnaire was shortened by comprehending some of the questions by giving options. For example, question 1.4 on reasons why respondents did not return to the clinic, and question 3.13 on what made them go that clinic for help.
- Some of the questions were rephrased, for example in question 4.2, a five (5) point scale with options was provided to describe the characteristics of service providers.

The quantitative aspect of this study entailed a survey using personal self-administered questionnaires completed by high school going youth in Kimberly.

Organisation of the questionnaire

The computer-coded questionnaires consisted of four sections which generated information regarding the following themes:

- Clinic attendance
- Biographic data
- The nature of the services
- Experiences of youth

Regarding the experiences at clinics and reasons for not utilising the services, a list of responses were given from which the respondents were instructed to indicate by means of a mark which responses applied to them.

Questionnaire design

The questionnaire included both closed and open-ended questions. Nineteen open and 14 close-ended questions were posed. Open-ended questions were utilised in cases where the respondents could provide their personal views, experiences, and/or perception as well as general comments. Table 3.1 below is an indication of the distribution of questions in the four sections.

Table 3.1 Distribution of questions in the questionnaires

Questions	Section 1	Section 2	Section 3	Section 4
Clinic attendance	1.1 – 1.4			
Biography		2.1-2.3		
Nature of services			3.1-3.20	
Experiences				4.1-4.6.1

The final version of the questionnaire had been constructed in English and Afrikaans seeing as these are the languages of instruction in high schools in Kimberley (refer Annexures F and G). As indicated earlier, the questionnaire was inly in the two languages because the DoE was of the opinion that all content subjects are taught either in English or Afrikaans in all high schools. All learners would be able to read and respond to in those languages.

3.5 DATA COLLECTION

Whereas Botma (2001) and Mqhayi et al. (2004) used exit questionnaires at clinics in their studies, the researcher chose a neutral and non-intimidating environment and time for respondents to complete the questionnaire. Hence data was collected from schools and not clinics. The school would ensure that the researcher does not only include those youth who are still consulting the clinics, but also those who may have decided not to return to the clinics.

This was to give the respondents an opportunity to reflect on all previous visits to clinics and not be influenced by a particular incidental experience that might have taken place in the approximate time frame close to the receiving of the questionnaire.

Respondents who met the inclusion criteria in each selected school were gathered in one classroom. The content of the consent form was read to the learners and those who were willing to participate were requested to sign a consent form, hence anonymity was said to be partial. Each of those who had signed was provided a questionnaire to complete. All respondents who decided to quit during the process were requested to hand back the questionnaires. This was in an effort to prevent

them from discussing the content with learners at other schools who could be in the sample.

The researcher monitored the progress made with the data collection by checking the number of questionnaires completed each day and also by checking each questionnaire for completeness of data. One school was visited per day. All incomplete questionnaires were discarded.

Termination

The other reason why teachers were not allowed into the venue where the respondents completed the questionnaires was to grant the respondents the right to withdraw at any point during the process, regardless of the fact that he or she initially agreed to participate. As indicated earlier, only 302 respondents participated in the survey after other respondents withdrew from the study. Table 3.2 is included to summarise how the number of respondents was finalized:

Table 3.2 Summary of number of respondents

Number of consent forms send to parents	Number of consent forms received back	Number of respondents of who took part in the survey	Number of incomplete questionnaires	Number of questionnaires suitable for data analysis
500	424 (84.8%)	302 (71.2%)	46 (15%)	256 (84.8%)

Table 3.2 above is an indication of the change or decrease of respondents from the onset of recruitment up to data analyses. The number decreased from 500 to 424 as a result of consent forms that reached the schools from the parents. This could either have been because parents did not agree or because the learners decided not to return the signed consent form to school, and thus not be part of the study.

The number was further reduced either because the respondents did not show at the venues used for data collection, or because they withdrew during the process of data collection as it was granted in the agreement that they could withdraw at any time during the process.

Finally, the number was reduced to 256 due to incompleteness of critical data such as not indicating that the respondent had consulted any clinic for information or advice.

3.6 DATA ANALYSIS

Data analysis was done by the researcher, who checked the completeness of the questionnaires, numbered each, categorised and coded them. Further they were programmed by a staff member of the Department of Bio-statistics at the University of Free State using the Statistical Package for Social Sciences (SPSS) for Windows software.

Based on the data analysis and interpretation, conclusions were made pertaining to the extent to which school going youth utilise available health services as well as the experiences of youth who were and/or are still consulting the services for advice, information, or treatment.

3.7 ETHICAL ISSUES

Several ethical issues were considered as important in order to add value to the study.

Accessing the gatekeepers

Gatekeepers are those individuals who can either facilitate or block access of the researcher in conducting the study (Cormack, 2000:131). This implies that gatekeepers should be identified and be very well informed regarding all aspects of the intended research. According to Cormack (2000:55), it is wise for the researcher to supply written material that accompanies any verbal information.

Ethical measures and consent

In most research, human beings become the focus of investigation and ethical implications must be looked into (Moule & Goodman, 2009:162). Ethical issues in research include protection from harm, informed consent, right to privacy, and honesty with professional colleagues (Leedy & Ormrod, 2005:101). Neuman (2007:

196) highlights ethical issues in surveys as voluntary participation, the exploitation of surveys, and misuse of survey results.

When conducting research with school going learners, there is a certain protocol to be followed regarding obtaining permission for the study. This process has a particular hierarchy regarding who is to give written consent for the research to proceed. The sequence of authority and the problems encountered with each is as follows:

Research and ethics committees: The Ethics Committee of the Faculty of Health Sciences, University of Free State as well as the Research Committee of the School of Nursing within the Faculty gave permission for the study to be conducted (refer Annexure A).

Provincial DoE, Northern Cape: Although this department gave permission for the study to be conducted, it did not obligate the schools or the learners to participate in the study (refer Annexure B).

Schools and principals: Extra letters requesting permission to participate in the study were sent to the principals only (refer Annexure C). It took about two months before permission was received from the sampled number of schools.

Parents or guardians: Legally and ethically, no child is competent enough to give informed consent. Such informed consent is obtained on behalf of children from a parent or legal guardian (refer Annexure D), except in cases where the child is older than 18 years (Polit, et al., 2001:83).

A total of 500 consent forms were distributed to the schools. It was unfortunate that, in all participating schools, not all 500 consent forms were signed and returned to schools. At the end of data collection, 424 (84.8%) questionnaires were collected from the six (6) schools; meaning that seventy six (15.2%) were not returned.

As a result, learners who did not return signed consent forms could not be included in the study, regardless of their willingness to participate. This had another negative

impact on the sample size. Parental consent was not the final step for inclusion in the sample as the respondents themselves had to give consent.

The respondents: Informed consent

In this study, the respondents were developmentally (chronologically and mentally) mature enough to understand the content in the consent form. The informed consent forms were also obtained from the respondents in respect of their right to self-determination (refer Annexure E). It must be noted that in this study, young people who were older than 18 years could be included without parental consent as they have reached the legal age to consent. But all those below 18 years would only be included if parents agree and they are willing to participate.

Prior to their participation in the completion of the questionnaires, the researcher read and explained the criteria for inclusion to all respondents who presented themselves voluntarily for data collection. All respondents were assured of confidentiality, anonymity, and privacy during and after the data were collected.

Confidentiality and anonymity

Confidentiality entails that no information provided by a respondent should be divulged or made available to any other person (Uys & Basson, 2000:98; Moule & Goodman, 2009:57, 64-65). Although the author specified that when a respondent agrees to participate in a research project by signing a consent form, there is partial and not completed anonymity, confidentiality and anonymity would be ensured in that no names of respondents or schools were indicated on the questionnaires nor would they be indicated in the report. Thus, it is not possible to relate particular data to a person or institution (Moule & Goodman, 2009:64-65).

Privacy

Privacy was ensured in that the names of the schools included in the study were not disclosed to any other school, department or individual except for research team. Secondly, no data of a private nature would be collected than was absolutely necessary for achieving the objectives of the study. In addition, no teacher, parent or official would be present in the venue where the respondents completed the

questionnaires so that the learners could behave and think as they pleased without interruption. Lastly, the respondents were also unknown to the researcher.

3.8 LIMITATIONS OF THE STUDY

This study has limited generalisation as it can only be generalised to school going youth in Kimberley due to the relatively small convenience sample.

Due to unforeseen circumstances, the research results could not be published within the year of collection nor in the following two years. For the purpose of completing the study, the researcher requested from the Ethics Committee of the University of the Free State to re-use the same questionnaire at the same schools and adhere to the same criteria, as a way of verifying whether there has been any change in the health care services provided to the youth in Kimberley. The two sets of data were compared to identify major differences, but none was identified. After consultation with the biostatistician, the study leader, and informal discussions with researchers in the School of Nursing it was decided that the original results be retained and applied to the study.

3.9 CONCLUSION

Although the methodology of the study was quite simple, the researcher experienced problems on different levels of implementation. Obtaining the necessary permission was very time consuming. When this was eventually sorted out, getting the respondents on board was another issue. Lack of understanding and completeness of questionnaires further made it difficult to conform to the proposed protocol. However, the results that were obtained in the end were sufficient to make valuable conclusions and recommendations.

CHAPTER 4
PRESENTATION OF RESULTS AND DISCUSSIONS

The previous chapter provided detailed information on the methodology, design, and technique used for collecting data on services provided to the youth in Kimberley. This chapter will present an analysis and interpretation of the data using descriptive statistics.

Statistics refer to a set of numbers such as census or a branch of mathematics, whereas descriptive statistics is commonly used to reduce large quantitative data in a way that enables researchers to reach meaningful conclusions (Babbie & Mouton, 2001:459; Neuman, 2007:317). The data will be organised into frequency distribution tables, figures, graphs, and charts.

The results will be divided in the following sequence: (1) clinic attendance, (2) demographics, (3) accessibility of services, (4) services provision, and (5) experiences of young people and the outcome thereof. Discussions pertaining to the findings will be provided after each presentation. Part of the information collected through the literature review will be used to support the discussions. The conclusions and recommendations will be dealt with in chapter five.

The "youth" and "adolescents" will be referred to as "respondents" and the results will only be generalised to the accessible target population of high school going youth in Kimberley and more abstractly to all young people who have consulted the PHC clinics in Kimberley as a population.

4.1 CLINICS ATTENDENCE

The opening question that served as an inclusion criterion verified whether the respondent had ever consulted a clinic for service, information or advice. A total of 256 questionnaires were analysed as it was explained in the previous chapter that

the total of completed questionnaires was reduced by 46 due to incomplete data provided by respondents and their withdrawal during the process. The findings are presented below.

In trying to identify the clinics used by young people in Kimberly, 242 (94.5%) of the respondents provided one name, while 4 (1.6%) mentioned more than one clinic, and 10 (3.9%) preferred not to disclose the names of clinics they attended.

Table 4.1.1 Clinics attended by the school going youth (N=239 and 17 missing) Q1.1

CLINICS	%	n=239
Betty Gaetsewe Clinic	38.9	93
Galeshewe Day Hospital	8.8	21
Recreation Clinic	8.4	20
Florianville Clinic	6.7	16
Dinokwane	6.3	15
Kimberley City Clinic	6.3	15
Thlokomelo Youth Centre	6.3	15
Medi Cross`	3.3	8
Boikhutsong Clinic	2.9	7
Kimberley Complex Clinic	2.9	7
Floor Clinic	2.5	6
Masakhane Clinic	1.7	4
Homestead Clinic	1.3	3
Matsepane Clinic	1.3	3
Roodepan Clinic	0.8	2
Pallmed Clinic	0.4	1
Pescodia Clinic	0.4	1
Danieskuil Clinic	0.4	1
Tlaganeng Clinic	0.4	1
TOTAL	**100**	**239**

The information on Table 4.1.1 above indicates that 19 clinics were attended by the different respondents, in the Northern Cape. Of the 19 clinics, the majority of respondents (38.9.8%/n=93) used Betty Gaetsewe Clinic, followed by Galeshewe Day Hospital (8.8%/n=21), Recreation Clinic (8.4%/n=20) and Florianville (6.7%/n=16). In turn, Dinokwane, Kimberly City and Thlokomelo Youth Centre were consulted by 15 (6.3%), while Medi Cross was attended by 8 (3.3%) and Boikhutsong and Kimberley Complex clinics had only seven (2.9%) respondents each.

The other clinics had very few respondents indicating that they consulted with them, ranging from 2 to 0.4 percent. In short, only eight clinics were attended by a large number of youth and the frequency differed from one clinic to the other. The researcher found it appropriate to explore how often the clinics were attended as indicated in Figure 4.1.1 below.

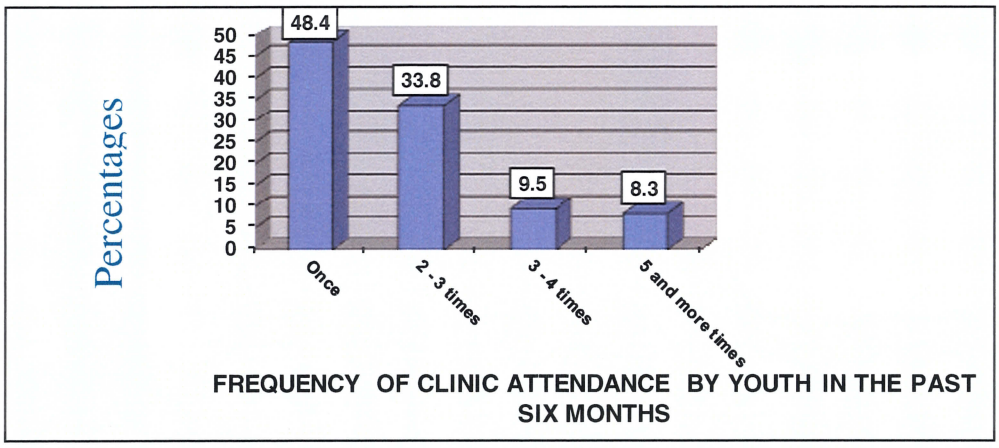


Figure 4.1.1 Frequency of clinic attendance by youth in the past six months (N=254) Q1.3

Looking into the frequency of clinic attendance, Figure 4.1.1 indicates that almost half of the sample, 48.4% (n=123) attended a clinic once only and never returned to the same clinics whereas 33.8% (n=86) went to a clinic two or three times and only 9.5% (n=24) and 8.3% (n=21) attended a clinic four times or more. Two (0.01%) respondents did not answer this question. Botma *et al.* (2001:2) stated that there

was a 50% decrease among young people who consulted clinics in Kimberley four to five times and more; and also that the number of those who only attended a clinic once had increased. The literature points out several reasons for inadequate use of PHC. For example, Little (1997:44 cited in Botma *et al.,* 2001:2) was of the opinion that young people were intimidated by clinics settings while others avoided the embarrassment of repeated visits.

Table 4.1.2 Reasons for not returning to the same clinic (N=123) Q1.4

REASONS FOR NOT RETURNING TO THE SAME CLINIC	%	n=123
Was discouraged by long waiting time/they could not attend to me because the clinic was too busy	39.1	42
Unfriendly or judgmental staff/staff members were rude	26.1	32
Not satisfied with the prescribed treatment/treatment was not good/no treatment given/shortage of medication	19.5	24
Consulted a private practitioner/I wanted a second opinion	15.4	19
Consulted a more youth friendly clinic	7.3	9
Moved to a new residential area/I visited another clinic nearer to home/I visit any nearest clinic	7.3	9
Complaint not addressed or not cured/there was no medication	5.7	7
Clinic was closed	5.7	7
Referred to other service for treatment	5.7	7
My problem was resolved/I was cured/treatment was effective/I got the information needed	4.0	5
To avoid embarrassment of repeat visits	3.2	4
They don't respect other people's jobs/they don't regard us as sick	2.5	3
My questions were not answered properly	2.5	3
We are always welcome/I go with friends	1.6	2

Attention is drawn to the fact that this question allowed a respondent to choose more than one response and as a result the totals seem to be more. The majority of respondents (39.1%, n=42) who did not return to the clinic were either discouraged by the long waiting time or could not be attended to because the clinic was too busy.

Thirty two (26.1%) pointed out that unfriendly and judgmental staff served as their barrier towards going back to the same clinic. Nine (7.3%) claimed they went for a more youth friendly clinic.

The findings agrees with Dickson-Tetteh (cited in Finger, 2000: Online) and Heunis, Ngwenya and Van Rensburg (2000:56) in a study assessing "A youth multi centre in the Free State", and Diale and Roos (2000:138) that more than 68% of youth need fast and accessible clinics service where they do not wait for a long time. Staff members should be friendly and not judgmental. The youth indicated that the judgmental attitudes amongst health care workers have a negative influence on their health-seeking behaviours and keep them away from the services.

Taking it further, 18 respondents (14.6%) indicated that they were not satisfied with the prescribed treatment and 17 (13.8%) resorted to private practitioners. Both issues were also identified in previous studies, conducted in South Africa. For example, respondents indicated in Matshego and Peltzer (2005:17) that the nurses give them medication for other diseases and not for what they are really suffering from. In explaining why private services were preferred above PHC clinics, one respondent said: "At private practitioners, they communicate with us very well. They don't shout at us and they also tell us to come again when you don't feel better".

Such supportive communication between the service provider and the service consumer make a person feel important, wanted, and they gain knowledge. Thus anyone would return to that service.

The reasons provided above indicate that only two respondents never consulted another clinic after what they experienced.

4.2 BIOGRAPHIC DATA

The biographic data will be presented to give better insight into the sample profile.

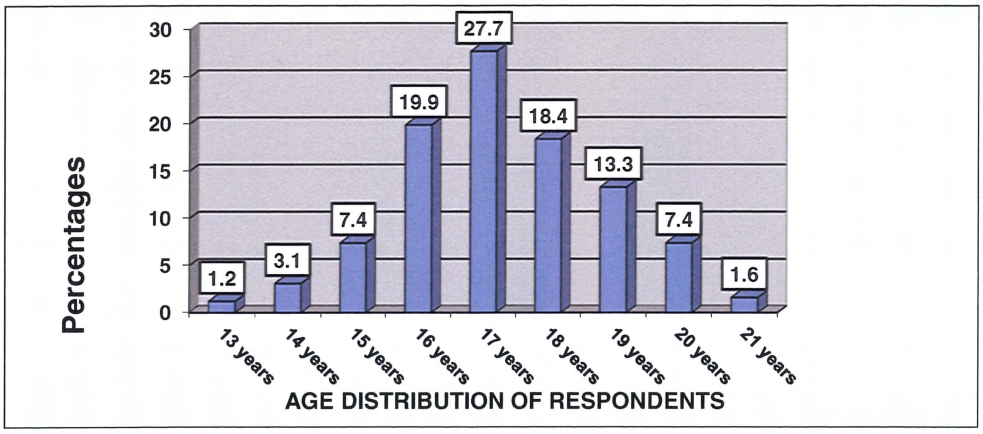


Figure* 4.2.1 *Age distribution of respondents (N=256) Q2.1

The figure above indicates that most of the respondents (94.1%) that access clinics range between the ages of 15 and 20 years but the majority (71/27.7%) are 17 years of age, while 11 (4.3%) were between 13 and 14 years and only 4 (1.6%) were 21 years old. This is in agreement with the results of the study by Botma and co-researchers in 2001 where the majority of youth who were interviewed in clinics in the Frances Baard district in the Northern Cape were between 19 and 21 years and with Phoofolo (2002:71) who indicated that 73.9% of the adolescents who claimed to be using reproductive services in Lesotho were 16 years and older as that study focused on unmarried women and not necessarily youth only.

There is a positive correlation between the results and the age limit used as criterion for inclusion in this study. The correlation supports the reason provided by the researcher that most of the young people who could be using clinics are within the high school going age.

Having the gender distribution in mind, it would be interesting to know what the gender distribution was as the criteria included both males and females in the sample. Figure 4.2.2 below shows the gender distribution.

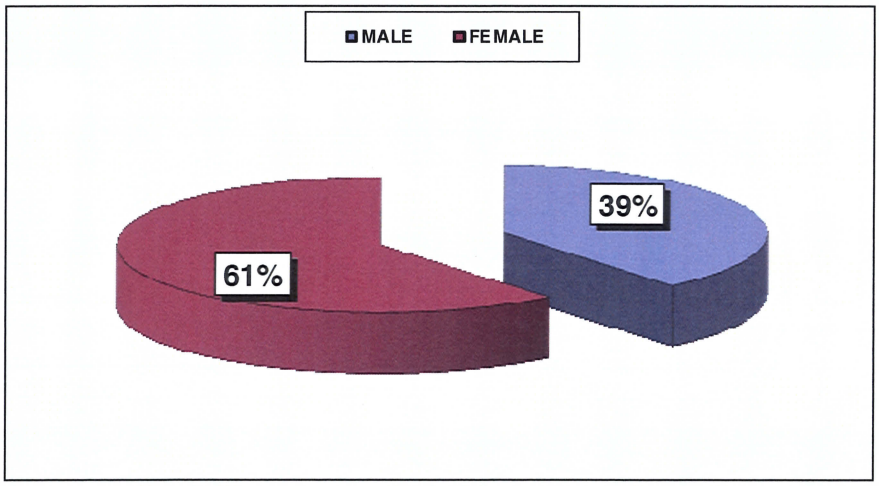


Figure 4.2.2 Gender distribution of respondents (N=256) Q2.2

The majority of respondents (155/61%) were female and 39% (n=101) male. Viewing such distribution against the mid-year populations estimates by Statistics South Africa (2010) where 25 662 300 (51.3%) were female and 24 329 000 (48.7%) male, a difference of 2%; the gender distribution among young people attending clinics has not changed. Erulkar, Beksinska and Cebekhulu (2001:1) undertook an assessment of 12 youth centres in South Africa which included two in the Northern Cape – Thlokomelo in Kimberley and the Upington Youth Centre in Upington. They thought the increase in the number of females who visited youth centres was linked to hormonal contraceptives that require regular (scheduled) visits. They argued that the males usually collected condoms from dispensers without any contact with service providers for record keeping.

According to Phoofolo (2002:48) in a study aimed at exploring the experiences of males attending reproductive health services in Lesotho, almost half the number of males (48%) were concerned that reproductive health services were planned for females, and therefore recommended that men-friendly programmes and services be designed. Nath and Garg (2008: Online) also indicated that boys receive less attention than girls in health services.

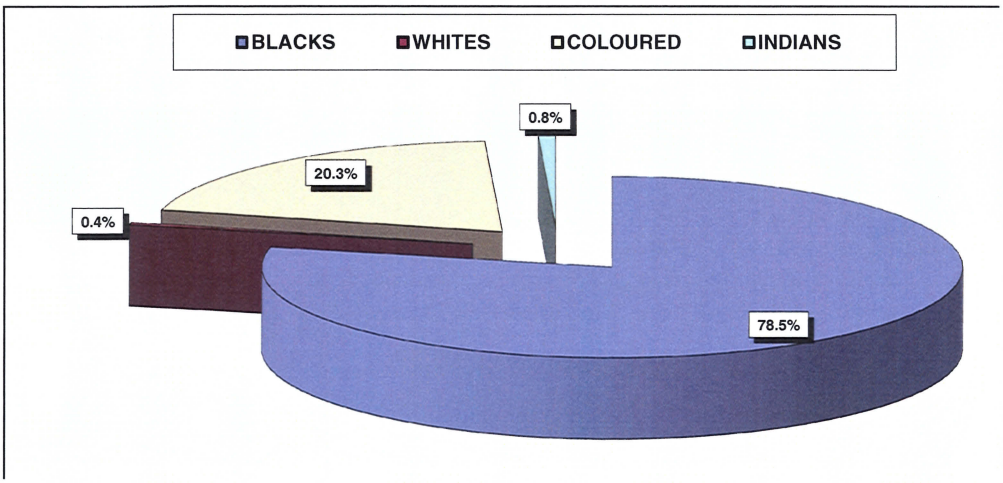


Figure 4.2.3 Race distribution of respondents (N=256) Q2.3

Figure 4.2.3 above outlines the racial distribution of respondents. Most of the respondents 78.5% (n=201) were Black, followed by 20% (n=52) who were Coloured. Only two (0.8%) Indian and one (0.4%) White respondent participated. The reason for this racial mal-distribution may have been the non-response from the multiracial schools, especially the decline from the one girl's only high school where most of the learners were white, as well as the withdrawal of the only predominantly white (Afrikaans medium) school.

Based on the reasons provided by the principal of the school that opted out, a large number of learners in that school claimed not to have ever consulted PHC clinics because they belonged to medical aid schemes which enable them to consult private practitioners.

One other reason that may have led to a large number of blacks participating could have been the fact that three of the high schools that eventually participated in the study were in the black township (Galeshewe). Although the other two schools – one Afrikaans and one parallel medium – were also in town, it was possible that the learners reside in the so-called Coloured areas.

4.3 NATURE OF SERVICES

Table 4.3.1 Clinics attended regularly by the youth (N=15) Q3.1

CLINICS ATTENDED REGULARLY	%	n=
Betty Gaetsewe	20.0	3
Floors Clinic	13.2	2
Florianville Clinic	13.2	2
Galeshewe Day hospital	13.2	2
Recreation Clinic	6.7	1
Kimberly Day Hospital	6.7	1
Dinokwane Clinic	6.7	1
Homestead Clinic	6.7	1
City Clinic	6.7	1
Tlhokomelo Youth Centre	6.7	1
TOTAL	**100**	**15**

Table 4.3.1. above indicates that ten clinics were attended regularly. Three (20%) of the 15 respondents who attended clinics regularly preferred Betty Gaetsewe. Floors, Florianville, and Galeshewe Day Hospital were visited regularly by two (13.2%) respondents each, whereas Kimberley Day Hospital, Recreation, Dinokwane, and Homestead clinics were each attended by only one (6.7%) respondent on a regular basis. The findings could suggest that respondents preferred to visit different clinics in case of sickness or when they needed information.

It was important for the researcher to quantify the regularity of clinic attendance by asking how many times each regular clinic was consulted in the past six months. The outcome is presented in Figure 4.3.1 below.

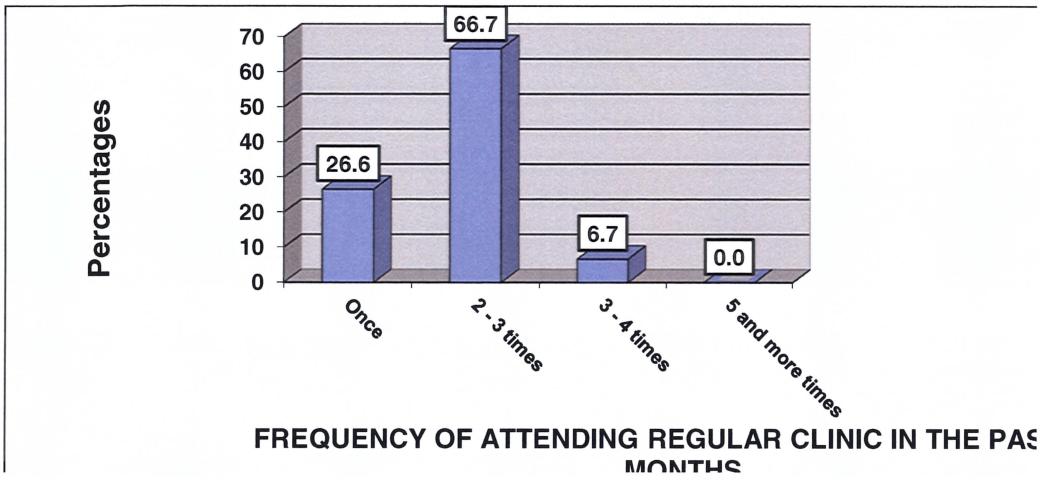


Figure: 4.3.1 Frequency of attending a regular clinic in six months (N=15) Q3.4

Ten (66.7%) of the 15 respondents who claimed to have attended a clinic on a regular base, had been to that clinic two to three times while 4 (26.6%) attended that clinic once only. Discouraging though, there was only one respondent (6.7%) who had been to a clinic three to four times and none of the 15 had ever been to a clinic five times or more in only six months.

It became important for the researcher to explore reasons why young people move from one clinic to the other within such a short space of time. Possible answers are listed in the table 4.3.2 below.

Table 4.3.2 Reasons for attending several different clinics in the past three months (N=82) Q3.5

REASONS FOR ATTENDING SEVERAL CLINICS	%	n= 82
Unfriendly, judgmental or impatient staff	35.5	29
Moved to a new residential area	13.4	11
Referred to other services for treatment	9.8	8
To avoid embarrassment to repeat visits	9.8	8
Lack of medication or other facilities such as sonar	7.3	6
Complaint not addressed or not cured	6.1	5
Clinic is not open, reception closed	6.1	5
Long waiting hours, too busy clinic, service slow	6.1	5

Rude, poor listening staff, and not treated properly	4.9	4
Low standard of the service	1.2	1

The findings in tables 4.3.2 and 4.3.4 were in agreement with each other. The percentage of respondents who alluded to the negative attitude of service providers increased from 26% to 36%. The reason why complaints were not cured was clarified by indicating that there was lack of medication and facilities. Furthermore, the long waiting hours alluded to either slow service or clinics that are too busy. Although 11 (13.4%) respondents claimed to have moved to a new residence, and eight (9.8%) were either referred to other services for treatment, an equal number (8/9.8%) avoided the embarrassment of repeated visits. Six (7.3%) indicated that there were inadequate resources such as medication and five (6.1%) felt that their complaints were not addressed. An equal number (6.1%) claimed that the clinics were closed and they had to wait for long periods because of a slow service or because the clinic was busy.

Although a lesser number (n=82) of respondents provided reasons for visiting different clinics in three months, the results confirm the existence of barriers in services delivered to the youth, and that such barriers have an influence on the use of available clinics or even make it impossible for services to retain service consumers, especially the youth. The results also reflect the findings by Abdool-Karim and Abdool-Karim (2010:318) that poor services throughout South Africa are problematic to the youth and impacts negatively on the use of available services.

Noting that lack of facilities, poor service, and complaints that were not addressed came up more and more, it was of necessity to explore what treatment was actually required from the clinics.

Table 4.3.3 Services provided at the clinics (N=256) Q3.6

SERVICES PROVIDED AT THE CLINICS	%	n= 256
Information on general health related topics	67.6	173
Contraception (including condoms)	39.8	102
Treatment for sexually transmitted diseases (STIs)	25.8	66
General health problems/illnesses (colds, etc.)	23.4	60
HIV counselling and/or testing	22.3	57
Termination of pregnancy counselling	22.3	57
TB treatment	21.1	54
Information on reproductive health	19.9	51
Surgical procedures (removal of stitches, wound care)	12.1	31
Ante/postnatal maternity care	9.4	24
Group discussion on teenage pregnancy, HIV/AIDS and rape	2.3	6

According to Table 4.3.3 above, an extensive number of respondents (67.6%/n=173) indicated that clinics do provide information on health topics, whereas 39.8% (n=102) specified contraceptives including condoms, 25.8% (n= 66) STIs and 23.4 % (n=60) indicated that other health problems such as common colds were treated. An equal number 22.3% (n=57) specified HIV counselling and testing as well as termination of pregnancy with counselling, as well as information (including discussions) were provided for these problems. Nine per cent (n=24) said maternity care. An extra 45% (n=91) added that other illnesses are also catered for. Reflecting on HIV and AIDS only, the Northern Cape has been providing testing in all fixed clinics since 1998, but only 22% of the respondents seemed to be aware of that (Department of Health, Northern Cape, 2002:21).

One would conclude that in essence the services rendered to the youth are comprehensive. This is suggested especially because even the most recent services such as termination of pregnancy where also available from the clinics. Although teenage pregnancy is regarded as a problem, only 9.4% of the respondents seemed to be aware that maternity services are available at the clinics within Kimberley.

Noting that services are available from the clinics, the researcher found it fitting to ascertain whether the specific needs of youth were catered for. That was explored by asking respondents to indicate services that should be provided by youth friendly clinics. Their responses are listed in Table 4.3.4.

Table 4.3.4 Services which should be provided from youth friendly clinics (N=256) Q3.7

SERVICES TO BE PROVIDED IN YOUTH FRIENDLY CLINICS	%	n= 256
HIV counselling and/or testing	51.9	133
Contraception (including condoms)	43.3	111
Treatment for sexually transmitted diseases (STIs)	41.8	107
Information on general health related topics	37.1	95
General health problems/illnesses (colds, etc.)	36.3	93
Termination of pregnancy counselling	30.4	78
Information on reproductive health	29.3	75
TB treatment	25.0	64
Ante/postnatal maternity care	17.9	46
Surgical procedures (removal of stitches, wound care)	17.2	44
Group discussion on teenage pregnancy, HIV/AIDS and rape	2.3	6

The majority of the respondents (52.9%/133) wished to have HIV counselling and testing included in youth friendly services. In turn, 43.3% (n=111) of the youth wanted contraceptives including condoms, while 41.8% (n=107) felt that sexually transmitted diseases should be treated. A further 37% (n=95) wished to have information on general health related topics and 36.3% (n=93) needed the treatment thereof. Thirty per cent (n=78) and 29.3 % (n=75) needed termination of pregnancy and information on reproductive health respectively. Surprisingly, only 2.3% (n=6) of the respondents indicated a need for group discussion on reproductive health issues that most researchers thought were pressing, for example teenage pregnancy, HIV and AIDS as well as rape.

A comparison of services that are provided to the youth and the services young people required from youth friendly services is provided in Figure 4.3.2 below.

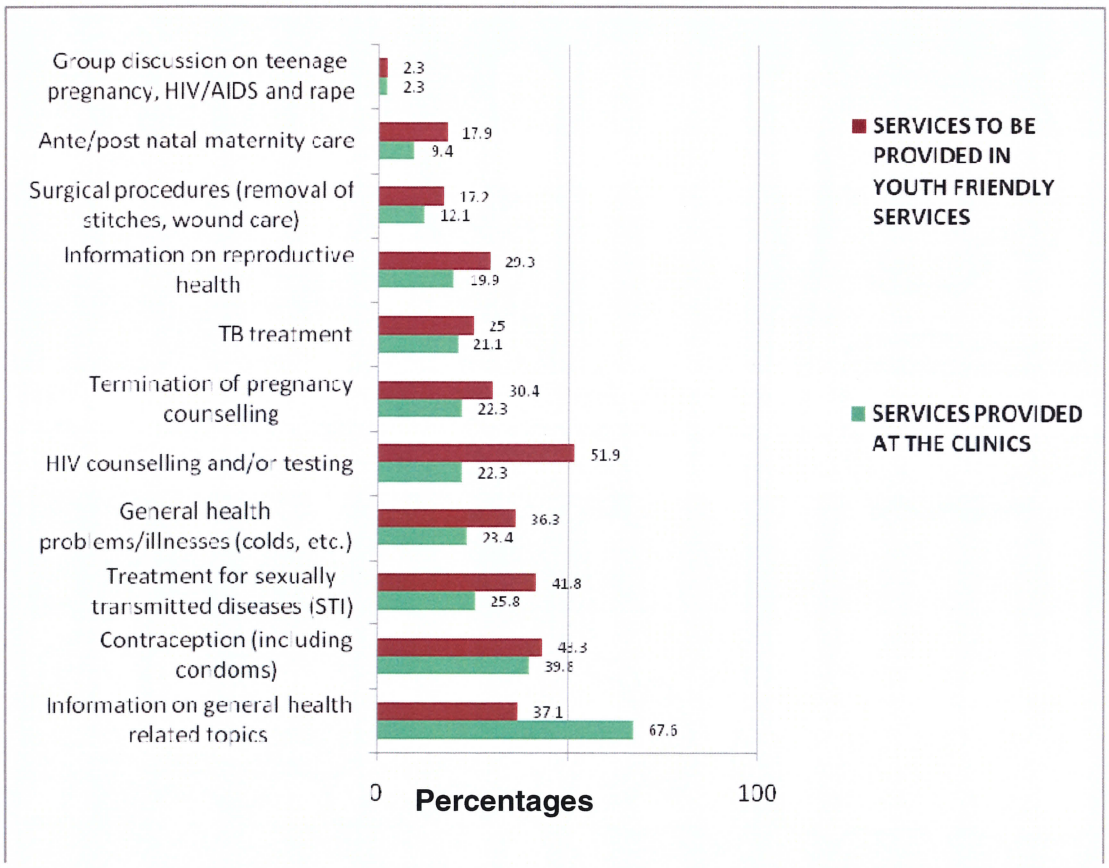


Figure 4.3.2 A comparison of services provided by the clinics and services requested by youth (N=256)

The findings above indicate that the youth expect youth friendly services to provide more reproductive health services such as HIV and AIDS (51.9%), treatment for STIs (41.8%), and contraceptives (43.3%), and less of the information on general health related topics. It is also interesting to note that the youth wish to have services for HIV and AIDS treatment almost doubled. The results reflect what was estimated by the WHO (2002: 18) – that the number of young people who will be infected may have doubled by 2010.

It does also show that services planned and provided to the youth would look different if the young service consumers could be involved in their planning.

Table 4.3.5 Hours of the day during which clinics should be open (N=251) Q3.8

HOURS OF THE DAY DURING WHICH CLINICS SHOULD BE OPEN	%	n=251
07:00 – 07:00 (24 hours)	55	138
07:00 – 19:00	19.5	49
07:00 – 17:00	16.3	41
07:00 – 16:00	9.2	23
TOTAL	**100**	**251**

The majority of respondents 55% (n=138) would like to have the services open 24 hours a day, while 49 (19.5%) would prefer the clinics to be operational for 12 hours. Forty-one (16.3%) indicated that ten hours will be suitable. Only 23 (9.2%) out of 251 respondents accept the current situation. The findings could suggest that the operational hours contribute to the inaccessibility of clinics to the youth, since the need for a 24-hour service at PHC clinics is not met yet. It was indicated in chapter 2 by Erulkar *et al.* (2001: Online) that Tlhokomelo Youth Centre in Kimberley was the only service that operated from 08:00 until 18:00 during the week and the one in Upington was open from 09:30 to 18:00.

Access to the clinics was further explored by enquiring about which days of the week young people would want clinics to be open. Penelope (2002: Online) states that most of the PHC services operate from Monday to Friday. It should be noted, however, that these are also days during which the research population in this study are at school.

Table 4.3.6 Days of the week during which clinics should be open (N=249) Q3.9

DAYS OF THE WEEK	%	n=
Monday to Saturday	56.6	141
Sunday to Saturday	21.7	54
Monday to Friday	21.7	54
TOTAL	**100**	**249**

In the table above, the majority of respondents (56.6%/141) would prefer to have clinics open six days a week from Monday to Saturday, while 54 (21.7%) wish to have the service open seven days a week, Sunday to Saturday. Another 54 (21.7%) support the status quo where clinics are open from Monday to Friday only. The findings suggest that current clinics are not necessarily functionally accessible to the youth seeing as they are close over weekends and public holidays when the majority of youth are not at school, which impacts negatively on the access of youth to the clinics.

It was important to explore the extent to which young people do get the services in operation.

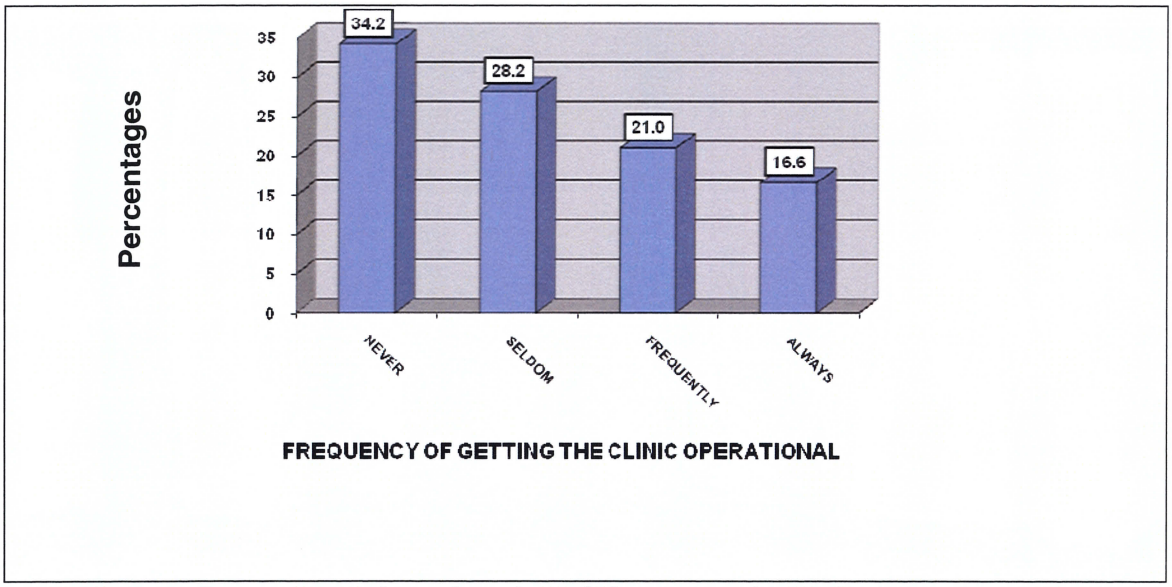


Figure 4.3.3 Frequency of getting the clinics operational (N=234) Q3.10

According to figure 4.3.3, 80 (34.2%) respondents indicated that they never find the clinics in operation, 66 (28.2%) said that they seldom find the clinic open, while 49 (21%) frequently find clinics in operation. Only 39 (16.6%) indicated that they always find clinics opened. A combination of the responses provided under category one, "never" and category two, "seldom" show that 146 (62.3%) of respondents were not able to find clinics in operation. A percentage of 37.6% (n=88) respondents found that the clinics were "frequently" or "always" open to provide services. Considering

these findings, one could conclude that clinics are not accessible to most of the respondents. .

Abdool-Karim and Abdool-Karim (2010:321), in their study on HIV and AIDS in South Africa, recommends that school-based programmes be considered as these increase access to health services, and also increase access to the youth as a target group for reproductive health.

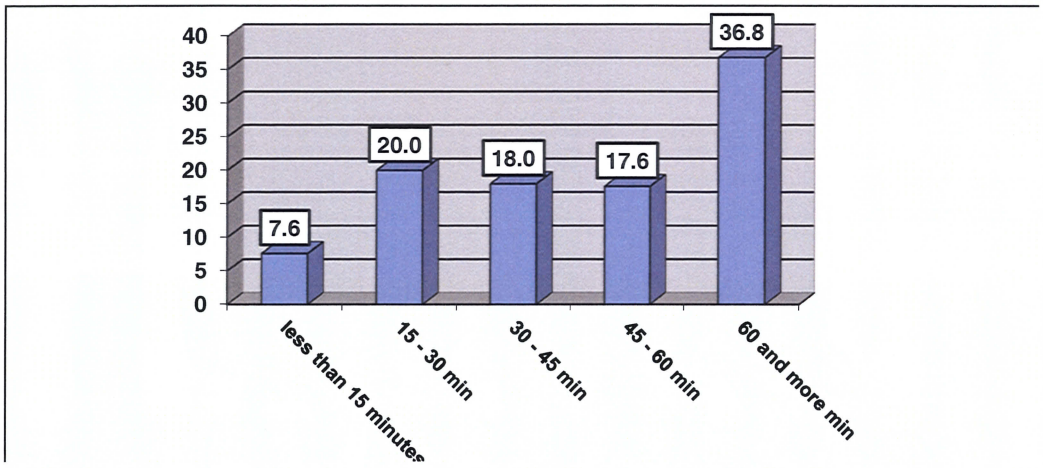


Figure 4.3.4 The longest waiting time at the clinics (N=250) Q3.11

Most of the respondents, 36.8% (n= 92), indicated that they spend more than an hour on average at the clinics before they get attention, while 20% (n=50) spend up to 30 minutes and 18% (n=45) stay up to 45 minutes awaiting care or information. Only 7.6% (n=19) of the 250 respondents indicated that they wait for less than 15 minutes in a clinic.

The findings support those presented in Table 4.2.3, on "reasons for not returning to the same clinic", which indicated that the majority of the respondents (31%/n=39) were discouraged by the long waiting hours. The same reason was reflected as an underlying constraint for functional accessibility. As a result, young people who are chased from clinics or instructed to come back later thus prefer private practitioners where they are attended to within a reasonable time (Abdool-Karim & Abdool-Karim, 2010:319).

The problem regarding long waiting hours at clinics should not be regarded as a new one. Spencer (1985:85) suggests that this problem be minimised by delegating routine work down the skill pyramid. This implies that routine work should not necessarily be carried out by professionals if a less qualified person is competent to do it. Spencer is of the opinion that this approach will also correct the impression that nurses are impatient, always in a hurry, and do not have time to talk to the youth; while the nurses' claim that they are overworked and short staffed. Noting that a considerable number of youth move from one clinic to the other, it was important to know what would help them to identify a youth friendly clinic. The findings are presented in table below:

Table 4.3.7 Treatment required from clinics in the last three months (N=256) Q3.12

TREATMENT REQUIRED FROM CLINICS IN THE LAST THREE MONTHS	%	n=
General health problems	51.95	133
Information on general health related topics	20	51
Contraception	14.1	36
Information on reproductive health	7.8	20
HIV counselling	6.3	16
Tooth extraction	6.3	16
Treatment for TB	4.3	11
Surgical procedures	4.3	11
Treatment for STIs	3.9	10
Medical tests	3.1	8
Termination of pregnancy	2.0	5
Maternity services	0.4	1

Table 4.3.7 indicated that respondents required certain services more than others. For example, 133 (51.95%) needed treatment for general health problems, while less than half of that 51 (20%) required information and not treatment as such. While 14% (n=36) were looking for contraceptives, half of those 7.8% (n=20) required only information on reproductive health. Both instances provided clarity on why

respondents would not wish to spend more time at the clinics waiting for information. It is also important to note the number of respondents that needed counselling with regard to HIV, TB and STIs.

Sixteen (6.3%) required HIV counselling, 11 (4.3%) needed treatment for TB, and ten (3.9%) sought treatment for sexually transmitted diseases. Only five (2%) required termination of pregnancy and, surprising enough, only one (0.4%) needed maternity care.

Although literature (WHO, 2002:24) suggested, for example, that STIs including HIV and AIDS, teenage pregnancy as well as the termination thereof were the putting teenagers under the spotlight, the demand of services in Kimberley reflects the opposite. Young people who had consulted clinics three months before the survey required treatment for other conditions or information pertaining to general health problems rather than reproductive health. This could be what Abdool-Karim and Abdool-Karim (2010:318) referred to as social inaccessibility, often thought to be due to service providers hostile towards the reproductive health needs of young people.

The reasons why respondents went to clinics for help were also investigated. Nine possibilities and an open-ended question were provided. The responses were as indicated in table 4.3.8 below.

Table 4.3.8 Reasons that made respondents go to the clinics for help (N=256) Q3.13

REASONS THAT MADE RESPONDENTS GO TO THOSE CLINICS FOR HELP	%	n=
My parents encouraged me	27.3	70
Although I did not want to come, the symptoms caused me to go	25.4	65
I was told I could get more information regarding a health need at a clinic	21.1	54
I identified a problem from information I received/read/heard (I went on my own)	19.5	50

My friends encouraged me	7.8	20
Hospital referred me	7.0	18
The staff was friendly, the help is fast, they care about people	5.5	14
I got sick at school and was taken to that clinic	3.1	8
My family doctor encouraged me	2.7	7
I did not want to go to the clinic nearer home	0.8	2
A traditional healer encouraged/referred me	0.4	1
It was the nearest to my home	0.4	1
I could walk to it as I did not have money for transport	0.4	1

The majority of the respondents (70/27.3%) were encouraged by parents; whereas the second largest number (65/25.4%) identified symptoms that made them go to the clinic. Again, the need for information accounted for 54 (21.1%) of respondents that visited the clinics, with an additional 50 (19.5%) that went to verify information they got from literature.

Eight per cent (n=20) were referred by friends while 7% (n=18) were referred by the hospital. Only 5.5% (n=14) of the respondents were attracted by friendly, helpful, or fast service. These results support the fact that the judgemental attitude of service providers deters the youth from going to clinics and impacts on their youth friendliness.

Although clinics in Kimberley were said to be providing comprehensive services that accommodate all age groups. Information provided in this study so far suggests that young people did not get what they were looking for. As such, services provided from the clinics were explored.

Table 4.3.9 Ways through which youth friendly clinics would be identified if one has never been to the clinics (N=256) Q3.14

WHAT WOULD HELP YOU IDENTIFY A YOUTH FRIENDLY CLINIC WITHOUT HAVING BEEN TO IT?	%	n=
When staff members working there are young	48.83	125
When a friend tells me it is	47.66	122
When there is a rape unit in it	46.88	120
I wouldn't know	46.09	118
When my parents believe it is	41.02	105
When a lot of youth go for it	39.06	100
When my health care workers believe it is	33.98	87
When there is a youth friendly sign/poster	32.81	84
When my teachers believe it is	30.47	78
When staff working there are trained on youth health	23.05	59
When it provides HIV and AIDS testing and counselling	21.09	54
When it serves youth only	1.95	5
When there are young people involved and participating in that clinic	0.78	2
When there are young people that support it	0.39	1
When youth serve in the committees	0.39	1

As indicated in table 4.3.9 that the majority of respondents (48.8%/125) are of the opinion that they would regard a clinic as youth friendly if staff members are young, while 47.7% (n=122) would consider a clinic based on their friends opinion, and 46.9% (n=120) would consider a clinic that has a rape unit as being youth friendly. Forty-six per cent (n=118) said they would not be able to identify a clinic without having been to it, whereas 41% (n=105) would accept it to be youth friendly if their parents believed it is. In turn, 39% (n=100) would depend on the number of youth going to the clinic. If a lot did, then it would be an indication of youth friendliness, while 21.09% (n=54) would expect a youth friendly clinic to provide HIV and AIDS testing. Only 2% (n=9) of the respondents said they would accept a clinic to be youth friendly if it serves youth only, and if young people are involved in voluntary and support services.

Table 4.3.10 Voluntary health care services available for the youth at clinics (N=256) Q3.15

VOLUNTARY HEALTH CARE SERVICES	%	n= 256
Counselling	41.4	106
HIV/AIDS counselling	28.9	74
Clinic committee	27.0	69
HIV/AIDS support groups	26.6	68
Health workers committee	19.5	50
Planned Parenthood Association of South Africa (PPASA)	19.5	50
Love Life Ground Breakers	13.7	35
Peer education	12.9	33
Crime prevention	8.6	22
Bereavement committee	0.78	2

Youth are involved in voluntary services available at clinics. At least 41.4% (n=106) are providing counselling in clinics, 28.9% (n=74) are involved in HIV/AIDS counselling Love Life projects, 27% (n=69) are serving on the clinic committee, and 26.6% (n=68) serve in a support group to HIV/AIDS patients. Furthermore, 19.5% (n=50) of them serve on the health workers committee while an equal number (19.5%) are involved in the PPASA project and 13.7% (n=35) are Love Life Ground Breakers. Thirty-three (n=33) of these young people are educating youth, 8.6% (n=22) participate in crime prevention, and only 1% (n=2) of them are serving on a bereavement committee.

This supports previous information cited by Diale and Roos (2000:139), in a study aimed at measuring the perceptions of sexually transmitted diseases among teenagers that young people would appreciate to be involved and participate in health care services. Senderowitz (1999:7) in a study titled "Make productive services youth friendly" also indicated that channels and models which trained young adults at community level to disseminate health education programmes within and outside youth centres proved to be more youth friendly and cost effective.

Table 4.3.11 Roles in voluntary programmes (N=256) Q3.16

ROLES IN VOLUNTARY PROGRAMMES	%	n=256
Organiser	46.5	119
Facilitator	32.0	82
Support group member	30.0	77
Educator	24.6	63
Counsellor	9.4	24
Peer group member	3.0	8

Looking at the involvement and roles the young people play within such programmes, the majority of respondents (46.5%/119) who are participating in the voluntary programmes in the clinics were organizers, while 32% (n=82) were facilitators and 24.6% (n=63) educators. Thirty percent (n=77) are members of the support group and less than 10% are either counsellors or members of a peer group. It was of interest to note that clinics were moving towards the important step of involving youth in the provision of services, as specified in the definition of youth friendly services.

It was important for the researcher to identify areas that still present with problems which may not have been covered by other questions.

In figure 4.3.5 the majority of respondents (53.6%/n=123) claimed that they did not encounter any problems with service provided from the clinics, compared to the (46.5%/n=107) that said they experienced a lot of problems.

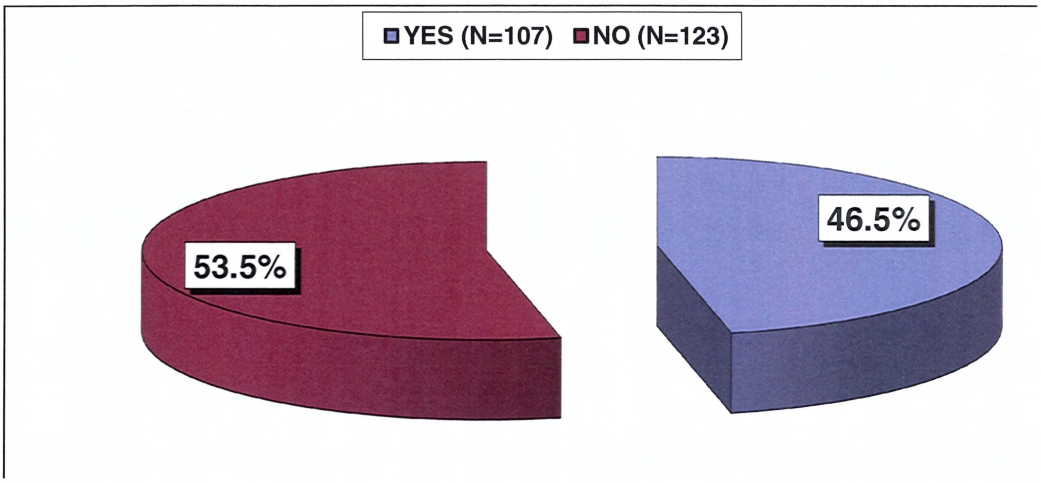


Figure 4.3.5 Problems encountered with service provision in clinics (N=230) Q3.17

It is important to note that youth experience the services differently and that a researcher has to identify what the problems are. Hence the respondents were requested to indicate the problems they encountered.

Table 4.3.12 Structural problems encountered with service provision in clinics (N=81) Q 3.18

PROBLEMS ENCOUNTERED: STRUCTURAL	%	n=
Lack of appropriate facilities	3.7	3

The problems encountered by youth who attended the clinics varied from structural to functional problems, however, only three (3.7%) of the respondents indicated that there was a lack of appropriate facilities. The majority of problems encountered were functional in nature, as indicated below.

Table 4.3.13 Functional p*roblems encountered in the provision of services in clinics (N=81)*

PROBLEMS ENCOUNTERED: FUNCTIONAL	%	n
Rude/unapproachable, judgmental and unfriendly staff including doctors	54.2	43
Long waiting queue/slow service	20.9	17
Lack of medication	6.0	5
Staff do not provide correct medication	6.0	5
Staff take many or long tea breaks	3.7	3
Poor listening/lack of interest in what patients are saying	3.7	3
Take long tea breaks/do not come back to serve patients	3.7	3
I am told I do not seem to be sick	3.7	3
Waited too long, turned back because clinic closing	3.7	3
Staff not interested in getting information from patients	3.7	3
Tells us to come after school	2.5	2
We are turned back when late	2.5	2
Insufficient staff	1.3	1

Referring to the functional issues, 54.2% (n=43) of the respondents indicated that the HCWs were rude, unfriendly, and judgmental towards them. Twenty-one per cent (n=17) attributed their problem to the long waiting time, and all other problems, for example lack of medication, incorrect prescriptions, poor listening staff, and school going youth who are instructed to come after school accounted for less than 7% (n=5 or less) each.

It was evident that the youth experienced the attitude of health care workers and the waiting time as major problems in the clinics. Noting that health care workers included different categories, as indicated in the definition, it was important to locate the origin of the problems.

Table 4.3.14 Areas which presented with problems (N=121) Q3.19

SPECIFIC PROBLEMS ENCOUNTERED IN CLINICS	%	n=121
Nurses	64.3	69
Reception clerk	20.6	22
Cleaners	10.3	11
Other clients	6.6	7
Other youth	5.6	6
Security entrance	5.6	6
TOTAL	**100.0**	**121**

The majority of respondents (64.3%/n=69) mentioned that they experienced problems with nurses, whereas 20.6 % (n=22) experienced problems at the reception areas. Ten per cent (n=11) of the respondents had problems with cleaners and a few respondents (5.6%n=6) had problems with the security officers and with other patients respectively. The information in Table 4.2.2.3 above suggests that the youth have problems with professional or trained staff.

It was important for the researcher to explore what resolutions the youth would suggest, as it is important to include them in any decision making. Table 4.3.15 below outlines suggestions provided by youth.

Table 4.3.15 Alternatives suggested resolving problems encountered within clinics (N=75) Q3.20

ALTERNATIVES SUGGESTED TOWARDS RESOLVING THE PROBLEMS	%	n=75
No discrimination of race	10.7	8
More support and attention to be provided	8.0	6
The staff should be patient and disciplined	8.0	6
Cleaners not to think they are nurses	6.7	5
Nurses be more organised	6.7	5
Staff should communicate more effectively	6.7	5
Nurses and reception clerks should work faster	6.7	5
Security should stop people from going into the clinic	4.0	3

There should be meetings between staff and patients	5.3	4
Staff should not be rude to people	5.3	4
Staff should be willing to assist people	2.7	2
There must be more medical supplies	4.0	3
Staff be prepared to assist people	2.7	2
Nurses be respectful/nurses be less accusing	2.7	2
Staff be approachable	2.7	2
Shorter waiting periods	2.7	2
There be more clinics	1.3	1
Appropriate service be provided	1.3	1
Should not discriminate when diagnosed with STI	1.3	1
Be examined before treatment is issued	4.0	3
Services be less confronting	1.3	1
Should take patients seriously	1.3	1
Nurses be less accusing	1.3	1
Cleaners be accommodating	1.3	1
Shorter tea breaks/don't go for tea when clinic is too busy	1.3	1
Clinics should open longer	1.3	1

The findings provided above will be categorised into the six areas. Seventy-nine percent (n=59) of the suggestions addressed staff issues, particularly the nursing staff, 6.7% (n=5) addressed the service itself, for example that more clinics and medication should be made available, and 14% (n=11) addressed the cleaners as well as the security. It is of concern that the largest number of youth has a problem with nursing personnel, but the researcher is of the opinion that it could be because people tend to classify all categories of nurses into one, yet there are different nursing categories within health.

Respondents were given the opportunity to identify problems, to make suggestions regarding services, and to indicate what their ideal PHC service is. The findings with regard to the ideal service in presented in Table 4.3.16 below:

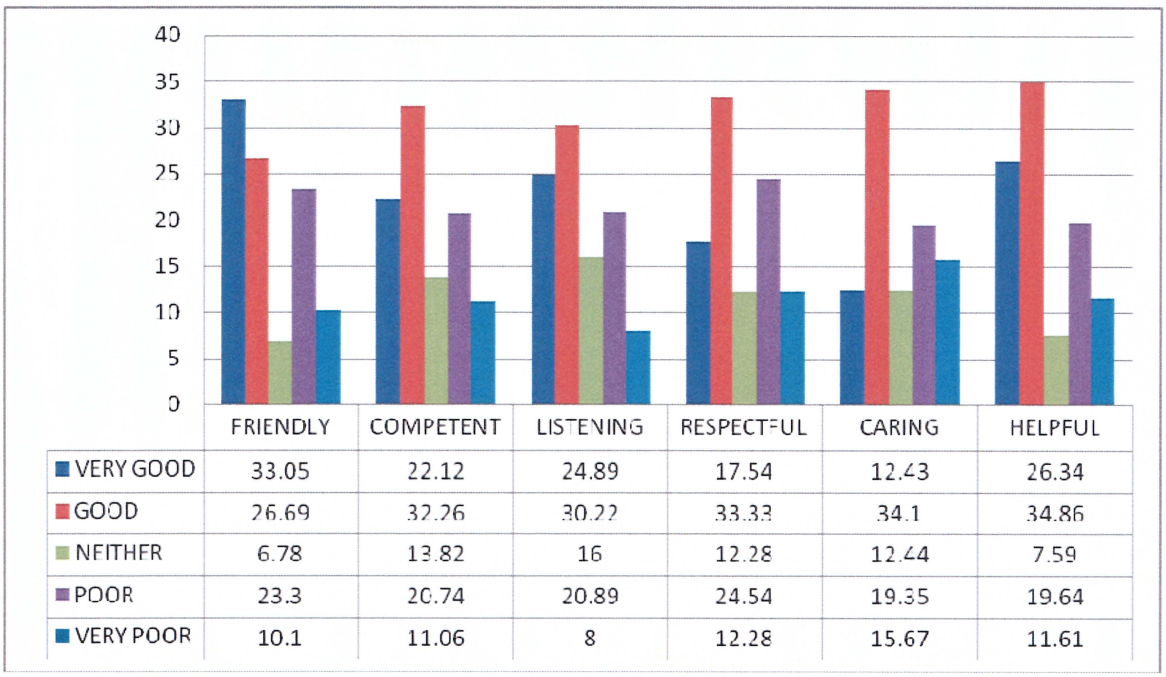
Table 4.3.16 A description of ideal youth friendly service (N=137) Q4.1

A DESCRIPTION OF IDEAL YOUTH FRIENDLY SERVICE	%	N=137
Youth only services/youth centres	13.1	18
Clinics that offer fair and quality care/staff be helpful and give advice/ a clinic were nurses are trained on youth related issues/treatment provided be effective or good/patients be examined properly	13.1	18
A clinic that understands, supports and satisfies the youth	13.1	18
Clinics with more doctors	9.5	13
Clinics that provide information freely to the youth/staff should provide guidance on health issues	9.5	13
Services that provide sonar/HIV testing and counselling/information	8.8	12
A clean clinic/hygienic environment/privacy	8.8	7
Should serve the entire community	8.8	7
There should be respect for each other/youth be given special treatment/staff should pay more attention to patients/youth are encouraged without being reprimand	4.4	6
There should be peer education/youth to serve others/where youth provide support to the clinic/a service were staff members are young people	3.6	5
A clinic that provides HIV testing and counselling	2.2	3
Clinic where staff are comfortable in serving youth	2.2	3
A clinic that does not only serve the youth	2.2	3
Extra finance for proper medication	2.2	3
Less waiting time	1.2	2
Cleaners not to interfere with patients	1.5	2
A service with more nurses/a service with a social worker/friendly receptionists	0.7	1
More medication available	0.7	1
Good communication between youth and staff	0.7	1
Clients should not be treated badly	0.7	1

The findings in table 4.3.16 indicate that the majority of youth (13.1%/n=18) would perceive an ideal youth friendly clinic that caters for youth only services to be rendered by nurses who are trained on youth related issues. Furthermore, those nurses should be supportive towards the youth. A further 9.5% (n=13) would want to have an ideal clinic with more doctors and information provided freely.

Figure 4.3.6 below indicates that young people perceive the staff members differently. While others indicated that they were not happy with the staff, others see them as friendly.

It was important for the researcher to explore the situation further by requesting respondents to describe clinic staff.



	FRIENDLY	COMPETENT	LISTENING	RESPECTFUL	CARING	HELPFUL
VERY GOOD	33.05	22.12	24.89	17.54	12.43	26.34
GOOD	26.69	32.26	30.22	33.33	34.1	34.86
NEITHER	6.78	13.82	16	12.28	12.44	7.59
POOR	23.3	20.74	20.89	24.54	19.35	19.64
VERY POOR	10.1	11.06	8	12.28	15.67	11.61

Figure 4.3.6 Characteristics of clinic staff as described by the youth Q4.2

The results in figure 4.3.6 indicate that 33.5% (n=78) described clinic staff as friendly, whereas 32.3% (n=70) said clinic staff were competent, and 30.2% (n=68) referred to them as good listeners. Almost the same number of respondents (33%/76) and 34.1% (n=74) said clinic staff were respectful and caring, while 34.8% (n=78) said they were helpful.

Negative ratings on staff at clinics were also provided. Respondents rated staff as unfriendly (23.3%/n=55), not competent (20.74%/n=45), poor listeners (20.98%/n=47), disrespectful (24.56%/56), uncaring (19.64%/n=42), and not helpful (19.64/n=44). Even though other researchers have highlighted that clinic staff need to change their attitude towards the youth, the majority of respondents in this study claimed to be satisfied with the staff at the clinics.

The results painted a confusing picture as in most questions asked, for example in table 4.1.2, (26%) and in table 4.3.2 (35.5%) of the respondents indicated that clinic staff were rude, judgmental, and unfriendly. This was also stated as the reason that made the respondents avoid the clinic or not return to it. It is interesting that the youth were in the same breath describing the staff as friendly, competent and caring. In trying to understand what the real reason was that made the youth go from clinic to clinic or even avoid going to the clinics, the respondents were asked to indicate whether they think service providers understand their needs as young people. Figure 4.3.7 provides the reader with the responses provided.

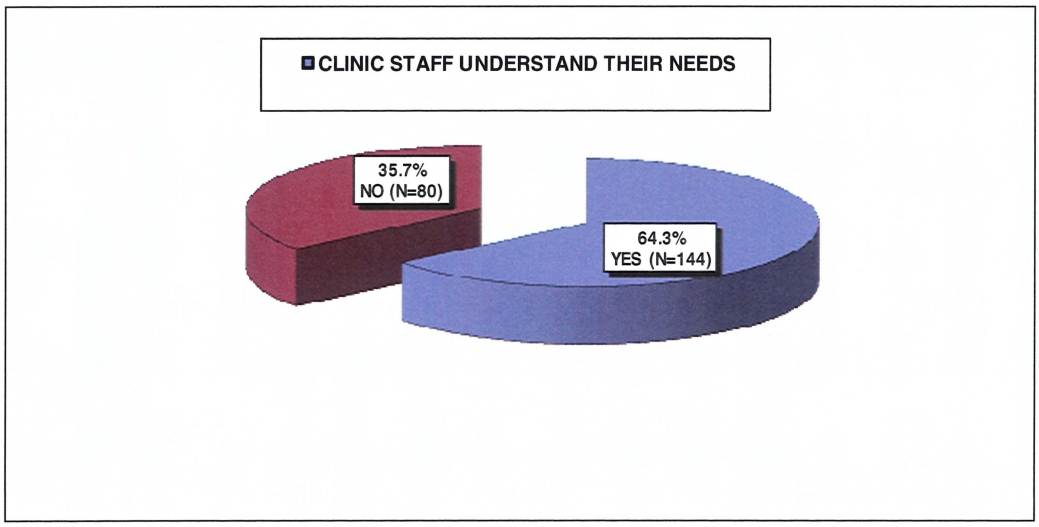


Figure 4.3.7 Staff's understanding of the needs of youth (N=224) Q4.3

The majority of respondents (64.3%/144) indicated that the clinic staff does understand their needs as youth, while (35.7%/80) stated the opposite. Of the 80

(35.7%) youth who felt that the clinic staff do not understand their needs as young people, the majority (37.6%/n=30) highlighted the unfriendliness of the staff, rudeness, unconcerned, and the undermining attitude of health workers as the main reason.

Noting the contradiction in the information provided earlier where respondents described health care workers as rude, judgemental and authoritative and then a percentage of the same sample thought that the same health care workers understood their needs, it was important for the researcher to request the respondents to motivate their answers.

Table 4.3.17 Motivations that clinic staff understand the needs of youth

Q4.3.1a

MOTIVATION THAT CLINIC STAFF UNDERSTANDS THE NEEDS OF YOUTH	%	n=144
Characteristics of service providers		
They are helpful, provide support, some were helpful	15.3	22
They communicate well with the youth/they understand when we talk to them, are willing to listen and comfort us	12.5	18
They explain the cause of our illness, provide helpful information	11.6	21
They are patient, need to be patient with us	9.7	14
They listen before giving advice	5.6	8
They do a good job, are serious about their work	2.8	4
They help the youth to make correct decisions, understand our situation as youth	3.5	5
Most of them are trained to help youth	2.8	4
They are trained to deal with youth and know how to approach youth	2.8	4
They are very co-operative towards the youth	1.4	2
They respect ones privacy and keep information confidential	2.1	3
They understand our major problem is HIV and the dangers youth are facing and want to protect us	1.4	2

They are always available when we need them	0.7	1
They have started providing workshops	0.7	1
The clinic is clean now	0.7	1

The findings in Table 4.3.17 indicate that 15.3% (n=22) of respondents thought that service providers understood their needs because they were helpful and supportive. Twenty-one of them (n=11.6%) perceived them to be doing a good job and be serious about it. They are described as good communicators who listen to what the youth are saying and explain what they are doing while answering the questions asked. Twenty-one (11.6%) indicated that service providers give them valuable information patiently and are co-operative to the youth. Reflecting on the service provided, the respondents (2.8%/n=4) said service providers were trained to deal with young people. Some (2.1%/n=3) felt that the service ensured their privacy and confidentiality by keeping the information safe. The youth described the clinics as clean and educational in that they provide workshops on HIV and AIDS.

Motivations to indicate that clinic staff does not understand the needs of youth also elicited a variety of responses, as indicated in Table 4.3.18

Table 4.3.18 ***Motivation that clinic staff does not understand the needs of youth (N= 254) Q4.3.1b***

MOTIVATION THAT CLINIC STAFF DOES NOT UNDERSTANDS THE NEEDS OF YOUTH	%	n=80
Characteristics of the service providers		
Unfriendly/rude/selfish nurses	21.3	18
The staff nurse don't understand any of the youth needs	16.3	12
They scold the youth as if we are always doing wrong	7.5	6
Are not serious with what they are doing	6.3	5
They are always busy with other things	2.5	2
They do not examine patients thoroughly and give wrong treatment	3.8	3
They ask unnecessary questions	6.3	5
They should support us	1.3	1

They make as wait too long	2.5	2
Not every clinic has a youth group or support group discussing youth issues	2.5	2
Facilities are poor	1.3	1
They are always convinced that people don't have problems	1.3	1
They don't want to give us condoms	3.8	3
They make you feel intimidated	1.3	1
When youth come with sex related matters they make you feel guilty and scared	1.3	1
They have to listen to our suggestions	1.3	1
They take it as a joke	1.4	2

Some of the respondents (21.3%/n=18) described the staff as rude, unfriendly and selfish. Sixteen percent (n=12) felt that service providers do not understand their needs as young people, and 6.3% (n=5) answered that service providers were not serious about what they were doing and that they do not examine young people thoroughly. Some 2.5% (n=2) thought that service providers asked unnecessary questions. Another 2.5% (n=2) indicated that service providers are always busy with other things, and that they do not want to provide youth with condoms. One (1.3) felt that they should be supported by clinic staff. Most of the statements made by the youth, especially about poor reception and treatment, have a negative impact on the access of youth to the service (Abdool-Karim & Abdool-Karim, 2010:318).

On the question whether their experiences have changed their feelings towards going to clinic, the respondents provided different answers. Forty-four percent (n= 99) felt that they could still go to those clinics regardless of what they experienced, whereas 56% had negative feelings. For example, some said "it's nice to go to a clinic where staff is friendly and you receive good treatment". The others indicated that made them feel free, happy, and no longer scared to go to the clinic as they do not feel judged and they enjoy the service.

Table 4.3.19 Youths' reaction to their experiences (N=99) Q4.3.4

THE REACTION OF THE YOUTH TO THEIR EXPERIENCES	%	n=
I encouraged my friends to go there	33.3	33
I reported the matter to my parents	22.2	22
I told friends about it	18.2	18
I never went back to that clinic	18.2	18
I told my boy/girlfriend about it	13.1	13
I spoke to the person concerned	7.1	7
I warned friends never to go there	6.1	6

In Table 4.3.1.9 it is reflected that the majority of respondents (33.3%/n=33) reacted to what they experienced by encouraging friends to go to that specific clinic. Twenty-two percent (n=22) of the respondents reported the matter to their parents while two groups (18.2%/n=18) reacted by telling other friends about the experience, or decided not to go back to that clinic.

Only 7.1% (n=7) of the respondents addressed the issue with the person concerned, and six (6.1%) warned their friends not to go to that clinic.

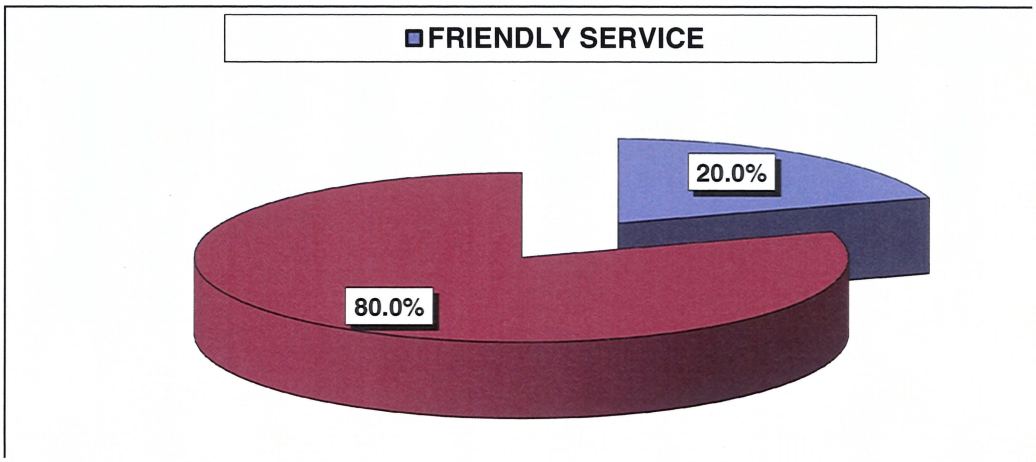


Figure 4.3.8: Distribution of respondents who have previously been interviewed on youth friendly services (N=22) Q4.6

The findings presented in Figure 4.3.8 indicate that the majority of respondents (80%/n=18) had never been interviewed on youth friendly services. Only 20% (n=4) were previously interviewed.

4.4 CONCLUSION

The conclusions regarding the research findings are provided in chapter 5. But it would be of value to indicate that the findings from the information provided by the respondents are conflicting. Whilst a considerable number was not happy about the time wasted in clinics before service was rendered and the judgmental attitude of service providers, almost the same number of respondents was of the opinion that service providers understand the health needs of youth.

The majority of youth consulted a clinic once and never returned to it, mostly due to the reasons outlined in the previous paragraph. Even those that indicated that they consulted a clinic on a regular base had only done so twice or thrice. Therefore the results suggested strongly that health care services provided to the youth in Kimberly were not attractive to the youth nor were they able to retain the youth as health care consumers, meaning that they are not yet youth friendly.

CHAPTER 5
CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

The research findings were presented and discussed in the previous chapter. This chapter will provide the conclusions, the limitations as well as the recommendations. The conclusions and recommendations are more or less presented according to the structure provided in chapter 2.

5.1 ACCESSIBILITY

5.1.1 Structural accessibility

5.1.1.1 Physical

Respondents (n=84/32.81%) said that they will consider a clinic as "physically" accessible if there are "youth friendly" signs or posters at the location or in the vicinity. Only a few respondents (n=9/7.3%) made reference to distance as a barrier to accessibility.

5.1.1.2 Financial

Dreyer *et al.* (2000:157) describe financial accessibility as an individual's ability to meet the cost of available health care. A request for extra finance for proper medication was made by only three (1.2%/n=3) respondents. As the matter was not listed by other respondents, one could conclude that the accessibility of services in this regard is not a pressing issue.

5.1.2 Functional accessibility

5.1.2.1 Range of service

The wide spectrum of youth, as indicated by the racial distribution, could have had implications for the type of services rendered. In this study, most of respondents –

78.5% (n=201) were Black, followed by Coloured at 20.3% (n=52), White at 0.4% (n=1), and Indian at 0.8% (n=2). However, considering the responses provided on "services required" and "services provided" by clinics, it seems that no additional services are needed. One should note, however, that HIV counselling and or testing was requested by 51.9% of the respondents.

5.1.2.2 Operating and waiting hours

Almost half of the sample – 48.4% (n=123) attended a clinic once only and never returned to the same clinic. When further investigated, it was found that 80 (34.2%) respondents said they never find the clinics in operation, and 66 (28.2%) said that they seldom find the clinics open. This means that 146 respondents have problems with the operating hours maintained by clinics (refer figure 2.4). When requested to indicate the hours of the day during which the clinics should be opened, the majority – 138 (55%) opted for a 07:00-19:00 (24 hours) operating time, 49 (19.5) said 07:00-19:00, and 41 (16.3) requested an extension in operating times.

The number of days that clinic service should be available was also investigated. Most respondents (56.6% /141) preferred to have the clinics opened from Monday to Saturday, while 54 (21.7%) suggested that service be delivered Sunday to Saturday. Another 54 (21.7%) support the status quo where clinics are open from Monday to Friday only.

Considering the youth's feedback on waiting hours, the picture is as follows: The long waiting period discouraged the majority of respondents (39.1%/n=42). According to this group, the clinic was "too busy" and they "could not be attended" by staff. Ninety-two (36.8%/N=250) respondents indicated that they spent an hour or more in clinics before they were served.

It seems that operating and waiting hours might be important issues to ensure functional accessibility of clinics.

5.1.2.3 Cultural

The fact that the majority of respondents (n=155/61%) were females and 31% (n=101) were males could be interpreted differently. Unfortunately, an in-depth

analysis of feedback provided by males was not done to find out what cultural barriers existed in this regard.

5.2 ACCEPTABILITY

5.2.1 Structural acceptability

5.2.1.1 Physical

The problems encountered by youth who attended the clinics varied from structural to functional problems. However, only three (3.7%) of the respondents indicated that there was a lack of appropriate facilities. One (1.3%) mentioned that "facilities are poor".

5.2.1.2 Waiting/reception areas

Twenty-two (20.5 %) of the respondents indicated that they had experienced problems at the reception areas. Eleven (10%) had problems with cleaners. Only a few respondents (5.6%/n=6) had problems with the security officers and with other patients respectively. Five (6.7%) respondents said "cleaners should not think that they are nurses'. Five (6.7%) stated that "nurses and reception clerks should work faster", and three respondents mentioned that "security should stop people from going into clinic".

5.2.1.3 Privacy and confidentiality

Privacy and confidentiality were not addressed by respondents. When asked to provide a motivation that clinic staff understand the needs of youth, only three (2.1%) confirmed that "They respect ones privacy and keep information confidential".

5.2.2 Functional acceptability

5.2.2.1 Provider client relationship and staff attitude

The relationship between respondents and the service providers, and staff attitude seemed to be important reasons why respondents did not return to clinics. Complaints included, for example, that "staff are unfriendly, rude, judgmental

(26%/n=32). Twenty-nine (35.5%/n=82) respondents provided the same reasons for attending several clinics in the past three months.

5.2.2.2 Communication

On a question regarding functional problems encountered, three (3.7%) respondents mentioned a "lack of interest" and "poor listening skills" as problems. On a rating scale regarding the characteristics of clinic staff, 68 referred to nurses as good listeners. Eighteen (12.5%) felt that nurses communicate well and understand when they talk to them. They also stated that nurses are willing to listen and comfort them.

5.2.2.3 Stigmatisation

Eight (9.8%) of the respondents stated that they attend several clinics "to avoid embarrassment to repeat visits", and two (n=2/0.8%) stated that they "did not want to go to the clinic nearer to home". Even though the statements do not explicitly refer to respondents' fear of stigmatisation, one could pay attention to recommendations to limit embarrassment.

5.2.2.4 Participation

Respondents (n=2/0.78%) consider clinics as youth friendly when there are young people involved and participating in that clinic, and when they serve in the committees (n=1/0.39%). According to the results, 41.4% (n=106) provide counselling in clinics, 28.9% (n=74) are involved in HIV/AIDS counselling Love Life projects, 27% (n=69) are serving on the clinic committee, and 26.6% (n=68) serve in support groups for HIV/AIDS patients.

When requested to indicate the role of youth in voluntary programmes, 119 (46.5%) stipulated "organiser", 82 (32.0%) "facilitator", 77 (30.0%) "support group member", and 63 (24.6%) "educator". It might be important to consider the feedback provided when the recommendations are made. Opportunities for participation should be available and promoted in clinics.

5.3 RECOMMENDATIONS

In this study, which focused on the delivery of youth friendly services in the Northern Cape, only one of the positive responses made was confirmed by (60%) of the respondents. In this case, they rated nurses as "good" to "very good" with regard to friendliness only. But at the same time, 64.5% of the respondents indicated that they experience problems with nurses. Therefore, by considering the following recommendations, PHC services rendered to youth can be revisited to ensure that quality care is rendered.

- There is a need for the Northern Cape DoE to put up signboards and posters in clinics that indicate where clinics are located so as to improve their accessibility to the youth.
- Although HIV counselling and testing services are provided at clinics, it is recommended that the youth be involved to identify needs or strategies to improve the services rendered. The respondents did indicate that they see themselves as organisers, facilitators, support group members, educators, and counsellors within the services. Service providers could utilise this feedback to facilitate a working relationship between providers and youth.
- The suggestion that operating hours be extended could be investigated. More information on the reasons why youth found clinics not operational should be obtained, and the findings used to guide service providers in this regard. The same strategy could be applied to solve problems regarding waiting hours and the days services should be available.
- Considering the problems respondents experienced with regard to waiting areas and or reception, it might be necessary to involve staff in a discussion to clarify their roles and to streamline job descriptions.
- The existing youth friendly training programme for nurses should be reviewed, and the inputs from the youth should form the foundation thereof. Aspects that need to be addressed are, for example, professional behaviour, communication techniques, and/or interpersonal relationships.
- Youth friendly services and the provision thereof should be included in the curricula for the training of health professionals.

- A follow-up study that will be much bigger, include other areas within the province as well as extend beyond the school going youth and health care workers is necessary for better planning of services.
- The extent of youth satisfaction concerning the services provided to them should be evaluated continuously and the findings communicated to the HCWs.

5.4 LIMITATIONS OF THE STUDY

- Limited literature is available on the delivery of youth friendly services in the Northern Cape.
- Generalisation of the research results to the entire Northern Cape would be impossible due to the wide geographic location of the districts from each other.
- A considerable amount of information provided by youth aged 13 to 14 years could not be used because of incomplete questionnaires.
- The withdrawal of the predominantly English and Afrikaans schools affected the racial distribution of the sample.
- The feedback on some questions, for example 5.1 and 5.2, overlapped and the structured format of most questions could have had an effect on the "depth" of feedback provided.
- Cultural barriers were not properly addressed in the questions or feedback of respondents.

5.5 IMPLICATIONS FOR FURTHER RESEARCH

- This study focused on the school going youth, but much can come out of the other categories of youth. For example, those out of school or those with disabilities.
- More information can come from the younger groups, 10 to 13 years, especially because schools commence with sexuality education at that age.
- A replication of the study using different research designs could be beneficial to service providers.

5.6 CONCLUSION

The aim of the study was to assess the delivery of youth friendly services in the Northern Cape. Both structural and functional accessibility and acceptability need to be addressed in order to enhance the services currently rendered to youth. Involving youth in either the delivery of voluntary services or in planning of needs-based services could be beneficial. If the study is replicated, the formulation of some questions should be revisited.

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ANNEXURE A

Letter from the Ethics Committee University of the Free State

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
YUNIVESITHI YA FREISTATA

Direkteur: Fakulteitsadministrasie / Director: Faculty Administration
Fakulteit Gesondheidswetenskappe / Faculty of Health Sciences

Research Division
Internal Post Box G40
☎(051) 4052812
Fax nr (051) 4444359

E-mail address: gndkhs.md@mail.uovs.ac.za

Ms H Strauss

2011-06-03

MS L NOGABE
SCHOOL OF NURSING
UFS

Dear Ms Nogabe

ETOVS NR 51/03
MS L NOGABE
SCHOOL OF NURSING
PROJECT TITLE: ASSESSING THE DELIVERY OF YOUTH FRIENDLY SERVICES BY HEALTH CARE WORKERS.

- You are hereby kindly informed that a member of the Ethics Committee approved the amendment to the project title of the above study and it will be condoned at the meeting scheduled for 7 June 2011.
- The project title changed to: "AN ASSESSMENT OF THE DELIVERY OF YOUTH FRIENDLY SERVICES IN THE NORTHERN CAPE."
- Committee guidance documents: Declaration of Helsinki, ICH, GCP and MRC Guidelines on Bio Medical Research. Clinical Trial Guidelines 2000 Department of Health RSA; Ethics in Health Research: Principles Structure and Processes Department of Health RSA 2004; Dept of Health: Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa, Second Edition 2006; the Constitution of the Ethics Committee of the Faculty of Health Sciences and the Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines.
- Any amendment, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.
- The Committee must be informed of any serious adverse event and/or termination of the study.
- A progress report should be submitted within one year of approval of long term studies and a final report at completion of both short term and long term studies.
- Kindly refer to the ETOVS reference number in correspondence to the Ethics Committee Secretariat.

Yours faithfully

.....
for CHAIR: ETHICS COMMITTEE

339, Bloemfontein 9300,RSA ☎ (051) 405 2812 StraussHS@ufs.ac.za
Republiek van Suid-Afrika / Republic of South Africa

ANNEXURE B

Letter from the Department of Education (Northern Cape)

DEPARTMENT OF EDUCATION
DEPARTEMENT VAN ONDERWYS
LEFAPHA LA THUTO
ISEBE LEZEMFUNDO

Education Building
156 Barkly Road
Homestead
KIMBERLEY 8301

Private Bag X5029
KIMBERLEY 8300
Republic of South Africa
www.ncedu.gov.za

Tel. (053) 839 6500
Fax (053) 839 6580/1

Enquiries :
Dipatlisiso : **Mr EAB. Williams**
Imibuzo :
Navrae :

Reference :
Tshupelo :
Isalathiso :
Verwysings :

Date :
Leshupelo : **Aug. 2008**
Umhla :
Datum :

TO WHOM IT MAY CONCERN

Subject: AN ASSESSMENT OF THE DELIVERY OF YOUTH FRIENDLY SERVICES ON LEARNERS IN THE NORTHERN CAPE DEPARTMENT OF EDUCATION

The Head of Department, Mr. Williams, hereby grants permission to conduct research on the topic stated above as per request of your letter.

In keeping with our policy tenets, teaching and learning should under no circumstances be disrupted during the undertaking of the research. Secondly it will be in the interest of our department and education in our province if you could provide us with a copy of the final product of your research.

We wish you well in your endeavor to improve education in general.

Kind regards

pp .....

Mr EAB. Williams
Head of Department: Education

HIV/AIDS is everyone's concern.

JUN.03.2011 12:45 0538396785 CHIEF DIRECTOR #1361 P.002 /002

ANNEXURE C

Letter to Principals of Schools

School of Nursing
Faculty of Health Sciences
University of Free State
P.O. Box 339 (Int. 99)
Bloemfontien
9300

The Principal
..... High School
P.O.Box .....
Kimberley

Re: Collection of research data in High Schools

Dear Mr/Madam

I am a Student, registered with the University of Free State for a Masters Degree in Nursing. I hereby request permission to collect research data from learners in your school, on **AN ASSESSMENT OF YOUTH FRIENDLY HEALTH SERVICES IN THE NORTHERN CAPE.**

I would first request to have a list indicating learner distribution in grades, meaning, (1) **the number of classes per grade, which reflects the number of learners and (2)the male/ female ratio per class.**

Please be informed that all learners are 18 years and younger will be included on condition that their parents or guardians have agreed to their inclusion.

This information will enable me to determine the total number of learners (sample size) per school and class as well as the ratio of males to females that should be selected for the research.

Please find enclosed a copy of the letter of permission granted by the Department of Education and the data collection instrument indicating the type of questions that learners will be expected to answer.

Thanking you in anticipation

.....

Lingiwe Nogabe (researcher)
Contact details: Tel: 051-401 2571 / Cel: 0827435235

ANNEXURE D

Consent form for parents

Consent form

RE: STUDY "**An assessment of the delivery of youth friendly health services in the Northern Cape**"

RESEARCHER: Miss L.E NOGABE

Dear Parent,

I am a Masters student doing research within the Faculty of Health Sciences, University of the Free State, and hereby request that your child who is a high school going youth be part of the study. He/she will only be included if he/she is between 13 and 21 years, has consulted a Primary Health Care clinic in Kimberley and is willing to participate.

Although the study may not benefit you directly, it will help by proving information that may lead to improvement in health care.

The study procedure involves responding to a questionnaire which is to be answered and sent back to the researcher within a week of receiving it. You are free to ask any questions about the study or about being a subject of respondent.

Miss L.E Nogabe may be contacted on:

The Study data will not be linked to his/her your name. Your identity will not be revealed while the study is being conducted or when the study is reported or published.

All the data will be collected by the researcher, stored in a safe place and not shared with any other person without your permission.

Please assist me by answering all questions to the best of your ability.

Thank you.

Yours

L.E Nogabe faithfully,

Cell: Only in original document

Work: Only in original document

If in agreement, please fill the information hereunder:

I ..... Have read this consent form and voluntarily consent to participate in this study.

SUBJECTS SIGNATURE DATE

I, Miss L.E Nogabe have explained this study in the above letter to the subjects and have sought their understanding for informed consent.

RESEARCHER'S SIGNATURE DATE

ANNEXURE E

Consent form for respondents

Informed consent form for the respondents.

Study title: An assessment of the delivery of youth friendly health services in the Northern Cape

Reasercher: Lingiwe Eldah Nogabe

You are invited to participate in a research study regarding youth friendly services. You will be requested to complete a questionnaire which will take approximately one hour.

The study has been approved by the Ethics committee of the Faculty of Health Science of the University of the Free State. There are no risks involved in completing the questionnaire. There may be no direct benefits to the participants of this study, but there may be improvements in the

Your participation in this study is voluntary, and you have the right to withdraw at any time without penalty and your school activities will not be affected. You will not get compensation for your participation.

Your name will not appear in the questionnaire. Study data will be coded so the data will not be linked to you. All study data will be collected by the researcher and stored in a safe place, no one will have access to the raw data. The final report containing anonymous quotations will be available to all at the end of the study.

I have read this consent form and voluntarily consent to participate in this study.

PARTICIPANT'S SIGNATURE DATE

I have explained this study to the above participant and have sought her understanding for informed consent.

RESEARCHER'S SIGNATURE DATE

ANNEXURE F

Questionnaire for youth

QUESTIONNAIRE FOR YOUTH

Questionnaire number

			1-3

Qualifying question

This question determines whether you qualify to participate in this study or not.

SECTION 1

For office use only

QUESTION 1

1.1 Have you attended any health care clinic for service, information or advice?

Yes	1
No	2

	4

If Yes, continue to Question 1.2

If No, thank the interviewee and explain that he/she can't continue with the study because he/she has never attended a clinic. Thank you

1.2 Which clinic/s do you attend?

_____

_____ 5 - 6

1.3 How often did you attend that clinic in the past 6 months?

Once	1
2 – 3 times	2
4 – 5 times	3
More than 5 times	4

7

If once, please answer question 1.4

1.4 **If once, which of the following would be the reason for not returning to the clinic?**

Not satisfied with the prescribed treatment	1
Consulted a private practitioner	2
Was discouraged by long waiting time	3
Consulted a more youth friendly clinic	4
Unfriendly or judgmental staff	5
Complaint not addressed or not cured	6
Moved to a new residential area	7
Referred to other service for treatment	8
Clinic not open	9
To avoid embarrassment of repeat visits	10
Other	11

8
9
10
11
12
13
14
15
16
17 – 18

1.4.1 Specify below:

_____

_____ | | | 19 – 20

_____ | | | 21 – 22

_____ | | | 23 – 24

SECTION 2

Demographics

2.1 How old are you?

_____ | | | 25 - 26

2.2 Gender

Male	1
Female	2

| | 27

2.3 Race

Black	1
Coloured	2
White	3
Indian	4
Other, please state here	5

| | 28

_____

_____

_____ | | 29

SECTION 3

Nature of services

3.1 Which clinic/s have you ever attended for service, information or advice in Kimberley? Specify names below:

_____

_____

_____

_____

_____

_____

30 - 31

32 – 33

3.2 If more than one, which of the clinics in Question 3.1 have you consulted more frequently in the past **six (6)** months?

_____

_____

_____

_____

_____

_____

34 – 35

If more than one, continue with question 3.3 and 3.4 below. If only one, go to question 3.5

3.3 Which of the clinics listed in 3.1 would you describe as your regular clinic? Specify below

_____

_____

36 – 37

3.4 How often did you attend that clinic in the past **six (6)** months?

Once	1
2-3 times	2
4-5 times	3
More than 5 times	4

38

3.5 Why did you attend several different clinics in the last **three (3)** months?

Unfriendly or judgmental staff	1		39
Complaint not addressed or not cured	2		40
Moved to a new residential area	3		41
Referred to other service for treatment	4		42
Clinic is not open	5		43
To avoid embarrassment of repeat visits	6		44
Other	7		

3.5.1 Specify below:

_____ | | | 45 - 46
_____ | | | 47 - 48
_____ | | | 49 – 50
_____
_____
_____

3.6 Which of the services are provided at the clinic/s you used?

Contraception (including condoms)	1		51
Treatment for sexually transmitted diseases (STIs)	2		52
General health problems/illnesses (colds, etc)	3		53
TB treatment	4		54
Information on reproductive health	5		55
Information on general health related topics	6		56
Ante/postnatal maternity care	7		57
Termination of pregnancy counseling	8		58
HIV counseling and/or testing	9		59
Surgical procedures (removal of stitches, wound care)	10		60 – 61

Other	11	

3.6.1 List other/s below

_____ | | | 62 – 63
_____ | | | 64 – 65
_____ | | | 66 – 67
_____

3.7 Which services do you think a youth friendly health clinic should provide?

Contraception (including condoms)	1		68
Treatment for sexually transmitted diseases (STIs)	2		69
General health problems/illnesses (colds, etc)	3		70
TB treatment	4		71
Information on reproductive health	5		72
Information on general health related topics	6		73
Ante/postnatal maternity care	7		74
Termination of pregnancy counseling	8		75
HIV counseling and/or testing	9		76
Surgical procedures (removal of stitches, wound care)	10		77 – 78
Other	11		

3.7.1 List other/s below

_____ | | | 79 - 80
_____ | | | 1 - 2
_____ | | | 3 – 4
_____

3.8 What time of the day do you think clinics must be open?

07:00 – 16:00	1
07:00 – 17:00	2
07:00 – 19:00	3
07:00 – 07:00 (24 hours)	4

☐ 5

3.9 On which days of a week do you think clinics must be open?

Sunday to Saturday	1
Monday to Friday	2
Monday to Saturday	3

☐ 6

3.10 How often are you able to get to the clinic when in operation?

Never	1
Seldom	2
Frequent	3
Always	4

☐ 7

3.11 What is the longest waiting time at the clinic on average?

Less than 15 minutes	1
15 – 30 minutes	2
30 – 45 minutes	3
45 minutes to 1 hour	4
More than 1 hour	5

☐ 8

3.12 What treatment or services have you sought from that clinic in the last **three (3)** months?

Contraception (including condoms)	1	☐ 9
Treatment for sexually transmitted diseases (STIs)	2	☐ 10
General health problems/illnesses (colds, etc)	3	☐ 11

TB treatment	4		12
Information on reproductive health	5		13
Information on general health related topics	6		14
Ante/postnatal maternity care	7		15
Termination of pregnancy counselling	8		16
HIV counselling and/or testing	9		17
Surgical procedures (removal of stitches, wound care)	10		18 – 19
Other	11		

3.12.1 List other/s below

_____ 20 - 21

_____ 22 - 23

_____ 24 - 25

_____

3.13 What made you to come to that clinic for help?

Although I did not want to come, the symptoms caused me to go	1		26
My parent/s encouraged me	2		27
My teacher/s encouraged me	3		28
My friend/s encouraged me	4		29
My family doctor sent me	5		30
Hospital referral	6		31
A traditional healer encouraged/referred me	7		32
I identified a problem from information I received/read/heard (I went on my own)	8		33
I was told I could get more information regarding a health need at a clinic	9		34
Other, list other/s below	10		

_____ 35 – 36

_____ | | | 37 - 38

_____ | | | 39 - 40

FOR OFFICE ONLY

3.14 If you have not been to a clinic before, how would you know whether a clinic is youth friendly or not?

If you choose options 2 – 7, then you can choose more than one but if you choose 1, then you cannot choose any other option.

I wouldn't know	1		41
When a friend/s tell me it is	2		42
When my parents believe it is	3		43
When my teachers believe it is	4		44
When health care workers believe it is	5		45
When a lot of youth go to it	6		46
When staff working there are trained on youth health	7		47
When there is a youth friendly sign/poster	8		48
When staff members working there are young	9		49
Other (specify below)	10		

_____ | | | 50 - 51

_____ | | | 52 - 53

_____ | | | 54 - 55

3.15 Which voluntary health care services are available for youth at the clinic you attend regularly?

Love Life ground breakers	1		56
HIV/AIDS counselling	2		57
HIV/AIDS support groups	3		58

Crime prevention	4	59
PPASA	5	60
Other (specify below)	6	61

_____ 62 - 63

_____ 64 - 65

_____ 66 - 67

3.16 What is your role in the programme?

Organiser	1	68
Facilitator	2	69
Educator	3	70
Counsellor	4	71
Support group member	5	72
Other (specify)	6	

3.16.1 List below

_____ 73 - 74

_____ 75 - 76

_____ 77 - 78

_____

3.17 Have you encountered any problem with the service provision in the clinics?

Yes	1	
No	2	79

3.18

If yes, what was/were the problem/s? Specify below:

_____

_____

_____ 80 - 1

3.19 If yes, where was the problem? (You may answer more than one)

Security at the entrance	1
Reception clerk	2
Nurses	3
Cleaners	4
Other clients	5
Others (specify)	6

	2
	3
	4
	5
	6

		77 - 78
		79 - 80
		1 - 2

3.20 What alternative/s would you suggest that could resolve the problem/s stated above?

_____

_____

_____

_____

		3 - 4
		5 - 6

SECTION 4

Experiences of youth

4.1 Describe your ideal primary health care clinic that caters for the needs of youth

_____

_____

_____

_____

		7- 8
		9 - 10
		11 - 12

4.2 Would you describe clinic staff at your clinic as:

Very friendly	Friendly	Neither	Unfriendly	Very unfriendly	13
Very competent	Competent	Neither	Incompetent	Very incompetent	14
Very good listeners	Good listeners	Neither	Poor listeners	Very poor listeners	15
Very respectful	Respectful	Neither	Disrespect-ful	Very disrespectful	16
Very caring	Caring	Neither	Uncaring	Very uncaring	17
Very helpful	Helpful	Neither	Unhelpful	Very unhelpful	18

4.3 Do you believe clinic staff understands your needs as a youth? Please motivate your answer

Yes	1	
No	2	19

4.3.1 Motivation

_____ 20 - 21

_____ 22 - 23

_____ 24 - 24

_____

_____

4.4 Have any of your experiences of going to a clinic changed the way you feel towards going there again? Please motivate your answer

Yes	1	
No	2	25

4.4.1 Motivation (specify the experience/s)

_____ 26 - 27

_____ | | | 28 - 29

_____ | | | 30 - 31

4.5 What was your reaction to the experience?

Spoke to the person concerned later	1	32
Reported the incident to my parents	2	33
I told my friends about it	3	34
I never went back to that clinic again	4	35
I warned my friends not to go there	5	36
I encouraged my friends to go there	6	37
I told my boy/girlfriend about it	7	38
Other	8	

4.5.1 Specify below

_____ | | | 39 - 40

_____ | | | 41 - 42

_____ | | | 43 - 44

_____

4.6 Have you been interviewed on youth friendly services before?

Yes	1	
No	2	45

4.6.1 If yes, where and when?

_____

_____ | | | 46 - 47

Thank you very much for making this study a success.

ANNEXURE G

Onderhoude vir jeugdiges

Vraelysnommer

			1-3

Kwalifiserende vraag

Hierdie vraag bepaal of die proefpersoon in die studie ingesluit gaan word of nie.

AFDELING 1

Alleenlik kantoorgebruik

VRAAG 1

1.1 Het u enige gesondheidsorgkliniek vir diens, inligting of advies besoek?

Ja	1
Nee	2

	4

Indien ja, gaan voort met vraag 1.2.
Indien nee, bedank die person en verduidelik dat hy/sy nie met die studie kan voortgaan nie omdat hy/sy nooit 'n kliniek besoek het nie. Dankie

1.2 Watter kliniek/e besoek jy?

_____

_____

		5 - 6

1.3 Hoe dikwels het jy die kliniek die afgelope 6 maande besoek?

Een keer	1
2 – 3 keer	2
4 – 5 keer	3
Meer as 5 keer	4

[ ] 7

Indien een keer, beantwoord vraag 1.4

1.4 Indien een keer, watter van die onderstaande kon redes wees waarom jy nie teruggegaan het nie?

Nie tevrede met voorgeskrewe behandeling	1	[ ] 8
Het 'n privaatdokter besoek	2	[ ] 9
Was ontevrede oor lang wagtyd	3	[ ] 10
Het 'n jeugvriendelike kliniek besoek	4	[ ] 11
Onvriendelike of veroordelende personeel	5	[ ] 12
Klagte(s) nie beantwoord of opgeklaar nie	6	[ ] 13
Verhuis na 'n nuwe woongebied	7	[ ] 14
Verwys na 'n ander diens vir behandeling	8	[ ] 15
Kliniek was nie oop nie	9	[ ] 16
Om die verleentheid van herhaalde besoeke te vermy	10	[ ][ ] 17 – 18
Ander	11	

1.4.1 Spesifiseer hieronder:

_____ [ ][ ] 19 – 20

_____ [ ][ ] 21 – 22

_____ [ ][ ] 23 – 24

Alleenlik kantoorgebruik

AFDELING 2

Demografie

2.1 Hoe oud is jy?

_____ | | | 25 - 26

2.2 Geslag

Manlik	1
Vroulik	2

| | 27

2.3 Ras

Swart	1
Kleurling	2
Wit	3
Indiër	4
Ander (spesifiseer)	5

| | 28

_____

_____

_____ | | 29

AFDELING 3

Aard van die diens

3.1 Watter gesondheidsorgdienste in Kimberley het jy al ooit vir diens, inligting of advies besoek? Spesifiseer name hieronder:

_____

_____

_____

_____ 30 - 31

_____ 32 – 33

_____

3.2 Indien meer as een, watter van die klinieke in vraag 3.1 het jy gedurende die laaste **ses (6) maande** meer gereeld besoek?

_____

_____

_____

_____

_____

_____ 34 – 35

Indien meer as een, gaan voort met vraag 3.3 en 3.4. Indien net een, gaan na vraag 3.5.

3.3 Watter van die klinieke gelys in vraag 3.1 sou jy as jou gereelde kliniek beskryf? Spesifiseer hieronder.

_____

_____ 36 – 37

3.4 Hoe dikwels het jy die kliniek die afgelope ses (6) maande besoek?

Een keer	1
2 – 3 keer	2
4 – 5 keer	3
Meer as 5 keer	4

38

3.5 Hoekom het jy verskillende klinieke in die laaste drie **(3) maande** besoek?

Onvriendelike of veroordelende personeel	1		39
Klagte(s) nie beantwoord of opgeklaar nie	2		40
Verhuis na 'n nuwe woongebied	3		41
Verwys na 'n ander diens vir behandeling	4		42
Kliniek was nie oop nie	5		43
Om die verleentheid van herhaalde besoeke te vermy	6		44
Ander	7		

3.5.1 Spesifiseer hieronder:

_____ | | | 45 - 46
_____ | | | 47 - 48
_____ | | | 49 – 50
_____
_____
_____

3.6 Watter van die onderstaande dienste word voorsien in die kliniek(e) wat jy gebruik?

Geboortebeperking (insluitend kondome)	1		51
Seksueel Oordraagbare Siekte-behandeling	2		52
Algemene gesondheidsprobleme / siektes (verkoue, ens.)	3		53
TB-behandeling	4		54
Inligting oor reproduktiewe gesondheid	5		55
Inligting oor algemene gesondheidsonderwerpe	6		56
Voor-/naboorte (kraam) sorg	7		57
Terminasie van swangerskap-berading	8		58

MIV-berading en / of -toetsing	9		59
Chirurgiese prosedures (verwydering van steke, wondsorg, ens.)	10		60 – 61
Ander	11		

3.6.1 Lys die ander hieronder:

_____ 62 – 63

_____ 64 – 65

_____ 66 – 67

_____

3.7 Watter dienste behoort 'n jeugvriendelike gesondheidskliniek te verskaf?

Geboortebeperking (insluitend kondome)	1		68
Seksueel Oordraagbare Siekte-behandeling	2		69
Algemene gesondheidsprobleme / siektes (verkoue, ens.)	3		70
TB-behandeling	4		71
Inligting oor reproduktiewe gesondheid	5		72
Inligting oor algemene gesondheidsonderwerpe	6		73
Voor-/nageboorte (kraam) sorg	7		74
Terminasie van swangerskap-berading	8		75
MIV-berading en / of -toetsing	9		76
Chirurgiese prosedures (verwydering van steke, wondsorg, ens.)	10		77 – 78
Ander	11		

3.7.1 Lys die ander hieronder:

_____ 79 - 80

_____ 1 - 2

_____ 3 – 4

_____

3.8 Op watter tye van die dag dink jy moet die kliniek oop wees?

07:00 – 16:00	1
07:00 – 17:00	2
07:00 – 19:00	3
07:00 – 07:00 (24 uur)	4

5

3.9 Op watter dae van die week moet die kliniek oop wees?

Sondag tot Saterdag	1
Maandag tot Vrydag	2
Maandag tot Saterdag	3

6

3.10 Hoe gereeld kan jy die kliniek besoek tydens operasionele ure?

Nooit	1
Selde	2
Gewoonlik	3
Altyd	4

7

3.11 Wat is min of meer die langste wagtyd by die kliniek?

Minder as15 minute	1
15 – 30 minute	2
30 – 45 minute	3
45 minute tot 1 uur	4
Meer as 1 uur	5

8

3.12 Watter behandeling of dienste het jy by daardie kliniek die afgelope **drie (3)** maande benodig?

Geboortebeperking (insluitend kondome)	1		9
Seksueel Oordraagbare Siekte-behandeling	2		10
Algemene gesondheidsprobleme / siektes (verkoue, ens.)	3		11
TB-behandeling	4		12
Inligting oor reproduktiewe gesondheid	5		13
Inligting oor algemene gesondheidsonderwerpe	6		14
Voor-/nageboorte (kraam) sorg	7		15
Terminasie van swangerskap-berading	8		16
MIV-berading en / of -toetsing	9		17
Chirurgiese prosedures (verwydering van steke, wondsorg, ens.)	10		18 – 19
Ander	11		

3.12.1 Lys hieronder:

_____ 20 - 21

_____ 22 - 23

_____ 24 - 25

_____

3.13 Wat het jou vir hulp na **<u>daardie</u>** kliniek toe laat kom?

Hoewel ek nie wou kom nie, het die simptome my laat kom	1		26
My ouer(s) het my aangemoedig	2		27
My onderwyser(s) het my aangemoedig	3		28
My vriend(e) het my aangemoedig	4		29
My gesinsdokter het my gestuur	5		30

Hospitaalverwysing	6		31
'n Tradisionele geneser het my aangemoedig / verwys	7		32
Ek het 'n probleem op my eie geïdentifiseer deur inligting wat ek ontvang /gelees /gehoor het (ek het op my eie gekom)	8		33
Ek is ingelig dat ek meer inligting oor 'n gesondheidsbehoefte by 'n kliniek kon kry	9		34
Ander (lys hieronder)	10		

_____ | | | 35 – 36

_____ | | | 37 - 38

_____ | | | 39 - 40

3.14 Hoe weet jy of 'n kliniek jeugvriendelik is indien jy nog nooit voorheen daar was nie?

Indien jy opsie 2 – 7 gekies het, kan jy meer as een kies, indien jy opsie een kies, kan jy nie van die ander opsies kies nie.

Ek sou nie weet nie	1		41
As 'n vriend(e) my vertel dat dit so is	2		42
As ouers my vertel dat dit so is	3		43
As onderwysers my vertel dat dit so is	4		44
As gesondheidsdienswerker(s) daaraan glo	5		45
As baie jeugdiges daarheen gaan	6		46
As die personeel wat daar werk, opgelei is in jeuggesondheid	7		47
As daar 'n jeugvriendelike plakkaat / aanwyser is	8		48
As die personeel wat daar werk, jonk is	9		49
Ander (lys asseblief)	10		

_____ | | | 50 - 51
_____ | | | 52 - 53
_____ | | | 54 - 55

3.15 Watter vrywillige gesondheidsorgdienste vir die jeug is beskikbaar by die kliniek wat jy gereeld besoek?

LoveLife ground breakers	1	56
MIV/Vigs-berading	2	57
MIV/Vigs-ondersteuningsgroepe	3	58
Geweldsbeskerming	4	59
PPASA	5	60
(spesifiseer hieronder)	6	61

_____ | | | 62 - 63
_____ | | | 64 - 65
_____ | | | 66 - 67

3.16 Wat is jou rol in die program?

Organiseerder	1	68
Fasiliteerder	2	69
Opleier	3	70
Berader	4	71
Ondersteuningsgroeplid	5	72
Ander (spesifiseer)	6	

3.16.1 Lys hieronder

_____ | | | 73 - 74
_____ | | | 75 - 76
_____ | | | 77 - 78
_____

3.17 Het jy al probleme met dienslewering in die kliniek gehad?

Ja	1
Nee	2

☐ 79

3.18 Indien ja, wat was/waar was die probleem/e? Spesifiseer hieronder:

_____

_____

_____

☐☐ 80 - 1

3.19 Indien wel, waar was die probleem?(Jy kan meer as een kies).

Sekuriteit by die ingang	1
Ontvangsklerk	2
Verpleegpersoneel	3
Skoonmakers	4
Ander kliënte	5
Ander (spesifiseer)	6

☐ 2
☐ 3
☐ 4
☐ 5
☐ 6

☐☐ 77 - 78
☐☐ 79 - 80
☐☐ 1 - 2

3.20 Watter alternatiewe sou jy voorstel om die bogenoemde probleem(e) op te los?

_____

_____

_____

_____

☐☐ 3 - 4
☐☐ 5 - 6

AFDELING 4

Ervarings van die jeug

4.1 Beskryf jou ideale primêregesondheid-kliniek wat ingestel is op die behoeftes van die jeug

_____

_____

_____

_____

		7- 8
		9 - 10
		11 - 12

4.2 Sou jy die personeel by u kliniek beskryf as:

Baie vriendelik	Vriendelik	Nie een nie	On-vriendelik	Baie vriendelik	13
Baie bekwaam	Bekwaam	Nie een nie	On-bekwaam	Baie onbekwaam	14
Baie goeie luisteraars	Goeie luisteraars	Nie een nie	Swak luisteraars	Baie swak luisteraars	15
Baie respekvol	Respekvol	Nie een nie	Dis-respekvol	Baie dis-respekvol	16
Baie sorgsaam	Sorgsaam	Nie een nie	On-sorgsaam	Baie onsorgsaam	17
Baie behulp-saam	Behulp-saam	Nie een nie	Onbe-hulpsaam	Baie onbe-hulpsaam	18

4.3 Glo jy dat die kliniekpersoneel jou behoeftes as jeugdige begryp? Motiveer jou antwoord asseblief.

Ja	1	
Nee	2	19

4.3.1 Motivering

_____ | | 20 - 21
_____ | | 22 - 23
_____ | | 24 - 24
_____
_____

4.4 Het enige van jou ervarings tydens besoeke aan die kliniek jou gevoelens om daarheen terug te gaan verander? Motiveer jou antwoord asseblief.

Ja	1
Nee	2

	25

4.4.1 Motivering (spesifiseer die ervarings)

_____ | | 26 - 27
_____ | | 28 - 29
_____ | | 30 - 31

4.5 Wat was jou reaksie teenoor die ervaring?

Ek het later met die persoon in beheer gepraat	1	32
Ek het dit aan my ouers gerapporteer	2	33
Ek het dit aan my vriende vertel	3	34
Ek het nooit na die kliniek teruggegaan nie	4	35
Ek het my vriende gewaarsku om nie na daardie kliniek te gaan nie	5	36
Ek het my vriende aangemoedig om te gaan	6	37
Ek het my kêrel/meisie daarvan vertel	7	38
Ander	8	

4.5.1 Spesifiseer hieronder:

_____ | | 39 - 40

_____ | | | 41 - 42

_____ | | | 43 - 44

_____

4.6 Is 'n onderhoud vir hierdie studie al voorheen met hierdie jeugdige gevoer?

Ja	1
Nee	2

		45

4.6.1 Indien ja, waar en waneer?

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_____ | | | 46 - 47

Bedank die persoon met wie u die onderhoud gevoer het dat hy/sy die studie suksesvol gemaak het.