

**COMPREHENSIVE SEXUAL AND REPRODUCTIVE
HEALTH CARE SERVICES FOR YOUTH: A HEALTH
SECTOR PRIORITY**

by

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Declaration

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I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Masters in Population Studies in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Abstract

Sexual and reproductive health care have become key priorities both within developing and developed nations. Young people have been identified as particularly vulnerable to negative health outcomes. South Africa is one such example of a country that presently faces significant challenges in addressing the unmet sexual and reproductive health needs of young people. With the enormous burden of reproductive health problems and the accelerating HIV epidemic, the provision of sexual and reproductive health services remains a challenge.

Though various studies highlight the importance of comprehensive services targeted at youth, there is a lack of adequate research in evaluating the extent to which health services are addressing the health needs of clients. This study aimed to address this gap by examining a health care facility for students at one of the largest tertiary institutions in KwaZulu-Natal. The core objective was to determine the extent to which the health services are responding to the sexual and reproductive needs of young people by, exploring the experiences and perspectives of service providers and young men and women in relation to comprehensive, youth-friendly sexual and reproductive health care. This was assessed using a revised version of the Bruce-Jain quality of care framework. Information for this study was obtained using quantitative and qualitative data collection methods including: an inventory of the facility and services, in-depth interviews with staff and exit interviews with 200 clients aged 18 to 24 years.

The findings of the study reveal that logistical constraints hindered effective implementation of comprehensive, youth-friendly services by providers. Providers missed opportunities to provide clients with much needed information and services due to staff shortage, client overload, lack of infrastructure, and poor continuity mechanisms. HIV, STIs and unwanted pregnancies were some of the most important health issues among young people visiting the health facility. Very few young men utilised the services. Some of the key findings were that clients continue to experience barriers in interpersonal relations while many expressed the need for more information from providers. In addition, many young women still have an unmet need for contraception. Policy makers need to incorporate the needs of young clients within sexual and reproductive health initiatives. Ideally young people should be involved in the design and implementation process of comprehensive, youth-friendly health initiatives. This would form a platform for addressing the barriers that hinder health service provision.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development (Cairo)
IUD	Intrauterine Device
MDG	Millennium Development Goal
SADHS	South African Demographic and Health Survey
STI	Sexually Transmitted Infection
UNFPA	United National Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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Chapter One

Introduction

“Youth are the valued possession of the nation. Without them there can be no future. Their needs are immense and urgent. They are the centre of reconstruction and development.”

*Nelson Mandela
(National Youth Commission, 1997:8)*

1.1 Background

Today’s generation of youth is the largest-ever generation in history, with more than 1.5 billion people, less than twenty five years of age (UNFPA, 2009). From past to present, societal shifts and behavioural patterns intensified by unique developmental challenges, have created a convergence of factors that place the present generation of youth at a heightened risk for poor health outcomes (Bearinger *et al.*, 2007). However, even in an era of the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), the major health problems experienced by young people are largely preventable. One sphere of health that has received renewed emphasis in recent years is sexual and reproductive health care.

Sexual and reproductive health, constitute a key component of a healthy transition to adulthood. However, the challenges facing the present generation of youth making the transition to adulthood are greater today than ever before (Tylee *et al.*, 2007). The health environment has been dramatically altered by global epidemiological shifts as well as significant changes in social, economic, cultural and health spheres (Lloyd *et al.*, 2005). These changing social contexts within which individuals are embedded have been well documented as contributing to the increasing vulnerability of young people to poor sexual health outcomes including early pregnancy, sexually transmitted infections (STIs) and HIV (Bearinger *et al.*, 2007). Patterns and trends that characterise youth sexual behaviour and risk have come to be varied by: race, gender, ethnicity as well as socio-economic status in both developed and developing countries (Marston and King, 2006). At the same time, numerous

studies over the past decades have emphasized that age of sexual debut, number of sexual partners, and use of contraceptive methods and condoms, together with educational and marital norms, form a host of factors that have a significant impact on young people's risks of experiencing early pregnancy, STIs and HIV (Biraro *et al.*, 2009; Gregson *et al.*, 2009). These historical changes along with numerous research has resulted in increasing recognition of the unique health related vulnerabilities of young people.

With the emergence of these trends, at the turn of the century, the World Health Organisation (WHO) highlighted sexual and reproductive ill-health as one of the major causes of morbidity and mortality in young people (WHO, 1998). Consequently, over the last two decades, sexual and reproductive health care has become a key priority both within developed and developing countries, with research drawing attention to the barriers young people encounter in accessing health care services (Tylee *et al.*, 2007). This has resulted in increasing recognition that young people require services that are sensitive to their unique needs and a move for health services to be made more youth-friendly has emerged. Recommendations encouraging the removal of these barriers have been strengthened by the growing call for the development of youth-friendly services, that is, services which are designed to make the use of existing sexual and reproductive health services more acceptable to young people, worldwide (Petroni, 2007; Tylee *et al.*, 2007).

The 1994 International Conference on Population and Development (ICPD) in Cairo was one of the most significant demonstrations of the global commitment to ensuring good sexual and reproductive health (Askew and Berer, 2003; Boonstra, 2008). Pledged to by more than 180 countries, the ICPD expressed a dramatically new approach to population issues, that placed emphasis on a more comprehensive, client-centered approach to sexual and reproductive health (Boonstra, 2008; Maharaj and Cleland, 2005). However, although sexual and reproductive health issues have irrefutably formed a significant area of focus in the past decade, relatively few programs since the 1994 ICPD and the initiation of the Millennium Development Goals (MDGs) have specifically focused on the sexual and reproductive health needs of youth within developing countries. Even though developmentally distinct from children and adults in relation to physical, cognitive and social characteristics, traditionally youth have been neglected as a distinct target group and subsumed under the promotion of family, women's and child health (Bearinger *et al.*, 2007). Regarding young people as a unique group in terms of health risks and services, is therefore a relatively new conception particularly in developing country contexts (Dehne and Riedner, 2001).

Due to continuing sensitivities around sexual and reproductive issues, health services for this age group present a particular challenge to health officials (Petroni, 2007; Tylee *et al.*, 2007). Traditionally, sexual and reproductive health services were offered as a component of maternal and child health services. In many developing countries health services were mostly tailored to meeting the needs of married women (Clarke *et al.*, 2006). Young women that were married were subsumed under reproductive health care for older women whereas; for unmarried young women, services were offered as part of child health care which did not include sexual and reproductive health (Bearinger *et al.*, 2007). Particularly in countries within sub-Saharan Africa, women's social status and gender identities are tied to motherhood and childlessness is highly stigmatized (Hindin and Fatusi, 2009). In these societies women are expected to begin childbearing soon after marriage in order to prove their fertility. However service provision related to pregnancy and childbirth as well as family planning services at the initial stage were tailored to provide services to married women who had completed their childbearing or who wanted to control child spacing as opposed to younger women (Senderowitz, 1997). This consequently led to the perception that sexual and reproductive services were for adult women, thus creating barriers to access for both men and youth. Because of the stigma attached to youth sexuality, access to sexual health services including HIV and AIDS services, were also restricted for fear of promoting promiscuity among this age group. In many parts of the world, where health services were available, restrictive laws and policies often prevented them from being provided to certain groups of young people (Tylee *et al.*, 2007). With this emphasis, health care facilities were therefore not perceived to be welcoming or relevant to young men and women who were not expected to require sexual and reproductive health services (Senderowitz, 1997).

Since then, many countries have begun to recognise the importance of promoting services to youth. However, although sexual and reproductive health clinics have expanded to include a broader range of services pertaining to the youth, studies reveal that these services continue to be largely avoided by young men and women (Tylee *et al.*, 2007). Much of the reluctance of young people to attend health facilities relates to the facilities past emphasis and environment (Senderowitz, 1997). Young people are often discouraged from using such services because of cost, disapproval by providers and the community, logistical constraints such as inconvenient hours or lack of transportation. One of the barriers often highlighted in preventing the use of health services by youth are the nature of interactions between health care workers and clients (Smith *et al.*, 2004). Since many young people are uncertain and

embarrassed when seeking services, the concern for privacy and confidentiality is of particular importance, which many fear will be compromised in clinical settings. Research reveals that young men and women were also less likely to seek health services if they feared being stigmatized, chastised, or punished for sexual involvement (Bearinger *et al.*, 2007). The nature of the interactions between health workers and clients may therefore serve to discourage young people from seeking methods of contraception or health care advice and thus perpetuate the increase of both pregnancy and HIV among youth.

In many countries, reproductive health information, counselling, and services have been made accessible to young people through alternative delivery points, such as pharmacies. However, time and again, essential information, advice, and services are not sought due to difficulties in accessing these sources and personal discomfort in seeking them (Tylee *et al.*, 2007). Consequently, youth in this context continue to be disproportionately burdened by threats to their sexual and reproductive health (Bearinger *et al.*, 2007; Marston and King, 2006). Youth-friendly health care services therefore play a pivotal role in addressing the sexual and reproductive health rights and needs of the youth. They play an important role in addressing the needs of young men and women as they offer an important entry point to reach young service users with information, counselling and services (Askew and Berer, 2003; Boonstra, 2008). Of an estimated 1.5 billion young people in the world today, 86% of these live in developing countries (Lloyd *et al.*, 2005). However the provision of specialized sexual and reproductive health information, counselling, and services to young people, is a relatively recent practice within developing countries and much research is required to determine the effectiveness of these services. There is therefore a need to assess youth clinic services to discover and launch more effective ways of reaching increasing numbers of youth, particularly those that are vulnerable to specific sexual and reproductive health problems.

1.2 Reasons for youth-friendly services

An extensive body of literature provides evidence that the negative outcomes of sexually transmitted diseases, including HIV, and pregnancy threaten the health of people in the second decade of life more than any other age group (Bearinger *et al.*, 2007; Hindin and Fatusi, 2009; Tylee *et al.*, 2007). According to the United Nations Population Fund, fourteen million girls between the ages of 15 and 19 give birth each year; while roughly five thousand youth become infected with HIV each day with one half of all new HIV infections occurring

in young people between ages 15 and 24 (Petroni, 2007). Estimates of unsafe abortions in Africa show that more than one-quarter were experienced by 15 to 19 year olds (Biddlecom *et al.*, 2007). Pregnancy and HIV have therefore been cited as leading causes of death for young men and women in the developing world (Hindin and Fatusi, 2009; Petroni, 2007). Existing literature suggests that behavioural patterns acquired in this period tend to last throughout adult life (Dehne and Riedner, 2001). Providing comprehensive health services for youth are hence imperative in addressing the enormous burden of sexual and reproductive health problems, as they target the most vulnerable groups in relation to sexually transmitted infections, unwanted pregnancies and HIV.

Many countries in the developing world presently face significant challenges in addressing the unmet sexual and reproductive health needs of young people as well as curbing the spread of HIV and AIDS, thereby hindering progress towards achieving the Millennium Development Goals by 2015 (Maharaj and Cleland, 2006; PATH, 2004). With the enormous burden of reproductive health problems and the accelerating HIV epidemic, sexual and reproductive health therefore remains an unfinished agenda (Bearinger *et al.*, 2007). In view of these challenges numerous theorists argue that clinical services should therefore be tailored to meet the needs of young people.

For various reasons young men and women have an urgent need for accessible, quality sexual and reproductive health care services and these are often not adequately available elsewhere. For instance, an expanded range of contraceptive methods are not readily provided at pharmacies, and STI diagnosis and treatment are commonly only available at clinical facilities. In addition, health care facilities are already established and available in many settings. With the provision of appropriate staff training, supervision, monitoring systems and other selected adjustments these services could be tailored to serve young people. At the same time, a number of young people visit health facilities for general health care reasons. These visits present opportunities to provide both sexual and reproductive health services such as: promoting and providing condoms and contraceptive methods; providing STI screening, diagnosis and treatment; providing HIV testing and counselling; and education on risk reduction, consequences and outcomes of STIs and HIV.

Evidence in both developed and developing countries, are showing higher rates of participation among young men and women at health care facilities (Petroni, 2007; Tylee *et al.*, 2007). While it requires time, effort, as well as a change of health service providers'

perceptions and attitudes about serving young people, the benefits of providing clinical services that are youth-friendly will inevitably be worth the investment. Country level data illustrates that continued investment in effective prevention and treatment strategies are fundamental to protect the sexual and reproductive health of young people (Bearinger *et al.*, 2007). Research has proven that while only a few countries have adopted comprehensive approaches to youth sexual and reproductive health on a large scale, in those that have, such as Brazil and Mexico, significant reductions in early pregnancy and HIV infection have occurred (Petroni, 2007). Addressing the needs of young people during this period of life therefore perhaps provides the greatest hope for turning the tide against early pregnancy, STIs and HIV (Bearinger *et al.*, 2007). In this context, the promotion of youth-friendly, comprehensive sexual and reproductive health care services for youth should therefore be a public health priority.

1.3 Objectives of the study

Numerous studies have shown the significant contribution that comprehensive, sexual and reproductive health services for the youth can make in addressing the prevention of unwanted pregnancy, STIs and HIV (Bearinger *et al.*, 2007; Maharaj and Cleland, 2006; PATH, 2004). However, although various studies highlight the importance of comprehensive sexual and reproductive health services targeted at youth, there is a lack of adequate research in evaluating the extent to which health services are addressing the health needs of young people particularly within developing country contexts.

The research presented, was conducted to address this gap, by examining an existing health care facility for students at one of the largest tertiary institutions in the province of KwaZulu-Natal, South Africa. The core objective of this study was to determine the extent to which the health services are responding to the sexual and reproductive needs of young people by, exploring the experiences and perspectives of service providers and young men and women in relation to comprehensive, youth-friendly sexual and reproductive health care.

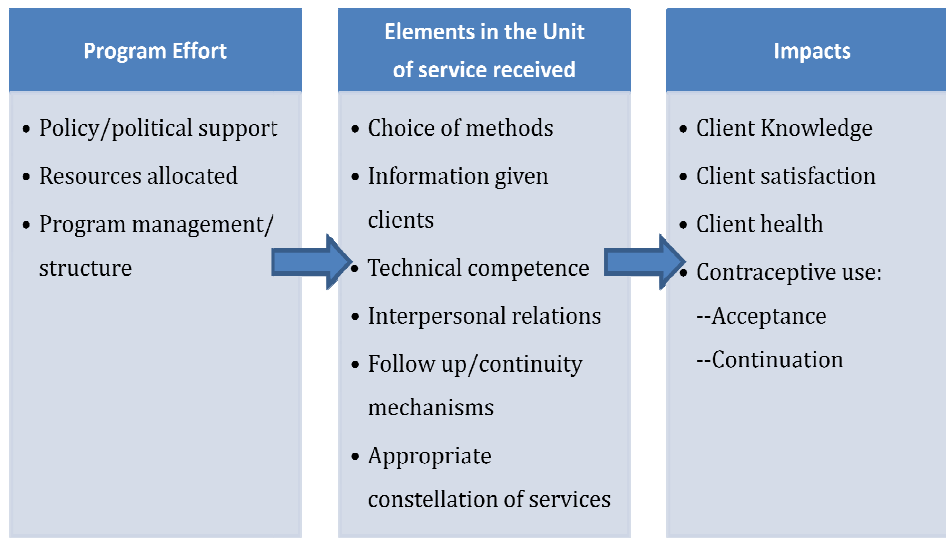
The World Health Organisation defines youth as persons between the ages of 15 to 24 years while young people are defined as those aged 10 to 24 years (WHO, 2002). However, all young people undergo the same physical, social, and cognitive changes through their transition into adulthood, and are confronted by the same difficulties in acquiring appropriate health care (Tylee *et al.*, 2007). In light of this and the various definitions used for the term young people, this study uses a broad definition of young people to include those aged

between 18 and 24 years, since this includes the age range of students and places them in a group at high risk of exposure to HIV, STIs, and unwanted pregnancies (Nshindano and Maharaj, 2008). Students are essentially an elite group with only 8% of South Africans having a tertiary education (Maharaj and Cleland, 2006). However, although far from being representative of typical young people, this group is of special significance for the future of the country. Important lessons can therefore be learnt that may have relevance to the wider population of youth.

1.4 Theoretical framework

The study presented, employed the key elements highlighted in the Bruce-Jain conceptual framework to address the comprehensiveness of health care services for youth. Developed in 1990 by Judith Bruce and Anrudh Jain, the Bruce-Jain framework forms one of the central paradigms for quality of care and has been widely adapted for use in sexual and reproductive health initiatives (Creel *et al.*, 2003). It provides a basis for assessing quality, which it defines as "the way individuals and clients are treated by the system providing services", in terms of six fundamental elements: choice of contraceptive methods, information given to clients, technical competence, interpersonal relations, follow-up or continuity mechanisms, and appropriate constellation of services (Bruce, 1990 cited in Creel *et al.*, 2003:2).

Figure 1.1: Quality of care framework



Source: Bruce (1990)

1.4.1 The six elements

One of the central principles of reproductive health programs are that a choice of methods should be provided. According to the Bruce-Jain framework, choice of methods refers to both the number of contraceptive methods that are offered on a reliable basis and their intrinsic variability (Bruce, 1990). This includes: methods offered to serve significant subgroups defined by age, gender, and contraceptive intention; health profile; lactation status; the degree to which the methods are meeting current or emerging need; and the range of choices for men and women with different reproductive needs (Bruce, 1990). Bruce (1990) highlights that having a choice of methods is both a practical and philosophical commitment to respond to the needs of users. The Bruce-Jain framework therefore emphasizes choice not only as the first, but as the fundamental element of providing quality in services.

Information given to clients refers to the information that is imparted during service contact which enables clients to choose and employ contraception with technical competence and satisfaction (Bruce, 1990). This includes: information about the variety of methods available, their advantages, disadvantages and scientifically documented contraindications; screening

out unsafe choices for specific clients, providing detailed information on how to use their selected method as well as the potential side effects of the method; and precise information about what clients can expect from service providers with regard to sustained support, advice, supply and referral to other methods or services (Bruce, 1990). According to the Bruce-Jain framework, the informational component is essential in ensuring that clients are aware of the proper uses, benefits and risks of contraceptives (Bruce, 1990). The framework thus highlights the informational component as a significant element in the provision of comprehensive services.

Technical competence refers to the providers' adherence to protocols, performance of clinical techniques, and competence in providing clinical methods (Bruce, 1990). According to Bruce (1990) technical competence is the one element in the framework which cannot be easily judged by clients. However, despite lacking the ability to appropriately evaluate clinical competence, the consequences of poor technique are often experienced by clients in the form of infection, pain and serious side effects (Bruce, 1990). Technical competence therefore forms an essential element in the Bruce-Jain framework in ensuring that providers understand the importance of adhering to safe clinical standards.

Interpersonal relations refer to the personal dimensions of service (Bruce, 1990). According to Bruce (1990) the relationship between providers and clients are influenced strongly by: the mission and ideology of a program; the management style; allocation of resources and supervisory structure (Bruce, 1990). The interpersonal relations element in the framework is a dimension that can strongly influence clients: confidence in their own choices and ability; satisfaction with services; and the possibility of a return visit (Bruce, 1990). The Bruce-Jain framework therefore emphasizes the element of interpersonal relations as a powerful dimension in quality care.

Mechanisms to encourage continuity refer to the procedures that health facilities have in place to encourage clients to continue using services (Bruce, 1990). This can be achieved through the media or specific follow-up mechanisms, such as appointments or home visits by workers. According to Bruce (1990) a programs willingness to establish continuity or follow-up mechanisms forms one measure of its long-term commitment to individual welfare. The aspect of institutionalising mechanisms to encourage continuity therefore forms an essential element of the Bruce-Jain framework.

Appropriate constellation of services refers to the provision of an array of services that can address the various needs of clients. According to Bruce (1990) services can be delivered through a vertical infrastructure or in the context of postpartum services, maternal and child health services, comprehensive reproductive health services and others. Of all the elements in the framework appropriate constellation of services is one that is highlighted as least universal and one that is largely conditioned by context (Bruce, 1990). An appropriate constellation of services forms an essential element in the Bruce-Jain framework as a way of providing a broader range of clinical services at one visit and meeting the different requirements and diverse needs of clients.

Since the development of the Bruce-Jain framework, several changes have been suggested to broaden or modify the framework to encompass a wider matrix of issues. Mora *et al.* (1993) cited in Creel *et al.* (2003), highlights the extension of the framework to include other aspects of reproductive health services such as: provision of maternal health services; prevention and treatment of sexually transmitted infections; as well as screening, counselling, and referral services. Bertrand *et al.* (1995) cited in Creel *et al.* (2003) emphasizes the need for considering clients access to reproductive health services, including: the distance clients have to travel to reach services; the costs of services; providers attitudes; and eligibility requirements that exclude clients based on gender, age or marital status.

The Bruce-Jain framework hypothesizes that the six elements reflect the six aspects of services which are critical and relevant to improving the quality of care. The present study therefore uses a modified version of the Bruce-Jain framework, integrating the six aspects of services within the wider matrix of issues which health specialists suggest are important, as one way of examining sexual and reproductive health services for youth in the South African context. This modification supplements the basic Bruce-Jain framework, placing the client at the center of the concept of quality of care; however emphasis is placed on the importance of increasing access to information and services as well as the provision of a comprehensive array of services (Creel *et al.*, 2003). By describing the specific ways in which these factors limit the quality of care received by young people programmatic conclusions can be drawn and used in future evaluation and implementation of projects aimed at improving youth health services.

1.5 Structure of the dissertation

The thesis is divided into six chapters. Chapter 1 introduces the study and outlines the theoretical framework, the Bruce-Jain Framework, in addition to defining the research aims and objectives. Chapter 2 provides a literature review relevant to understanding the research. Chapter 3 will focus on the research context; methodology, including the advantages and limitations; and tools used to analyse the data. In chapter 4, a detailed review on the observations made and findings obtained from the study will be provided. The concluding chapter, chapter 5, will provide an in-depth discussion of the research findings; highlight recommendations; and cite the overall relevance of the study in terms of the research objectives.

Chapter Two

Literature Review

2.1 Introduction

The present generation of youth is the largest recorded in history. However, unlike in the past, young people today face far more complex challenges to their health and development. Worldwide, young people are having early sexual debuts, expanding the gap between puberty and marriage, and delaying childbearing (Hindin and Fatusi, 2009). In addition, the rising prevalence and incidence of HIV, STIs and unwanted pregnancy has heightened awareness of the vulnerability of young people. In light of this, from past to present there has been increasing acknowledgement of the importance of providing comprehensive, youth-friendly health services in addressing the sexual and reproductive health needs of both young men and women worldwide (Boonstra, 2008). This chapter begins by discussing the patterns of sexual behaviour among young people and the reproductive health outcomes. It then highlights existing literature on various dimensions of health care services and provides a descriptive review of evidence that implementation of such services are beneficial to health outcomes for youth.

2.2 Sexual and reproductive health

For more than a quarter of a century health services have been internationally recognized as a vital element in improving the sexual and reproductive health of young people (Bearinger *et al.*, 2007). Various studies have highlighted the significance of encompassing an array of accessible, available and appropriate services for youth (Berer, 2006; Hindin and Fatusi, 2009; Petroni, 2007). However, investing effectively in youth services can only be achieved

with an understanding of the distinctiveness of this age group as well as the social contexts that increase young people's vulnerability to poor sexual and reproductive health outcomes.

2.2.1 Sexual behaviours

Behaviours that young people adopt during the early stages of life have critical implications for their future health and mortality (Lloyd *et al.*, 2005). Various literature highlight age at first sexual intercourse and marriage as significant individual level risk factors for STIs, including HIV, and unplanned pregnancy (Gregson *et al.*, 2009; McGrath *et al.*, 2009). Historically in many parts of the world sexual activity generally occurred within the context of marriage (Bearinger *et al.*, 2007; Clark *et al.*, 2006). However, various societal changes have seen the interval between sexual debut and marriage widening as a result of earlier sexual debut and/or delayed marriage. While the actual age of sexual debut varies across regions evidence suggests that rates of sexual initiation during early adulthood are rising or remaining unchanged in many developing countries (Biraro *et al.*, 2009; Cremin *et al.*, 2009). However, although trends in marriage and age at sexual initiation are being delayed, studies worldwide suggest that the context of the first sexual experience is changing with a greater likelihood now that first sex will be experienced prior to marriage (Lloyd *et al.*, 2005; Slaymaker *et al.*, 2009).

These widening gaps between age at marriage and first sexual intercourse are of public health concern. Numerous studies reveal that young people who begin sexual activity at an earlier age and prior to marriage are more likely to engage in sex with a larger number of partners and older partners (Hindin and Fatusi, 2009; Zaba *et al.*, 2009). Consequently, they are at a greater risk for exposure to STIs and HIV. Data on sexual initiation reveals that sexual debut is occurring earlier in Latin America at age 15, compared to sub-Saharan Africa and Asia where the median age is 18 to 20 among females and 15 to 20 among males (Shisana *et al.*, 2009). In the context of South Africa, studies on sexual and reproductive health suggest that pre-marital sexual activity as well as earlier sexual debut is relatively common among young people (Makiwane and Kwizera, 2008). An analysis of a nationally representative survey of youth in South Africa reveals that the median age at sexual debut is 16 years for males and 17 years for females (Makiwane and Kwizera, 2008). In addition, according to Shisana *et al.* (2009), further variations can also be observed in relation to age, sex and locality. For instance, findings among rural males in South Africa show that 13% of 15 to 24 year olds

have had their first sexual relationship prior to age 15 (Shisana *et al.*, 2009). Young men and women are consequently engaging in risky sexual behaviour for longer periods of time and are therefore at an increased risk for STIs, including HIV, and unplanned pregnancy.

Concurrent or multiple sexual partnerships have also emerged as a critical factor contributing to young people's vulnerability to HIV. Epidemiological evidence suggests that individuals in multiple sexual partnerships are at an increased risk for contracting STIs including HIV, since it creates multiple pathways for transmission to occur (Bearinger *et al.*, 2007; Shisana *et al.*, 2009). Despite this, a growing body of literature suggests that many young men and women in developing countries have had two or more partners in the past year (Bearinger *et al.*, 2007; Nshindano and Maharaj, 2008). While the tendency to have multiple sexual partners is not unique to Southern Africa, various studies provide evidence that it is particularly frequent among young people (Carter *et al.*, 2007; Nshindano and Maharaj, 2008). A survey conducted in South Africa found that young people reported more frequent multiple sexual partnerships than other age groups (Shisana *et al.*, 2009). While evidence suggest that young people were generally aware of the health-related risks associated with risky sexual behaviour they are often compounded by various social and cultural norms which prevents them from changing their sexual behaviour (Marston and King, 2006; Nshindano and Maharaj, 2008). Other behavioural factors that predispose youth to STIs, HIV and unwanted pregnancy include: unprotected sexual intercourse, sexual experimentation, inconsistent use of condoms, and poor knowledge on sexuality and reproductive function (Hindin and Fatusi, 2009).

2.2.2 Contraceptive use

Contraceptives, including condoms, form one of the key means of preventing negative sexual and reproductive health outcomes among youth. In recent times, a growing body of evidence suggests that contraceptive use among young people has increased (Berer, 2006). Studies in Latin America show that contraceptive use rates are increasing among sexually active women, particularly those that are unmarried (Lloyd *et al.*, 2005). Within sub-Saharan Africa contraceptive use ranges from a low of 3% in Rwanda to a high of 56% in Burkina Faso (Hindin and Fatusi, 2009). At the same time, although condom use remains relatively low, evidence from Eastern and Southern Africa suggests that condom use at last sex has increased among young people (Gregson *et al.*, 2009).

In the context of South Africa, a study on condom use among college students revealed that 66% of men and 59% of women reported using a condom at most recent sex (Maharaj and Cleland, 2006). However, although condom use has increased worldwide, consistent use remains elusive particularly among youth. The study among college students revealed that only 24% of men and 28% of women classified themselves as always using condoms (Maharaj and Cleland, 2006). Inconsistent use, low use, and non-use are also common among people who have multiple sexual partners. According to the South African Demographic and Health Survey condom use among individuals with multiple partners was 15% for primary partners compared to 47% among non-primary partners (Department of Health, 2003). Consequently, these levels of use among young people are still not sufficient to substantially reduce the spread of STIs, HIV and prevent unwanted pregnancies.

2.2.3 STIs (including HIV and AIDS)

The World Health Organisation estimates that worldwide the largest proportion of STIs are occurring in young people below the age of 25 (Bearinger *et al.*, 2007; Tylee *et al.*, 2007). Self-reported data from Demographic and Health Surveys in sub-Saharan Africa show that one to 11% of sexually-experienced 15 to 24 year old females and two to 16% of males in 20 countries reported having an STI in the 12 months prior to the survey interview (Biddlecom *et al.*, 2007). In developing countries, HIV and AIDS is the leading cause of death for women aged 15 to 29 and one of the leading causes of death for men in the same age group (Lloyd *et al.*, 2005; Petroni, 2007). According to Bearinger *et al.* (2007) 6000 young people around the world are infected with HIV every day. Literature reveals that almost half of the newly acquired HIV infections occur among young people living in developing country contexts (Tylee *et al.*, 2007).

Within South Africa, a country which has experienced one of the most severe AIDS epidemics in the world, the patterns of health among youth are of grave concern. Twenty years into the AIDS epidemic has only seen a metamorphosis of the disease increasingly becoming a disease of the young. Epidemiological studies in relation to this have shown that the peak incidence of HIV is occurring between those aged 15 to 24 years (Makiwane and Kwizera, 2008; Shisana *et al.*, 2009). At the same time, statistics reveal that there are marked gender disparities in HIV prevalence. The Human Sciences Research Council reports that HIV prevalence is disproportionately high among young females in comparison to males

(Shisana *et al.*, 2009). In South Africa, HIV prevalence among females aged 15 to 19 and 20 to 24 is twice as high as that of males (Shisana *et al.*, 2009). One reason for this is that young women are significantly more susceptible to contracting HIV than young men due to their higher biological vulnerability. This biological vulnerability compounded by a variety of social and environmental factors results in young women being disproportionately affected by HIV and AIDS. Other behavioral determinants of HIV in South Africa, where the dominant mode of transmission is through heterosexual sex, include age of sexual debut, multiple sexual partnerships, and unprotected sexual intercourse (Shisana *et al.*, 2009).

2.2.4 Pregnancy and abortion

The adverse consequences of pregnancy and abortion among youth have become a matter of increasing concern particularly within developing countries. It is estimated that within sub-Saharan Africa, 14 million unintended pregnancies occur each year, with almost half occurring among women aged 15 to 24 years (Williamson *et al.*, 2009). Survey data in this context reveals that one in three women experience premarital birth by age 20; while abortion statistics show that one-quarter of the estimated 20 million unsafe abortions and 70 000 abortion related deaths occur every year among women aged 15 to 19 years (Biddlecom *et al.*, 2007; Williamson *et al.*, 2009).

In a South African context, although the country's total fertility is low in comparison to other African countries; overall, it has high levels of fertility particularly among young females (Makiwane and Kwizera, 2008). Birth rates among youth are intertwined with rates of spontaneous and induced abortions. Although abortion figures in most countries are unreliable, in the context of South Africa, prior to the amendment of the legislation governing the termination of pregnancy (TOP), it was suggested that between 6000 and 12 000 illegal abortions were undertaken per annum, most of which were on young women (Smith *et al.*, 2004). In most instances abortion is particularly hazardous for young women because of the circumstances under which they are likely to occur. Research suggests that while young women are not disproportionately likely to have abortions, they are more likely to delay seeking them and more likely to use an unskilled abortion provider (Lloyd *et al.*, 2005). Estimates from Africa show that more than one-quarter of unsafe abortions were experienced by 15 to 19 year olds (Biddlecom *et al.*, 2007). Focusing on the needs of young women is particularly important not only in addressing the levels of unwanted pregnancy but the

prevalence of STIs and HIV as well. In light of the fact that pregnancy and abortion form one of the main factors affecting the health and mortality of young women, these patterns are imperative in understanding the barriers to health care and reflect the urgent need for accessible health services for youth.

The kinds of sexual behaviours that young people adopt contribute significantly to reproductive health problems as well as the morbidity experienced by young people. In light of the fact that sexual behaviour patterns established during this developmental period may influence behaviour in later life; there is an urgent need to assess health services and the manner in which they are responding to the sexual and reproductive health problems facing the youth of this generation.

2.3 Factors facilitating the use of health care services

2.3.1 Addressing unmet need

A decade since the MDGs advocated for universal access to reproductive health, the unmet need for contraception remains a challenge in many developing countries. Though contraceptive use has increased globally, an extensive body of literature suggests that there continues to be a limited range of methods in addressing the needs of specific sub-groups of the population (Barroso, 2010; Berer, 2006; Hindin and Fatusi, 2009). Evidence from sub-Saharan Africa and Latin America suggest that many young people in particular continue to have an unmet need for contraceptives (Barroso, 2010; Gregson *et al.*, 2009).

Unmet need for contraception can be defined as physical, economic, cultural and medical barriers, or non-use of methods despite the desire to limit births or delay them for at least two years (Hindin and Fatusi, 2009). According to Hindin and Fatusi, (2009) unmet need is particularly high among unmarried youth in sub-Saharan Africa with more than 40% in most countries. In comparison, 10 to 31% of unmarried youth in Latin America are considered to have an unmet need (Hindin and Fatusi, 2009). Recent evidence suggests that a substantial proportion of young women are expressing the need to postpone or avoid pregnancy (Barroso, 2010). However, due to the lack of information and accessibility to contraceptives

as well as the limited variety of methods available, many young people are unable to satisfy their sexual and reproductive health needs.

Meeting this huge unmet need for contraception can have important sexual and reproductive health outcomes. Several impact studies have shown that a positive and consistent relationship exists between the availability and accessibility of a range of contraceptive methods and contraceptive prevalence rates (Creel *et al.*, 2003; Smith *et al.*, 2004). Data from sub-Saharan Africa, Latin America and Asia reveal that contraceptive availability and choice were strongly associated with use, increased continuation rates and total contraceptive prevalence (PATH, 2004). There is therefore an increased emphasis for the provision of affordable, effective and safe contraceptive methods that are able to address the needs of young people within developing nations (PATH, 2004; Rutenberg and Baek, 2005).

2.3.1.1 Choice of contraceptive methods

Concerns about the negative consequences of unwanted pregnancies and the risks of contracting sexually transmitted infections among youth has in recent decades led to a growing consensus that providing access to a choice of methods is important. Choice does not necessarily imply that health services should provide all methods; however the services offered should ensure that prospective users have reasonable access to a variety of methods (Bruce, 1990).

Though comparative data on contraceptive choice and availability from developing countries is limited, studies suggest that within developing country settings, fewer cohorts of women have passed through reproductive ages when a meaningful choice of methods was available (Berer, 2006). Existing situation analyses of African family planning sites in the early 90s reveal that many family planning sites had only limited contraceptive choice (Mensch *et al.*, 1994; Turner, 1994). South Africa however has a unique history. During the apartheid period the government implemented various family planning measures to control population growth specifically among the black population. This support for family planning was fuelled not only by the fear that rapid population growth would undermine the country's economic prosperity but that the African population would overwhelm the minority white population. Unlike in other sub-Saharan African countries, women in this context therefore had access to a variety of methods (Smit *et al.*, 2004). With this historical background, contraceptive trends

in Africa have been varied. Recent data from sub-Saharan Africa reveals that only small proportions of unmarried young women have used medical contraceptives, including contraceptive pills, implants, injectables and intrauterine devices (Bearinger *et al.*, 2007; Hindin and Fatusi, 2009). For instance only 5% in Zimbabwe, 8% in Uganda, 11% in Kenya and 12% in Mali reported using medical contraceptive methods (Bearinger *et al.*, 2007). In comparison, medical contraceptive use in other countries around the world is higher among young women with 41% in Brazil, 34% in Nicaragua and 30% in Columbia. In South Africa there is great reliance on certain methods such as injectables and contraceptive pills (Smit *et al.*, 2004). In recent years, with the HIV and AIDS epidemic, condoms have gained popularity and are often considered accessible and in some cases more attractive than other modern contraceptive methods. Overall, though contraceptive trends in Africa can be attributed to past policies and social norms, qualitative research reveals that the low contraceptive use rate among youth can be attributed to the various obstacles they face when seeking medical contraceptive methods. These include: limited access to services, insufficient knowledge of modern methods and provider bias (Bearinger *et al.*, 2007; Hindin and Fatusi, 2009; Williamson *et al.*, 2009).

Worldwide, there is a need for an expanded range of methods if the incidence of HIV, STIs and unwanted pregnancies among youth is likely to be reduced. Not all contraceptive users are the same and no one method is perfect. Increasing contraceptive prevalence therefore requires access and choice to a wide range of methods. Each method introduced can attract a different segment of the population and thus meet the diverse needs of young men and women (PATH, 2004). Aside from providing young women with significant benefits related to: preventing early first births, lengthening birth intervals, and reducing maternal and infant mortality, providing a choice of contraception can also prevent unplanned pregnancies and mother-to-child transmission of HIV. Meeting the huge unmet need for contraception would therefore have important reproductive health and HIV and AIDS outcomes.

2.3.1.2 Discontinuation of methods and contraceptive failure

One of the rationales for offering an increased range of methods for young people is method failure and abandonment. Survey data reveals that contraceptive failure rates are higher among young women than adult women in all countries (Blanc and Way, 1998). Contraceptive failure, which occurs when an individual becomes pregnant while using a

method, is common among youth since many young people find it difficult to use contraceptives consistently and effectively (Hindin and Fatusi, 2009; Maharaj and Cleland, 2006). In addition, contraceptive use also requires accurate knowledge of the reproductive cycle and co-operation of partners (Blanc and Way, 1998; Hindin and Fatusi, 2009). Numerous studies in Africa, Asia, Latin America and the Caribbean have also found that method discontinuation in the first year among young people was largely attributable to method failure or side effects (Berer, 2006). If young people are unaware of side effects such as bleeding, nausea and cramping they were more likely to abandon the method.

Most contraceptive methods, with the exception of male and female sterilisation, are physiologically safe for young people (Bearinger *et al.*, 2007). Discontinuation, method failure and switching are therefore often indicators of: insufficient contraceptive supplies; limited access and range of methods; outdated or incomplete information and fears surrounding the use of contraceptive methods (Berer, 2006; Hindin and Fatusi, 2009; PATH, 2004). The availability of a contraceptive method is a prerequisite for the choice of methods that a provider can offer. However the availability of a full range of contraceptives is often influenced by costs, staff training and logistical constraints (Cleland *et al.*, 2006). Limited numbers of appropriately trained providers are also likely to be an important determinant of the choice of methods available (PATH, 2004). For instance, intrauterine devices (IUDs) and implants are often inserted by doctors and nurses who are appropriately trained in IUD and implant insertion. An absence of trained staff therefore leads to restricted availability and accessibility of methods at health centres.

The rates at which young people discontinue using methods provide significant insight into the adequacy of service delivery (Blanc and Way, 1998). At a broader level contraceptive failure and abandonment rates point to the need for greater understanding of the distinctive needs of young people.

2.3.1.3 Provider bias

Providers' attitudes are critical determinants to sexual and reproductive health. Over the past decade numerous studies have documented the importance of the attitudes of providers to young people accessing family planning, STI and HIV services (Askew and Berer, 2003; WHO, 2010). Quantitative and qualitative research suggests that providers sometimes erect

barriers based on marital status, age and other criteria. In a number of African countries, relatively high proportions of service providers stated that marriage was a prerequisite to obtaining family planning services (Askew and Berer, 2003; WHO, 2010). In addition many providers also enforced minimum age requirements for contraception thereby restricting young people's choice of methods. These attitudes were also found in STI and HIV services specifically orientated towards youth. Historically, in most societies within Africa, there was a deep resistance and refusal to recognize young people as sexual beings and as a result, entitled to rights (Barroso, 2010). The implementation of restrictive laws and policies prevented sexual and reproductive services from being provided to young people, specifically those that were unmarried (Tylee *et al.*, 2008). Many societies also disapproved of premarital sex. Health providers were therefore often unwilling to provide information and services to young people. These perceptions continue to persist; consequently provider bias still forms a key factor that limits access to sexual and reproductive health services.

Contraceptive method bias is another factor that limits young people's access to a range of methods. Studies show that providers often tend to have biases or preferences for certain methods and tend to promote those which they perceive to be the best option to clients (Askew and Berer, 2003). The World Health Organisation (2010) found that at government health facilities for young people in Tanzania, researchers determined different levels of contraceptive denial based on the providers belief about the safety of the method. In the urban areas providers most commonly recommended injectables, oral contraceptives and IUDs. In community-based clinics providers cited that they would never provide the pill to a young woman who has not given birth. This was due to the perception of providers that the pill would cause infertility (WHO, 2010). Research reveals that denial of contraceptive choice is a powerful variable in explaining the tendency to discontinue use (WHO, 2010). Provider bias and lack of information can therefore greatly reduce the choice of methods available as well as impact on a client's ability to make an informed choice.

In recent years condoms have gained increasing popularity among young people with its dual protection against HIV and unwanted pregnancy. Despite its association with promiscuity, disease and commercial sex, cultural acceptability of condoms has increased among youth (Williamson *et al.*, 2009). However various studies have highlighted that understanding of dual protection and dual method use for protection against HIV, STIs and unwanted pregnancy is limited among providers (Bharat and Mahendra, 2007; Kleinschmidt *et al.*, 2003; Maharaj and Cleland, 2006). An analysis of the national family planning programme in

Zambia, found that only few providers understood and were aware of Zambia's policy on promoting dual protection and counselled people in this regard (Bharat and Mahendra, 2007). Berer (2006) argues that limited definitions of dual protection and biases against condoms have served to make dual protection one of most under-rated and under-promoted public health practices. Many of the definitions of dual protection are often limited to only one type of protection, most commonly condoms, and less often with other contraceptives (Berer, 2006). Awareness therefore needs to be created among providers about the range of options that provide dual protection and the manner in which diverse needs of different population sub-groups can be met (Berer, 2006).

The 1994 ICPD was monumental in achieving global consensus that all people are entitled to sexual and reproductive health rights regardless of age, marital status, sexual orientation or ethnicity. There is however still a need to promote this notion among service providers particularly within developing country contexts where negative perceptions and biases continue to form a barrier to young people's access to services.

2.3.2 Information given to clients

Information is a key component of health service systems. In recent times information about sexual and reproductive health facilities, have been imparted through multimedia communication, print media, as well as during counselling sessions (Petroni, 2007). The provision of accurate information is fundamental in enabling young people to understand and make an informed choice about the methods and services that best satisfies their sexual, reproductive and health needs (Hindin and Fatusi, 2009). Lack of information about methods and services is often highlighted as one of the key barriers that affect the sexual and reproductive health of young men and women (Askew and Berer, 2003; Blanc and Way, 1998; Tylee *et al.*, 2008).

2.3.2.1 Information on services

Studies from developing countries suggest that many young people do not access available services because they lack knowledge of what the services offer (Bharat and Mahendra, 2007; Tylee *et al.*, 2008). Biddlecom *et al.* (2007) highlights that within sub-Saharan Africa, lack of

knowledge about services among young people, forms an important barrier to obtaining both STI and contraceptive services. A study on youth sexual and reproductive health services revealed that a substantial proportion of sexually active young people did not know of any source to obtain contraceptive methods, ranging from 22% of females in Malawi and 49% in Ghana to 25% of males in Uganda and 41% in Burkina Faso. In the case of STI services 7 to 20% of sexually active youth in all four countries did not know where to access such services (Biddlecom *et al.*, 2007). Lack of visibility and publicity of health services within developing countries therefore remains one of the key concerns. According to Tylee *et al.* (2008) even where health services are available these factors may render them inaccessible to young people.

2.3.2.2 Information on methods

Information about contraceptive methods is important in enabling clients to choose and employ contraception with satisfaction and technical competence (Pathfinder International, 2005). Although contraceptive use has increased over the past few decades studies suggest that there are still gaps with regard to the proper use, risks, and benefits of contraceptives (Askew and Berer, 2003; Bearinger *et al.*, 2007; PATH, 2004).

A study on youth sexual behaviour in South Africa revealed that young people held serious misconceptions about contraception such as the perception that hormonal contraceptives and intrauterine contraceptive devices offer protection against HIV infection, or that the same condom may be used more than once (Eaton *et al.*, 2003; Williamson *et al.*, 2009). Widespread myths about condoms also persist, such as the belief that condoms can “disappear” into women and result in serious injury (Eaton *et al.*, 2003: np). There are also concerns about modern hormonal methods, particularly its impact on future fertility (Williamson *et al.*, 2009). In Africa, where young women are pressurized to remain fertile and bear children, this belief has a particularly negative effect on contraceptive use. Williamson *et al.* (2009) found that even abortion was viewed as more appropriate than hormonal contraceptives for some young women because it was believed to be less risky and detrimental to their future fertility. Providing information, both oral and written, about the advantages and disadvantages of methods therefore not only enables the user to employ the method effectively but also creates awareness about the potential physical and health effects of the method which can have a significant impact on contraceptive use. In addition, if clients

are not given correct information, they cannot comply with the requirements of self-administered methods such as oral contraceptives and condoms (Askew and Berer, 2003). In a review of qualitative research on contraceptive use by young women, Williamson *et al.* (2009) found that even though awareness of modern hormonal contraceptive methods was high, many young women had limited knowledge of how to use them properly. A general misperception was that the pill should only be taken when engaging in sexual intercourse (Williamson *et al.*, 2009). PATH (2004) highlights that misperceptions and lack of information can be a significant barrier to the use of clinical methods. If clinical methods, such as IUDs, are not explained adequately studies reveal that users are much more likely to discontinue use (Askew and Berer, 2003; PATH, 2004).

Consultation also provides a key opportunity for information about sexual health to be imparted to clients. A study at eight health facilities in KwaZulu-Natal, found that many providers made limited use of the opportunity that consultation provided, to raise the topic of STIs among family planning and maternal and child health clients (Maharaj and Cleland, 2005). Although 32% of clients rated their risk as high or medium and in need of STI and HIV information, advice and counselling, only 6% of family clients and 15% of maternal and child health clients actually received any information during the consultation. Overall, though 30% of family planning and 27% of maternal and child health clients were concerned about their risks of HIV infection, none received relevant information or advice during consultation (Maharaj and Cleland, 2005). One of the key reasons that has been identified as a barrier in the provision of information to young people is the belief that positive information about contraception will promote sexual experimentation and activity among youth (Swann *et al.*, 2003). For the same reason, young people's access to sexual and reproductive health services has often been curtailed. However, contrary to this belief, existing research suggests that withholding information about contraception including condoms can actually place young people at greater risk for STIs, HIV and pregnancy (Dailard, 2002). In light of this, there is a need for service providers to recognise that young people become sexually active at an early age and therefore require information about services and how to access them if we are to prevent negative sexual and reproductive health outcomes.

A growing body of literature has highlighted the impact that information on contraception can have on contraceptive prevalence among youth. A study on youth-friendly interventions in China found that information and education activities of health workers in health facilities were considered key contributors in changing the sexual behaviours of youth (Tylee *et al.*,

2008). The interventions which aimed to increase contraceptive use in unmarried young people aged 15 to 24 years found that use of contraceptives were significantly higher in communities where information was provided (Tylee *et al.*, 2008). Mass-media communication has also proved effective in increasing awareness and knowledge as well as reducing high-risk behaviours. The National Research Council which reviewed six quasi experimental studies of mass media-based interventions aimed at influencing knowledge, attitudes, and behaviours among young people in Africa and Latin America, found that all but one of the interventions were successful in improving knowledge or attitudes while all five of the evaluations that measured behavioural impacts found impact on at least one behavioural outcome such as greater use of condoms and other contraceptive methods (Petroni, 2007). Petroni (2007) also highlights Population Services International's work in Cameroon, Botswana, Guinea and South Africa as an example of effective mass media programming. Using a combination of radio, television and print media, as well as social marketing of condoms, evaluations conducted between 1997 and 1999 found greater use of condoms among young people, delayed sexual initiation among young women, and fewer multiple partners among young men in the intervention sites (Petroni, 2007).

Studies suggest that an increasing number of young men and women are deeply concerned about getting pregnant or infected with HIV and are consequently willing to take precautions to protect themselves (Maharaj and Cleland, 2005). Knowledge and education for both providers and clients therefore forms an essential element in addressing this issue (Askew and Berer, 2003; Maharaj and Cleland, 2005). Education on contraceptive use, unsafe sex and STIs particularly are needed in counselling of family planning clients and users. However, literature suggests that if education is to be effective, this would require intensive training of health care professionals both in technical as well as communication skills (Askew and Berer, 2003; Bharat and Mahendra, 2007). Providing information and educating young people about the consistent use of contraceptives and other family planning methods can therefore be effective in addressing both the issues of HIV infection and unwanted pregnancies.

2.3.3 Technical competence

Technical competence which involves the providers adherence to protocols and their performance of clinical techniques, has gained increasing attention in the context of sexual and reproductive health (Bharat and Mahendra, 2007). Though clinical incompetence is

rarely reported, indirect evidence of the impact of insufficiently trained providers can be detected in certain studies on service delivery (Bharat and Mahendra, 2007; Bruce, 1990). Some concerns that are often expressed in relation to poorly functioning sexual and reproductive programs, are: lack of trained health professionals, insufficient resources and inappropriate supervision and monitoring systems (Askew and Berer, 2003).

2.3.3.1 Factors impacting on technical competence

To perform competently providers must have appropriate resources, training and monitoring (Askew and Berer, 2003). Lack of sufficient supplies of basic items such as needles, syringes, alcohol swabs, gloves and surgical instruments force many providers to omit procedures within sexual and reproductive health services (Bharat and Mahendra, 2007). The availability of protective equipment is often problematic in developing countries, consequently the fear of HIV infection forces providers to skip certain procedures or refer patients seeking services to other facilities. In this context people who are HIV positive may be neglected. Other structural constraints include inadequate drug supplies, poor working environment and lack of water and electricity which form the basis for poor service delivery.

Level of training, motivation and level of preparedness have also been highlighted as crucial determinants of quality service delivery (Bharat and Mahendra, 2007; Shapiro and Ray, 2007). For instance, certain contraceptive methods such as IUDs are often inserted by doctors and nurses who are appropriately trained in IUD insertion skills. Medical examination of patients in addition to taking medical histories is important for all current and potential contraceptive users. For example, the appropriate medical practice for IUDs includes questioning clients about infectious systems, performing pelvic examination and asking about their last menstrual period (PATH, 2004). However lack of basic equipment and sterile supplies can make providers reluctant to undertake these procedures. This can impact significantly on service delivery. Studies in sub-Saharan countries reveal that only small fractions of providers in rural areas are trained in family planning with the majority located at hospitals (Bharat and Mahendra, 2007). In countries such as Ghana, Malawi and Uganda, even when trained staff are available at family planning sites many remain underutilized due to barriers in access (Biddlecom *et al.*, 2007).

Health care providers play a crucial role in preventing the spread of negative sexual and reproductive health outcomes. Improving infrastructure and workplace environment are therefore essential in ensuring comprehensive service delivery for young people particularly in resource poor settings.

2.3.3.2. Constraints on health service provision

Inadequate training has a significant impact on the quality of service delivery (Bharat and Mahendra, 2007; Shapiro and Ray, 2007). A study of health facilities in South Africa found that while 80% of providers received training in child immunisation, growth monitoring, antenatal care and family planning, less than half received training in STI diagnosis and treatment and only one-quarter were trained in HIV counselling or testing (Maharaj and Cleland, 2005). Evidence from health facilities in countries such as Zambia and Tanzania revealed that many providers did not receive regular training and information updates, consequently many were constrained by outdated knowledge and limited counselling skills (Bharat and Mahendra, 2007).

Sub-Saharan Africa is experiencing a severe shortage of qualified health care workers, especially doctors. In Kenya, for example, statistics show that only 14 doctors are available per 100 000 people in the population. In Ghana and Zambia many health facilities are experiencing a shortage of nurses trained in STI diagnosis and management (Bharat and Mahendra, 2007). In addition heavy patient loads, low morale, and high staff turnover were some of the factors that affected the pace and quality of service delivery of services. In South Africa healthcare workers are already scarce. At the same time, factors such as excessive workloads, insufficient subsidized posts, affirmative action and brain drain are contributing to the scarcity of health care professionals. In KwaZulu-Natal, in 2005 up to 37% of health posts were vacant and some hospitals did not have pharmacists (Chopra *et al.*, 2009). The World Health Organization recommends a minimum of 20 doctors per 100 000 people, yet many countries within Africa have far fewer. Allowing lower-level providers to receive training and perform some of the tasks normally reserved for higher-level providers has been proposed as one way to overcome this shortage. Bharat and Mahendra (2007) also found that poor, delayed or no salaries severely affected providers provision of services and in some instances even resulted in denial of services. These findings suggest that provider satisfaction is closely related to proper service delivery. Such constraints therefore undermine the role of

health care providers and have a detrimental effect on the quality of health services (Bharat and Mahendra, 2007).

2.3.4 Interpersonal relations

Interpersonal relations between the provider and client can strongly influence young people's confidence in their own choices, satisfaction with the services and the possibility of a return visit (Bearinger *et al.*, 2007; Bruce, 1990). The World Health Organisation has found that ensuring providers are trained in youth reproductive health issues and communication, are respectful, have a non-judgmental attitude, and maintain confidentiality and privacy can increase young people's use of services (Petroni, 2007).

Studies from around the world indicate that young people are often unwilling to obtain much needed health services due to the nature of interactions between health care workers and clients (Smith *et al.*, 2004; Tylee *et al.*, 2007). The fear that health workers will scold, be judgmental or ask difficult questions form some of the key reasons for low acceptability of services among youth (Tylee *et al.*, 2007). Studies in South Africa found that providers were particularly antagonistic towards unmarried young women seeking obstetric care because they felt that they were immoral for getting pregnant (WHO, 2010). Providers were found to be verbally coercive and even physically violent to young women particularly when seeking services at times that were inconvenient for them. The attitudes of health care workers are therefore one of the barriers often highlighted in discouraging the use of health services by youth (Smith *et al.*, 2004). The judgmental attitudes of health workers often act as a barrier to young people seeking methods of contraception. In many African countries blatant provider biases were found, including denial of services on the basis of age (WHO, 2010). These types of barriers serve to perpetuate the increase of both unwanted pregnancy and HIV among the youth. Smith *et al.* (2004) emphasizes that in many instances the behaviour and attitudes of health workers also contribute to maternal mortality and morbidity. The harsh treatment of women and girls, physical and psychological abuse, and the humiliation of patients are some of the issues that demand urgent attention particularly in developing countries (Smith *et al.*, 2004). Studies conclude that health workers should therefore be trained to address issues related to sexual and reproductive health in an empathetic manner particularly when interacting with young people (Petroni, 2007; Smith *et al.*, 2004; Tylee *et al.*, 2007). Young women should also be empowered to negotiate decisions on condom use,

family planning and pregnancy. Studies on contraceptive use among young women highlight that partners' attitudes towards contraception are often crucial in determining use (Williamson *et al.*, 2009). Williamson *et al.* (2009) found that partners use manipulation, force, threats, and violence to prevent young women from using contraception. This was particularly common with condoms where partners argued that they reduced sexual pleasure. Other reasons for partners not wanting to use contraceptives include the desire for pregnancy in order to demonstrate the woman's fertility.

Since many young people are uncertain and embarrassed when seeking help, the concern for privacy and confidentiality is of particular importance, which many fear will be compromised in clinical settings. For instance, fears about being recognised in a clinic waiting room and the fear of family or friends finding out about a visit to a health facility deters young people from visiting health services (Tylee *et al.*, 2007). Research reveals that young men and women are less likely to seek health services if they feared being stigmatized, chastised, or punished for sexual involvement (Bearinger *et al.*, 2007). Stigma prevents many young people living with HIV and STIs from receiving the treatment and care they require.

Data on contraceptive services reveal that 10 to 18% of young females and 5 to 11% of young males in Ghana, Malawi, and Uganda felt that their privacy was not respected and that they were not treated nicely by staff (Biddlecom *et al.*, 2007). Similar barriers also emerged for the diagnosis and treatment of STIs. In Uganda and Malawi, females were more likely than males to perceive provider-specific barriers in terms of both STI and contraceptive services (Biddlecom *et al.*, 2007). A lack of privacy may also prevent clients from disclosing information during the counselling process. Biddlecom *et al.* (2007) found that young people rated confidentiality as one of the most important characteristics of health services (WHO, 2010). This agrees with studies conducted in South Africa which reveal that providers who violated young people's confidentiality by informing their parents or demanding parental consent discouraged young people from utilising the services again (WHO, 2010). The nature of interactions between health workers and clients therefore forms a significant element in determining young people's use of sexual and reproductive health services.

In many developing countries, heavy patient loads together with high staff turnover and other logistical problems result in limited contact time with patients (Bharat and Mahendra, 2007). A study at three family planning clinics in Zimbabwe found that providers spent only 40% of their time in consultations with clients (Janowitz *et al.*, 2002). Similarly a study of eight

health facilities in KwaZulu-Natal found that most providers dealt as quickly as possible with patients needs under the pressure of long queues (Maharaj and Cleland, 2005). For instance, 23% of clients reported inadequate privacy while 45% felt there was insufficient time to ask questions. Limited consultation time prevents many clients from addressing concerns they may have. At family planning sites in Nigeria only one-third of clients were asked if they had any questions (Speizer *et al.*, 2000). The failure to ask questions is often one of the reasons why clients do not receive the care they require. Another key area of concern that is often highlighted is excessive waiting time. Data from 10 to 19 year olds in Kenya and Zimbabwe showed that young people rated short waiting times as one of the most important characteristics of health services (Biddlecom *et al.*, 2007). Surveys conducted in eight Latin American and Caribbean countries found that more than 70% highlighted waiting time as the area of quality that most required improvement (Williams *et al.*, 2000). At eight health facilities in KwaZulu-Natal the most common complaint by clients was excessive waiting time with 57% of clients reporting unreasonably long waiting periods (Maharaj and Cleland, 2005). Waiting time is considered as an important factor affecting the acceptability of services. Petroni (2007) found that clinics with a shorter waiting time attracted more clients. Aside from confidentiality, short waiting time and friendly staff, young people highlighted low cost as one of the most important factors determining their use of health facilities (Biddlecom *et al.*, 2007). Financial constraints, particularly in developing countries, remain a common barrier to accessing and receiving services. Focus group discussions with 14 to 19 year olds in four African countries about STI related health services found that many young people consulted traditional healers and herbalists instead of government health facilities because they were not only believed to provide confidential services, but also allowed patients to pay in instalments (Biddlecom *et al.*, 2007).

Youth-friendly health services are designed to make the use of existing sexual and reproductive health services more acceptable and less traumatizing to young people (Petroni, 2007). An extensive body of literature has shown that training health care workers to be more youth-friendly can impact positively on the utilisation of health services by young people (Boonstra, 2004). One such example is the Promotion of Youth Responsibility Project in Zimbabwe which, after the training of health care providers in interpersonal communication and youth counselling skills, found that youth were more likely to abstain from sex, have fewer recent sexual partners, use contraceptives and utilise clinic services (Boonstra, 2004). The campaign also had a significant impact on clinic attendance among some of the groups

less likely to seek services namely men and sexually inexperienced youth. According to Bruce (1990) for many clients, being treated badly is worse than receiving no care at all. Ensuring providers are trained in youth reproductive health issues and communication, are respectful, have a non-judgmental attitude, and maintain confidentiality and privacy can therefore increase young people's use of services (Petroni, 2007).

2.3.5 Follow-up or continuity mechanisms

Mechanisms to ensure continuity have emerged as an important element of service delivery. The procedures that health facilities have in place as well as the actions of the providers are essential in encouraging clients to continue using services (Brown *et al.*, 1995).

Ensuring that health facilities have adequate supplies of medication and contraceptives is necessary in ensuring continuous use. In many developing countries inadequate stock has been cited as one of the reasons for discontinuation of a method (Berer, 2006; Hindin and Fatusi, 2009; PATH, 2004). For instance at health facilities in Ghana, Kenya and Zimbabwe despite the existence of inventory systems, more than a third of facilities experienced inadequacy of stock (Biddlecom *et al.*, 2007). Discontinuation is therefore often an indicator of insufficient contraceptive supplies. Maintaining a system to track clients who have been lost in the follow-up process is also important in ensuring continuity of clients. However within developing countries follow-up support is often compounded by a lack of resources and distribution systems (Bharat and Mahendra, 2007). In addition many facilities do not maintain daily registers and records of clients. Poorly maintained tracking systems undermine effective follow-up of clients.

Providers also play a key role in ensuring that clients follow-up and use contraceptives on a continuous basis. According to Askew *et al.* (1994) aside from emphasizing acceptance of a particular contraceptive method a provider should encourage sustained use of family planning services. Though the mechanisms that facilitate follow-up are important, the information that the provider imparts to the client about follow-up and resupply are essential in ensuring continuity. For instance, studies reveal that with new acceptors of condoms, pills, injectables, and spermicides providers who did not inform young clients about resupply undermined the client's continued use of a method (Blanc and Way, 1998; Hindin and Fatusi, 2009).

Demographic and Health Survey data reveal that discontinuation rates are high among young people in all countries (Blanc and Way, 1998).

2.3.6 Appropriate constellation of services

In recent years, there has been increasing recognition of the importance of providing an appropriate constellation of services in addressing the sexual and reproductive health needs of young men and women worldwide (Boonstra, 2008). Various studies have shown that universal access to sexual and reproductive health services provided at “one-stop” through integrated comprehensive systems rather than separate vertical programs improve customer satisfaction by providing a more comprehensive response to the sexual and reproductive needs of both men and women (Askew and Berer, 2003; Maharaj and Cleland, 2005).

Integrating sexual and reproductive health services offers many benefits to both young men and women. In many developing countries integration of services was found to increase uptake in family planning and contraceptives as well as other health services (Askew and Berer, 2003; Berhane and Tsui, 2006; Kleinschmidt *et al.*, 2003). A comprehensive review by the World Health Organization highlights several examples of comprehensive services that have produced not only higher levels of condom distribution but have also increased the uptake of other contraceptive methods (Askew and Berer, 2003). In Ethiopia, a study on integration of family planning and voluntary counselling and testing (VCT) services revealed that contraceptive uptake increased significantly with 30% of VCT clients adopting a family planning method (Berhane and Tsui, 2006). This study highlighted that at a broader level integration improved existing services and after training was provided to service providers, contraceptive uptake tripled in many areas (Berhane and Tsui, 2006). The findings of this study agrees with evidence from Zambia which showed that after the introduction of youth-friendly services at two pilot clinics in the Lusaka region, the number of new contraceptive users among young people aged 10 to 24 tripled (Scholl and Finger, 2004).

A study of youth-friendly services in northern Uganda and Ethiopia observed a high demand for services when they began integrating STI diagnosis and treatment with VCT into family planning (Berhane and Tsui, 2006). Similarly in Kampala, after the introduction of sexual and reproductive health programs in urban poor schools, students’ knowledge and management of sexual and reproductive health issues improved, they exhibited improved academic

achievement and reduced failure rates. In all these instances, services provided were youth-friendly through the use of recreational activities, peer education, networking clubs and capacity building activities (Berhane and Tsui, 2006). A comprehensive review by the World Health Organization has also shown that integrated services can improve providers' attitudes, counselling skills as well as performance (Askew and Berer, 2003).

Integrated services are also significant in targeting a broader range of clients and underserved groups such as men who may not necessarily be visiting family planning clinics. In Tanzania male involvement in sexual and reproductive services was found to increase with integration (Berhane and Tsui, 2006). At the same time integration also attracts more women than stand-alone clinics. Creel *et al.* (2003) found that clinics in Bangladesh attracted more women by providing a mix of services and by having well-trained paramedical personnel, rather than physicians alone, perform pelvic exams, IUD insertions, and menstrual regulation services. Similar evidence from Madagascar reveals that providers trained in youth-friendly services, STI treatment and contraception contributed to the increased use of services by young people and improved access to condoms (Scholl and Finger, 2004). In this context, these visits also present the opportunity to give information and services to prevent the sexual transmission of HIV by: promoting and providing condoms during pregnancy and family planning or dual protection afterwards; including HIV testing and counselling; and education on risk reduction, consequences and outcomes of HIV (Askew and Berer, 2003). Interventions within communities and health care facilities can therefore provide a broader range of preventive and clinical services at one visit, hence better meeting the diverse needs of clients. Askew and Berer (2003) found that integrated services improve customer satisfaction by providing a more comprehensive response to the sexual and reproductive needs of both men and women.

The 1994 ICPD and the MDGs highlight some of the most significant demonstrations of the global commitment towards sexual and reproductive health with various countries pledging their support of comprehensive sexual and reproductive health services. However despite this, in many sub-Saharan African countries the sexual and reproductive rights and needs of young people remain unmet. Despite the differences in service provision and social context, studies reveal that help-seeking behaviour in the developed and developing world is remarkably similar. Research, mainly from developed countries, indicates that 70 to 90% of young people contact primary-care services at least once a year (Tylee *et al.*, 2007). Linking sexual and reproductive services can therefore help address the sexual and reproductive

health needs of young people by providing a broader range of services hence better meeting their diverse needs.

2.4 Summary

In this chapter, a review of the literature revealed that in recent years, the vulnerability of young people to negative sexual and reproductive health outcomes has been highlighted in numerous studies. Some of the important factors which have been identified as contributing to these health patterns include: early sexual debuts, delayed marriage and childbearing, multiple partners, inconsistent contraceptive use and risky sexual behaviour. At the same time, there is a greater recognition that young people are exposed to different constraints and challenges that shape their health. An examination of existing literature on various dimensions of health care services reinforces the important role that health services can play in addressing the needs of young men and women. However, from the preceding review it is evident that more research is needed to establish guidelines for the comprehensive provision of health services for young people. In addition, there is a lack of adequate research in evaluating the extent to which health care providers are addressing the health needs of young people particularly within developing country contexts. This research attempts to address this gap by providing a more in-depth account of how health services are responding to the sexual and reproductive needs of young people by exploring the experiences and perspectives of service providers and young men and women in relation to comprehensive, youth-friendly sexual and reproductive health care. The following chapter, chapter 3 will focus on the research methodology used for the study, including the advantages and limitations; as well as the tools used to analyse the data.

Chapter Three

Methodology and Data

3.1 Introduction

The purpose of this chapter is to discuss the research methodology that was applied for this study in more detail. The first part of this chapter focuses on the research context which guided the study. The research design and method of data collection is then discussed in detail. This is of particular significance since the research design and methods enabled the researcher to explore the experiences and perceptions of providers and young men and women. The remainder of the chapter highlights the procedures used to analyse the data. The chapter concludes with an overview of the ethical considerations and limitations of the study.

3.2 Context of the study

South Africa is a country located at the southern tip of Africa. The population of South Africa is approximately 49.9 million, of which currently, around 25 million are under the age of 25 (Statistics South Africa, 2010). These young people account for approximately half of the total population. At the beginning of 2010, an estimated 5.2 million people were living with HIV in South Africa (Statistics South Africa, 2010). The national HIV prevalence rate among young people is relatively high at 9% (Shisana *et al.*, 2009). At the same time, pregnancy among young people in South Africa is also relatively common, with more than one-third of women having a child before reaching the age of 20 (SADHS, 1999). At a provincial level KwaZulu-Natal is the province most severely affected by the HIV epidemic while also accounting for significant levels of pregnancy among young women.

Figure 3.1: Map of South Africa



Source: South Africa.info (2010)

KwaZulu-Natal is located on the eastern seaboard of the South African coast. According to 2010 mid-year population estimates by province, with approximately 10.6 million people, of the nine provinces, KwaZulu-Natal has the second largest population in South Africa (Statistics South Africa, 2010). In relation to its demographic characteristics, data indicates that of the 10.6 million people, there are 5.5 million females and 5.1 million males (Statistics South Africa, 2010). According to recent survey estimates the province continues to have the highest HIV prevalence in South Africa at 16%. Prevalence among young people aged 15 to 24 stands at 15% (Shisana *et al.*, 2009). Young women in particular continue to be disproportionately affected. According to the KwaZulu-Natal Department of Health (2010), approximately 22% of 15 to 24 year old women attending state antenatal clinics in the province were HIV positive. At the same time statistics reveal that the burden of curable STIs is also severe with an incidence rate of 78 per thousand of the population in KwaZulu-Natal (Department of Health, 2003). At a provincial level reported condom use at last sex was 66% (Shisana *et al.*, 2009).

The high incidence of HIV and STIs in the province highlights the potential impact of the epidemic on the youth. In addition, the high levels of pregnancy among young women demands urgent focus. The study presented here was thus conducted among students at one of the largest tertiary institutions in the province of KwaZulu-Natal. University students were chosen primarily because a vast majority of the population falls within the age ranges of 18 to 24, which places them in a group at high risk of exposure to HIV, STIs, and unwanted pregnancies (Nshindano and Maharaj, 2008). Important lessons can therefore be learnt that may have relevance to the wider population and enable health services to launch more effective ways of reaching increasing numbers of youth, particularly those that are vulnerable to specific sexual and reproductive health problems.

3.3 Study setting

The largest tertiary institution in KwaZulu-Natal, with a total student population of approximately 42 000, was chosen for the study. A demographic profile of the students reveals that the majority are African (51%) followed by Indian (31%), White (15%) and Coloured (3%). Student distribution by gender is 56% female and 44% male (University of KwaZulu-Natal, 2010). The university is divided into 5 campuses in two major cities, four in Durban and one in Pietermaritzburg. Each campus has its own health facility for students.

For the study presented, one campus health care facility in Durban was sampled. This allowed for the researcher to fully evaluate the selected facility over the study period. The selected clinic had fully trained nurses on duty as well as a doctor by appointment. The services provided included: assessment and treatment of health problems; contraception and counselling; pre and post-test counselling for STIs and HIV; assessment and referral of drug and alcohol-related problems; monitoring of general health problems; health education and voluntary counselling and testing. The study was limited to this health care facility as it is the only health care facility at the university campus. In addition the health facility operates around university hours. A vast majority of students therefore rely on this facility for their health needs.

3.4 Research design

An exploratory research design was used for the study to identify the key elements that facilitate the use of the health care facility by students and to establish if, and to what extent these health services are responding to the sexual and reproductive health needs of young people. The exploratory research design is often employed when researchers seek to explore the perceptions and interpretations of specific phenomenon (Cresswell, 1994; Dey, 1993; Ulin et al., 2002). This research design was employed for the study in order to explore the topic and enhance the researcher's insight and understanding of health care services for young people.

The study used triangulation which refers to the combination of quantitative and qualitative research methods (Bryman, 2006; Patton, 1999). Triangulation ensures comprehensiveness and encourages a more reflexive analysis of the data by using more than one method of data collection to answer a research question (Barbour, 2001; Mays and Pope, 2000). Information for this study was obtained using a range of quantitative and qualitative data collection methods including an inventory of the facility and services, in-depth interviews with staff and exit interviews with clients.

3.4.1 Inventory of the facility and services

The purpose of the inventory for this study was to gather information about the clinic's technical competency and services. This was obtained through discussion with management and staff in charge of the health services at the facility. The researcher in addition did attempt to verify the existence of equipment and supplies as well as the conditions of the health facility through observation. The instrument used for data collection covered service availability; equipment and supplies; as well as drugs and commodities (see appendix 1).

3.4.2 Client exit interviews

Exit interviews were also held with clients between the ages of 18 to 24 years. In total, there were 200 exit interviews conducted at the selected health care facility. This was done between August and September 2010. Exit interviews as a data collection method benefit from the respondent's ability to recount details of their experience since the interviews are

conducted immediately after the client has received services. The strength of using this method for the study presented was that it allowed for the researcher to compare the interviews with clients to that of providers. This enabled the researcher to establish the extent to which the health services were responding to the sexual and reproductive needs of young people by exploring their experiences and views.

The six elements from the Bruce-Jain framework were used in designing the data collection instrument (see appendix 2). The questions asked of clients attending the clinic for family planning and STI services covered clients background characteristics; satisfaction with services; and knowledge, attitudes and behaviours regarding sexual and reproductive health. Family planning clients were asked additional questions regarding the family planning services received. The instrument had a total of 44 questions and contained a structured sequence of both open and closed ended questions. A likert scale was used for responses to questions about satisfaction with aspects of services. *Pilot testing, which forms a vital element of the research design, was used for developing and testing the adequacy of the survey instrument used for the exit interviews with clients (Teijlingen and Hundley, 2001).* The survey instrument was pilot tested with a sample of 10 students, in the age range 18 to 24 years, months prior to administration. The aim of the pilot test was to ensure that respondents understood the intended meaning and order of the questions as well as the range of answers on multiple-choice questions. After a review of the responses and accounting for the comments of participants provided at the end of the pilot test survey, the instrument was improved on and revised accordingly. In addition, the pilot testing of the instrument enabled the researcher to improve on the internal validity of the instrument.

Non-probability purposive sampling was used for the study presented since it targeted a specific predefined group relevant to the topic of investigation and most likely to produce valuable data (Babbie and Mouton, 2001). The advantage of using purposive sampling was that it facilitated reaching the target sample quickly, was relatively economical and was more likely to elicit the true opinions of the target group (Babbie and Mouton, 2001; Denscombe, 1998). One of the main limitations of using this method of sampling is that it is not possible to generalise the results to the entire population (Babbie and Mouton, 2001; Barbour, 2001). However, the fundamental aim of this study was not to generalise, but to explore. Thus, the representativeness of the sample was less significant.

Since the clinic is relatively small, all clients visiting the clinic during the days of the study were asked for an interview. However, the researcher did ensure that the results were representative of clinic attendees by ensuring that the sampling procedure was systematic and ordered (Babbie and Mouton, 2001). Clients were sampled on different days of the week as well as at different times of the day. All respondents were approached after they had completed their consultation with the provider and, after being briefed by the researcher about the purpose of the research, asked if they would be willing to participate in the study. Each interview lasted approximately twenty minutes. Recruitment of clients stopped when the pre-determined sample size, which was deemed sufficient for descriptive purposes, was achieved. The researcher encountered very few refusals with an overall participation rate of 97%.

Table 3.1: Reasons for clients visiting the health facility on campus

Reason for visiting clinic	Number of individuals (%)
Family planning	52 (26)
HIV counselling	24 (12)
Personal illness	124 (62)
N	200

3.4.3 In-depth interviews

The qualitative data for the study was obtained from four in-depth interviews held with clinic management and senior clinic staff, in August and September 2010. The key objective of the in-depth interviews was to explore the health providers' experiences at the health facility in addressing the sexual and reproductive health needs of young people. These respondents, with their particular knowledge and understanding, were able to provide insights and useful information on sexual and reproductive health services.

An in-depth interview stakeholder guide was used to guide the interview (see appendix 3). Topics explored with providers included: their training and education; information about the health services available to young people; opinions about how health services are responding to the sexual and reproductive needs of young people; and the barriers in the provision of health care. The interview schedule was pilot tested with two health care workers months prior to the study. The objective was to ensure that respondents understood the intended

meaning of the questions and answered coherently. The interview schedule was modified accordingly after a review of the responses and accounting for the comments of respondents.

Though interviews are beneficial in that they allow the researcher the opportunity to clarify ambiguous issues and inconsistencies, a key disadvantage is the inability to generalize results to the larger population since the sample of informants for the study is relatively small and random sampling methods are not used (Boyce and Neale, 2006; Gaskell, 2000). This type of interview is also time intensive because it requires scheduling and logistical planning.

At the beginning of the study the key stakeholders at the clinic were contacted and informed of: the purpose of the interview, the research objectives, the sample selection strategy, and the expected duration of the interview. One in-depth interview with a clinic staff member was conducted per day. In total, four in-depth interviews were conducted. Although expected to typically last 20 to 30 minutes once engaged, many respondents were willing to speak longer. The interviews were tape-recorded with the permission of the respondents.

3.5 Data analysis

Since the study presented used triangulation both qualitative and quantitative data were obtained. This data was therefore analyzed using an integrated qualitative and quantitative analysis. According to Rocco et al. (2003) by combining multiple methods researchers can hope to overcome the intrinsic bias that comes from single method studies. Triangulation also enables the researcher to develop further insight into relationships between the methods chosen and the phenomenon studied, thereby allowing the researcher to improve their understanding of that phenomenon (Rocco et al., 2003).

The quantitative data obtained from the exit interviews with clients and inventory was entered and analyzed using the statistical software STATA (version 11). The advantage of using STATA is that it can compute a very large amount of data quickly while also providing data management, analysis and graphing. Descriptive analysis was conducted consisting of frequency distributions and cross-tabulations to study the relationship between variables.

Qualitative data for the study was obtained from transcribed in-depth interviews and open ended questions in the survey. Thematic analysis was used to identify themes and patterns related to the phenomenon of interest. With thematic analysis the codes of findings are

organised into 'descriptive' themes, which are then further interpreted to yield 'analytical' themes (Barnett-page and Thomas, 2009:3). Since the interviews were recorded, a substantial amount of time was spent translating the tapes, reading through the transcripts and categorising the data according to particular themes or recurrent ideas. Once the themes were identified the researcher then examined how they were patterned in terms of possible relationships between the themes, contradictory responses or gaps in understanding. These were then categorised according to the key elements in the Bruce-Jain framework which include: choice of methods, information given to clients, technical competence, interpersonal relations, follow-up or continuity mechanisms and appropriate constellation of services. *The* themes that emerged from the interviews and open ended questions with respondents were then linked together to form a comprehensive picture of their collective experience.

3.6 Ethical considerations

The code of ethics in research served as a guideline for the researcher in the interaction with the respondents of the study. Three core principals which form the universally accepted basis for research ethics in qualitative research were employed namely: voluntary participation, informed consent and confidentiality.

Voluntary participation requires the researcher to respect the right of individuals to agree or refuse to participate in research. Voluntary participation of the respondent implies his or her right to withdraw from the study at any time, thus counteracting potential coercion and undue influence (Kuale, 1996). It also includes the rights of participants to refuse to answer any questions they find intrusive. The researcher explicitly informed the respondents that participation was voluntary. None of the participants were pressurized to take part in the survey and the researcher thanked those who did not wish to participate.

The principle of informed consent entails informing the research subjects about the overall purpose of the study and the main features of the design, as well as any possible benefits and risks from participation in the research project so they can decide in a conscious, deliberate manner whether they want to participate (Kuale, 1996). The researcher briefed the participants on these issues prior to conducting the interviews. In addition, an explicit cover letter was included on the overall purpose of the study and main features of the design which participants were requested to read and ask for clarification if necessary.

Confidentiality in research implies that private data identifying the subjects will not be disclosed or reported (Kuale, 1996). The researcher was cognizant of the need for confidentiality in this study. At the beginning of the study the respondents were assured that confidentiality, anonymity and privacy would be strictly observed and no identifying information will be revealed to anyone else. The identity of service providers and clients was protected by not recording names and identifying features. The researcher used instead a code to identify participants.

Prior to conducting the study, in order to gain access to the health facility, permission was obtained from Durban Health Services. Ethical approval for the study was obtained from the University of KwaZulu-Natal and a letter of ethical clearance was issued.

3.7 Limitations of the study

As with most studies of sexual behaviour, the value of this study is dependant on the reliability of the reported behaviour. A limitation of the survey is that many of the questions are qualitative and test the perceptions of young people and providers. The researcher did attempt to encourage respondents to answer honestly by ensuring that the questionnaires were anonymous however ultimately the results may be more subjective and context-based. Nonetheless this will not invalidate the findings, since decisions for service providers are often influenced by the needs and perceptions of the clients. A limitation of the client exit interviews are that they exclude people who do not visit the health facility. This is of particular concern since these respondents could provide insight into the reasons for the non-utilisation of services. At the same time, the data will not be generalisable to the entire population because it is based on a relatively small sample. While the study's focus on college students does raise issues about sample bias, research has suggested that HIV, STIs and unwanted pregnancy in South Africa is not primarily a disease of the underprivileged, but is also prevalent among wealthier and more-educated sectors of the population (Maharaj and Cleland, 2006).

3.8 Summary

The purpose of this chapter was to describe the research context and methodology of the study; describe the procedure used in designing the instrument and collecting the data; and provide an explanation of the procedures used to analyse the data. Since this study used triangulation, a combination of quantitative and qualitative methods including an inventory of the facility and services, in-depth interviews with staff and exit interviews with clients were used for data collection purposes. This was beneficial in that it allowed for both qualitative and quantitative data to be obtained thereby enabling the researcher to gain more insight into the experiences and perceptions of providers and young men and women. The quantitative and qualitative data obtained were analysed using descriptive analysis and thematic analysis respectively. In the following chapter 4, a detailed review of the research results obtained from the study will be provided.

Chapter Four

Results

4.1. Introduction

A number of studies have documented the importance of comprehensive, youth-friendly services however; relatively few have focused on the perception of young clients and providers in the provision of these services. This chapter draws on data collected from the exit interviews with clients and the in-depth interviews with providers at the health facility. The aim is to explore young peoples and providers experiences and perceptions of comprehensive, youth-friendly services. This is analysed using the six key elements highlighted in the Bruce-Jain conceptual framework, namely: choice of contraceptive methods, information given to clients, technical competence, interpersonal relations, follow-up or continuity mechanisms, and appropriate constellation of services. The chapter begins with an overview of the inventory and observations made of the health facility and services. This is followed by a summary of the characteristics of the respondents. The remainder of the chapter provides a detailed presentation of the results obtained from the interviews with providers and clients. In the light of foregoing suggestions that services for youth may not be comprehensive or youth-friendly it is important to determine the extent to which they are able to respond to the needs of young clients.

4.2. Inventory and observation of the facility and services

The health facility at the tertiary institution operates around university hours and has fully trained nurses on duty as well as a doctor who can be seen by appointment. Though the facility provides services for all staff and students at the university, it is utilised primarily by students. The services provided at the health facility included: contraception and counselling; pre and post-test counselling for STIs and HIV; health education and voluntary counselling and testing. Other services provided included: assessment and treatment of health problems; assessment and referral of drug and alcohol-related problems; and monitoring of general health problems. With regard to contraceptive methods, the clinic offers condoms, injectable contraception and combined and progestin-only oral contraceptives including emergency

contraceptives. The diaphragm, male and female sterilization, IUDs, and spermicides were not offered at the health facility. If the need arises for these methods, the clients are transferred to other facilities which offer these services. With reference to the tests provided, the clinic offered pregnancy tests, pap smears and breast examinations. The health facility did not do STI testing however it adhered to the government protocol of syndromic management which does not require testing. All specimens were sent out to government or private laboratories for testing. In relation to supplies the health facility had key equipment including stethoscopes, blood pressure gauge, scale, flashlight, needles/syringes and gloves, antiseptic and plastic buckets for decontamination. All equipment was in working order and available at the time of the study.

4.3 Characteristics of respondents

This study included both providers and clients to assess their perceptions of whether health services are responding comprehensively and in a youth-friendly manner to the sexual and reproductive needs of clients. Of the four providers who were interviewed at the health facility, 3 were female while only one of the providers was male. Respondents ranged in ages from 36 to 56. Three providers were African and one was White. All providers had professional nursing qualifications and received formal nursing training. This included qualifications such as: diploma in primary health care; psychiatry; community health; and nursing management. Providers received family planning and STI training as either part of their curriculum or as an additional course. In terms of nursing experience, the providers interviewed had on average 15 years of professional experience. With regard to training, all providers received refresher courses on family planning, STI management and HIV on an annual basis. This forms one of the key requirements for professional practising health workers. Staff at the health facility also attended courses on youth-friendly service provision to enable them to interact with students. This entails training in interpersonal communication as well as youth counselling skills.

Of the 200 students who were interviewed at the health facility, 85% were female while only 15 % of the clients were male. The distribution by race was as follows: 88% African, 6% Indian, 4% Coloured and 2% White. The mean age of the sample was 20. The majority of students were between the ages 20 to 22 followed by those aged 18 to 19. With regard to their relationship status 56% of clients interviewed were single, while 42% reported having a

steady relationship. Less than 2% were married which was not unexpected since early marriage is not the norm in South Africa. Of the total sample, 48% of students were residing at the campus residence while 42% were residing off-campus. Table 4.1 summarises the demographic characteristics of the client sample. A large majority (74%) of respondents (100% males and 74% females) reported ever having sexual intercourse. All STI clients and family planning clients were female. Overall, 19% of students reported having had an STI infection while unwanted pregnancies were reported among 15% of students (refer to Table 4.2). A large percentage (72%) of young people interviewed cited that they thought about their own chances of getting HIV and AIDS.

Table 4.1: Demographic characteristics of the client sample

Demographic characteristics		%
Age	18-19	31
	20-22	56
	23-24	13
Sex	Male	15
	Female	85
Race	African	88
	Indian	6
	Coloured	4
	White	2
Marital status	Single	56
	Married	2
	In a relationship	42
Residence	On-campus	48
	Off-campus	42
N		200

4.4 Perspectives of providers and clients

4.4.1 Sexual behaviours

In the in-depth interviews, the majority of health care providers stated that HIV, STIs and unwanted pregnancies were some of the most important health issues among young people visiting the health care facility. Providers emphasized that although many of these health patterns among youth are a consequence of behavioural factors such as unprotected sexual intercourse, sexual experimentation, inconsistent use of condoms, and poor knowledge on sexuality and reproductive function; at the same time there are various barriers in health care service provision that perpetuate these patterns of ill-health.

Health providers admitted that sexual activity among unmarried youth was relatively common. The median age at first sex reported by young people aged 18 to 24 years. The results reveal that average age at sexual initiation was 17 years for males and 18 years for females. Early sexual debut increases vulnerability to STIs and HIV infection among young people. Males were found to have an earlier age at first sex than females who reported experiencing sexual initiation at a later age. Overall, the percentage of males who reported having started sex before the age of 18 years was nearly three times the percentage of females. Multiple sexual partnerships, which substantially increase young people's chances of experiencing negative sexual health outcomes, were also reported by young clients. Table 4.2 shows that 8% of young people reported having multiple sexual partnerships. Overall, of the 8%, 13% of males highlighted having multiple sexual partners while 4% of females stated that they had more than one partner. Men were also more likely than women to report a greater number of sexual partners in the past 12 months.

Table 4.2: HIV and pregnancy risk factors

HIV and pregnancy risk factors	%
Multiple sexual partnerships	8
Ever had STI	19
Used condom at last sex	46
Ever had unwanted pregnancy	15
N	200

In relation to the perceived individual level risk factors for the high levels of HIV, STIs and unwanted pregnancies, most health care providers felt that these trends among youth could be

attributed to their risky lifestyles. Despite young people knowing the consequences of risky behaviour, health care providers felt that youth engaged in risky behaviour such as multiple partnerships and unprotected sexual intercourse which predisposed them to negative health outcomes. In the interviews with clients, one of the reasons which emerged for these trends was peer pressure and the need for social acceptance. When asked about the reasons for engaging in sexual behaviour, 22% of young people reported feeling under pressure from others to have sex. A large majority of young people indicated friends as a source of peer pressure. To feel a sense of inclusion and identify themselves as part of a group many admitted to beginning sexual relationships at university. The fear of exclusion was cited by many respondents as a reason for feeling pressurized to engage in sexual behaviour. This was heightened as young people often discussed sexual experiences and encounters with their friends. A young male respondent suggested that his friends would accuse him of being gay if he did not have sexual intercourse with a female. Some of the comments by respondents are illustrated in the quotes below:

'I am a very outspoken person so I hang out with the cool students who have seen it all so it was like I am missing out' (Female, age 18, client)

'My friends made it seem that not having sex was such a bad thing and I feared being the odd one out' (Female, age 22, client)

'I am the only girl in my group of friends that is still a virgin so I feel under pressure' (Female, age 20, client)

'Almost all my friends have had sexual intercourse and they sometimes talk about it in my presence' (Female, age 20, client)

'My friends would say that I was gay if I do not have sex with a female' (Male, age 19, client)

Providers regarded young people from rural areas as particularly vulnerable to adopting the attitudes of their friends and engaging in behaviours that compromised their health. Many young people from rural areas are often exposed to city life for the first time when they begin university. Providers felt that while some engaged in risky behaviour to feel a sense of inclusion among friends, for others, being away from the home environment and not having the constant support of family contributed to reckless behaviour.

'Peer pressure is another reason we have picked up... you will find a child from a rural area coming here having not had sex at all but here they are influenced by their peers and they start to forget themselves' (Male, age 55, nurse)

The interviews with clients revealed that relationship dynamics had a significant impact on their sexual behaviour. Of the 22% of young people who reported feeling under pressure from others to have sex, a substantial number of young people indicated their partners as a source of pressure. While many stated that sex was a way of pleasing their partner or strengthening their relationship others admitted to fearing retribution from their partners. This is reflected in the following responses by two female clients:

'Before I was active, my boyfriend really wanted us to do it and he passed bad remarks to me. I reached a stage where I said to myself I rather do it. It is bad because I thought I was going to lose it much later' (Female, age 22, client)

'When I do not want to have sex, my boyfriend asks me a lot of questions, which makes me feel bad' (Female, age 22, client)

Health care providers similarly cited that with young women, discussion of contraception with a partner and the partner's approval of contraceptive use, were important indicators of contraceptive behaviour among young women. In addition, socio-economic factors played an important role in the risky behaviour of young people visiting the health facility. Providers noted that young women at university engaged in sex with older men in exchange for material or financial resources.

'They will come here for emergency contraceptives and we will ask why are you not using protection? Sometimes they will say my boyfriend does not want me to use contraception' (Female, age 56, nurse)

'Sometimes you find that a student will fall in love with an older person just for financial support' (Male, age 55, nurse)

4.4.2 Contraceptive choices

The choice of contraception offered is important in ensuring that the diverse sexual and reproductive needs of clients are met. The health facility provided hormonal methods, which

included the injectable contraception and combined and progestin-only oral contraceptives as well as non-hormonal methods such as the condom. The diaphragm, male and female sterilization, IUDs, and spermicides were not offered at the health facility since it did not have the trained personnel or the physical as well as resource capacity to provide the method. All providers stated that each family planning client is offered a range of contraceptives methods. Providers highlighted that they did not recommend or insist on any one particular method. Instead, after taking into account the clients' health status and contraceptive experience, clients were asked which methods they preferred. If the methods requested were not offered at the health facility, providers then referred clients to another facility which had the method available. In addition providers highlighted that both oral and written information on the advantages, disadvantages and side effects of the methods available were given to all clients. This enabled clients to make an informed choice about the methods that best met their sexual and reproductive health needs.

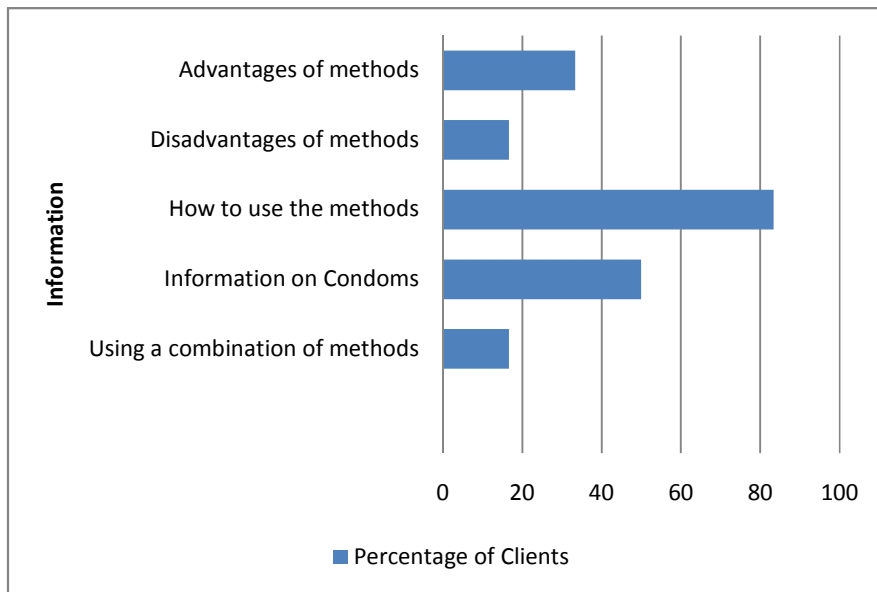
'We leave the choice for them to decide. We say look we have these methods, these are the side effects, these are the advantages, and these are the precautions you should take when you are using them and then we leave it to them to decide which method they prefer' (Male, age 55, nurse)

'What I do is put a method on the table and the client decides what they want to use. We explain how it works because if I say use a pill because it is better she is going to forget the pill and fall pregnant. She must be well motivated and it must be a method that she wants to use and she is comfortable with' (Female, age 56, nurse)

To determine if clients were able to make an informed choice regarding a contraceptive method, the 52 clients who identified family planning as the main reason for their visit, were asked whether they received information on the advantages and disadvantages of methods. Figure 4.1 illustrates the kinds of information that clients accepting contraceptive methods reported receiving from providers. A total of 33% of clients stated that they were given information on the advantages of methods from providers, while only 17% reported that they received information about the disadvantages. For this reason, a significant number of clients expressed that the methods offered at the clinic did not meet their needs. While providers stated that they enabled clients to make an informed choice about the methods that best met their sexual and reproductive health needs, a large majority of clients stated that they did not receive information on the advantages, disadvantages or side effects of the methods.

Consequently, clients felt that they were not able to make an informed choice or choose the method that best suited their needs. A positive finding was that the large majority of clients, as suggested by providers, were given instructions on how to use their selected methods. Overall, just over half of all family planning clients felt that the methods offered at the clinic met their sexual and reproductive health needs. One reason for this which was stated by the majority of clients was that the provider often gave them the method they wanted.

Figure 4.1: Types of information that clients accepting contraceptive methods received from providers



Despite the available information on contraceptives, providers stated that misconceptions and fears around contraceptive use often emerged with young clients visiting the health facility. One example was the fear among young people that contraceptives will make them fat or that contraception will turn their body into jelly. Consequently many choose not to use contraception and opt for emergency contraceptives. In the interviews with clients, a small but important minority (2%) stated that they accepted emergency contraceptives during their visit at the health facility.

‘When they come in for emergency contraceptives and we talk to them... and ask if you are sexually active why are you not protecting yourself? They say this thing is going to make me fat, make my body like jelly, there are so many things that they say.

Then you try to correct them but inspite of this you find that they keep coming back here' (Female, age 56, nurse)

Some health care providers felt that the availability of these sexual and reproductive health services may inadvertently serve to encourage risky behaviour with the knowledge that treatment is available in the event that they experience negative outcomes related to their sexual behaviour. Consequently unwanted pregnancies, HIV and STIs are a serious problem among young people who visit the health facility.

'Lots of them come in with unplanned pregnancies..the majority who are unmarried and who have unplanned pregnancies now opt for termination of pregnancies because they know this is readily available. They do not prevent the pregnancies, they let it occur and then they go for termination of pregnancy' (Female, age 49, nurse.)

In the context of KwaZulu-Natal the high levels of both HIV and pregnancies among youth necessitate condom promotion as central in health service provision. Providers admitted that the demand for condoms had increased among young people. This was based on the uptake of condoms at the health facility which providers stated had increased significantly over the past year. Condoms were freely available at the health facility in a box located outside the entrance. These were freely accessible even after hours and during the university holidays. All the providers interviewed who provided sexual and reproductive services to young people in the past three months, claimed to have recommended condoms at some time. In this regard however only half of all clients, who were asked whether the provider had given them information about condoms, reported that condoms were discussed during consultation. A vast majority of clients therefore did not receive information about condoms. This presents missed opportunities to provide young people with important information on how to protect themselves against negative sexual health outcomes.

All providers cited inconsistent condom use and resistance to condom use by young clients. In the interviews with clients, less than half of young people reported always using condoms while 20% said that they used condoms occasionally. A small, but important minority stated that they used condoms only with a new partner while 7% of young people reported never using condoms. To determine consistent use of condoms, clients were asked if they used a condom at their last sexual encounter. Just under half of all clients reported using a condom at their last sexual encounter. Condom use at last sex for individuals with multiple sexual

partners was relatively high among males while a smaller percentage of females reported using a condom at their last sexual encounter.

Table 4.3: Percentage of clients reporting condom related behaviour

Statement	%
I always use a condom during sexual intercourse	41
I only use condoms with a new partner	6
I use condoms only occasionally	20
I never use condoms	7
I used a condom at my last sexual encounter	46
N	156

Some of the cases mentioned by providers suggest that young people do not use condoms consistently or correctly which contributes to its ineffectiveness in preventing STIs, HIV and unwanted pregnancy. In some cases clients will only report using the condom during the first round of sexual intercourse. In addition, providers reported that slippage and breakage of condoms during sexual intercourse were common issues mentioned by clients. However, they felt that young people excuse their risky behaviour and blame negative health outcomes on condom failure. As a result providers felt that young people failed to take responsibility and accept the outcome of their own behaviour. Beliefs that condoms reduce sexual pleasure and satisfaction were also highlighted as preventing the uptake of condoms and perpetuating risky behavior.

‘Not many of them do accept condoms. They feel that they have no satisfaction when using condoms...also the famous saying is how can I eat a sweet with a wrapper on it?’(Female, age 49, nurse)

‘I think they are not using the condom correctly or they are not using the condom at all because whenever they have a problem they blame the condom. They will say the condom slipped off or the condom ruptured. They have got so many excuses’ (Male, age 55, nurse)

‘When they come to us with a STI, I will say do you know why you have this? And they will say I think it is an STI. Then I will ask, why do you think you get an STI? Then they will keep quite. Do you use a condom? They will say sometimes I use. I will say but why do you use it sometimes why do you not use it always? Then they keep quite’ (Female, age 56, nurse)

‘The uptake (of condoms) is high, but whether they use them after taking them or not, we do not know... Sometimes when they come here with problems and we try to find out what happens you find that the person does not use a condom. He or she will tell you we used it on the first round and then on the second round we did not use it, which does not help at all’ (Female, age 36, nurse)

Understanding of dual protection and dual method use for protection against unwanted pregnancies, HIV and other sexually transmitted infections, was reflected by all health providers. In addition providers highlighted that dual protection was widely promoted and clients were counselled in this regard. From the interview with clients, less than a quarter reported that the provider had mentioned that condoms could be used in combination with other contraceptive methods. In this regard only 6% of clients, who accepted a method of contraception during their visit, also highlighted accepting condoms. However, providers did understand the importance of promoting dual protection in addressing both unwanted pregnancy and STIs (including HIV and AIDS). This was reflected in their responses to a scenario where they were asked to advise a family planning client who appeared to be at risk of STIs or HIV. Overall, providers admitted to promoting condoms as a means of dual protection.

‘We advise them to use double protection, to use a hormonal contraceptive and condom at the same time because the hormonal prevents you from getting pregnant but it will not prevent you from getting STIs and HIV’ (Male, age 55, nurse)

‘We tell them that being sexually active is your choice but if you decide that you want to be sexually active you have to make a correct choice... you have to protect yourself by using condoms for dual protection because even if you are using an oral contraceptive to make sure that you do not get an STI infection you still have to use a condom’ (Female, age 56, nurse)

To ascertain if the contraceptive needs of clients were met, all family planning clients were asked a series of questions around contraceptive service provision. Of the 52 family planning clients who visited the health facility, 25% highlighted adoption of a method as a reason for the visit, while 8% of clients reported method change and 6% cited problems with the method as a reason for the visit.

Table 4.4: Percentage of family planning clients reporting reason for visit

Reason for visit	%
Adoption of method	25
Method change	8
Problem with method	6
Re-supply	58
N	52

When asked if the provider offered them a range of contraceptive methods, of those who adopted a method 67% of clients stated that they had not been offered a range of contraceptives. This is reflected in the following quotations by female clients:

‘The provider did not offer me a choice of other methods to choose from’ (Female, age 20, client)

‘I was not given a choice and so I chose what I was familiar with’ (Female, age 19, client)

Overall, the choice of contraceptive methods offered to family planning clients was relatively limited. This was largely attributable to the restricted range of methods that the health facility had available. Consequently clients did not receive information about a wide range of methods. Those that were commonly mentioned were the pill, followed by the injection and the condom.

4.4.3 Information given to clients

Information was highlighted as a key component of the health service system. Providers emphasized that health information as well as information about the sexual and reproductive health services available at the health facility were imparted through: print media at the clinic, university and student residences; oral presentations and campaigns conducted at various venues around the university; as well as during counselling sessions at the health facility. In addition, the health facility displayed posters on the walls of the waiting and consultation rooms announcing the availability of services as well as key health related issues.

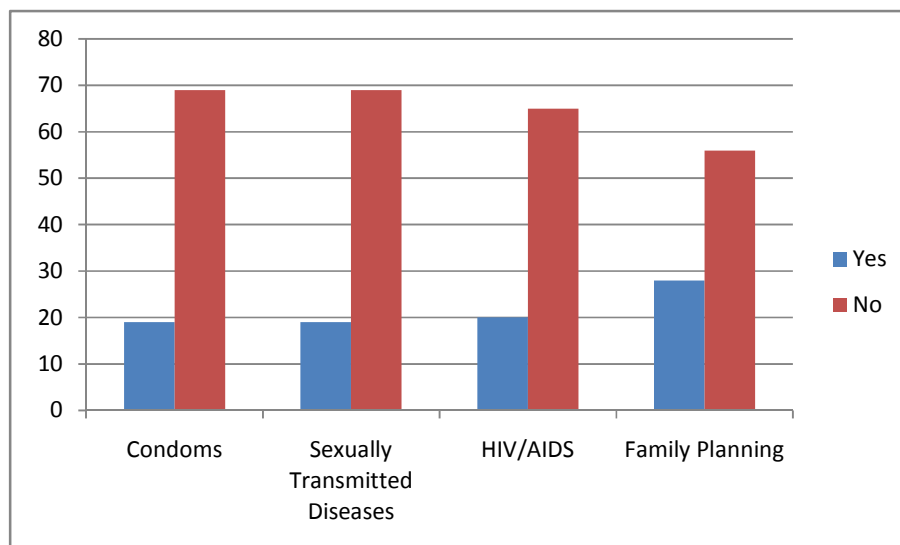
Health providers felt that information and education were key elements in encouraging young users' to utilise the health services as well as in preventing ill-health among young people.

'The younger people of today should be given more education on health hazards and should be advised to attend health centres promptly for treatment and not be afraid to take contraceptives or go for VCT and change their lifestyle'(Female, age 49, nurse)

'Prevention is firstly to give them knowledge about the transmission of diseases'(Male, age 55, nurse)

An objective measure was used to determine if clients received enough information on STIs, HIV and family planning during their consultation. To objectively measure the need for more information, all clients were asked to assess their personal risk of infection with HIV and risk of unwanted pregnancy as high, medium, or low. A total of 17% of STI and 33% of family planning clients rated their risk of HIV infection as high or medium while 33% of STI and 33% of family planning clients rated their risk of unwanted pregnancy as high or medium. These clients were classified as needing information on STIs, HIV and family planning.

Figure 4.2: Percentage of clients reporting exposure to a range of topics by providers at the health facility



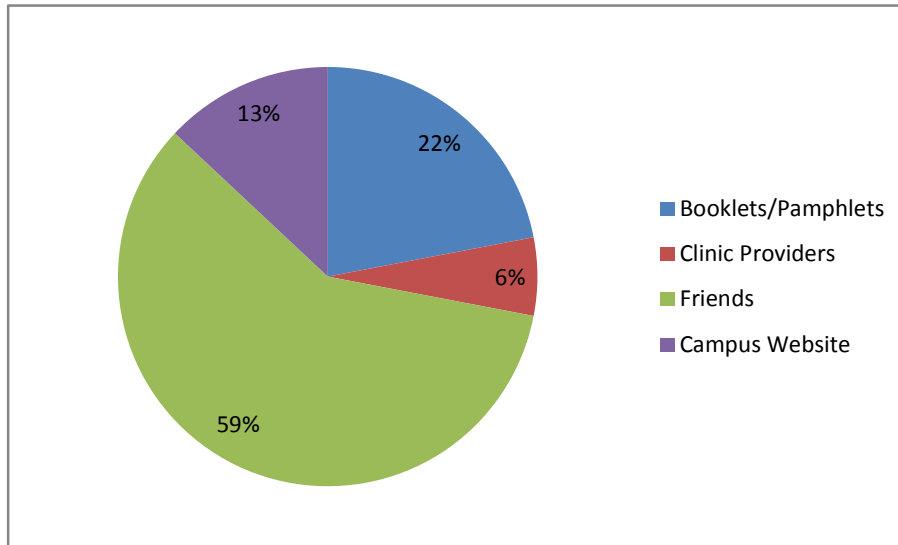
All clients who perceived themselves at risk for STIs, HIV and unwanted pregnancy were asked a series of questions to determine whether or not providers had initiated the topic of

STIs, HIV and family planning during the clinic visit. Among those defined in need of STI and HIV information, 33% of STI clients and 17% of family planning clients actually received any information on STIs and HIV. In addition, 31% (one-third) of women who perceived themselves at risk for unwanted pregnancy received information on family planning during consultation. Overall, 25% of STI clients and 57% of family planning clients, who were concerned about their risks of HIV infection, and 67% of family planning clients and 36% of STI clients, who felt at risk for unwanted pregnancy, did not receive any relevant information during their consultation at the clinic. Figure 4.2 shows the percentage of clients who reported either been exposed or not exposed to a range of topics by providers at the health facility.

In addition family planning and STI clients were asked if they needed more information from the providers at the health facility. Almost 42% of family planning clients and 33% of STI clients interviewed stated that they needed more information. Overall, 63% of all clients felt they had enough information while 30% of clients would have welcomed more from providers. Interestingly enough however, though written material on family planning, STIs and HIV are available at the clinic, only a small minority (9%) of clients who stated that they needed more information actually took pamphlets on these topics during their visit to the clinic.

Information about the clinic services is important in ensuring that students access these facilities. Students received information about the services from a variety of sources. The majority of students (59%), who were clients at the health facility, obtained information about the services at the health facility from friends. The media was also an important source of information among young people. A substantial majority indicated that they learnt about the services through the media including the internet (13%) and booklets (22%). This is often presented during university orientation which creates awareness of the health services offered at the campus health facility for new students. Only 6% of students received information from providers. This is illustrated in Figure 4.3.

Figure 4.3: Source of information about health services



4.4.4 Interpersonal relations

Providers felt that the interpersonal relationships between staff and young clients were influenced by many factors. One factor that was mentioned by providers as a barrier to young clients was the negative attitudes of staff. Some staff were judgemental about young people utilising sexual and reproductive health services consequently they were impatient and rude with clients. Health workers cited that staff attitudes acted as a deterrent to young people seeking sexual and reproductive services.

‘The staff do have increased knowledge of youth-friendly services because we send them to the courses on how to deal with students. It is just that you can give a person education and knowledge but it is difficult to change a person’s attitude’ (Male, age 55, nurse)

Another key concern mentioned by the majority of providers was limited contact time with patients. Staff at the health facility encountered heavy patient loads of up to 100 clients a day. Providers emphasized that due to the lack of staff limited time was spent in consultation with clients. Most providers stated that they dealt as quickly as possible with patients needs under the pressure of long queues. This also presented missed opportunities to provide information and counselling on sexual and reproductive health and services to young people. Providers admitted that they dealt mainly with the curative aspects of services due to the limited

consultation time and were not always able to provide young people with enough information or counselling. This is important since providers felt that information and education were key elements in encouraging young users' to utilise the health services as well as in preventing ill-health among young people. For this reason all providers expressed that they felt overworked and frustrated.

'We tend to focus mainly on curative aspects because we are short staffed and when the clinic is full all you are doing is pushing the queue and not giving enough information to the students to prevent the sexually transmitted diseases' (Male, age 55, nurse)

'I think institutions are understaffed....staff do not have the time to sit and counsel individual clients and spend a lot of time with them....staff are overworked, they are frustrated' (Female, age 56, nurse)

Health care workers also cited communication and cultural factors as barriers to service provision. Health care staff felt that young clients do not always speak openly to providers about health problems due to a variety of factors such as the age and gender of the provider. For instance, providers felt that female clients were more likely to discuss sexual and reproductive health issues with female providers rather than male providers because they would feel more comfortable. Another common belief among service providers was that clients perceive them as mother or father figures since they are much older. Culturally, they may therefore be afraid to discuss sexual and reproductive issues since it could be perceived as disrespectful. For this reason they felt that young people did not always disclose their health problems. This is illustrated in the following quotations:

'The age difference is a barrier. It takes time for a student to get used to me as an adult, to open up to me; they see us as mother and father figures' (Male, age 55, nurse)

'I am not saying that we do not interact but there is that fear. They look at us as parents so that becomes a barrier' (Female, age 56, nurse)

To determine the nature of the interpersonal relationship between clients and providers, clients were asked to rate their interactions with providers during their time spent at the clinic by agreeing or disagreeing with specific statements. Table 4.5 shows that with the majority of clients who utilised the health services privacy received the highest number of positive

responses at 85%. A large majority of respondents who attended the health facility also perceived providers as helpful and friendly and felt that they were treated in a respectful manner. Though in general, clients expressed positive feelings towards providers the results also show that a significant number of students cited barriers in interpersonal relations when asked about their dissatisfaction with services. Some of the respondents stated that they felt judged and disrespected because staff were rude and unfriendly. This is illustrated in the following responses:

'The staff are too tense and not friendly enough. They do not give you advice; it is more like they judge you' (Female, age 18, client)

'The staff are too rigid. They should learn to be more friendly and engage with patients' (Male, age 19, client)

'Some nurses judge you and speak to us without respect. Some of them are rude and impatient with us' (Female, age 19, client)

As suggested by staff, limited consultation time was an issue at the health facility. Only 63% of students felt that there was sufficient time to ask questions while 65% felt that they were afforded the opportunity to ask questions about issues they thought were important. In this regard many students also reported not feeling comfortable enough to open up to providers or ask for information because they were unfriendly and intimidating, as reflected in the responses of female students:

'The nurses are terrifying and not friendly so it makes us scared to fully give them information about our illness' (Female, age 18, client)

'Nurses are intimidating and not easy to approach. My first time was a horrible experience I could not speak up' (Female, age 20, client)

A sizeable minority (30%) of respondents also felt that they were not provided with all the information they wanted during the consultation. Some respondents reported experiencing difficulties in communicating with providers. For instance, young people felt that the staff did not always explain what was wrong with them or why they were being given certain medication. This is illustrated in the following quotation by a female client:

‘They do not communicate with the patient or explain fully what is wrong with him or her. They do not explain why they administer the medication they do’ (Female, age 20, client)

Table 4.5: Percentage of clients who agree with specific statements related to health service provision

Statement	%
Staff at the clinic were friendly	74
Staff made every effort to ensure my privacy	85
Staff gave me the opportunity to ask questions about important issues	65
Staff were helpful in providing information	69
There was sufficient time for me to ask questions	63
All my expectations of service delivery were met	65
N	200

Another barrier to service provision mentioned by the majority of health providers was the accessibility and availability of the health services. Providers felt that young people may be prevented or discouraged from using the health services because of logistical constraints such as inconvenient hours. In this regard 46% of clients did not find the opening and closing hours of the clinic convenient. Since the clinic is open only between certain times in the day, young people who are attending lectures or have transport constraints, are not able to access the services.

‘With the clinic operation times we close between half eleven and two. Sometimes you find that for a student that is the only time that they are free to use the clinic but cannot because it is not accessible at that time so it becomes a barrier to the student’ (Male, age 55, nurse)

‘I think if they are at university they do not have the time because these services are provided during the day at certain times and if they are in lectures it is probably a time constraint’ (Female, age 49, nurse)

Effective provision of comprehensive services for youth was also hindered by a host of logistical problems. Common constraints expressed by staff included shortage of human resources, lack of infrastructure and high-case loads. This leads to longer waiting times and

loss of clients. Consequently the process of care and support is affected and forms a barrier to young people receiving the quality of care they need.

'With the shortage of staff, clients have to sit here for longer times so some leave before they are seen' (Male, age 55, nurse)

Agreeing with the perspectives of the providers, some of the common complaints by clients included the long queues and excessive waiting times that they experienced at the clinic facility. This served as a deterrent to young people utilising the services. Many clients reported having to make appointments to see a doctor on a later date or being referred to other facilities for services as reflected in the statements below:

'The staff is short, so it is always full and sometimes you go back without seeing the nurses' (Female, age 19, client)

'I have to sometimes make an appointment to come back later to see a doctor' (Male, age 18, client)

4.4.5 Mechanisms to ensure continuity

Though providers stated that they did encourage young people to continue using services there were no specific mechanisms to ensure continuity in place. The health facility did maintain personal record cards of all clients, containing their personal information as well as a record of their previous visits. Follow-ups were only done when necessary using the contact details provided in the clients files. To ensure continuity with clients, a continuous supply of contraceptive methods is essential. In this regard health providers stated that they did not experience stock-out of methods in the past 6 months. As a mechanism for ensuring continuity from a technical perspective, the health facility did monthly stock taking as a system for monitoring materials, equipment and supplies.

To determine the extent to which providers encouraged continuity of use, clients were asked about the follow-up mechanisms that providers gave them. A large majority (58%) of family planning clients who visited the health facility said they were not given appointments for the next visit by the service provider. Of the 33% of family planning clients who were given dates for follow-up, all stated that they adhered to those dates. The results suggest that student's visit the health facility three times a year on average. One of the reasons for this is

the high number of students who utilise health facilities outside campus. In this regard, 81% of students interviewed at the health facility stated that they preferred health services elsewhere. Overall, 43% preferred going to private services followed by the government hospital and finally the youth centre. Some of the reasons that clients gave for using other services were that staff were more friendly and did not judge them. They were therefore able to talk about their sexual and reproductive health issues. Clients also stated that these health facilities did not have long queues and they were able to spend more time in consultation with providers. At the same time they offered a broader range of services which the clinic on campus did not provide. These are illustrated in the following statements:

‘They give us time and listen to all your problems’ (Female, age 18, client)

‘The staff are more friendly there and I am able to talk about my sexual life without being judged’ (Female, age 19, client)

‘They do not have long queues and have all the services that the clinic does not’ (Female, age 18, client)

These statements are reflective of the barriers mentioned in the utilisation of the campus health facility such as unfriendly staff, limited consultation time and long queues. Consequently many clients were discouraged from seeking services at the clinic on campus and utilised other health services.

4.4.6 Appropriate constellation of services

All providers felt that the provision of comprehensive services for young people was essential in reducing negative sexual and reproductive health outcomes. One of the common concerns expressed by providers in relation to service provision was the need for integrated sexual and reproductive health care services. At the health facility, family planning and STI services were offered separately. Consequently young clients visiting the health facility were not always offered a comprehensive range of services that would protect them against unwanted pregnancy and STIs, including HIV. Some providers acknowledged that integrated services would be more efficient and effective in serving the needs of young people as opposed to vertical programs since clients would have all their sexual and reproductive needs met at one service delivery site.

‘Services should be integrated at all health centres because it makes it easier for the client to attend family planning, to attend VCT, on the same day whereas if the services are not integrated they have make appointments for other days. As a result they may not attend because they do not have the time or it is not easily available or easily accessible to them’ (Female, age 36, nurse)

Clients were asked to rate the appropriateness of the services offered at the clinic. Two-thirds of clients felt that the clinic had all the services they required while a substantial majority felt that the staff could respond to all their health needs. Some of the positive aspects of the clinic highlighted by clients were the provision of free services as well as the convenience of the services on campus. Just under half of the clients interviewed highlighted that they had to go to another facility for services they required due the limited resources and services provided at the health facility on campus.

Table 4.6: Percentage of clients who agreed with specific statements related to the comprehensiveness of the health services

Statement	%
The clinic has all the health services I require	63
The staff are able to respond to all my health needs	65
I do not have to go to another facility for services that I need	45
N	200

4.3 SUMMARY

In this chapter a detailed review of the research results was presented revealing the perceptions and experiences of both clients and providers in relation to comprehensive, youth-friendly health service provision. Overall, the perspectives of both the providers and clients suggest that, an individual level, sexual behaviour is strongly influenced by social pressures. These individual level risk factors which predispose young people to negative health outcomes are significant in understanding for instance why young people are inconsistent condom users. Young people cited reasons beyond access to services which

influence their sexual behaviour. These findings therefore shed insight into why sexual and reproductive health services may not always be effective.

With regard to health service provision, the results show that while providers stated that they enabled clients to make an informed choice about the methods that best met their sexual and reproductive health needs, a large majority of clients did not receive information on the advantages, disadvantages or side effects of the methods. Consequently clients were not able to choose a method that best suited their needs. Providers are missing opportunities for providing clients who may be at risk of STIs or unwanted pregnancy with a method that may be more appropriately suited for them. Staff at the health facility also missed opportunities to provide young people with important information about condoms. It was encouraging to note however that providers recognized the importance of promoting dual method use among young people at risk of STIs and unwanted pregnancy. Mechanisms to ensure continuity of contraceptive supply were in place. The health facility did not experience a stock out of methods. However the follow-up mechanisms for clients at the health facility were poor. A large proportion were not given follow-up dates. This discourages continuity of use and places young people at risk of negative health outcomes.

In general, clients described providers as helpful, respectful and friendly. However, at the same time both providers and clients cited barriers in interpersonal relations. Providers admitted to providing limited consultation time with clients under the pressure of heavy patient loads. This presented missed opportunities to provide information on sexual and reproductive health to young people. In this regard, clients felt that they could have been provided with more information during their consultation. A sizeable fraction of clients complained that they did not get an opportunity to raise concerns with providers. Clients were also in need of information on STIs, HIV and family planning which many did not obtain during their visit at the health facility.

In view of the logistical constraints that providers at the health care facility expressed, effective implementation of comprehensive, youth-friendly services is inevitably hindered. In addition, there are various barriers in health service provision that challenge the provision of youth-friendly services.

Chapter Five

Conclusion

and Recommendations

5.1. Introduction

The 1994 ICPD called for all individuals to have access to safe, acceptable and effective services (Boonstra, 2008). It expressed a dramatically new move towards a more comprehensive approach to sexual and reproductive health. However, the provision of comprehensive health services for young men and women presents major challenges to many developing countries. The first part of this chapter seeks to expand knowledge on the key issues faced in the provision of comprehensive, youth-friendly services by examining the experiences and perceptions of young people and providers. This will provide insight into the extent to which health services are responding to the sexual and reproductive needs of young people. The final part of the chapter will present the major conclusions reached by the research. Given the widely held belief that the provision of comprehensive, youth-friendly services are necessary in improving the health outcomes of young people, this will draw attention to issues that demand public health priority. Based on the conclusions made, recommendations and policy applications will be suggested for future studies and applications in this field of research.

5.2 Discussion

The study presented was conducted in a setting where the case for comprehensive, youth-friendly sexual and reproductive health services is particularly strong. KwaZulu-Natal currently has the highest incidence of HIV prevalence in South Africa and one of the highest in the world (Statistics South Africa, 2010). At the same time high levels of unwanted pregnancy among young women are an urgent concern. Young people between the ages of 18 to 24 years have been identified as particularly vulnerable to negative sexual and reproductive health outcomes (Nshindano and Maharaj, 2008). Despite this, although various studies highlight the importance of comprehensive sexual and reproductive health services targeted at youth, there is a lack of adequate research in evaluating the extent to which health services are addressing the health needs of young people particularly in developing country contexts. The current study aimed to redress this imbalance by exploring the perspectives and experiences of service providers and young people in relation to comprehensive, youth-

friendly sexual and reproductive health services. These findings are particularly significant in understanding the success and challenges of health services targeted at youth since South Africa has progressed further than most African countries on the path towards comprehensive health care service provision (Maharaj and Cleland, 2005). The evidence obtained will therefore be beneficial to other countries in the sub-Saharan African context with similar sexual and reproductive health profiles among its young population.

The research findings suggest that young people's sexual behaviour continues to place them in a group at high risk of exposure to HIV, STIs, and unwanted pregnancies. These findings are consistent with previous literature on the topic which suggest that universities in the context of Africa are high-risk institutions for negative sexual and reproductive health outcomes among youth due to high-risk behaviours such unprotected casual sex with multiple partners and 'sugar-daddy' practices (Njagi and Maharaj, 2006). As in studies conducted in other parts of Africa the results reveal that median age at first sex differs between male and females (Hindin and Fatusi, 2009; Slaymaker *et al.*, 2009). Agreeing with the findings from the nationally representative HIV prevalence, incidence, behaviour and communication survey of youth in South Africa, young men in this study overall reported having an earlier sexual debut than young women (Makiwane and Kwizera, 2008; Shisana *et al.*, 2009). This can be attributed to social norms around masculinity and peer pressure which were cited as reasons for sexual initiation by the majority of respondents interviewed. About two-thirds of young people reported having multiple sexual partnerships, a figure comparable with findings of university students in other developing countries (Nshindano and Maharaj, 2008). Literature on multiple partner relationships in KwaZulu-Natal reveal these types of relationships are often considered an acceptable practice among young men due its traditional acceptance as well as cultural expectations linked to African manhood (Hunter, 2005). These notions of masculinity however translate into risky sexual practices by young men and women thereby increasing their risk of STIs, HIV and unwanted pregnancy.

Within this context, the results of the study revealed that young people utilised the clinic services for a variety of reasons. A substantial number of young people reported attending the clinic for family planning services (52) while a significant minority reported HIV and STIs (24). An interesting finding was the lack of male clients utilising the health facility. Only 15% of clients interviewed were male. These findings agree with previous literature on sexual and reproductive health services which suggest that young men are reluctant to utilise health services due to the environments past emphasis on women (Tylee *et al.*, 2007). In recent

years there has been increasing acknowledgment about the important role of men in sexual and reproductive health. Young men in particular remain excluded from health services. This presents a huge problem since men are often perceived as the driving force behind the spread of sexually transmitted diseases including HIV (Clark *et al.*, 2006). As highlighted in the findings of the study, young men had earlier sexual debuts and were more likely to engage in risky sexual behaviour such as multiple partner relationships. Consequently they place themselves as well as their partners at increased risk of negative sexual outcomes. Male involvement in sexual and reproductive health services is therefore essential. These services present the opportunity to provide young men with important information around sexual and reproductive issues which in the long-term can translate into behavioural and attitudinal changes (Hoffman, 2006). Sexual and reproductive health policies should aim to promote gender equality in services. Health facilities should encourage men to utilise health facilities by providing a wider range of services.

The main concern of the study centred on health services responding to the needs of young clients. Several key issues around health service provision have emerged from the study results. The clinic on campus did not provide a wide variety of contraceptives however it did ensure that users had reasonable access to hormonal and non-hormonal methods including condoms, injectable contraception and combined and progestin-only oral contraceptives. Though providers stated that each family planning client is offered a range of contraceptives, the results of the study show that only a small percentage of clients who adopted a method reported that the provider offered them a choice of contraceptive methods. The most commonly mentioned methods by clients were injectables and pills. As suggested by previous studies these therefore continue to be widely practiced methods of contraception by young women and confirms that there has been little change in the available range of contraceptive methods in South Africa (Cooper *et al.*, 2004). For these reasons a significant number of clients expressed that the methods offered at the clinic did not meet their needs. Meeting this unmet need for contraception can have important sexual and reproductive health outcomes. As highlighted by several impact studies, availability and accessibility of a range of contraceptive methods are associated with increased use, continuation rates and total contraceptive prevalence (PATH, 2004; Rutenberg and Baek, 2005; Smith *et al.*, 2004). There is therefore a need for the health facility to ensure that young people are provided with an increased range of methods that are able to address their different needs.

Providers at the university health facility recognised the essential elements of informed choice. Providers also understood the importance of offering clients information about the variety of methods available and enabling clients to make their own choices about the methods they want. However, the findings of this study showed that only a small minority of the clients actually reported receiving information on the advantages and disadvantages of methods from providers during their consultation. This is of particular significance since research shows that method discontinuation among young people during the first year is often attributed to side effects (Berer, 2006). If young people are unaware of the disadvantages and side effects of methods, such as bleeding, cramping or nausea, they are more likely to abandon a contraceptive method. More than half the clients interviewed felt that the methods offered at the clinic met their sexual and reproductive health needs largely because they were given what they wanted. However, one of the downfalls of allowing clients to make their own contraceptive choices is that most clients lack experience in making health care decisions (Eaton *et al.*, 2003; Williamson *et al.*, 2009). Providers can help overcome these barriers by providing clients with comprehensive information on a range of contraceptive methods including its advantages, disadvantages and side effects. Though clients autonomy is often emphasised in the decision making process, providers should ideally question young people's contraceptive choices during the counselling session to validate the reasons for their decisions. This is significant since research reveals that young people place more emphasis on anecdotal information obtained from friends than statistical evidence (Tylee *et al.*, 2007). This process can help verify the client's level of understanding and information in making reproductive health decisions and prevent method discontinuation, failure and switching.

With the twin risks of HIV and pregnancy among youth, the promotion of dual protection needs to play a significant role in public health interventions. Understanding of dual method use was widely expressed by providers at the health facility however, less than a quarter of clients reported that the provider had mentioned that condoms could be used in combination with other contraceptive methods. This presents missed opportunities for providers to provide young people with important information on how to protect themselves against STIs and unwanted pregnancy. At the same time, as highlighted in previous studies, condoms remain the mainstay of dual protection (Berer, 2006). Many of the definitions of dual protection expressed by providers were limited to condoms and less with other contraceptive methods. These limited definitions of dual protection and biases against condoms therefore continue to make dual protection one of most under-rated public health practices (Berer, 2006). This

draws attention to the need for awareness to be created among providers about the range of methods that can provide dual protection, aside from the condom, which can meet the diverse needs of different population sub-groups. One such contraceptive option that was offered at the health facility was emergency contraception. Emergency contraception can provide a backup for barrier methods of contraception and prevent unwanted pregnancies to women that do not have continuous access to contraceptives (Rogan *et al.*, 2008). Despite this, interviews with providers suggest that emergency contraception was not promoted and rarely requested by young women. The findings of this research therefore maintain that there is a need for educational interventions to increase awareness about the expanded range of methods that can be used to achieve dual protection. In the long-term the development of highly efficacious methods of dual protection and a wider range of condoms that will address different groups of people is necessary (Askew and Berer, 2003; Bearinger *et al.*, 2007; Berer, 2006). This is imperative in addressing the needs of people in diverse settings.

Despite biases against condoms, there is still a need for prevention strategies to encompass the importance of condom use among youth not only in terms of preventing HIV and AIDS but also as a method of prevention of pregnancy. As documented in numerous studies on sexual behaviour even with the high uptake of condoms, condom use among young people continues to be inconsistent (Maharaj and Cleland, 2006). In addition, despite almost two decades of promotion on condoms, the findings of the study show that there is a perpetuation of negative perceptions and attitudes around condoms (Marston and King, 2006; Preston-Whyte, 1999). This is summed up in statements such as ‘how can I eat a sweet with a wrapper on it?’ hence, even though knowledge of condom use is argued as being universal among the youth, the connotations and perceptions attached to the method still differ markedly between individuals. At the same time however condoms have gained acceptance among the majority of young people. Findings from the study reveal sufficiently high levels of use at last sexual encounter. This is supported by previous research on condom use among college students in KwaZulu-Natal which demonstrate high levels of condom use and awareness among young people (Maharaj and Cleland, 2006). Condom use at last sex for individuals with multiple sexual partners was also relatively high. The South African National HIV prevalence, Incidence, Behaviour and Communication Survey for 2008 highlighted similar findings among young people in the province (Shisana *et al.*, 2009). Positive perceptions should therefore continue to be reinforced among youth.

The findings of the study show that young men reported higher levels of condom use than young women. One of the reasons for this could be gender roles and dynamics which form a significant factor that influences decisions about contraception use. This study suggests that 'sugar-daddy' practices continue to place young women at risk. Due to financial constraints many young women are involved in relationships with older men for financial support thereby increasing their vulnerability to sexual coercion and domination (Njagi and Maharaj, 2006). The need for the partner's cooperation may therefore serve as a barrier to the use of condoms among females (Hoffman, 2006). One manner in which this social epidemiology can be addressed is by providing methods over which women have some control such as female condoms. These however were not offered at the health facility. In light of the fact that gender inequalities continue to perpetuate the spread of HIV particularly within developing countries, the promotion of these methods remains a key priority. There is also a need for the development of other methods over which women can have some control (Smith and Magnet, 2007; Smith *et al.*, 2004). These new methods need to be targeted at men if we are to address women's vulnerability against HIV and AIDS. In this sense both men's and women's responses need to be incorporated in research and development of new methods (Smith and Magnet, 2007). Studies reveal that the prevalence of sexual coercion within their own relationships and those of their peers particularly within traditional settings, seem to reinforce young women's views that these practices are norms which inevitably serves as a barrier in addressing this social epidemiology (Hoffman, 2006; Hoffman *et al.*, 2004). At the micro and macro level there is therefore a need to develop interventions that alter norms supporting various forms of gender inequalities. Sexual and reproductive health policies should aim to promote gender equality and address gender norms to reduce the vulnerability of young women by involving both men and boys in prevention efforts (Hoffman, 2006). Ideally these programs should have as their basis the promotion, protection and respect of human rights.

One of the most significant issues raised by the study was the need for health promotion and preventative health education to mitigate negative health outcomes among youth. It was encouraging to note that providers at the clinic seemed to utilise clinic visits as the opportunity to counsel youth about the risks of unprotected sexual intercourse and how to protect themselves. However, a large majority (42% family planning and 33% STI) of the clients visiting the health facility expressed the need for more information. In addition, an objective measure of the need for more information revealed that among clients who rated

their risk of unwanted pregnancy or HIV as high or medium, a significant majority did not receive any relevant information during their consultation at the clinic. One of the key reasons discerned for the relative failure of health providers at the university health facility to provide clients with much needed information, was a shortage of staff. Staff at the health facility encountered heavy patient loads of up to 100 clients a day. Under the pressure of long queues providers admitted to dealing as quickly as possible with clients immediate needs. Consequently clients received limited consultation time with the providers. These findings are consistent with studies conducted at other health facilities in South Africa which show that due to a shortage of staff providers spend only a small percentage of their time in consultation with clients (Maharaj and Cleland, 2005). One possible strategy to increase the time spent in consultation is to lengthen the visiting hours of the health facility. Since the health facility was opened only between certain hours this resulted in an overload of clients between these times reducing the amount of contact time providers had with individual clients. This may however prove difficult due to legalities as well as logistical problems. Another method of disseminating health information to students is through the media. This study revealed that a large majority of students gained awareness of the health services through the internet and written material. By employing mass-media communication the health facility can increase knowledge and awareness among youth. Existing studies show that media campaigns are often significant in influencing behavioural changes among youth (Petroni, 2007). By presenting this information during university orientation the health facility can target existing students as well as new students transitioning from school to university.

One of the essential preconditions for the provision of comprehensive, youth-friendly health care is the availability of staff who are trained in all key dimensions of sexual and reproductive health and are able to impart this knowledge to young clients. All staff at the university health facility were trained in family planning and the majority received additional training on STI and HIV diagnosis, counselling and care. In addition staff received refresher courses on a yearly basis and attended training on youth-friendly health service provision. The results in this regard show that staff were competent to address the health needs of young people visiting the health facility. However, the ability to successfully translate this knowledge into practice was lacking. Though in general, respondents described providers as friendly and helpful, many students cited problems with interpersonal relations and communication during their visit. In addition, some clients complained that they did not have

the opportunity to raise concerns with providers. These findings agree with other research conducted in public health services within the context of South Africa which found that interactions between providers and clients were limited to brief instructions and cursory explanations (Ndhlovu *et al.*, 2003). Given that the interpersonal relations dimension influences to a large extent the uptake of services, there is an urgent need for improving this element of service delivery. Since providers training places emphasis on technical issues, the interpersonal dimension of services is often neglected. If providers do not discuss the client's personal issues and concerns, young people may not understand how these issues impact on their sexual and reproductive health. Adequate training in interpersonal relations within youth-friendly service provision is essential in helping overcome communication problems and enabling providers to interact with young clients at a more personal level.

One of the more important findings of the study is that both providers and clients appear to welcome a comprehensive range of services. The findings of the study suggest that integrated service provision remains a challenge for health services in the context of South Africa. This is of particular concern since integrated services have been shown to make important contributions towards the prevention of negative sexual and reproductive health outcomes (Berhane and Tsui, 2006; Scholl and Finger, 2004). This study revealed that only two-thirds of clients felt that the health facility had all the services they required while only 65% felt that the staff could respond to all their health needs. Just over half of clients highlighted that they had to attend other health facilities for services they required due the limited services provided at the health facility on campus which were unable to respond to all their health needs. Integrated services can help address this issue by providing a range of services at one facility through integrated comprehensive systems (Askew and Berer, 2003). This has also been shown to be significant in targeting a broader range of clients such as young men, couples, and married young people (Berhane and Tsui, 2006). This can provide the opportunity to increase male involvement in sexual and reproductive health services which was shown to be lacking in the findings of the study.

Increasing utilisation of health services is essential in preventing and reducing negative health outcomes among youth. This issue is of particular importance since the findings of the study in this regard were disappointing. Young people reported utilising the health facility only three times a year on average. Making the health facility on campus more youth-friendly presents one of way of increasing the uptake of services by youth. Studies in developing country contexts show increased utilisation of health facilities by young people were

attributed to making health facilities more youth-friendly by: adjusting waiting times, the clinic environment, staff attitudes, and prevention programs (Fleischman, 2006; Tylee *et al.*, 2007). In this regard some of the common complaints by clients were related to the opening and closing times of the clinic, increased waiting times, as well as the attitude of providers which served as deterrents to the use of the health facility. In addition, there is a need for improved mechanisms to ensure continuity of services at the health facility. More than half of family planning clients stated that they had not been given a date for follow-up. By providing clients with dates for their next visit, providers can be more active in ensuring that health services are used consistently and more often by young people.

With the high levels of STIs, HIV and pregnancy among young people comprehensive, youth-friendly services provide the opportunity to address problems among youth in a holistic manner. Policy makers need to acknowledge the significance of providing these services for young people. While the Bruce-Jain conceptual framework needs to be integrated into a wider matrix of issues which health specialists suggest are important, it provides a good basis for examining sexual and reproductive health services for youth in the South African context. For this study, it has provided insight into the aspects of health services which are important to young people and require policy attention such as improving communication between providers and young clients. At the same time it has drawn attention to the kinds of services that may encourage young people to utilise health facilities and meet their sexual and reproductive health needs. One advantage of the Bruce-Jain framework is its focus on reproductive health services which is significant in determining the unmet need for contraception among young women. This aspect sheds light into the most effective ways of encouraging young people to adopt and use contraceptive methods which in the long-term are imperative in addressing negative reproductive as well as sexual health outcomes. Though there is a need to broaden the framework, it allows for programmatic conclusions to be drawn for the implementation of services aimed at improving the health of youth people.

5.3 The next steps

The goals of the 1994 ICPD recognised sexual and reproductive rights as one of the fundamental human rights and advocated for universal access to safe, affordable and comprehensive health care (Boonstra, 2008). However, almost two decades since, the goal of providing comprehensive, youth-friendly sexual and reproductive health services remains

a challenge. The research findings suggest that despite numerous literature on the barriers that young people encounter in accessing health care services, this has not been effectively and comprehensively translated into the design of youth-friendly services within the mainstream health care system such as the health facility at the tertiary institution.

In highlighting the challenges, at a programmatic level, health service infrastructure and provision are greatly fraught with economic and political restrictions. As highlighted in the analysis of the health facility and consistent with previous findings, common concerns that have been expressed in relation to poorly functioning sexual and reproductive health programs are: lack of trained health professionals, insufficient resources and inappropriate supervision and monitoring systems (Bharat and Mahendra, 2007). In this context, responding to health needs of young people has therefore become overburdening and unfeasible. Issues of provider bias, motivation and level of preparedness have also been highlighted as crucial determinants undermining comprehensive service delivery (Bharat and Mahendra, 2007). These constraints have undermined the expanded role of health care providers and have inevitably had a detrimental effect on the quality and pace of services that young people are receiving. At the same time the benefits of youth-friendly initiatives are not significantly visible in the current health patterns among young people (Tylee *et al.*, 2007). Young people between the ages of 18 to 24 continue to experience negative sexual and reproductive health outcomes.

Some recommendations that have emerged in light of these findings include the need for continued investment in youth-friendly services to prevent unwanted pregnancy, STIs, and the spread of HIV among young people. Within South Africa some of the political and economic factors that influence the implementation of comprehensive, youth-friendly services include: reductions in donor funding, as well as separate funding streams for sexual and reproductive health; policy restrictions relating to funding and activities; and a lack of political conviction by donors and national governments to make youth-friendly services a policy priority (Fleischman, 2006; Maharaj and Cleland, 2005). Particularly in the context of developing countries, young people are therefore often not high priority when resources are allocated (Bearinger *et al.*, 2007). Promoting linkages between youth services and general health services therefore provides an important way forward in addressing this issue, in that one can capitalize on the resources available in the wider health system. This should be utilised for strengthening the capacity of health services, improving information systems and monitoring and evaluation of programs which are necessary steps in accelerating our

trajectory towards the health goals set out by the 1994 ICPD and MDGs (Bearinger *et al.*, 2007; Tylee *et al.*, 2007). Country level data illustrates that continued investment in comprehensive approaches to youth sexual and reproductive health has had significant outcomes for the health of young people (Bearinger *et al.*, 2007). University health facilities form the basis for targeting young people since they operate around the basic principles of youth service provision and should therefore be prioritised when resources are allocated.

Policy makers need to incorporate the needs of young clients within sexual and reproductive health initiatives. Ideally young people should be involved in the design and implementation process of comprehensive, youth-friendly health initiatives (Tylee *et al.*, 2007). This would form a platform for addressing the barriers that hinder health service provision and uptake by creating linkages at the policy levels, with service providers, and the community. This would help ensure that health services are tailored to the unique developmental needs of young men and women as well as the context within which they are embedded (Petroni, 2007). To support this, ultimately the key priority should be to ensure that all countries adopt policies that encourage the provision of comprehensive health services which respond to the needs of young people (Tylee *et al.*, 2007). Keeping in mind that young people cited reasons beyond access to services which influence their sexual behaviour; this will ensure that the social context within which they are embedded will be taken into account. One of the key initiatives, in the context of youth health service provision that needs to be expanded on, is health promotion and preventative health education and information. Worldwide evidence has proven the usefulness of investing in youth development strategies for improving both long and short-term health outcomes (Bearinger *et al.*, 2007). Provider training needs to be restructured to incorporate preventative and promotive health. This is one of the key steps in improving the health outcomes among young people since research shows that risk behaviours among young people increase their vulnerability to STIs, HIV and unwanted pregnancy.

An important finding that has emerged from the study is the need to have a variety of sexual and reproductive services combined with information and education to guide the sexual choices of young people. Integrating sexual and reproductive services provides a comprehensive way of dealing with family planning, STI and HIV services. Analysis of integrated programs have shown that integrated youth centres experience higher uptake of services by young people as well as providing a broader outreach to underserved groups such as young men (Berhane and Tsui, 2006). Integrated services were also shown to improve

customer satisfaction by providing a more comprehensive response to the sexual and reproductive needs of both men and women at one visit hence better meeting the diverse needs of clients (Askew and Berer, 2003). Perhaps more significantly integrated services have been shown to improve providers' attitudes, counselling skills as well as performance which were some of the common concerns expressed by young clients in the study presented. Various studies show promising results of the impact of service integration on cost. A study on the cost of integrating sexual and reproductive clinics in South Africa revealed that compared to the cost of setting up stand-alone centres, it is more cost-effective to fully integrate services within an existing setting (Berhane and Tsui, 2006). In light of the fact that the highest rates of STI and HIV infections as well as unwanted pregnancies are occurring among the younger age groups, there is an urgent need for significant investment aimed at improving health infrastructures if we are to reap the benefits of integration. Though in the long-term, more attention is essentially needed in order to assess whether integration is feasible, effective, and whether the quality of reproductive and sexual health services will decline with integration (Askew and Berer, 2003).

Though this study explored the extent to which health services are able to address the needs of young people, there is still a need for more evidence to support the effectiveness of youth-friendly services beyond its role in improving access. Initiatives to improve health services for young people will not be effective in reducing negative health outcomes without the support of a wider public health response (Petroni, 2007). Positive signs of progress towards comprehensive health care service provision are visible. Health services have made greater effort towards promoting sexual and reproductive health pointing to greater openness towards the sexuality of young people (Tylee *et al.*, 2007). In addition more young women have access to contraception and information on sexual and reproductive health issues.

5.4 Conclusion

Essentially if we are to achieve the goal of comprehensive, youth-friendly health care within the next few years the fundamental goals of health services within developing countries, should acknowledge that health and development are inextricably linked and empowering young men and women, investing in health and education, including sexual and reproductive health, are essential not only for individual welfare and the protection of human rights but for development as well. The success and sustainability of youth-friendly initiatives depends not

only on committed support and consensus at the international level but the willingness of national and government institutions to form partnerships with groups at the community level to create supportive environments for young people with policies that take into account the social context within which young people live (Bearinger *et al.*, 2007; Petroni, 2007; Tylee *et al.*, 2007). Only by working together to achieve the targets set out by the 1994 ICPD and MDGs can countries realise the universal goal for the healthy outcomes of young people.

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Appendix 1: Inventory guide for the health facility and services

1. What types of contraceptive methods are provided?

Type of contraception	Method provided at facility	Available today	Stock out in last 6 months
a. Combined pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Progesterone-only pill	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Injectables	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Condoms	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. IUD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Spermicides	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Diaphragm	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. What types of tests are provided?

Type of test	Test provided at facility	Available today	Stock out in last 6 months
a. Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. STI	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Is any laboratory testing available?

Yes No

4. What types of services do you offer?

Type of service	Service provided at facility	Available over last 6 months	If no, reason not available
a. STI treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. HIV testing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Family planning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Contraceptive method counselling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Pre and post-test counselling for STIs and HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. Post abortion services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Health education	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
h. Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

5. Which of the following equipment and supplies are available and in working order?

Equipment and supplies	Available at facility	In working order
Stethoscopes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Needles/syringes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sterile Gloves	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sterile swabs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antiseptic	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clean instrument containers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plastic buckets for decontamination	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scale	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood pressure gauge	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Flashlight/lamp	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Examination table/couch	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recovery room	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Is there a system for monitoring materials, equipment and supplies?

Yes No

7. If yes, can you describe briefly

.....

THANKYOU FOR YOUR TIME

INSTRUCTIONS: Please indicate your response by making a cross (X) in the appropriate box or typing in the spaces provided

Section A: Biographical Information

1. Gender:
 Male
 Female

2. What was your age at your last birthday?
 Age in complete years

3. What is your race group?
 African/Balck White
 Coloured Indian
 Other (Specify): _____

4. What is your current relationship status?
 Single
 Have a steady boyfriend/girlfriend
 Married
 Other (Specify): _____

5. Do you stay at the campus residence?
 Yes No

SECTION B: CHOICE OF METHODS

6. What was your main reason for visiting the clinic today?
 Family planning (contraception) - answer Q7-12
 Personal illness
 STI management
 HIV/AIDS testing
 HIV/AIDS counselling

7. If you answered family planning what was the reason?
 Adoption of a new method
 Re-supply
 Method change
 Problem with method
 Other (Specify): _____

8. Did you receive contraceptives today?
 Yes No

9. If yes, which methods did you accept?
 Pill
 Condom
 Injection
 Other (Specify): _____

10. Did the provider give you a choice of other methods?
 Yes No
 Explain: _____

11. Were you given information on:

	Yes	No	Do not Know
Advantages of methods			
Disadvantages of methods			
How to use methods			
Information on condoms			
Using a combination of meth			

12. Do you feel that the methods offered at the clinic are meeting your needs?
 Yes No
 Explain: _____

SECTION C: INFORMATION GIVEN TO CLIENTS

13. Where did you get information about the clinic services from?
 Booklet/pamphlets Friends
 The clinic providers Campus website

14. During your visit did health providers give you information about:

	Yes	No	Don't Know
Condoms			
Sexually transmitted diseases			
HIV/AIDS			
Family planning			

15. Did you take any of the written material at the clinic?
 Yes- No

16. If yes, what was the subject of the written material?
 Family planning
 Sexually transmitted diseases
 HIV/AIDS
 Other (Specify): _____

17. Do you feel that you have enough information from the service providers?
 Yes No
 Explain: _____

SECTION D: INTERPERSONAL RELATIONS

18. Please answer the following statements with regard to your visit. (Cross the appropriate box number 1-4. The following numbers represent your answers: 1 = Strongly agree, 2 = Agree, 3 = Disagree, 4 = Strongly disagree

	Strongly Agree	Agree	Disagree	Strongly Disagree
a) Staff at the clinic were friendly	1	2	3	4
b) Staff made every effort to ensure my privacy	1	2	3	4
c) Staff gave me the opportunity to ask questions about issues that I thought was important	1	2	3	4
d) Staff were helpful in providing information	1	2	3	4
e) I was provided with all the information I wanted during the consultation	1	2	3	4
f) There was sufficient time for me to ask questions	1	2	3	4
g) The staff answered all my questions to my satisfaction	1	2	3	4
h) All my expectations of service delivery were met	1	2	3	4
i) I would recommend the services at the campus clinic to someone else	1	2	3	4

19. Please answer the following statements with regard to provider and student relations at the campus clinic:

	Strongly Agree	Agree	Disagree	Strongly Disagree
a) The staff are helpful	1	2	3	4
b) The staff treat me with respect	1	2	3	4
c) Staff are difficult to understand	1	2	3	4
d) Staff are too busy to answer my questions	1	2	3	4
e) I find it difficult to talk to staff about my sexual life	1	2	3	4

SECTION E: CONTINUITY MECHANISMS

20. How often do you visit the clinic on campus?

21. When you visit, are you given appointments for the next visit, by staff?

Yes No

22. If yes, do you follow these dates?

Yes No

23. If you receive services elsewhere, where do you go?

- Youth centre
 Government hospital
 Private hospital

Other (Specify): _____

24. Why did you prefer going elsewhere rather than the campus clinic?

SECTION F: CONSTELLATION OF SERVICES

INSTRUCTIONS: Please indicate your response to the following statements by making a cross (x) in the appropriate box number (1-4)

25. The following numbers represent your answers: 1 = Strongly agree, 2 = Agree, 3 = Disagree, 4 = Strongly disagree

	Strongly Agree	Agree	Disagree	Strongly Disagree
a) The clinic has all the health services I require	1	2	3	4
b) I do not have to go to another facility for services that I need	1	2	3	4
c) The opening and closing hours of the clinic are convenient	1	2	3	4
d) The staff are able to respond to all my health needs	1	2	3	4

26. Which services do you use the most at the clinic?

27. What do you like most about the services offered at the clinic?

28. What do you not like about the services offered at the clinic?

29. Are there any improvements to the services offered at the clinic that you would make?

SECTION G: SEXUAL BEHAVIOUR

30. Have you ever had sexual intercourse?

Yes (answer Q36-42) No (answer Q43-47)

31. If yes, at what age did you first have sexual intercourse?

Age in complete years

32. How many sexual partners do you have?

Number of current sexual partners	<input type="text"/>
Number of sexual partners in the last 12 months	<input type="text"/>

33. Please answer Yes or No for the following statements:

	Yes	No
a) Did you use a condom at your last sexual encounter	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you ever had a sexually transmitted infection	<input type="checkbox"/>	<input type="checkbox"/>
c) If yes, have you been treated for a sexually transmitted infection in the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you ever had an unplanned/unwanted pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
e) If yes, did you go to a health care facility for a check-up	<input type="checkbox"/>	<input type="checkbox"/>

34. People have different reasons for having or not having sex. What would be your reason?

35. Did you feel under pressure from others to have sex?

Yes No

36. If yes, please explain from whom and how?

37. Before today have you thought about your own chance of getting HIV/AIDS?

Yes No

38. Do you consider your chance of getting HIV/AIDS as:

High
 Medium
 Low

39. Do you consider your chance of getting pregnant as:

High
 Medium
 Low

40. How often do you use condoms?

Always With a new partner
 sometimes Never

Appendix 3: In-depth stakeholder interview guide

1. How long have you been working here at this facility?

2. How long ago did you finish your basic training?

(Probe: Can you explain what your training included? Did you receive any additional training since then?)

3. I would like to ask you some general health questions about the young clients attending the health care facility.

What are the most important health issues you find affecting young people that visit this health facility?

(Probe: what else?)

4. If not mentioned above, how serious a problem are HIV/STIs for young men and women who visit this clinic?

(Probe: what do you think causes HIV/STIs among youth? What could they do to avoid HIV/STI's? What are the kinds of things that the health care staff recommend to prevent or treat this?)

5. If not mentioned above, how serious a problem are unwanted or unplanned pregnancies for young women who visit this clinic?

(Probe: Why do think this is so? What advice do staff give on family planning? What methods do you recommend? What methods do you not recommend? Are condoms known and accepted by young clients? Are condoms promoted as a method of family planning? why is this?)

6. If a client who is currently using the pill comes for check-up or re-supply and appears to be at high risk of STI/HIV what advice would you normally give her?

7. I would like to ask you about the services you provide to young people at this facility over the last three months. In the last three months what services have you actually provided or recommended to young people firstly at risk for unwanted pregnancy and secondly at risk for HIV/STI's?

(Probe: How important is it to include sexual and reproductive services at the facility for young people?)

8. What services would you recommend be sustained and/or scaled up? Please provide a justification for your response.

9. What are some of the constraints that health care staff face in providing services?

(Probe: Staff turnover? Lack of key support? Lack of technical assistance? Opening/closing hours of clinic?)

10. What are some barriers, if any, in interpersonal relations, that you encounter in dealing with your young clients?

(Probe: Do young clients speak openly to staff about health problems? Do you think they are afraid/embarrassed/scared of seeking health services? Are they afraid/embarrassed/scared of seeking family planning/contraception? Are they afraid of getting tested for STI/HIV? Why do you think young people find it difficult to seek/attend sexual and reproductive health services?)

11. How do you overcome these barrier(s)?

(Probe: What would encourage more young people to use these services?)

12. What effect, if any, do you feel that the services at the campus clinic have on youth?

(Probe: Increased use of services by youth? Increased knowledge of youth friendly services by clinic staff? Changes to the clinic(s) to make them more youth friendly?)

13. What recommendations do you have for future efforts (making services more youth friendly) such as these?

Is there anything more you would like to add?

I will be analyzing the information you and others gave me. I will be happy to send you a copy to review at that time, if you are interested.

THANK YOU FOR YOUR TIME