

**An exploration of school health nurses' understanding and experiences of
adolescent sexual and reproductive health programme in a selected health
district in KwaZulu-Natal**

A dissertation submitted in partial fulfilment of the academic requirements for the
degree of Master of Nursing Sciences (Community Health Nursing), in the School
of Nursing and Public Health, College of Health Sciences, University of
KwaZulu-Natal

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DECLARATION

I Patience Primrose Khuzwayo declare that this research dissertation titled: “An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programme in a selected health district in KwaZulu Natal” is my innovative work which has certainly not been acquiesced for any other purpose or to any academic institution. Information used in this project has been acknowledged in the list of reference.

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DEDICATION

This dissertation is dedicated to my darling husband BS Khuzwayo (Vusi) and our wonderful youngsters: Bonga, Nhlakanipho, Ngcebo and Sinegugu who have been a source of encouragement through their effortless support, inspiration and my extended families, without their support my academic life would have been impossible to achieve. You have been a consecration for me and thank you for having confidence and trust in me. You are a crest of my happiness that I will cherish for the rest of my life.

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ABSTRACT

Introduction: Unprotected sexual activity has a negative effect to the reproductive health of adolescence, because they are physically immature and are at risk of unwanted pregnancy. Sexual and reproductive health (SRH) programmes form the backbone of school health package for school health nurses (SHNs) dealing with adolescent health. The SRH is vital in addressing sexually transmitted infections, unplanned teenage pregnancies and abortions being experienced by adolescents globally. However in South Africa, there is a high prevalence of Human Immune Deficiency Virus (HIV) in adolescents aged between 15 and 24 years. While globally unsafe abortions accounts for the main cause for adolescents' mortality. The SHNs are the most suitable health professionals to promote students sexual health in the school settings. The SHNs should have skills that will facilitate access to information and resources to decrease the negative consequences of early, unprotected, or forced sexual intercourse.

Aim: The purpose of this study was to explore the selected SHNs' understanding and experiences of the implementation of the adolescents' SRH programmes in a selected health district in KwaZulu Natal.

Methodology: This study adopted a qualitative approach utilizing a descriptive and exploratory research design. Non-probability purposive sampling was employed to select participants and a semi-structured interviews guided collect data. A total of seven school health nurses participated in the study. Data was analysed using descriptive content analysis.

Findings: The study findings revealed the five major themes which were consistent with the objectives of the study. The SHNs demonstrated a much understanding of adolescents' SHR programmes and had both positive and negative experiences on the implementation of the programme. Most of the SHNs acknowledged that they were inadequately equipped with knowledge and skills to provide high-quality and comprehensive adolescents' SRH programmes. In spite of the challenges faced by SHNs it was also found that there were some positive experiences that enabled them to continue with the implementation of the SRH programme to the adolescents.

Conclusion: The SHNs had an understanding of what the program entails as well as their role in its implementation. The SHNs had limited resource but did their best to implementing the programmes. However, it is necessary that the SHNs are equipped

with the necessary skills and teaching resources to increase their effectiveness in the implementing of adolescents' sexual and reproductive programme.

Keywords: school nursing, SHNs role, understanding, experience, adolescent' SRH programme, sexuality education

LIST OF ACRONYMS AND ABBRECIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANA	American Nurses Association
CHC	community health centres
DBE	Department of Education
DOH	Department of Health
DSD	Department of Social Development
HCT	HIV Counselling and Testing
HIV	Human Immune Deficiency Virus
HPS	Health Promoting Schools
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
ISHP	Integrated School Health Policy
KZNDOH	KwaZulu Natal Department of Health
NASN	National Association of School Nurses
NDBE	National Department of Basic Education
NDOH	National Department of Health
NGO	Non-Governmental Organisation
MDGs	Millennium Development Goals
MMC	Male Medical Circumcision
PHC	Primary health care
PMTCT	Prevention of mother to child transmission
SA	South Africa
SHN	School health nurse
SRH	Sexual and reproductive health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOP	Termination of Pregnancy
UNESCO	United Nations Organization for Education, Science and Culture Organization
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

1.1 Introduction and background

School health nursing as stated by the National Association of School Nurses (NASN) is a specialised discipline of professional nursing that advanced the well-being, academic success, life-long achievement and health of students (NASN, 2011; Rollins, 2011). The discipline of school health nursing has its roots in England, in the late 19th century. Since the origin of school health nursing, the role of school health nurses (SHNs) has expanded greatly and is multi- faceted within the school setting. While SHNs are expected to deal with childhood diseases at primary school level, once at the adolescent level they are required to deal with special programmes relating to the adolescents' sexual health needs.

Lloyd (2007) states that less attention is being devoted to the contemporaneous links between being a student and acquiring specific health-related knowledge and skills. It is evident that there is a significant unmet need for information, education, and services for married and unmarried adolescents regarding sexual and reproductive health (Shaw, 2009). In 2014, the WHO released a statement that there is a growing need for research that focuses on adolescent sexual and reproductive health (SRH), in order to make sure that adolescents' reproductive health needs are met (WHO, 2014).

In South Africa there is limited literature on school nursing, specifically regarding the services offered by SHNs. School nursing existed many years ago in South Africa, and the current government has recently strengthened the practice, proposing that it be revived through the re-engineering of Primary Health Care (PHC) (NDOH and NDBE, 2012). School health services are presently provided by SHNs, who are part of the PHC staff constituent. SHNs plays a crucial role in the implementation of the SRH programmes for children and adolescents in the school. SHNs have to understand their role and must have knowledge of the appropriate adolescent SRH programmes offered. SHNs requires the understand of the context of adolescents' sexual activity, to be able to identify their needs in respect of SRH and improve programmes that will address those needs (Biddlecom, Hessburg, Singh, Bankole, and Darabi, 2007).

A good understanding of the SRH programme is essential for SHNs to deliver effective sexual and reproductive information to adolescents. It is vital that SHNs possess the

understanding that sexuality is not just about sexual intercourse. Sexuality is an individual's need for recognition and acceptance as a sexual entity and includes their sexual attitude, behaviour, feelings, love, confidence, friendship, affection, touching and being touched (Rana, Kanik, Ozcan, and Yuzer, 2007).

The concept of SRH was adopted for the first time by governments at the International Conference on Population and Development (ICPD) in Cairo in 1994 (Chandra-Mouli, Svanemyr, Amin, Fogstad, Say, Girard et al., 2015). The Cairo agenda called on governments to provide sexuality education to promote the well-being of adolescents (Haberland and Rogow, 2015). According to Haberland and Rogow (2015), such education should occur both in schools and at the community level, be age appropriate, begin as early as possible, and foster mature decision making. Bearinger, Sieving, Ferguson, and Sharma (2007) and Francis (2011) argues that sex education programmes should provide accurate and comprehensive information, while building skills for negotiating sexual behaviours.

Programmes such as SRH forms the backbone of the school health package for SHNs dealing with adolescent health. Pettifor, Rees, Kleinschmidt, Steffenson, MacPhail, Hlongwa-Madikizela et al. (2005) recommend the implementation of programmes which promote partner reduction, consistent condom use and prompt treatment for sexually transmitted infections (STIs), while also addressing contextual factors. Adolescents' SRH programmes contributes to the reduction of the incidence of Human Immunodeficiency Virus (HIV) infections by; postponing sexual debut among those who are sexually inexperienced, promoting consistent use of condoms, and reducing the number of concurrent sexual partners (UNAIDS, 2013). Sexual debut is the beginning of a sexual trajectory leading either to responsible or high-risk behaviours.

Adolescence (10-19 years of age) is a period marked by significant emotional, physical and psychological changes. These changes, according to Beksinska, Pillay, Milford, and Smit (2014), influence decisions to engage in risky behaviour such as sexual activity, alcohol consumption, smoking and using drugs. This is characterised by an increased level of autonomy, a sense of identity, self-esteem and progressive independence from adults (Sawyer, Afifi, Bearinger, Blakemore, Dick, Ezech et al., 2012). Early adolescence (10-14 years of age) is characterised by the initiation of physical changes, as well as rapid brain development; while in middle adolescence (15-16 years of age)

there is a progressive development of sexual orientation, where peers becomes the source of influence. In the late adolescent stage (17-19 years of age), though they might look and act as adults, they lack cognitive, behavioural and emotional maturity (Sawyer et al., 2012).

In South Africa (SA), previous literature reveal that adolescents between 15-24 years old have an HIV prevalence of 7.3 per cent in 2012 (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu et al., 2014), and 19.2 per cent of females between 12-19 years have had at least one pregnancy, while according to statistic gathered in 2007 boys of the same age group have impregnated a girl (Mchunu, Peltzer, Tutshana, and Seutlwadi, 2012). Holt, lince, Hargey, Struthers, Nkala, McIntyre et al. (2012) reports that in 2008, about 30 per cent of female learners reported having had sex, with 24 per cent having been pregnant, while 15 per cent of sexually active learners reported inconsistent use of contraceptives and 67 per cent of these females reported never having used condoms at all. Of the sexually active males, 71 per cent did not use condoms and half of the 4.4 per cent of learners who have had sexually transmitted infections (STIs) were not treated for them (Holt et al., 2012).

The SA government according to the Integrated School Health Policy (ISHP) has decided to partner with the public sector, non-governmental organisations (NGOs) and the private sector to address the vulnerability of adolescents (NDOH and NDBE, 2012). The National Department of Health (NDOH), together with the National Department of Basic Education (NDBE) and the National Department of Social Development (NDSD) in South Africa has embarked on a strategy to develop a school health programme comprising screening, immunisation, sexual and reproductive health and substance abuse services (NDOH and NDBE, 2012). According to Mohlabi, Van Aswegen, and Mokoena (2010) prior to 1994 school health services lacked collaboration for support services within and outside the Department of Health. The Department of Health was also viewed as the sole department responsible for delivering school health services, while nurses employed by the Department of Education were disassociated from the Department of Health's school teams (Mohlabi et al., 2010). Comprehensive school health education programme requires partnership beyond the health sector for it to be successful in promoting school health.

According to Beksinska et al. (2014), the current government has passed several policies as an initiative to address youth SRH. These are reflected in Table 1.

Table 1. Policies addressing youth SRH in SA

1999	National Policy on HIV and Acquired Immune Deficiency Syndrome (AIDS) for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions
2000	National HIV and AIDS Life Skills Education Programme
2000	The HIV and AIDS Emergency: Guidelines for Educators
2003	National School Health Policy
2005	South African Child Act
2009	Revised National HIV and AIDS Life Skills Education Programme
2012	Integrated School Health Policy
2013	Department of Health Integrated Strategy on HIV, STIs and TB, 2012-2016

Adapted from (Beksinska et al., 2014).

According to Francis (2011), policies such as (a) the National Policy on HIV and Acquired Immune Deficiency Syndrome (AIDS) for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions, (b) the Department of Health Integrated Strategy on HIV, STIs and tuberculosis (TB), 2012-2016 and (c), The HIV and AIDS Emergency: Guidelines for Educators, focus on the discourses of the disease rather than on the broader issues of sexuality such as relationships, desire or sexual orientation. There is therefore a need to strengthen the policy regarding the issues of the implementation of the SRH programme in schools.

The Integrated School Health Policy (ISHP) of 2012 is one example of the South African governments' initiatives that is aimed at improving the general health of school-going children, the environmental conditions in schools and tackling the health barriers related to learning, for the improvement of the educational outcomes related to access to school, retention within school and achievement at school (NDOH and NDBE, 2012). This policy requires SHNs to deliver health education and promotion of SRH to all learners in different developmental stages. It also requires all boys in the senior phase to be informed about the health benefits of Male Medical Circumcision (MMC) and to refer learners to appropriate health services for MMC (NDOH and NDBE, 2012).

In terms of the school health package developed by the National Department of Health, SHNs are required to counsel learners on SRH (NDOH and NDBE, 2012). It further states that SHNs have to provide: Dual protection contraception and HIV Counselling

and Testing (HCT) and screening for STIs for sexually active learners (NDOH and NDBE, 2012). According to the ISHP, these services can be provided on-site or learners can be referred to a health facility where these services are provided. Other components of this policy include the provision of information for the education of learners on menstruation, contraception, STIs including HIV/ AIDS, teenage pregnancy, choice of termination of pregnancy (TOP), prevention of mother-to-child transmission of HIV (PMTCT), HIV counselling and testing (HCT), stigma mitigation and male circumcision, including male medical circumcision (NDOH and NDBE, 2012). In SA, according to the ISHP, the school health package requires the SHNs to provide specific services to learners as specified in Table 2.

Globally, unsafe abortions are a major cause of death among adolescents, with about 2.5 millions of these abortions occurring among adolescents (Sedgh, Finer, Bankole, Eilers, and Singh, 2015). SA is among some of the African countries where abortion is legally offered in the first trimester. According to Panday, Makiwane, Ranchod, and Letsoalo (2009) the choice of Termination of Pregnancy (TOP) Act, No. 1 of 2008, allow less than 18 year old women to terminate pregnancies without parents' consent

In South Africa HIV prevalence in 2008, according to Hubacher, Mavranezoul, and McGinn (2008), was 27.8 per cent for girls and 30.1 per cent for boys between the ages of 15-24 years. This high HIV prevalence among youngsters in South Africa, particularly young women, confirms that the youth engages in sex without the use of any contraceptives. Panday et al. (2009) added to this view by reporting that in KwaZulu-Natal (KZN) during the period 2004 to 2008, there were about 62.24 pregnant learners per 1000 learners registered.

Table 2. Package of school health services

Health screening	On-site services	Health education
Foundation phase (Grades R-3)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment (Gross & fine motor) • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial support 	<ul style="list-style-type: none"> • Parasite control: Deworming and bilharzia control (where appropriate) • Immunisation • Oral health (where available) • Minor ailments 	<ul style="list-style-type: none"> • Hand washing • Personal and environmental hygiene • Nutrition • Tuberculosis • Road safety • Poisoning • Know your body • Abuse (sexual, physical and emotional abuse)
Intermediate phase (Grades 4-6)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment • Mental Health • Tuberculosis • Chronic illnesses • Psychosocial Support 	<ul style="list-style-type: none"> • Deworming • Minor ailments • Counselling regarding SRH (if indicated), and provision of and referral for services as needed 	<ul style="list-style-type: none"> • Personal and environmental hygiene • Nutrition • Tuberculosis • Traditional and Medical Male circumcision (MMC) • Abuse (sexual, physical and emotional abuse, including bullying, and violence) • Puberty (e.g. physical and emotional changes, menstruation and teenage pregnancy) • Drug and substance abuse
Senior phase (Grades 7-9)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental health • Tuberculosis • Chronic illnesses • Psychosocial support 	<ul style="list-style-type: none"> • Minor ailments • Individual counselling regarding SRH, and provision of or referral for services as needed 	<ul style="list-style-type: none"> • Personal and environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, and violence) • Sexual and reproductive health • Menstruation • Contraception • STIs incl. HIV • Traditional and MMC • Teenage pregnancy, CTOP and PMTCT • HCT and stigma mitigation • Drug and substance abuse • Suicide
Further education and training (Grades 10-12)		
<ul style="list-style-type: none"> • Oral health • Vision • Hearing • Speech • Nutritional assessment • Physical assessment incl. anaemia • Mental health • Tuberculosis • Chronic illnesses • Psychosocial support 	<ul style="list-style-type: none"> • Minor ailments • Individual counselling regarding SRH needs, and provision of or referral for services as needed 	<ul style="list-style-type: none"> • Personal and environmental hygiene • Nutrition • Tuberculosis • Abuse (sexual, physical and emotional abuse including bullying, and violence) • Sexual and reproductive health • Menstruation • Contraception • STIs incl. HIV • Traditional and MMC • Teenage pregnancy, CTOP and PMTCT • HCT and stigma mitigation • Drug and substance abuse • Suicide
All schools: Environmental assessment: - <ul style="list-style-type: none"> • First aid kit • Cooking area • Ventilation (airborne infections) • Food gardens 		
<ul style="list-style-type: none"> • Water and sanitation • Physical safety • Waste disposal • Recycling 		

(Adapted from NDOH and NDBE, 2012; Integrated school health Policy).

Unprotected sexual activity poses risk to the reproductive health of adolescents because they are physically immature and are at risk for unwanted pregnancy (Biddlecom et al., 2007; Bearinger et al., 2007). Thus SRH is vital in addressing the STIs, unplanned teenage pregnancies and abortions being experienced by young people around the world (Kirby, Laris, and Rolleri, 2007). According to Shaw (2009), SRH also assists in reducing maternal and child mortality, reduces poverty and empowers women. Previous literature has demonstrated that students who have received school-based sexuality education interventions have greater knowledge of HIV, skills to refuse sex, condom use, had fewer sexual partners and less initiation of first sex during follow-up interviews (Fonner, Armstrong, Kennedy, O'Reilly, and Sweat, 2014).

Evidence from international studies conducted in the United Kingdom (UK) and United States (US) have shown that SHNs are in the most suitable candidates to promote student sexual health services in school settings (Farrag and Hayter, 2014; Westwood and Mullan, 2006). These findings mirror those found by Haglund (2006). Thompson, Casson, Fleming, Dobbs, Parahoo, and Armstrong (2008) state that SHNs are the first contact adolescents have with the health care system and this contact offers the opportunity to promote sexual health issues in conjunction with other problems. Hayter, Piercy, Massey, and Gregory (2008) assert that, sexual health is therefore seen as an integral aspect of the health promotion role of the SHNs. It is for this reason that SHNs should be equipped with skills that ultimately aim at improving the access to information and the resources to mitigate the negative consequences of early, unprotected, or forced sexual intercourse in adolescents (Jackson, 2011).

Lindberg and Maddow-Zimet (2012) report that sex education about abstinence and birth control is associated with healthier sexual behaviours and outcomes as compared with no instruction on the subjects. Evidence reveals that informed adolescents are able to make healthy decisions and have knowledge of where to seek assistance if there is a need for it (Fonner et al., 2014). Panday et al. (2009) report that the attitudes displayed by health care workers towards adolescents' sexuality, promotes unacceptability of the services that are available thus preferring not to use contraceptives and only attend antenatal clinics at a very late stage. Knowledge about access to and the importance of using emergency contraceptives can assist in avoiding many adolescents' unintended pregnancies.

Javadnoori, Zangeneh, Tadayon, and Akhoond (2016) in their study determining the competence of healthcare workers in sexual health education for female adolescents at schools, found that they have poor performance in teaching sexual health to female adolescents as well as teaching students the required skills. A survey conducted in the UK by Westwood and Mullan (2006), found that SHNs lack appropriate knowledge to teach successfully about STIs or emergency contraception.

A study conducted in Turkey, exploring nurses' approaches to sexuality among adolescents reveal that lack of skills, education and training was the reasons for not providing appropriate sexual health to adolescents (Rana et al., 2007). Similarly a research study on undergraduate child health nurses reveal that they received limited and inconsistent education in their undergraduate programme. Which according to Johnston (2009) the perceived lack of education equates to the student nurses not having sufficient knowledge to enable them to feel comfortable and confident in discussing sexual health matters with youth. This might be different in SA, where all nurses go through some form of reproductive health training, however, there might be insufficient content on school nursing and reproductive health specifically for young people.

An Egyptian study exploring SHNs' attitudes and experiences toward sexuality and relationship education reveals that participants are concerned about their lack of skills and knowledge in the area of sexuality education, and that they are more willing to provide sexuality education to girls than talking to boys about sex (Farrag and Hayter, 2014). Hordern and Street (2007) in their study reveal that nurses viewed discussion of intimate topics with non-western clients as inappropriate and often not done. These findings shows that SHNs still regard sexuality education as a challenging and contentious topic (Farrag and Hayter, 2014).

1.2 Problem statement

Adolescents' sexuality education is a contentious area of health practice in every culture and society, as people fear that SRH promotion in schools can encourage sexual activity in adolescents. In developing countries there is a rapid growth in school attendance and attainment rates, with a subsequent rise in the proportion of young people who are sexually mature while still at school.

Adolescents have a growing interest in sexuality and sexual information is readily accessible via mass media and the internet. This information delivers a great many

messages about sexuality, relationships and developing a mature identity, however these messages are often damaging to adolescents. This can contribute towards a situation in which adolescents fail to resist the pressure of engaging in premature sexual intercourse without protection and having multiple sexual partners. This predisposes adolescent to STIs, HIV transmission, pregnancy and abortions, which undermine their present and future health and wellbeing, the health of their children and their nations' social and economic prospects (Sawyer et al., 2012).

It has been discovered that adolescents lacks the information and skills needed to protect themselves against HIV, unintended pregnancy and unwanted sex. However, adolescents needs accurate and comprehensive sexuality education so as to practice healthy sexual behaviour. Comprehensive sexuality education results in postponing sexual debut to the sexually inexperienced, promoting consistent condom use and reducing the number of concurrent sexual partners for those that are sexually active.

Literature review demonstrates that informed young people worldwide engage more in protective behaviour than uninformed young people. There is therefore a fundamental need to provide the nation's adolescents with SRH education, evidenced by South Africa's position of having the highest rate of adolescent pregnancy, sexually transmitted infections and HIV/AIDS. In sub-Saharan Africa, about 14 million unintended pregnancies occur every year, of which half occur among women who are aged between 15-24 years and who were predominantly still at school. In South Africa a national survey of HIV prevalence and sexual behaviour in the age group of 15–24 year olds confirms a high HIV prevalence among this age group, with women at greater risk (Pettifor et al., 2005). A study conducted in South African townships post-apartheid reveals that premature sexual intercourse resulted in the increase of the rates of STIs, HIV transmission, adolescent pregnancy and abortions (Mkhwanazi, 2006). This is supported by the findings by Morake (2011) which shows that schoolgirl pregnancies have doubled in the past year, despite promotion of sexuality education and HIV and AIDS awareness.

Literature has identified SHNs as the key contributors to sexual health education in schools, due to their access to the school-age population. The SHNs play a role in adolescents' development by assisting them to maintain good health as they develop into adults. Thompson et al. (2008) assert that SHNs are the first contact that

adolescents have with the health care system and this provides them with the opportunity to promote sexual health issues, together with other health problems which predisposes adolescents to high morbidity and mortality.

In South Africa, little research has been done in this regard even though SRH promotion has been integrated into the school health programme, and there is no evidence of any studies focusing on SHNs' understanding and experiences of the implementation of the SRH programme in the South African setting. Despite the introduction of the various policies and programmes since 1999, South Africa still has a high incidence of adolescents with STIs and unintended pregnancies, so besides SHNs needing to have an understanding of sexuality and that it is not just about sexual intercourse, it is also important that they understand their role in implementing the SRH programme for adolescents.

1.3 Research purpose

The purpose of this study was to explore and describe school health nurses' understanding and experiences of the implementation of adolescent sexual and reproductive health programme in a selected health district in KwaZulu Natal.

1.4 Research objectives

- 1.4.1 To explore the school health nurses' understanding of adolescents' sexual and reproductive health programme.
- 1.4.2 To describe the school health nurses' experiences of adolescent sexual and reproductive health programme.

1.5 Research questions

- 1.5.1 What are the school health nurses' understanding of adolescent sexual and reproductive health programme?
- 1.5.2 What are the school health nurses' experiences of the adolescent sexual and reproductive health programme?

1.6 Significance of the study

Adolescence is a period of increase in risk taking behaviour and a growing interest in sex. Adolescents who lacks sexuality skills and access to sexuality information and health services are at significant risk for unwanted pregnancies and STIs. In terms of the

Integrated School Health Policy, SHNs are mandated to provide SRH to learners (NDOH and NDBE, 2012). Literature reveals that SRH education that is given to very young adolescents before they are sexually active provides positive results. Learners who have received school-based sexual education are knowledgeable in terms of protecting themselves against HIV, are able to refuse sex, use condoms and postpone their sexual debut.

The Department of Health, together with the Department of Education embarks on a strategy to ensure that SRH is offered in all schools in South Africa. Studies relating to sexuality education in KZN have mainly focused on learners as the recipients of the service and educators as disseminators of sexuality education. No studies has focused on SHN as implementers of the SRH programme.

It is hoped that the findings of this study will inform the implementation of school health programme in general, but specially on the issues relating to adolescent' SRH programmes. The research findings will hopefully also contribute to other areas as follows:

Nursing education

It is hoped that the findings of the study can be used by nursing education institutions as part of community health nursing curriculum to enhance the school health nursing component of the curriculum.

Health policy

The research findings might also contribute to the improvement of the re-engineering of the PHC policy, specifically with regards to school nursing and adolescents' sexuality and reproductive health.

Research

The research findings might also contribute to the body of evidence and may trigger the need for further studies in this regard.

1.7 Operational definitions

School health nurse according to the Royal College of Nursing (RCN), is a qualified nurse with a public health specialisation and registered with the Nursing and Midwifery Council. The school health nurse works thru educational and health sector, providing a

link between school, home and the community to benefit the health and wellbeing of children and young people (RCN, 2012). In this study the school health nurse will mean any registered nurse working with adolescents in the school setting. The term SHN will be used interchangeably with school nurse or school-based youth health nurse.

Understanding according to Stevenson (2010) is an individuals' perception or judgement of a situation. A person may have a good ability to predict the behaviour of an object, or system or situation and therefore may have developed their own understanding of such concepts which may be equivalent, better or worse than the recognized standard of such concepts and theories. In this study, the understanding will mean having knowledge and comprehension of adolescent sexual and reproductive health.

An experiences is defined as narratives of an encounter, or a series of encounter: something which had been participated in or lived through (Cohen, Manion, and Morrison, 2011). In this study an experiences will mean personal encounters, knowledge, skill, or practical wisdom accumulated as a result of direct participation in the adolescent sexual and reproductive health programme. Experiences will covers both the rewards and challenges encountered in the process of implementing the SRH programme.

Adolescent is a period in human growth and development that occurs from ages 10 to 19 (WHO, 2006). Adolescent in this study will therefore mean a child between the ages of 10 to 19 years, and is attending school.

Sexual and reproductive health programme in this study will refer to any school-based health programme that offers health promotion and disease prevention services to school going adolescents by a healthcare provider, in this case a school health nurse. The programmes an comprise of all or some of the following services: abstinence messages; health rights that would include issues such as, teenage pregnancy; abortion; STI and HIV/AIDS programme; sexual decision making; birth control or contraceptive services; preventing STIs; relationships and dating; puberty changes and SRH services (Evans, 2013; Kohler, Manhart, and Lafferty, 2008).

Health promotion is a process that enables individuals and communities to take action for their health, fostering leadership for public health, promoting intersectoral action to build healthy public policies in all sectors and creating sustainable health systems

(Kumar and Preetha, 2012). In this study health promotion will be defined as the development of all aspects of well-being and quality of life. The term is used interchangeably with the term 'health education'.

1.8 Format of this dissertation

Chapter 1: This is an introductory chapter that introduces the whole research study. It provides background information to the study, the problem statement, research objectives and research questions, the significance of the study and operational definitions.

Chapter 2: This chapter deals with reviewed literature and sections are organised by topic or themes and sub-themes that emerged from the reviewed literature. These include the conceptualisation of school health nursing, the settings approach to health promotion, sexual and reproductive health programmes, the role of school health nurses, the experience of SHNs with regard to adolescents SRH programme and the conceptual framework.

Chapter 3: This chapter outlines the research methodology used in this study; the study design and approach; the research paradigm; the study location and context; population; sampling technique and sample size; the data collection process and instrument; the pilot study; data analysis; trustworthiness of the qualitative data; ethical considerations; data management and dissemination.

Chapter 4: This chapter presents the research findings of this study. This will be done in accordance with the themes that emerged during the analysis of data. It will also describe the factors that facilitate or hinder the implementation of SRH to adolescents.

Chapter 5: This chapter covers the discussion of findings in relation to existing literature or previous studies; the conclusion to the study; recommendations and finally limitations, including research methodology limitations and study limitations.

1.9 Chapter summary

This chapter presents the background to the adolescents' sexual and reproductive health programme implemented by SHNs. The chapter highlights the areas of focus, as well as the purpose for the study. It also gives the rationale for the study and provides a

background review indicating the need for the study as well as the overview of the research methodology. This chapter also provides the overview of the whole study. Chapter two will provide a review of literature relating to this problem.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

A literature review was done to generate the understanding of what was known about a particular phenomenon or situation and to identify the knowledge gaps that existed. This served to clarify which problems had been investigated, which require further investigation or replication and which had not been investigated, while at the same time it facilitated in designing the study and interpreting the outcomes (Burns and Grove, 2009). Polit and Beck (2008) acknowledged that it provided a foundation and the context in which to base new evidence, and the review was conducted before data collection. A literature review relates to what had been discovered about a particular topic and offered an understanding of the conclusions that had been reached by researchers and scholars in prior studies and discussions about the topic (Creswell, 2009).

Databases used in searching for literature included the Cumulative Index To Nursing and Allied Health Literature (CINAHL), the Academic Search Premier, the Educational Resource Information Center (ERIC) and EBSCO. Search terms used were school nurses, sexuality education, and knowledge of sexual health, attitude towards sexual health, health promotion, health education and school nursing.

Little was known about the SHNs' understanding and experiences of adolescents' sexual and reproductive health programme and consequently, for this study the researcher could not use the conceptual framework to look at data without preconceived ideas or influence. According to Brink, van Rensburg, and van der Walt (2012), qualitative research may not use the theoretical or conceptual framework to explain the problem. The literature review in this study was based on the conceptualisation of school health nursing, the settings approach to health promotion, the SRH programme, and the role of SHNs and the experience of SHNs with regards to sexuality.

2.2 Conceptualisation of school health nursing

According to the National Association of School Nurses (NASN), school health nursing was “a specialised practice of professional nursing that advances the well-being, academic success, and lifelong achievement of students. To that end, SHNs facilitated positive student responses to normal development; promoted health and safety; intervened with actual and potential health problems; provided case management

services; and actively collaborated with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning” (NASN, 2010).

The school nursing service was described by Lee (2011) as a vital component of the services required for the health and safety of school children while at school. The SHN was a registered professional nurse working in school setting who had a commitment to lifelong learning (NASN, 2010). A SHN could also be described as a professional nurse working in the educational setting.

The NASN had determined that the minimum qualifications for the professional SHNs should include licensure as a registered nurse and a baccalaureate degree from an accredited college or university. The SHN should continue to pursue professional development and continuing nursing education (NASN, 2010). The National Association of School Nurses further recommended that the ratio of school nurses to students should be 1:750 for well learners; 1:225 for learners that require daily professional school nursing services or interventions; 1:125 for learners with complex health care needs and the ratio should be 1:1 for students with multiple disabilities (NASN, 2011).

The NASN and the American Nurses Association (ANA) guide for school health nurses was based on the ANA’s Nursing Scope and Standards of Practice for all registered nurses (ANA, 2010). In SA the scope of practice of the school health nurse was based on the scope of practice of the professional nurse, as stated by the South African Nursing Council (SANC) in terms of Section 30 in respect of that practitioner in the Nursing Act, 2005 (SANC, 2005). It was also based on the Primary Health Care Package for South Africa which stipulated a set of norms and standards that dealt with staff competency.

School nursing in United Kingdom (UK)

School nursing in the UK, as stated by the Royal College of Nursing (RCN), had been described as the occupational health service for school-aged children and young people (RCN, 2012). In the UK, the school nurse was a qualified nurse with a public health specialisation. These nurses were registered with the Nursing and Midwifery Council. The school nurse worked across education and health, providing a link between school, home and the community to benefit the health and wellbeing of children and young people. The school nurse functioned as both health promoter and health educator, and

worked in collaboration with teachers, youth workers and counsellors. In some parts of the UK, they used the titles 'school nurse' and 'specialist community public health nurse'. In Scotland the titles 'public health nurse' and 'school health advisor' were used.

School nursing in Canada and Australia

According to Seigart, Dietsch, and Parent (2013), school nursing in Canada and Australia was similar and varies only by regional area. Not all schools had a full-time school nurses and as a result, many learners lacked access to on site comprehensive health services. The role of school nurses was also not clear (Seigart et al., 2013; Moses, Keneally, Bibby, Chiang, Robards, and Bennett, 2008). In these two countries community health nurses often functioned as school nurses, so the ratio of students to nurses was high. For example in Ontario and Quebec, a ratio of 1 nurse: 3000 students was not unusual (Seigart et al., 2013).

In Canada and Australia school nurses, according to Seigart et al. (2013), functioned as surveillance professionals, educators and counsellors. Their work was to promote school health and assist teachers, students and families with referrals and health education. In Ontario and Quebec school nursing was done sporadically, with nurses providing with vaccinations, infection control, intermittent sexuality education classes, teaching staff on how to deal with allergies and medication administration. Notably, Seigart et al. (2013) added that school nurses could dispense contraceptives in Quebec.

School nursing in the United States (US)

School nursing in the US was provided by a professional school nurse, who were registered nurse with a baccalaureate degree from any accredited college or university. The school nurse should also have a licensure to practice as such. Schools in the US either had a full time school nurse or share one with one or two other schools. According to Seigart et al. (2013) school nurses in the US differ from those in Canada and Australia, in that they provided hands on care, as well as health education and promotion, staff education and referrals. The nurse to student ratio varies from 1:700 to 1:1500.

School nursing in Massachusetts

In Massachusetts in the US, school nursing was regulated by the state laws in terms of the number of school nurses and their practice. In public schools physicians and registered nurses were appointed by a school committee (Brewin, Koren, Morgan,

Shipley, and Hardy, 2014). Schools with an enrolment of 250 to 500 learners were allocated one full-time nurse; while those with more than 500 learners, the number increased by 0.1 for each additional 50 learners, and where the enrolment was below 250 learners, the staffing was calculated as 0.1 nurses for every 25 learners (Brewin et al., 2014).

School nurses were licensed by the Board of Registration in Nursing (BORN) and the Massachusetts Department of Elementary and Secondary Education (DESE) awards certification/licensure (Brewin et al., 2014). According to Brewin et al. (2014) for the school nurses to get a license they had to obtain a bachelor's degree, 2 years of work experience in a related field, and had completed an orientation on delivering of school health care services.

The school nurses' role included maintaining immunisation, keeping of health records, administering prescribed medications, carrying out routine health screenings to collaborate with teachers, students, parents, administrators and school committees, and being involved in programme planning (Brewin et al., 2014).

School nursing in New Zealand

In New Zealand there was a variation of the school health services. According to Buckley, Gerring, Cumming, Mason, McDonald, and Churchward (2012) school health services were provided by public health nurses who were employed by the District Health Boards (DHBs) or Primary Health Organisations (PHOs). Here, the school nurses did not have a defined role with scopes of practice and minimum qualification requirements, nor was school nursing a specialty practice (Buckley et al., 2012). School nurses were registered nurses with a minimum of a three year bachelor degree, who had fulfilled the necessary registration requirements, while some schools employed enrolled nurses who had completed an 18 month training course as well as the enrolled nurses' exam. According to Kool, Thomas, Moore, Anderson, Bennetts, Earp et al. (2008) in New Zealand there were no specific postgraduate school nursing qualifications, professional colleges or a national association of school nurses, and there were also no national policies or guidelines to guide practice.

School nursing in South Korea

In South Korea there had not been any systematic school health education provided to school children (Lee and Ham, 2013). About 63 per cent of primary and secondary

schools had school nurses as health teachers, while about 37 per cent did not, according to Lee, Higuchi, Ham, Yoo, and Lee (2007). The title of school nurses, according to the Primary and Secondary School Education Act in 2002, was changed to that of health teachers, and according to the School Health Law in Korea, all the health teachers in primary and secondary schools should be registered nurses who completed teacher training courses in undergraduate or diploma programmes (Lee and Ham, 2013). The nurse-to-student ratio in Korean schools was low, as the school health ordinances mandated that primary and secondary schools should have one health teacher regardless of the school size or the number of students (Lee and Ham, 2013).

School nursing in Egypt

School nursing in Egypt was an evolving discipline. According to Farrag and Hayter (2014) school nursing incorporated nurses with either paediatric or community nursing backgrounds. The nurses' role encompassed health screening, vaccination and first aid, as well as sexuality education.

School nursing in Nigeria

School health services in Nigeria were provided by school health nurses, physicians, dentists, teachers and other appropriate personnel. Their role was to appraise, protect and promote the health of the school community. School health services provided preventative and curative services to learners and staff within the school setting (UNICEF, 2006).

School nursing in South Africa

School health nursing in South Africa was provided by professional nurses from the PHC staff constituency. The SHN was a professional nurse registered with the SANC. The minimum qualification of a SHN was a Diploma in General nursing, with or without a Diploma in Community Health nursing from an accredited college of nursing. The school health nurses that worked in the public schools were employed by the provincial or municipal Department of Health, while those working in private schools were privately employed by the school. The SHN worked with the school community to benefit the health of the learners and the staff. The recommended norm for individual learner assessments was one registered nurse for every 2000 learners, to be assessed every year (NDOH and NDBE, 2012).

Different terms were used in different countries for similar roles, as demonstrated below in Table 3.

Table 3. Terms used for SHNs in different countries

Term	Country
School nurse	America, Canada, New Zealand, Massachusetts, Taiwan, Hong Kong, Egypt
School health advisor, Public health nurse	Scotland
School health nurse	South Africa, Nigeria, Sweden
School-based youth health nurses	Australia
Specialist community public health nurse, School nurse	UK
Health teacher	Korea

2.3 Settings approach to health promotion

The Ottawa Charter, according to Whitehead (2006) led to the development of a series of ‘settings-based’ health promotion strategies. A settings approach to health promotion was orientated to practices that were organised in relation to the environment in which people lived, worked, and played (Poland, Krupa, and McCall, 2009). Settings-based health promotion offered practical opportunities for the implementation of comprehensive strategies.

Hayter et al. (2008) proclaimed that schools were important social spaces in which sexuality and sexual behaviour converge with particular clarity, while Pearson, Chilton, Woods, Wyatt, Ford, Abraham et al. (2012) argued that schools were the key sites for the implementation of health promotion programmes due to their potential for reaching the whole population in particular age-groups, to instil healthy patterns of behaviour early in life. du Plessis, Koornhof, Daniels, Sowden, and Adams (2014) expanded further, stating that school children constituted a large population and schools were accessible over prolonged periods of time. Health promotion programmes for schools were intended to supplement the regular curriculum (Peters, Kok, Ten Dam, Buijs, and Paulussen, 2009).

The school as a setting for health promotion had adopted the concept of health promoting schools (HPS). The concept of HPS was based on the Ottawa Charter for

health promotion in 1986 (Whitehead, 2006). According to du Plessis et al. (2014) the HPS is part of the Global School Health Initiative which was launched by the WHO in 1995. A HPS is described as a place where all members of the school community worked together to provide pupils with integrated and positive experiences and structures, which promoted and protected their health (du Plessis et al., 2014). The KZN Department of Health defined an HPS as a place where members of the school community worked, learnt, lived and played to promote the health and well-being of learners, staff, parents and the wider community (KZNDOH., 2001). The HPS initiative could be achieved through: Provision of formal and informal curricula in health creation of a safe and healthy school environment; the provision of appropriate health services; and the involvement of the family and wider community in efforts to promote health (du Plessis et al., 2014).

According to Whitehead (2006) SHNs should view the health-promoting school movement as an opportunity to embrace broad-based health promotion concepts. Health promoting schools serve to address the multiple and varied factors influencing health (Fritsch and Heckert, 2007). According to the Global School Health Initiative, a health promoting school:

- Fostered health and learning with all the measures at its disposal;
- Engaged teachers, teacher unions, students, parents, health providers and community leaders in efforts to make the school a healthy place;
- Strived to provide a healthy environment, school health education and school health services, along with school/community projects and outreach programmes, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion;
- Implemented policies and practices that respected an individual's well-being and dignity, provided multiple opportunities for success, and acknowledged good efforts and intentions as well as personal achievements;
- Strived to improve the health of school personnel, families and community members as well as pupils; and worked with community leaders to assist them understand how the community contributes to, or undermines, health and education.

Health promoting schools focused on:

- Caring for oneself and others;
- Making healthy decisions and taking control over life's circumstances;
- Creating conditions that are conducive to health through policies, services and physical / social conditions;
- Building capacities for peace, shelter, education, food, income, a stable ecosystem, equity, social justice and sustainable development;
- Preventing leading causes of death, disease and disability: Helminths, tobacco use, HIV/AIDS/STDs, sedentary lifestyle, drugs and alcohol, violence and injuries, and unhealthy nutrition;
- Influencing health-related behaviours: Knowledge, beliefs, skills, attitudes, values, and support.

2.4 Sexual and reproductive health programmes

School as a setting offered an important access point for interventions on SRH. Most learners who were registered in schools were not sexually active while for others, schooling was associated with the commencement of sex. Adolescents in the school setting were in a better position to delay the initiation of sex and to ensure adequate protection when sexually active (Kirby, Obasi, and Laris, 2006).

School health programmes delivered through health promoting schools were an essential means of achieving 'health for all by the year 2020' and 'education for all', according to the goals set out by the WHO (du Plessis et al., 2014). School health programmes which focused on SRH during high school contributed to the reduction of HIV and AIDS, as well as the reduction in maternal mortality by reducing teenage pregnancy rates (Sawyer et al., 2012; Fritsch and Heckert, 2007). Sexuality education programmes could support young people to delay sexual activity and improve their contraceptive use when they begin to have sex (Boonstra, 2011).

According to Walcott, Meyers, and Landau (2008) SRH intervention programmes should be dependent on the needs and characteristics of the participants. They further posited that STI/HIV prevention programmes were required to consider the developmental and gender issues, as well as cultural norms and values in order for them to be effective. Evidence based sexual health programmes reduced adolescent sexual risk behaviour and promoted sexual health by building life skills for interpersonal communication and decision making (Bearinger et al., 2007).

School-Based sexuality education

Shrestha, Otsuka, Poudel, Yasuoka, Lamichhane, and Jimba (2013) attested that School-Based sexuality education was an effective intervention for reaching many adolescents with fundamental health information and life skills that could prevent unintended pregnancies and sexually transmitted infections (STIs) including HIV/AIDS.

Formal School-Based sexuality education programmes which aim at reducing the risks of teenage pregnancy and STIs were generally promoted through: (1) abstinence-only messages, or (2) comprehensive sexuality education messages (Kohler et al., 2008). Abstinence-only messages taught the importance of delaying sex until marriage while emphasising the ineffectiveness of birth control methods. Comprehensive programmes included abstinence messages as well as information on birth control methods to prevent pregnancy and condoms to prevent STDs (Kohler et al., 2008).

A study by Ezeama, Ezeamah, and Enwereji (2016) entitled 'HIV And AIDS Risk Reduction Intervention Programmes Among In-school Adolescents In Imo State, Nigeria'. The results showed more effective risk reduction practices among the intervention groups than control group. These findings were consistent with subsequent literature (Shrestha et al., 2013; Sulak, Herbelin, Fix, and Kuehl, 2006); where study results showed that students who received more information on HIV and sexual health via their schools had positive attitudes toward abstinence and greater intentions for safer sex. Receipt of sexuality education leads to significant improvement in sexuality knowledge, resulting in a positive attitude change towards risk reduction, delayed onset of sexual activity, a decreased number of sexual partners and an increase in condom usage.

A systematic review done by Kirby et al. (2006) of 22 interventions performed in the school setting also reported positive outcomes in postponing sexual activity, reducing sexual partners, reducing the frequency of sex and increasing condom and contraceptive use. The programme had an effect on knowledge, while there was no improvement of skills, changing values, attitudes and peer norms noted (Kirby et al., 2006).

Kirby (2008) reviewed 56 studies that assessed the effect of abstinence and comprehensive sexuality and STI/HIV education programmes on adolescents' sexual behaviour. The findings revealed that most abstinence-only programmes did not delay initiation of sex while the comprehensive programs showed a strong evidence of change

in young people's sexual behaviour, including both delaying initiation of sex and increasing condom and contraceptive use. These findings were contradictory to those of Inyang and Inyang (2013) where abstinence-centered education for very young adolescents reduced sexual initiation, the number of sexual partners, and that it did not deter the use of condoms.

Life skills programmes

Life skills programmes were introduced in South African schools in response to the explosion of the HIV epidemic in the 1990s. Life skills programme was thought to have a potential to influence to the trajectory of teenage pregnancy. The aim was to increase learners' knowledge of HIV, improve their skills for engaging in healthy relationships by improving their communication and decision-making abilities, and to shift attitudes about people living with HIV and AIDS (Panday et al., 2009).

A study conducted in KwaZulu-Natal by James, Reddy, Ruiter, McCauley, and van den Borne (2006) confirmed an increase in the learners' knowledge about HIV and the positive effects on their awareness of sexual behaviour, social connectedness, levels of sexual activity and condom use.

Peer programmes

Peer programmes entice and train a group of adolescents. These adolescents became role models and sources of information and skills developer on adolescent sex. Panday et al. (2009) confirmed the peers as significant determinants in adolescent sexuality and a range of adolescent risk behaviours. Peer counsellors who were two to four years older than programme participants had been shown by Shin and Rew (2010) to be effective in transmitting information and counselling younger adolescents on safe sex. Peer education provided the opportunity for repeat contact and was effective in reaching marginalised or vulnerable young people (Chandra-Mouli, Lane, and Wong, 2015).

Previous literature on five meta-analyses of peer education programs that were implemented in different contexts over many years concluded that peer education programmes were more beneficial for the peer educators than for their intended beneficiaries (Chandra-Mouli et al., 2015). These programmes did, however, result in information sharing and had a limited effect in promoting healthy behaviours and improving health outcomes in the target groups.

Youth friendly services

According to the International Planned Parenthood Federation (IPPF) (2007) youth friendly health services were health services that attract young people, reacts to their needs and retain young clients for continuing care. Love Life in SA had been influential in introducing and disseminating the concept of youth friendly clinics, through the National Adolescent-Friendly Clinic Initiative (NAFCI) (Panday et al., 2009).

According to Panday et al. (2009) the NAFCI was a shared project between Love Life, the Reproductive Health Research Unit and the Department of Health. The goals of the programme were to advance the accessibility and acceptability of public health services by adolescents and to build the capacity of health workers to provide quality care to young people (Panday et al., 2009).

2.5 The role of school health nurses

The role of the school nurse had been studied in Western countries (Piercy and Hayter, 2008; Hayter et al., 2008), and in Asian countries (Lee, 2011). According to Lee (2011) the role of the school nurse encompassed both the health and educational goals. The role of the school nurse was focused on a primary health care model. It incorporated immunisation; keeping of health records; administering prescribed medications and carrying out routine health screenings; collaborating with teachers, students, parents, administrators and school committees; and programme planning.

Brooks, Kendall, Bunn, Bindler, and Bruya (2007) posit that the SHN is concerned with children's well-being that goes across the home, the school and the wider community of the child, as well as connecting with the multi-sectoral services for young people. SHNs facilitated positive student responses to normal development; promoted health and safety, including a healthy environment; intervene with actual and potential health problems; provided case management services; and actively collaborated with others to build student and family capacity for adaptation, self-management, self-advocacy and learning (NASN, 2011).

SHNs were also responsible for addressing the needs of children over most years of childhood, providing an opportunity to develop an in-depth knowledge of individual and family needs over time (Brooks et al., 2007). Additionally, SHNs had expertise to provide comprehensive responses to complex health needs, as they combined clinical knowledge relating to the school-age population with an understanding of the

connection between the social determinants of health and the delivery of effective health promotion (Brooks et al., 2007).

A study conducted by Lee (2011) in Hong Kong revealed diverse roles of SHNs. These roles included those of health providers, promoters, counsellors, referrers, leaders, collaborators, administrators and housekeepers. Health education was an important role for nurses in all settings. This might take the form of a one-on-one teaching, which focuses on the specific information needed by an individual at a particular time. Health education could be customised to an individual's situation and their level of understanding.

SHNs function as health educators that promoted students' health needs. The SHNs, according to Lee (2011) provided health education to improve school personnel's knowledge and skills in the management of students' healthcare needs. (Lee, 2011) further stated that the health education and promotion role of school nurses included sexuality education and the prevention of infectious diseases. Sexuality and HIV/STD education programmes that were implemented among groups of learners in school, clinic, or community settings reduced adolescent sexual risk behaviours (Kirby, Laris, and Roller, 2007). Sexual health care was part of the high-quality holistic care that professional nurses should offer to clients, regardless of whether the setting was a hospital, family, school or community (RCN, 2013).

SHNs provided information, advice and preventive health services (Ashton, Dickson, and Pleaner, 2009). According to Jackson (2011) SHNs could improve access to information and resources to mitigate the negative consequences of early, unprotected, or forced sexual intercourse through open communication with adolescents. School nurses played a critical role in assisting adolescents in making informed decisions and also by referring them to the relevant resources (Will, 2008).

Westwood and Mullan (2006) asserted that in the UK the school nurses were the key contributors to sexual health education, due to their access to the school-age population, an assertion which is echoed by Brewin et al. (2014) and Farrag and Hayter (2014). According to Ashton et al. (2009) school health nurses played an important role in the health and development of adolescents by assisting them to maintain good health as they develop into adults.

In a study conducted by Brewin et al. (2014) titled ‘Behind the closed doors: School nurses and sexual education’, the results showed that school nurses provided sexual health education through informal sessions. Sexuality education for school children was a socially, politically and emotionally sensitive area of health practice in every culture and society (Hayter et al., 2008). SHNs thus had a key role in the promotion of sexual health (Farrag and Hayter, 2014; Brewin et al., 2014).

Sexual health promotion involved activities that promote positive sexual health, reduced the incidence of STIs including HIV, reduced unintended pregnancies including teenage pregnancy, promoted sexuality and relationship education, brought about change in prejudice, stigma and discrimination, and general awareness-raising work (Thompson et al., 2008; Kirby et al., 2007).

The roles of school health teachers in Korea included school health planning, health screening, disease prevention, management of health problems, health education, environmental sanitation, as well as being in charge of health clinics (Lee and Ham, 2013). A study in the UK, showed that school nurses are involved in health education in a supportive, advisory or signposting role or through directly delivering education (Hoekstra, Young, Eley, Hawking, and McNulty, 2016). According to Hoekstra et al. (2016) the health education school nurses delivered was determined by local priorities and capacity of the school nurse team.

2.6 Experience of school nurses towards sexuality

SHNs had a variety of experience when dealing with adolescents’ SRH. Some SHNs encountered challenges when providing SRH to learners. Sometimes they came across barriers that prevent them from implementing the SRH programme effectively, but at the same time some were motivated to continue providing the SRH programme to the learners. These are the mixture of experiences that the SHNs encounter.

2.6.1 Motivators

A study on nurses’ approaches towards the sexuality of adolescent patients in Turkey found that nurse-midwives with more education and those who had received continuing education on adolescent sexuality and reproduction showed a tendency towards more youth friendly attitudes (Rana et al., 2007). This was supported by Brewin et al. (2014) where SHNs testified that continuing nurse education enabled them to reach out to students even when confronting barriers. Similar results were found in studies of the

attitudes of health professionals to adolescent SRH problems concerning the provision of services in Kenya, Zambia (Warenius, Faxelid, Chishimba, Musandu, Ong'any, and Nissen, 2006), Swaziland (Mngadi, Faxelid, Zwane, Höjer, and Ransjo-Arvidson, 2008), and Uganda (Kipp, Chacko, Laing, and Kabagambe, 2007).

The ability of SHNs to comfortably deal with sensitive topics to assist students in sexual health issues was seen as an encouraging factor to students who were hesitant to ask for assistance, according to (Brewin et al., 2014). Establishing a trusting relationship with adolescent clients was essential to initiating and maintaining communication, and ensuring privacy by providing sexuality education 'behind closed doors' encouraged students to share their concerns (Brewin et al., 2014).

2.6.2 Barriers

A study conducted in Massachusetts by Brewin et al. (2014) on SHNs and sexual education found that SHNs lacked appropriate preparation to effectively teach about STIs or emergency contraception. According to Brewin et al. (2014) SHNs stated that students needed more sexual health information than they had to offer. Other barriers included a lack of comfort and confidence in addressing sexuality and failure to make time to discuss patient sexuality concerns (Magnan and Reynolds, 2006). (East and Hutchinson, 2013) in their study, revealed that SHNs lacked confidence and were aware of their need for continued education on teaching sexual health and reproductive health.

Klein, Sendall, Fleming, Lidstone, and Domocol (2013) in their study titled 'school nurses and health education: the classroom experience', revealed that SHNs lacked support from school management and felt that this restricted their ability to deliver health education in the classroom. Similar findings were noted by Brewin et al. (2014) where the SHNs in that study also lacked support from the schools' administration departments, committees and boards. This was further confirmed by the findings of Hayter et al. (2008) where SHNs reported concerns about school administrators conducting surveillance by being present during an education session in the classroom.

A qualitative study that explored key informant (KI) perceptions of the barriers to effective sexual health promotion programme in Australia was conducted by (Newton, Keogh, Temple-Smith, Fairley, Chen, Bayly et al., 2013). Barriers identified were: - Difficulties associated with programme evaluation; lack of involvement of the target community; the short-term nature of programme; problems with programme resources

and concerns about the content of the programme; a lack of cultural sensitivity; a failure to acknowledge differences in literacy, knowledge, and language skills; stigma and shame associated with sexual health; and continued use of programme that lacked inclusivity.

A study conducted in Ghana on the attitudes of gatekeepers towards adolescent sexual and reproductive health highlighted challenges which included resistance from parents, negative attitudes of the adolescents, a communication gap between adults and adolescents and poor attitudes of health care providers towards providing SRH (Kumi-Kyereme, Awusabo-Asare, and Darteh, 2014).

2.7 Conceptual framework

Little was known about the SHNs' understanding and experiences of adolescents' SRH programme, and as a result the researcher could not use the conceptual framework in order to look at data without preconceived ideas or influence for this study. According to (Brink et al., 2012) qualitative research may not use the theoretical or conceptual framework to explain the problem. The goal of qualitative research was the understanding of the intricate world of human experience and behaviour from the point of view of those involved in the situation of interest (Nieuwenhuis, 2007). It was therefore expected that the investigator will have no prior, well-delineated conceptualisation of the phenomenon rather, this conceptualisation is to emerge from the interaction between the participants and the investigator.

2.8 Conclusion

This chapter has examined some of the available literature on SHNs' understanding and experiences of the adolescents' SRH programme. This chapter focused on the health promotion aspect where sexuality education was embedded, and the motivators and barriers to the promotion of adolescents' SRH. The next chapter looked at the methodology and the research design for this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Methodology according to Holloway and Wheeler (2010) is the framework of theories and principles from which a research design and method are based. Corbin and Strauss (2008) in their book, stated that research methodology was a way of thinking about and studying social phenomena, while Polit and Beck (2008) described it as the technique used to structure a study and to gather and analyse information in a systematic fashion.

This research aimed to explore the selected SHNs' understanding and experiences of the implementation of the adolescent SRH programme in a selected health districts in KwaZulu Natal, as little was known about this in the South African context. This chapter described the methodology adopted to meet the study objectives.

3.2 Research design

The research design served as the blueprint of how the study was conducted. The research design influenced the type of population, the sampling procedure, method of measurement and the plan for data analysis (Burns and Grove, 2009). To be able to extract the richness of the human experiences of this group, the study utilised an exploratory contextual descriptive design.

According to Burns and Grove (2009) exploratory research was conducted in order to gain new insight, discover new ideas and to increase knowledge of a phenomenon. It was for this reason that the researcher chose this method. The exploratory research method assumed that the phenomenon can be explored through the experiences described by individuals (Burns and Grove, 2009). The researcher therefore entered the research field with curiosity from the point of not knowing (Burns and Grove, 2009; Creswell, 2009).

Qualitative description was a distinct method of naturalistic inquiry that uses a rich description of the experience using everyday language (Sullivan-Bolyai, Bova, and Harper, 2005). Sullivan-Bolyai et al. (2005) advanced that qualitative description pursued an understanding of complex experiences, events or processes that were embedded within the human context, while Neergaard, Olesen, Andersen, and Sondergaard (2009) suggested that it was aimed at describing the informant's perception and experience of the world and its phenomena.

According to Sullivan-Bolyai et al. (2005) there are two main elements which are consistent with qualitative descriptive studies in nursing research, namely: 1) learning from the participants and their descriptions, and 2) using the knowledge to influence interventions. It was therefore logical for this researcher to use a qualitative descriptive approach to inform the SHNs' knowledge, practices and policies, as the goal was to present these participants' understanding and experiences in the implementation of the adolescent sexual and reproductive health programme with minimal transformation.

3.3 Study approach

A qualitative research approach was used in this study. The researcher decided to use the qualitative research as there was insufficient research to provide information concerning the SHNs' understanding and experiences in the implementation of the adolescents' sexual and reproductive health programme. Denzin and Lincoln (2011) posited that a qualitative approach enabled the researcher to conduct a detailed and rich description and analysis of participants' narratives. According to Erlingsson and Brysiewicz (2013) the researcher in a qualitative study is part of the study and the research instrument. A qualitative approach enabled the researcher to explore the phenomenon under study in depth and detail, producing a wealth of information about a much smaller number of people.

Borbasi and Jackson (2012) argued that qualitative research examined subjective human experience by using non-statistical methods of analysis. In addition, qualitative research contributed to the understanding of perceived situations and of human conditions in different contexts (Bengtsson, 2016). The theoretical philosophy that underpins this qualitative research was naturalistic inquiry.

3.4 Research paradigm

A paradigm is a pattern of beliefs that act as lenses, frames and processes on how to conduct an investigation (Polit and Beck, 2008). The study was based on a naturalistic inquiry paradigm. Naturalistic inquiry focused research on how people behave in their natural settings while engaging in life experiences (Denzin and Lincoln, 2011). According to Denzin and Lincoln (2011) and Awty, Welch, and Kuhn (2010) naturalistic enquiry was concerned with subjectivity, uniqueness of the person, holism and interpretation as a means of explaining understanding. Naturalistic inquiry is aimed

at understanding peoples' constructed meaning of truth and reality, add (Awty et al., 2010).

To understand naturalistic enquiry, it was necessary to describe its ontological and epistemological underpinnings. Ontology deals with the nature of reality. According to the naturalistic inquiry, reality is constructed in the mind of the individual (Denzin and Lincoln, 2011). People's perceptions, expectations, values, culture and relationships were critical to how the world was understood and experienced. Reality is a dynamic, varied and subjective phenomenon and the essence of truth is the meaning that is given by individuals (Awty et al., 2010).

Epistemology conversely focuses on the process of how people study the world and how knowledge of the world is gained (Polit and Beck, 2008). Knowledge is shaped by the person's perceptions of reality and personally constructed meaning. Consequently, the meaning given by the person is their truth (Awty et al., 2010). Hence, a naturalistic methodology was found to be an appropriate mode of inquiry for exploring the SHNs' understanding and experiences in the implementation of the adolescents' SRH programme.

3.5 Study location and context

The study was conducted in the clinics which were affiliated to the community health centres (CHC), in the selected health district in the province of Kwa-Zulu Natal. Each clinic had a SHN who was allocated to a number of schools within its perimeters. The SHNs were selected per clinic rather than per school. The selected health district employed school health nurses who were based in different clinics that were affiliated to the CHCs within the selected health district. There were eight CHCs in the selected health district. The selected health district were divided into south, west and north service areas. The south area were further subdivided into eight subdivisions; the west area had four subdivisions and the northern area had five subdivisions. These service areas catered for schools in urban, suburban/peri-urban and rural areas.

3.6 Population

Polit and Beck (2008) referred to the population as an entire set of individuals having some common characteristics. The target population for this study was all SHNs working in the public schools of the selected health district. According to a personal

communication with Ntombela (2015) the current manager of School Health in the selected health district, there were currently 44 SHNs employed in this district.

3.7 Sampling technique

This study used the purposive sampling technique, which is a non-probability sampling method. The researcher selected participants based on personal judgement about which participants would be the most informative to include in the study (Burns and Grove, 2009; Polit and Beck, 2008).

Burns and Grove (2009) posited that purposive sampling was used to gain insight into a new area of study or to obtain an in-depth understanding of a complex experience or event. The purpose of using this type of sampling was for the researcher to purposefully select suitable, information rich participants (Denzin and Lincoln, 2011; Polit and Beck, 2008).

Purposive sampling uses samples which are small in size as, according to Sarantakos (2013) a small sample size was sufficient, given that the goal of qualitative research was data saturation and not the number of participants. This sampling was therefore more applicable to this study as there were very few SHNs in the selected health district. The small sample was selected by means of purposeful sampling and a network of contacts.

3.7.1 Inclusion criteria

- A participant were to be a professional nurse (labelled for simplicity throughout this paper as a school health nurse) working in school nursing and providing adolescent sexual and reproductive health programme in the schools;
- The participants were to have a minimum of one year's experience in school nursing. This length of time constitutes a sufficient period to obtain the lived experiences in adolescent sexual and reproductive health programme; and
- Participants were to be willing to be interviewed and audio recorded.

3.7.2 Exclusion criteria

- Any professional nurse (labelled for simplicity throughout this paper as school health nurse) not involved in providing adolescent sexual and reproductive health programme in the schools;
- Less than a year's experience in school health nursing. A shorter duration of experience in school nursing would not provide sufficient time to gain the

knowledge and in-depth understanding (lived experiences) required for this study; and

- Unwillingness to be interviewed and audio recorded.

3.8 Sample size

Qualitative studies tend to use relatively small samples due to the nature of the data collected and the time consuming process of data analysis (Trotter, 2012). There was no rule that dictates the exact numbers, however Brink et al. (2012) posited that the number of experienced participants who can provide the required information for a specific study should be between five and fifteen. The initial sample consisted of six purposively sampled SHNs, two from each of the three areas of the selected health district, namely the south, west and north service areas. In this study, the sample was considered adequate when seven interviews were done and information redundancy was reached, with no new information seen to be contributing to meeting the primary aims of the study (Burns and Grove, 2009; Polit and Beck, 2008).

3.9 Data collection process

Burns and Grove (2009) define data collection as a precise, systematic gathering of information relevant to the research objectives, questions or hypothesis of the study. The researcher collected qualitative data through individual interviews with participants. Conducting face-to-face interviews with the SHNs allowed the researcher to observe their level of understanding, co-operation and interaction, and misunderstood questions were quickly and easily clarified (Polit and Beck, 2008).

A semi-structured, open-ended question interview guide was used with questions aimed at enabling participants to describe as much of their understanding and experience of adolescents' sexual and reproductive health programme as they considered relevant (see Annexure A). This strategy was chosen as it was congruent with the philosophical framework of the research paradigm and methodology, and enabled access to the participants' experiences. Polit and Beck (2008) define semi-structured interviews as interviews that were structured according to a particular area of interest, and that expand closed-/ and open-form questions with probes designed to obtain additional clarification.

The data collection process commenced after the approval to conduct the study was obtained from the University of KZN's Humanities and Social Sciences Research Ethics

Committee (Reference number HSS/1448/015M) (see Annexure C), the KZN Provincial DOH (see Annexure D) and the selected district DOH (see Annexure F). Permission was also obtained from the Chief Executive Officer of the CHCs that were involved in the study (see Annexure H). The Nursing Service Managers were then approached to facilitate the meeting of the SHNs with the researcher, and the researcher was introduced to the SHNs.

Before data collection the researcher had a follow-up meeting with each SHN, where an information letter (see Annexure I) detailing the information about the study was given to each participant to read and understand. The researcher explained the purpose of the study and the importance of the participants' involvement. Participants were also informed that they were free to opt not to participate in the study and that they could withdraw at any time if they felt uncomfortable with the study, without any prejudice.

Participants were given assurance about the confidentiality of the data and informed that the interview would be audio recorded and would take about 30 to 60 minutes. Some participants became anxious when they heard that the interview would be audio recorded. This was one of the disadvantages of audio recording as it can make the respondents anxious and less likely to reveal confidential information. Once they had agreed to participate in the study, the participants were requested to sign a declaration form (see Annexure J) and an informed consent form for audio recording (see Annexure K), prior to the interview. These were kept separate from the data to ensure that there was no way of linking the names of the participants to the collected data.

The interviews were conducted in the SHNs' consultation office at the time preferred by each participant and when the work area was not busy. According to Bryman (2008) it was important that the interview be conducted without any disruptions, to ensure the researcher's active listening and to assist the participant to feel more at ease. This was at times impossible to achieve during the data collection process. Tong, Sainsbury, and Craig (2007) explain that it was important for the researcher to describe the context in which data was collected, as it illustrates why participants respond in a particular way.

A single face-to-face, interview was conducted with each of the seven SHNs. The interviews were conducted by the researcher in English. Each interview took about 30 to 60 minutes, depending on the richness of their experiences discussed during the interview. The interviews were audio recorded and transcribed verbatim with the

knowledge and consent of the participants, as Tong et al. (2007) state that audio recording and transcription accurately reflect the participants' views.

Reflective notes were made immediately after the interview, to maintain contextual details and non-verbal expressions for data analysis and interpretation (Tong et al., 2007). Reflective notes represented the researcher's personal journal, and Polit and Beck (2008) advance that reflective notes also serve as a second data source. Non-verbal behaviours showed by the participants during the interview were included in the discussion of the findings in Chapter five.

During the interviews participant characteristics, such as basic demographic data, were collected and were reported on so that readers can consider the relevance of the findings and interpretations to their own situation (Tong et al., 2007). The key questions which were asked from participants were to describe: 1) their understanding of adolescents' SRH programme as well as their role; and 2) their experiences in the implementation of the adolescent SRH programme, including motivators and barriers.

The researcher used reflection such as summarising, paraphrasing and mirroring verbal responses to ensure that there were no misunderstandings. Where necessary, the researcher used probes and follow-up questions to encourage participants to talk about issues pertinent to the research question (Polit and Beck, 2008; Tong et al., 2007). The researcher displayed good listening techniques such as nodding, attending and verbal confirmations like "*mmm...mmm*", and showed interest by maintaining appropriate eye contact with the participants throughout the interviews.

Questions were aimed at exploring SHNs' understanding and experiences of the implementation of the adolescents' SRH programme. On completion of each interview, the researcher thanked the participant and explained that if necessary, the participant would be contacted by the researcher to obtain verification of the transcribed data and/or further exploration of issues.

3.10 Instrument

The research instrument paid particular attention to the understanding and experiences of the SHNs in adolescents' SRH programme. A semi-structured interview guide with open-ended questions was used (see Annexure A). According to Polit and Beck (2008) a

semi-structured and open-ended interview guide ensured that researchers did not limit the participants' responses but rather encouraged them to express themselves freely.

The interview guide was designed by the researcher for this study as no previous interview guide could be found on this topic. The questions were derived from the literature and research questions. The interview guide was written in English, a language medium understood by the SHNs. The interview guide consisted of three phases: *Preliminary questions* that were used to establish a rapport and begin building a relationship, *Core questions* that were to reach to the heart of their experience by probing for their descriptions, and the *Closing phase* expressed the researcher's gratitude for sharing their knowledge.

Preliminary questions consisted of demographic characteristics of the participants to facilitate a better understanding of the participants. These included: age (in years), gender, professional education, years involved in school health, training received in sexual and reproductive health promotion and their location of work.

The *Core questions* were based on the two main research questions of this study:

- What was the SHN's understanding of adolescents' SRH programme? This would answer the first objective.
- How the SHNs did experienced the implementation of the adolescent sexual and reproductive health programme? This would answer the second objective.

3.11 Pilot study

According to Lincoln and Guba (2005) the researcher is seen as the orchestrator or facilitator of the enquiry. Prior to conducting the study, the researcher conducted one pilot interview. The purpose of the pilot study was to test the interview guidelines and probing questions, identify barriers in the data collection process and to minimise researcher bias. The pilot study also assisted in checking whether the instrument checked what it was supposed to test. The pilot study assisted the researcher to develop interview skills, identify cues to probe and to get used to the audio recorder. The sample for the pilot study was one SHN in the same health district who did not participate in the main study. The pilot interview was transcribed and presented but the information was not used as part of the data.

3.12 Data analysis

The data was analysed simultaneously with data collection to allow the researcher to make adjustments along the way (Nieuwenhuis, 2007). The aim of qualitative description in analysis was a rich, straight description of an experience or an event (Neergaard et al., 2009; Sullivan-Bolyai et al., 2005). The researcher used participants own words to describe the informants' experiences in easily understood language (Sullivan-Bolyai et al., 2005).

The data from the recorded individual interviews were transcribed verbatim and analysed using descriptive content analysis. The following five steps were followed in data analysis as done by Taylor-Powell and Renner (2003).

Step One: Getting to know the data

Step Two: Focusing the analysis

Step Three: Categorise information

Step Four: Identify patterns and connections within and between themes.

Step Five: Interpretation – bringing it all together.

These steps have been further discussed below.

Descriptive content analysis is a systematic approach to qualitative data analysis and is employed when working with narratives such as qualitative responses to open-ended questions on surveys, interviews or focus groups (Nieuwenhuis, 2007). According to Sarantakos (2013) descriptive content analysis aims at identifying and describing the main content of data, chronologically, thematically or otherwise. It identifies and summarises message content with an intention of identifying keys in the text that will assist in the understanding and interpretation of the raw data (Nieuwenhuis, 2007). It uses narratives to make descriptions vivid and to bring its content close to the natural setting (Sarantakos, 2013).

Sarantakos (2013) report that content analysis as a method of analysing data is widely used in qualitative research techniques. According to Elo and Kyng (2008) content analysis is used to analyse written, verbal or visual communication messages. The aim of content analysis is linking the results to the context or the environment where they were produced (Bengtsson, 2016). According to Bengtsson (2016) in qualitative content analysis data is presented in words and themes, making interpretation of the results possible. The researcher described what the informants actually said, used the

participants' actual words, and described the visible and obvious in the text. The analysis process consists of five steps.

Step One: Getting to know the data

The researcher listened to the audio recording twice while transcribing verbatim. On completion of transcription, the researcher once more read the transcript while listening to the audio recorded interviews, thus ensuring that the transcript was accurate.

According to Crowe, Inder, and Porter (2015) the transcribed interview becomes the raw data and the unit of analysis. Once each interview was transcribed, the researcher conducted a member check by going back to each participant to validate whether the core of the interview had been correctly captured. The researcher read and re-read the transcribed interview to understand what the transcribed data was talking about.

Step Two: Focusing the analysis

The researcher reviewed the purpose of the research, which was to explore the selected SHNs' understanding and experiences of adolescent SRH programme in one of the selected school districts. The key questions which needed to be answered by the analysis were identified as: What was the SHNs' understanding of adolescents' SRH programme; and, what were the SHNs' experiences in the implementation of the adolescents' SRH programme.

Data was organised by question, to look across all respondents and their answers in order to identify consistencies and differences. The researcher read the text data until information relating to the purpose of the study was identified.

Step Three: Categorise information

The researcher identified themes by reading the text data until information that recurred in the data was identified. These became the themes. The identified themes were organised into coherent sub-themes that summarised and brought meaning to the text. The table below demonstrates a few themes that emerged during data analysis (Table 4).

Table 4. Categorising information according to the research questions

Question: What is your understanding of the adolescent sexual and reproductive health programme?		
Participant	Response	Theme
1 5	We talk about family planning in grade 12. We tell them about decent family planning and that they need to protect themselves and talk to them about HIV. We tell them about different family planning methods for now and for future when they go to high school, so that they can protect themselves from getting pregnant and from contracting STIs. The girls; we teach them about family planning if they are now sexually active. We teach them about different types of contraceptives that are available to them and we tell them that they must go to the clinic. We explain all the contraceptives to them and then they must decide on which one to use.	Role of SHN in SRH
6 2	You have to tell about abortion; even though it may go against what you believe in but it is a must. You have to tell the learners that they have an option of abortion. But most of the times you find them pregnant and at a very later stage because they keep it a secret until it shows. Maybe by that time abortion is no longer an option. We only provide the information on where they can access contraceptives and condoms because that is still not approved of in the policy guide that we have on service delivery at schools. We also speak about the services available to them and the access of the services that we have and the age groups for them.	Health services provision
3 2	Last year December we were told that grade 4's is no more our target. The target now in the school is grade R, grade 1, grade 8 to grade 10. We deal with all the aspects that are covered in the legislation in the Sexual Reproductive Manuals and Health Act that is covered there.	Legislative component
Question 2: What are your experiences in delivering this sexual and reproductive health?		
3 6	My experiences are that some learners are very interested to know about sexual health. They are very interested, they concentrate, and they ask questions. I would say it is the topic they love the most. So the way I see it, as adults if we don't speak about it we are depriving them because they want to know. They are very eager to know everything, they ask questions as adult you were not expecting, and you wouldn't think it bothers them.	Motivators

	I love working with kids. I was once a teenager and passing on the knowledge that I have to the kids and especially if there are kids who really get help from what I do, that motivates me to come back and help more.	
4	To the learners, it is okay but in some schools it is problem with the teachers. There was one school that did not want the boys and the girls teamed together; grade 4. They wanted them separated because the teachers felt the boys must not know about the girls menstruating – it was a problem in one school.	Barriers
7	The other barrier is that we are only two in our team; we are supposed to be four to make it easier for us to do our health education. So, we are really lacking in giving our health education because we are only two and we have got primary schools, we have got target groups. And the other barrier in high schools is that they do not give us enough time. They normally want to give us 14H00 in the afternoon; by then we should be getting back to our clinics. So they only give us time at 14H15 in the afternoon and the problem there is that we have to come back, do our paperwork and take copies to our mother clinic, and at that time the children know that it is their time to go home. So, they don't listen, they are not interested.	

Step Four: Identify patterns and connections within and between themes

The data was organised into two main questions which answered the research objectives. The researcher began to see patterns and connections, both within and between the themes.

Step Five: Interpretation – bringing it all together

The researcher used the themes and connections to explain the findings.

3.13 Trustworthiness of qualitative data

Qualitative research, according to Patton (2014) was often questioned by positivists since it used a different concept to address validity and reliability. Qualitative researchers had however demonstrated that they could effectively deal with the issues of validity and reliability (Patton, 2014). Trustworthiness in qualitative research was used to test rigor. This study used the principles described by Lincoln and Guba (2005) to

establish the trustworthiness of the qualitative design. These principles included credibility, transferability, dependability and conformability (Lincoln and Guba, 2005).

3.13.1 Credibility

Credibility refers to ensuring that the description of the reality explored is accurately conveyed (Denzin and Lincoln, 2011). The researcher adopted a well-established qualitative research method for this study. To ensure honesty of information, each participant was informed that participation in the project was voluntary, so that the data collected was from participants who were genuinely willing to take part and prepared to offer data freely. Participants were encouraged to be honest and were assured that there was no right or wrong answer to the questions that would be asked. The researcher allowed sufficient time for interviews to establish rapport, build a trusting relationship, encourage openness without interruptions, and to convey the meaningfulness of their contribution to the project.

The researcher used individual face-to-face interviews. The interviews were audiotaped and verbatim transcribed in order to accurately reflect the participants' views (Tong et al., 2007). The interview guideline consisted of open-ended and semi-structured questions to ensure trustworthiness and credibility of the data obtained (Denzin and Lincoln, 2011). Probes were used to elicit detailed data, together with iterative questioning where the researcher returned to matters raised by the participant to extract data through rephrased questions. The researcher also took reflective notes during and after the interviews.

To ensure the credibility of the data, the researcher listened to the audio recordings and compared them to the transcripts. An original transcript, raw data, is included in this study to ensure credibility (see Annexure H). Frequent debriefing sessions were held between the researcher and supervisor to discuss alternative approaches and to draw attention to flaws in the proposed course of action. Debriefing sessions assisted the researcher to recognise their own biases and preferences.

Credibility was further established by member checking. This was done 'on the spot' in the course of the interview, by means of probing, to ensure that the researcher understood the participant's meaning. Member checks, according to Denzin and Lincoln (2011) were considered the most important provision that could bolster a study's credibility. Member checks were also done at the end of the data collection interview.

Informants were asked to read the transcripts of the interview in which they had participated. The emphasis was on whether the informants considered that their words matched what they had actually intended.

Thick description of the phenomenon under scrutiny was used and where possible, the participant's words were used to allow them to speak for themselves. Denzin and Lincoln (2011) describe thick description as a way of achieving a type of external validity. By describing a phenomenon in sufficient detail it was possible to evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations, and people.

The researcher used an additional analyst to review the findings: The researcher and the supervisor independently analysed the same qualitative data set and compared their findings. According to Patton (2014) the use of multiple analysts allows the researcher to check for selective perception and blind interpretive bias.

The researcher had a Degree in Nursing Science and had majored in Community Health Nursing. The researcher had not worked in school health nursing and thus had no experience in this field of nursing or prior knowledge of the adolescents' sexual and reproductive health programme.

3.13.2 Transferability

Transferability means showing that the findings have applicability in other contexts (Denzin and Lincoln, 2011; Polit and Beck, 2008). To ensure transferability in this study the researcher provided a thick, rich description of the data collection process and analysis. The description included that of the population taking part in the study and where they were based; the type and number of participants involved; the data collection method; the number and length of the data collection sessions; as well as the time period over which the data was collected (Polit and Beck, 2008). The researcher gave detailed descriptions of the information obtained from the participants so that someone other than the researcher would be able to determine whether the findings could be applied to another research study.

3.13.3 Dependability

Dependability of qualitative data, according to Polit and Beck (2008) refers to data stability over a period of time and over different conditions. Dependability is equivalent to validity in quantitative studies (Polit and Beck, 2008). In this study, dependability

was achieved by providing a detailed report of the processes within the study (Hadi and José Closs, 2016). The researcher personally collected data, transcribed the audio recordings and then checked the transcripts by listening to the audio recordings, thus ensuring that the data was transcribed verbatim. The researcher documented all the raw data generated, including field notes and interview transcripts. As advised by Polit and Beck (2008) the method and source of data generation, the analysis decisions and the operational details of the data gathering were also documented. This in-depth coverage allowed the reader to assess the extent to which proper research practices were followed. The researcher conducted a research audit by comparing the data with the research findings and interpretations (Thomas, 2006). A proposal for this project was presented to a panel of experts at the University to evaluate whether the process for the research project was appropriate to answer the research questions.

3.13.4 Confirmability

Polit and Beck (2008) stated that confirmability refers to the objectivity or neutrality of the data. Confirmability determined how the research findings were supported by the data collected. In this study an audit trail was used to ensure confirmability and to promote neutrality. According to Kohn and Truglio-Londrigan (2007) an audit trail can be used to assess the confirmability of data. An audit trail occurred when the researcher performed an audit of the research process (Kohn and Truglio-Londrigan, 2007). In this study, the interviews were conducted by the researcher and were audiotaped with the participants' consent. The researcher transcribed the audio recorded interviews word for word. The researcher, together with the research supervisor, agreed on the emerging themes. The research document showed how the raw data was collected and analysed. Jackson and Verberg (2007) asserted that the use of an audit trail enables the researcher to make conclusions similar to those which the original researcher made. Field notes were written during and immediately after each interview to ensure that the participants' lived experiences were recorded accurately from their perspectives. The participants reviewed the transcripts and a follow-up telephone interview was done for further clarification. The researcher also admitted their own biases to ensure confirmability.

3.14 Ethical considerations

Permission: Data was collected after the researcher had obtained ethical clearance from the University of KZN, Humanities and Social Sciences Research Ethics Committee. Permission to conduct the study at the CHCs of the selected health district was obtained

from each CHC involved, the selected health District DOH and the KZN Provincial DOH. Only once the approvals were granted could the data be collected.

Informed consent and respect for autonomy: The participants' agreement to take part in the study was obtained through written and signed informed consent forms. The purpose of the study was explained to the participants to ensure that they fully understood the requirements of the study. The subjects were advised that participation in the study was voluntary and those willing to participate in the study were required to sign an informed consent and declaration form. Subjects who were not willing to participate in the study were informed that nothing would be held against them. Participants were also informed that they could withdraw from the study at any time without any adverse repercussions.

Anonymity: For the purpose of this study, the participants' identities were protected. Numbers were used to identify the participants rather than their names, to ensure anonymity.

Confidentiality: Participants were informed that confidentiality would be maintained throughout the study. Each participant was allocated a number to maintain their confidentiality, and the participants were assured that their participation and all information provided by them would not be used against them in any way. The rights of the participants were respected which, according to Polit and Beck (2008) included the right to freedom from harm and discomfort, the right to self-determination, the right to full disclosure and the right to fair treatment. All data obtained from this study was accessible only to the researcher, and would only be used for the purpose of this research project.

3.15 Data management

All data collected was only used for the purpose of this study. Individual interviews were done by the researcher alone to ensure that confidentiality was maintained. The data was transcribed and proof read by the researcher. No names or personal information appeared on any transcripts. Numbers were used to maintain the confidentiality of the participants. The interview tapes and original transcripts were kept in a locked cupboard accessible only to the researcher for the duration of the research period, to prevent accidental erasure of the tapes. Computer data was kept confidential on a computer which had a code of access known only by the researcher. Data would be

kept in a secured location for a period of five years, by arrangement of the supervisor at the school. After five years the data stored on the computer would be erased from both programme files and the recycle bin, and the hard copies would be incinerated.

3.16 Data dissemination

The findings of this study were to be presented to the University of KZN School of Nursing and Public Health as a hard copy and further copies would be made available to the KZN Provincial DOH, the selected health District DOH and the CHCs where this study was conducted. The researcher and the supervisor would also publish the findings in an accredited scientific nursing journal. The names of the participants and the institutions that were used as the research setting in this study would be kept confidential.

3.17 Conclusion

This chapter provided the methodological framework for the research. This study used a qualitative approach which was guided by the naturalistic inquiry paradigm and a descriptive and exploratory research design. The necessity to use a qualitative approach and an exploratory descriptive design as an appropriate method in addressing the research questions was highlighted. The interviews were conducted in a natural setting convenient and comfortable for each SHN. Non-probability purposive sampling was employed to select participants. Semi-structured interviews were used to collect data. Ethical considerations were adhered to in this study, and measures were taken to ensure credibility, transferability, dependability and confirmability. Data management and dissemination were also discussed. Details on how the data obtained for the study was analysed are provided in chapter four, which presents the research findings.

CHAPTER 4: FINDINGS OF THE STUDY

4.1 Introduction

This chapter presents the findings of the study, namely the analysed data that was collected by means of the individual interviews conducted with seven SHNs involved with the adolescent SRH programme in the selected health district. A semi-structured, open-ended questions interview guide was used as the primary source of data collection. The data from individual recorded interviews was transcribed verbatim. Written consents were sought prior to the data collection. The interview provided a narration of the understanding and the experiences of the seven SHNs working with the adolescents' SRH programme.

The findings in this section are grouped into two main objectives. Some of the participants' views will be presented as direct quotations which will reveal the participants level of emotion, thoughts, views, experiences and their perceptions about their understanding and experiences of the adolescents' SRH programme (Sarantakos, 2013). The findings of the pilot study are also presented here but will not form part of the analysis.

4.2 Findings of the pilot study

The SHN who participated in the pilot study was a 56 year old Indian female. The participant had 8 years of experience working as a SHN. The level of education for this participant was a Diploma in General Nursing and Midwifery, as well as a Diploma in Community Health Nursing. The participant had been trained in SHN as it was part of the module when studying for the Diploma in Community Health Nursing. The participant also attended a workshop on sexual health education.

4.3 Sample data realisation

Table 5. Demographic characteristics of participants

Participant	Age	Gender	Race	Level of education	Years in SHN	Location of work	Formal training in SHN	Training on sexual health
1	54	Female	Indian	<ul style="list-style-type: none"> • Diploma in General Nursing and Midwifery • Diploma in Community Health Nursing 	25 years	Sub-urban	Yes	Yes
2	60	Female	Coloured	<ul style="list-style-type: none"> • Diploma in General Nursing and Midwifery • Diploma in Community Health Nursing 	14 years	Sub-urban	Yes	Yes
3	37	Female	African	<ul style="list-style-type: none"> • Diploma in General Nursing and Midwifery • Diploma in Primary Care and Community Health Nursing 	2 years	Urban	Yes	Yes
4	58	Female	Indian	<ul style="list-style-type: none"> • Diploma in General Nursing and Midwifery • Bachelor Degree in Nursing 	23 years	Sub-urban and rural	Yes	Yes
5	52	Female	African	• Diploma in General Nursing	1 year	Rural	No	Yes
6	32	Female	African	• Diploma in General Nursing	1 year	Rural	No	Yes
7	56	Female	Coloured	<ul style="list-style-type: none"> • Diploma in General Nursing and Midwifery • Diploma in Community Health Nursing 	30 years	Urban	No	Yes

This section presented the findings on the participants' demographic characteristics. It aimed to provide a concise description of the characteristics of the participants and their possible influence in the study. The information was collected by asking the individual participants about their demographic characteristics. Their responses were tape recorded during the individual interviews. The seven participants who were approached and requested to participate in the study all agreed to participate in the study.

The ages of the participants ranged from 32 years to 60 years. The mean age was 50 years. There were no significant differences in the views expressed by each participant in this age range on their experiences in the adolescent sexual and reproductive health programme. All participants were females. The sample did not represent both genders, and included all racial groups except whites.

The SHNs' levels of education ranged from diplomas to a bachelor's degree; two participants had degrees and five had diplomas. The duration of the participants'

involvement in school health nursing varied from 1 to 30 years. Three participants had between one to two years of experience, while the other four participants' years of experience range from 14 to 30 years.

The work location varied between urban and rural areas. There were three participants who worked in a sub-urban area, one worked in an urban area, two worked in a rural area, and one worked in both the urban and rural setting. Of the seven participants, three had no formal training while four had formal training in school health nursing. All of the participants interviewed had some sort of training on sexual education, in the form of in-service education.

4.4 Presentation of the findings

The presentation of findings was guided by the study objectives. The following data was presented based on the two objectives: 1) The SHNs' understanding of the adolescents' SRH programme and 2) The experiences of the SHNs in dealing with the adolescents' SRH programme. Table 6 below displays the identified themes and sub-themes which emerged from the data. These themes and sub-themes are discussed further below.

Table 6. Themes and sub-themes from the collected data

With regards to the understanding of SRH, the following themes and sub-themes emerged:	
Theme	Sub-theme
The roles of SHNs	<ul style="list-style-type: none">• Health educator• Health promotor• Health provider• Collaborator• Counsellor
Health service provision	<ul style="list-style-type: none">• Termination of pregnancy• Family planning• Male Medical Circumcision
Legislative components	<ul style="list-style-type: none">• Target population• Age appropriate topics
With regards to the experiences of the SHNs, the following themes and sub-themes emerged:	
Motivators	<ul style="list-style-type: none">• Acceptability• Attitude of SHNs• Change in learner behaviour
Barriers	<ul style="list-style-type: none">• Resistance from teachers and school governing bodies/lack of support• Learner cooperation• Persistent risky sexual behaviour/ unintended programme outcome• Lack of resources• Lack of training /skills• Legislative issues

4.4.1 SHNs' understanding of the adolescents' SRH programme

This section presents the findings on the SHNs' understanding of the SRH programmes. The main question asked in this section of the study was; "What is your understanding of the adolescents' SRH programmes?" The SHNs were found to have a different understanding of the programme. While for some SHNs, SRH was mainly the provision of health promotion services, it was evident in the findings that other SHNs understood SRH to be more than just health promotion; rather it included the empowerment of these young people with health skills.

What was common in the findings was that they all understood SRH to be the provision of health services to the young people at schools. All participants understood SRH programme to be based on the Integrated School Health Policy. The findings could be placed under the following themes i.e. SHNs' roles in providing SRH, health service provision and legislative components. These themes will be discussed below.

4.4.1.1 Theme one: The roles of SHNs

The SHNs understood sexual and reproductive health to relate to their role as professional nurses who were expected to provide health services to the learners on a daily basis. These roles were mainly related to a community health nurse's roles of health promotion and disease prevention. The SHNs' understanding was that their role was broad and depends on whether the school was in the rural, urban or sub-urban setting, and on the health needs of the learners and programme. In terms of their roles, all SHNs understood their role to be health education, health promotion and disease prevention, health assessment, treatment and referrals, and collaboration with teachers, parents, communities and other health care services.

Sub-theme one: Health educator

Some of the participants stated that their roles include talking to the learners about everything that pertains to their sexuality. This included topics such as: puberty, contraception and teenage pregnancy. This was to enable the learners to understand their bodies and the changes that occur as they were growing up, and to be reassured that they were following the normal growth path.

Puberty/ growth and development

Puberty is the period whereby growing boys or girls undergo the process of sexual maturation. Puberty is characterised by growth of body hair; increased perspiration and oil production in the hair and skin; growth in height and weight; breast and hip development and the onset of menstruation in girls; and lastly growth in the testicles and penis, wet dreams and deepening of the voice in boys (Sawyer et al., 2012). Most of the participants stated that the SRH programme involved talking to the learners about the changes that occurs in their bodies as they grow up, for example; breast development in girls, growth of pubic hair, voice change in boys and menstruation.

Participant 1:

We normally talk about the changes that occur. It would be like hair under their arms, private areas and we tell them about breast development and then the process where they eventually start to menstruate. At 9 years we don't touch too much on sexual fundamentals. It's just all the changes that will occur as they are growing up.

Participant 6:

We do talk about menstruation because you can find that the child has started menstruation at the age of 9. So, in menstruation we talk about how you take care of yourself once you have reached that stage, the bathing in the morning and in the afternoon, the changing of pads during the day. Even offer medication because others have heavy bleedings, so we have to offer medication for that.

Reproductive health

The findings of this study proclaimed that most of the participants viewed contraception as part of the SRH programme. The participants stated that they had to talk to the learners about contraceptives, and about the different types of contraceptives that were available to them. They also had to inform the learners as to where they can access these contraceptives. The participants expressed that it was their role to educate the learners that once they decide to be sexually active they should visit the clinic to obtain the necessary contraceptives. The participants had to stress the importance of taking contraceptives to prevent adolescent pregnancy, so that the learners can further their studies until they are ready to have babies. The participants also stated that when talking to learners they promoted dual protection. This was to protect them from falling pregnant and also from acquiring STIs including HIV. This was illustrated in the following statements:

Participant 1:

We talk about family planning in grade 12. We tell them about decent family planning and that they need to protect themselves, and talk to them about HIV. We tell them about different family planning methods for now and for future when they go to high school, so that they can protect themselves from getting pregnant and from contracting STIs.

Participant 5:

The girls; we teach them about family planning if they are now sexually active. We teach them about different types of contraceptives that are available to them and we tell them that they must go to the Clinic. We explain all the contraceptives to them and then they must decide on which one to use.

The participants stated that they used different techniques when teaching learners about contraceptives. Some participants stated that they brought samples to school in order to show the learners the different types of contraceptive. Other participants stated that they did not bring any samples to school as they were not allowed. This showed that there was lack of consistency in terms of this practice. As some participants remarked:

Participant 4:

We talk about different types of contraceptives available. I do have samples that to show them, namely the two months or three months injection, the implants, the male and female condom and tablets. The males as well; we deal with the contraceptives.

Participant 7

We do not show them methods of contraceptives because we do not have consents from their parents. We need consent from their parents. The only consent we got only talks about contraceptives; that doesn't have anything about family planning methods.

Teenage pregnancy

The participants' understanding was that they had to play a major role in educating adolescents about abstinence and birth control, in order to reduce the rate of teen pregnancy. The findings of this study illustrated that SHNs believed that talking to learners about teenage pregnancy was an important topic for the SRH programme. The participants emphasised that there was a proportion of learners who were pregnant while at school. Some of the participants expressed that they were not required to be judgemental if they happened to see an adolescent who was pregnant, as the adolescent might have lacked information on contraceptives to make an educated decision. The participants stated that, it was their role to educate learners that if they have sex without any form of protection, then the learners would fall pregnant.

Participant 1:

We tell them that now that they have started menstruating, if they have sex with boys they can get pregnant. When dealing with teenage pregnancy, it's basically that we tell them the fact that if you are sleeping with the boys without any protection there is a bigger chance of getting pregnant.

Participant 6:

We do talk about how to prevent pregnancy, which is abstinence of course, but you know children do not listen, so the best way is to offer condoms. The importance of knowing should you have a sexual intercourse, you must know that you are going to be pregnant if that guy is not wearing a condom and if you are not on any contraceptives.

Sub-theme two: Health promotor

Health promotion and primary prevention emerged as a sub-theme from the findings of this study. The participating SHNs felt that health promotion should be used as a tool for reducing or changing modifiable health risks and irresponsible sexual practices. Most of the participants stated that they functioned at a preventative level, thus they dealt with health promotion so as to prevent diseases. The participants revealed that they provided health information to individual students and to groups of students. They dealt with topics which included the prevention of STIs and other infectious diseases, and the prevention of adolescent pregnancy. The majority of the participants regarded the promotion of abstinence, condom usage, contraception, MMC and the prevention of STIs including HIV as their primary role. A few participants, however, did not regard the promotion of abstinence as their primary role, and only mention it to learners in passing.

Promotion of abstinence

The participants understood their role in SRH as that of using the ‘ABC strategy’, which was to abstain, be faithful and condom use to prevent STIs and unwanted pregnancies. Promotion of abstinence was regarded as part of the SRH programme, however very few participants actually emphasised abstinence. Abstinence seemed to merely be mentioned in passing. Not much was mentioned about the importance of abstaining, to encourage the learners to embrace the concept of abstinence. Instead, the participants were of the view that they cannot stop the learners from having sex, and felt that their role was to provide the learners with the necessary information so that they were able to make informed decisions regarding sexuality.

Participant 3:

We emphasize that they must abstain from sex. But we cannot prevent them from having sex, so we must have all the information and we must give those options.

Participant 5:

Those who are not sexually active we encourage them to abstain from sex. We tell them that they are still young, they need to abstain, and they need to wait for their time to come.

Promotion of safe sex /Condom usage

Condoms have the potential for a collective protection against STDs, HIV, and unintended pregnancy. The findings from this study demonstrated that promotion of condom usage among learners was part of SHNs health promotion role. Participants related that they talked to the learners about usage of condoms as it was important to prevent both teenage pregnancy and STIs including HIV.

Participant 2:

We promote condom usage but we do not supply male and female condoms nor do we supply contraceptives.

Participant 6:

We talk about condom usage to prevent sexual transmitted diseases.

Male Medical Circumcision

The findings of this study showed that the promotion of MMC was viewed as one of the roles of the SHNs. Nonetheless very few participants spoke about it to the learners. The participants stated that they had to promote MMC by encouraging learners to undergo the procedure. The participants revealed that they would even checking with the clinics as to the availability of dates for the procedure. The participants encouraged the learners to talk to their parents about it and to obtain their parents' consent for the procedure.

Participant 5:

We talk about male medical circumcision and tell them that since there are these infectious diseases like HIV, STI's they need to do circumcision. It is not like they don't get such diseases but it decreases the chances of getting the STIs including HIV, when they have done circumcision.

Participant 6:

We advise boys about male medical circumcision. Telling them the importance of removing the foreskin, so as to prevent themselves from contacting STIs and to minimise the chances of HIV.

Prevention of STIs and HIV

The findings of this study established that health promotion for the prevention of STIs and HIV was viewed as the SHNs role when dealing with adolescents' SRH. Most of the participants, when talking to the learners, encouraged them to always use condoms once they decided to become sexually active, in order to protect themselves from getting infected with STIs and HIV. The participants expressed that there were many students who were sexually active, who do not take preventative measures. This was evident as there were a lot of learners who were pregnant while still at school.

Participant 1:

We tell them the fact that if you are sleeping with the boys without any protection there is a bigger chance of getting pregnant and that you can be infected with STIs. We talk to them about HIV and STIs prevention by emphasising the importance of using condom when having sex.

Participant 5:

We promote condoms usage if they are sexually active, to prevent themselves from diseases like STIs and HIV/AIDS. We also talk about male medical circumcision and tell them that since there are these infectious diseases like HIV, STI's they need to do circumcision.

Sub-theme three: Health provider

Health assessment, provision of medication and referral appeared to be one of the sub-themes in this study. The participants understood that their role as SHNs required that they do health assessments of learners and provide treatment for minor ailments as well as referral of learners to other health facilities. Those learners who required further treatment were referred to the appropriate health services. During interview the participants stated that if they found a child that was ill, they gave them necessary medication as required of them. Participants also stated that learners who required contraceptives were referred to the family planning clinic and those who were pregnant were referred to the antenatal clinics. The learners requiring a MMC were also referred to the relevant health facility to book an appointment for the procedure.

Participant 5

If they are pregnant we refer them to attend Clinic, it is easy to pick up whatever is wrong with pregnancy.

Participant 6:

On assessment should the child be diagnosed as having sexual transmitted diseases, we give medication.

Sub-theme four: Collaborator

It was important that SHNs work with parents, teachers, school governing bodies as well as the community in an effort to effectively reduce the prevalence of STDs, HIV, and pregnancy among adolescents. Collaborators in health promotion activities included local hospitals, local health departments, and other health-related organisations. Most of the participants mentioned that they collaborated with the school personnel in terms of what they taught the learners. The participants also collaborated with the local health service for the purpose of referring learners.

Participant 6:

Well, we have these things called war-rooms in the communities where I have to go and introduce myself as a SHN and to briefly explain to them what I'm doing at the schools.

Participant 4:

I do talks at schools; whatever model or poster that I use, I showed it to the teacher or principal and then they approve then I can go ahead.

Sub-theme five: Counsellor

It has emerged from this study that SHNs functioned as counsellors. While for some SHNs SRH was mainly the provision of health promotion services, it was evident in the findings that some SHNs understood SRH to be much more than just health promotion, in that it empowered young people with health skills. The participants' stated that they counselled learners in either as individuals or in groups.

Empowerment and skills development

The findings of this study revealed that the participants had to empower the learners so that they obtain the necessary skills and information to prevent teenage pregnancies and STIs, including HIV. The participants stated that they would go to the extent of demonstrating how to use a condom. Some participants would even bring samples of contraceptives to school so that the learners would know what they looked like. One of

the participants however stated that they do not perform a demonstration of how to put a condom on, as they did not have the necessary consent. Instead, they only gave health education.

Participant 3:

We also demonstrate how to use it, how to discard it, how to keep it and all that, and remember there is also a female condom as well. We also demonstrate all that and then about tablets; we bring tablets..., we show them all the different types of tablets..., how they work and then the injectable, and we explain that when you go to the clinic you make a choice which one you want and the side effects.

Participant 4:

I even have a model to show them how to put the condom on, disposable of the condom. When we talk about the erect penis, it's all laugh cause all of them, they feel they know everything and they ask what size must we use, the boys – I don't know whether they are trying to make fun of us or whether they know everything.

Awareness of good and bad touch

Some of the participants' regarded talking to learners and creating awareness about good and bad touch as one of their roles and responsibilities. The participants revealed that they talked to the learners from Grade R about the good and bad touch. The participants also talked to learners about the importance of reporting to adults when they felt that they have inappropriately been touched by someone.

Participant 4:

In Grade R and grade 1 what I usually do - because they are so small - I talk to them about good touch and bad touch. I will tell the girls that no one is allowed to touch their breasts. Your private part, buttocks; no one is allowed to touch you. Even if your Dad is bathing you, you wash yourself and we talk about reporting, who to report to.

Participant 6:

You have to tell the child that if a man touches you like this, that is wrong. So we try to be relevant, to make these teachings to their level. We tell them

that you cannot let a man touch you in these particular places. It is wrong, you have to report if such a thing is happening.

4.4.1.2 Theme two: Health services provision

Health services was an important component in improving adolescent SRH, as health services are aimed at preventing a health problem, or detecting and treating one. These services should be available, accessible, acceptable and appropriate for adolescents. Participants in this study understood fully that there should be sexual and reproductive health services available in order to promote healthy sexuality among the adolescents, and that it was important for them to provide the learners with the information about the services available and how to access these services. The participants stated that they had to reassure the learners that they had to go to any clinic that they felt comfortable to attending. The health services that the participants referred the learners to in case of need were for the termination of pregnancy (TOP), family planning and MMC.

Sub-theme one: Termination of pregnancy

It has emerged from this study that while termination of pregnancy is one of the available services for pregnant learners, most of the participants did not discuss the available choices for pregnant learners. The participants who mentioned discussing the choice of termination with the learners' stated that most of the time it was not necessary as teenagers only seek assistance when their pregnancy was already too advanced for termination to be an option. Participants also felt that further discussion about options was not warranted because adoption of the babies was not part of the learners' culture.

Participant 5:

We don't talk about the choices that they can make since they are pregnant, unless if the child says she wants to do termination. Otherwise we don't.

Participant 6:

You have to tell about abortion even though it may go against what you believe in, but it is a must. You have to tell the learners that they have an option of abortion. But most of the times you find them pregnant and at a very later stage because they keep it a secret until it shows; maybe by that time abortion is no longer an option.

Sub-theme two: Family planning

The findings of this study revealed that almost all of the participants' viewed family planning services as part of the SRH programme, and agreed that they had to refer learners who are sexually active to family planning clinics. The participants stated that they had to talk to the learners about the different types of contraceptives available to them, and about the clinics where they could access these contraceptives, as it was part of their role as SHNs to educate the learners and encourage them to use contraceptives once they had made the decision to engage in sexual activity. The participants had to stress the importance of taking contraceptives to prevent adolescent pregnancy, so that the learners could further their studies and wait until they were ready to have babies. The participants further stated that when talking to learners they promoted the concept of dual protection, as besides protecting them from falling pregnant, this would also protect them from acquiring STIs, including HIV. This was illustrated by the following statements:

Participant 2:

We only provide the information on where they can access contraceptives and condoms because that is still not approved of in the policy guide that we have on service delivery at schools. We also speak about the services available to them and the access of the services that we have and the age groups for them.

Participant 5:

The girls, we teach them about family planning if they are now sexually active. We teach them about different types of contraceptives that are available to them and we tell them that they must go to the clinic. We explain all the contraceptives to them and then they must decide on which one to use.

Sub theme three: Male medical circumcision

It emerges from this study that MMS was one of the health services that is provided for the learners. The participants stated that they made arrangements for the learners in order to undergo MMS. This was illustrated by this statement:

Participant 4:

What I usually do is to check with the clinics the dates available and I give them the available dates so they can go there and talk about the consents and the parents must be involved.

4.4.1.3 Theme three: Legislative component

Most of the participants understood that their role was guided by the legislation that governs their practice. They understood that they had to provide a service to all the learners in schools, which was appropriate for their age groups and their developmental stages.

Sub-theme one: Target population

The findings of this study established that the adolescent SRH programme was targeted at a specific population. The participants stated that when delivering this SRH programme, they had to focus on certain grades or age groups of learners. This, according to the participants, was the requirement that is stated in the Integrated School Health Policy.

Participant 3:

Our target grade is grade 4, grade 8 and grade 10.

Participant4:

Last year December we were told that grade 4's is no more our target. The target now in the school is grade R, grade 1, grade 8 to grade 10.

Sub-theme two: Age appropriate topics

Age appropriate topics emerged as one of the sub-themes in this study of the SHNs' understanding of the adolescents' SRH programme. The participants in this study stated that the information regarding the adolescents' SRH that was conveyed to the learners had to be age specific and appropriate. This was according the Integrated School Health Policy.

Participant 2:

Firstly, before we could even teach the children, we understand developmental stages and classifying the child according to their ages.

Participant 4:

We deal with topics that are age group related.

4.4.2 The experiences of SHNs in dealing with the adolescents' SRH programme

This section presents the findings on the SHNs' experience of the SRH programmes. The main question asked in this section of the study was; "What is your experience in dealing with the adolescents' SRH programme?" The findings of this study showed that the SHNs had a mixture of experiences when dealing with adolescent SRH. Participants identified some rewarding aspects of their extensive role, as well as a number of barriers that they encountered in providing the adolescents with SRH services. These experiences were divided into motivators and barriers. These are discussed further below.

4.4.2.1 Theme one: Motivators

The study findings noted that, in spite of the barriers faced by SHNs in dealing with adolescents' SRH, it was also found that there were some positive experiences that enable them to continue with the implementation of the SRH programmes to the adolescents. Participants reported that despite the barriers faced with the implementation of the programmes, they all experienced some form of encouragement when realising that some of the learners were interested in gaining information that would assist them in the prevention of pregnancy, STIs and HIV. The participants mentioned that a change in behaviour, even of just one learner, gives them strength as they realise that not all of the messages fell on deaf ears.

Sub-theme one: Acceptability

The participants revealed that there were learners who were interested in knowing as much as possible about the adolescents' SRH programme. The participants stated that some learners would ask questions perhaps not usually expected of a learner to ask. The participants took this to show that learners out there needed a lot of information in order to make informed decisions about their behaviour. The participants also stated that, they realised that the learners who had fallen pregnant might have done so through ignorance rather than purposeful intent.

Participant 6:

Ja, learners are willing to accept the services; they are willing to listen, but others are not. People are not the same. Most of the times you find kids who

really want to be assisted; so as we offer the services they accept them, and the teachers as well in the schools.

Participant 3:

My experiences are that some learners are very interested to know about sexual health; they concentrate, and they ask questions. I would say it is the topic they love the most. So the way I see it, as adults if we don't speak about it we are depriving them because they want to know. They are very eager to know everything, they ask questions as adult you were not expecting, and you wouldn't think it bothers them.

Sub-theme two: Attitude of SHNs

The attitude of the SHNs working in the schools was found to be one of the sub-themes of the study findings. Most of the participants stated that they were dedicated and loved working with learners. The participants revealed that they were aware that negative attitude towards the learners would either facilitate or constitute a barrier to adolescents seeking sexual and reproductive health information from them.

Participant 2:

We shouldn't be parental with them or judgmental, and we should just guide them onto the right path - to go to the clinic and protect themselves so that they can further their goals in life.

Participant 6:

I love working with kids. I was once a teenager and passing on the knowledge that I have to the kids and especially if there are kids who really get help from what I do, that motivates me to come back and help more.

Sub-theme three: Change in learner behaviour

The participants stated that a change in a learner behaviour motivated them. Although the SHNs reported that there was still an increase in the number of pregnant learners, the fact that a change could be seen in the behaviour of even just a few learners motivated them.

Participant 2:

It motivates if we can save one single child and guide them onto the right path. That is the guiding force because, at the end of the day, the purpose at school is to be educated and to pass and to further their careers.

Participant 3:

It motivates to see the change, even if it is not the change in the whole population. But seeing the change even in one school or one group of learners, it motivates me because when you get the feedback from the teenagers. When you speak you don't know who is listening and who is not, who is taking that information. But if you see the results, even if it's just one child that comes back to me and say thank you, I have always wanted to know about this but was afraid to talk. It encourages me and motivates me to carry on because I know, even if it can be a group of 50 learners, I know that someone is listening, at least one child has achieved from this.

4.4.2.2 Theme two: Barriers

The results indicated a number of barriers confronting the SHNs. These barriers included resistance from teachers and the school governing body; a lack of learner cooperation, a lack of resources, a lack of training/skill, and legislative issues.

Sub-theme 1: Resistance from teachers and school governing body/lack of support

The findings of this study revealed that the SRH programme was not acceptable to some teachers and members of the school governing body. SHNs were therefore unable to provide information on SRH effectively. This was shown by the fact that the schools sometimes dictated what the SHN should talk about to the learners. In some cases the teachers would insist that the participants showed them their teaching material for prior approval. Participants stated that some school governing bodies are of the view that the provision of SRH services in schools encourages adolescents to engage in premarital sex. This emerged from discussions with some of the SHNs, as the following quotes illustrated:

Participant 2:

In certain schools governing bodies, depending on the cultural predominance at that school, some of them prefer not to be having these programmes done by us but they cover it in their own school life orientation topics with their educators. So, the school actually gives us a guide as to

what we can cover and what we shouldn't cover because it is quite a sensitive issue at some of the ex-model C school.

Participant 4:

Teachers, but it was just one school that the teacher did not want me to discuss certain topics with the learners. But now what I have learnt as well with my years, before I do talks at schools, whatever model or poster that I use, I showed it to the teacher or principal and then they approve them I can go ahead.

Sub-theme two: Learner cooperation

A lack of learner cooperation was viewed as a barrier by most of the participants. This prevented the SHNs from addressing the sexual and reproductive health needs of these learners. Most participants stated that most of the learners did not attend the class where the SRH talks were held. The participants revealed that the problem was with the teachers who usually told the learners that it was a free period. Uninterested learners would disappear, while others who were interested attended the sexuality health talks. Participants revealed that some learners also felt that they were being taught something that they already knew, so they sometimes did not attend the talks or had a negative attitude if they do attend. The following quotes summarised the participants' observations in this regard:

Participant 4:

They will not listen to us, so that is a real challenge for us with the grade 8's.

Participant 6:

Maybe the kids do not want to come to attend, because we call them to the clinic to have health education there. We have low attendance – so it is better if we go to the schools where we can find them and introduce ourselves.

Sub-theme three: Persistent risky sexual behaviour/ unintended programme outcome

The findings of this study revealed that despite the sexuality health talks, there were learners who still engaged in risky sexual behaviour. This was shown by the number of

adolescents who fell pregnant while still at school. Learners thus still engaged in sexual activity without protection.

Participant 2:

A lot of them still take risks. They are having unprotected sexual intercourse and they know about the morning-after pill but they know that services are available but still they don't access it.

Participant 6:

We find a lot of kids that are pregnant, at times. We give to them advice or health education on the importance of attending antenatal clinic at first because we are now no longer concentrating on the school kid, we are also concentrating on the child inside you. She must go to the clinic, do her clinic visits properly. She must still continue taking care of herself; she must watch her diet, she must eat properly – you know vegetables and fruits.

Sub-theme four: Lack of resources

Most of the participants interviewed revealed that they did not have teaching aids to assist them when providing health talks or education. Those who had been in school health nursing for a longer duration had tried to source some material to assist them when teaching. The shortage of staff also made it impossible to cover both the primary and the high schools in the time that was allocated to them.

Participant 3:

I would say we don't have any barriers relevant except teaching aids. That is the only problem. We only give verbal information, we don't have any teaching material like videos or projectors, and we just give verbal information. I wish we could get more of the teaching aid because they like learning about something visible, it is different from just talking to them. If they will be able to see them in front of them it could make a difference to them, it might have an interest on that topic

Participant 7:

The other barrier is that we are only two in our team. We are supposed to be four to make it easier for us to do our health education. So, we are really lacking in giving our health education because we are only two and we have got primary schools; we have got target groups. Other barrier in high

schools is that they do not give us enough time. They normally want to give us 14H00 in the afternoon; by then we should be getting back to our clinics. So they only give us time at 14H15 in the afternoon and the problem there is that we have to come back, do our paperwork and take copies to our mother clinic, and at that time the children know that it is their time to go home. So, they don't listen, they are not interested.

Sub-theme five: Lack of training/skills

Lack of training emerged as one of the sub-themes, as most of the participants stated that they had not undergone any proper training on sexual and reproductive health. Some participants even stated that they had not even done basic training on school health nursing. This made it difficult for them to work in this programme.

Participant 5:

I cannot say a lot because we haven't been trained, we just pick things along the way. We get that small information along the way. We are not properly trained. We don't know anything – what we are doing. We are just doing it on our own thinking and knowledge that these kids needs to be taught this and that and with our own knowledge, what we know personally.

Sub-theme six: Legislative issues

From the findings of this study, legislative issues in terms of what services can be provided on the school premises appeared as one of the sub-themes. Participants' felt that the provision of offsite services for learners was a barrier, as learners did not want to go to the clinics where they were referred to obtain their contraceptives. The learners had fear of being seen in the family planning clinic by relatives and neighbours.

Participant 2:

To date, we are not allowed to do HIV testing in schools. We are not allowed to provide condoms....we only promote condom usage but we do not supply male and female condoms, nor do we supply contraceptives.

4.5 Conclusion

This chapter presented an in-depth outcome of the research findings. The findings incorporated the themes and sub-themes that emerged from the data analysis, with the actual quotes from the participants as evidence of their lived experiences. The SHNs

working in school health nursing shared their experiences as they reflect on their understanding of the adolescents' SRH programme. The next chapter would present the discussion of the major findings, recommendations, limitations and conclusion.

CHAPTER 5: DISCUSSION OF THE MAJOR FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This chapter discussed the main findings of the study which were presented in chapter four. The reviewed literature will be brought into the discussion to position the findings within the global discussions of empirical evidence. The objectives of the study were to explore the SHNs' understanding of the adolescents' SRH programme and their experiences of the implementation of the adolescents' SRH programme.

This chapter would also discuss the contributions that the current study would make to the body of scientific knowledge, and the strengths and limitations of the study. It would also present the recommendations and the conclusion.

5.2 Demographics description

Seven SHNs from the selected health district were interviewed. The sample consisted of only females as there were no male nurses involved in the school health nursing programme. All racial groups were represented except whites. The SHNs ages ranged from 32 to 60 years, with a mean age of 50 years. Most of the SHN had been involved in school health nursing for more than two years, with only two SHNs having been in the programme for less than two years. This indicated that the SHNs had some understanding and experience of the SRH programme. The educational preparation of the SHNs varies; two had a Diploma in General Nursing; five had a Diploma in General Nursing together with a Diploma in Community Health Nursing; and two of the five SHNs had a Bachelor's Degree. The fact that most of the SHNs had Diplomas in Community Health Nursing indicated that they have had some training in school health nursing.

5.3 Discussion of findings in relation to the emerging themes

The major findings that were discussed in accordance to the themes and sub-themes that emerged from the individual interviews. The responses of the participants were grouped into six themes, which were:

1. The role of SNHs
2. Health services provision
3. The legislative component

4. Motivators
5. Barriers to service delivery

Three of the themes addressed the first objective and two answered the second objective.

5.3.1 The role of SHNs

It was evident from the study that the roles of SHNs were diverse. These roles included SHN as a: Health educator, health promotor, health provider, collaborator as well as health counsellor. The participants were confident about their roles in the provision of the SRH programme to adolescents, and all of the participants had an understanding of their roles in the programme. This was congruent with the findings of a study conducted by Alldred and David (2007), entitled 'Get real about sex: The politics and practice of sex education'. All the seven interviewed SHNs viewed themselves as key players in the delivery of SRH as they were experts in sexual health.

Health educator

Sexuality education was aimed at enabling learners to acquire knowledge, attitudes, skills and values to assist in making appropriate choices in their sexual behaviour, in order to experience a healthy sexual life that was age-appropriate (Loeber, Reuter, Apter, van der Doef, Lazdane, and Pinter, 2010). It was evident from this study that SHNs provided sexual health education to the learners and they were confident that they were playing a crucial role in the provision of this education. The SHNs stated that their role included talking to the learners about puberty, contraception and teenage pregnancy. This was important as literature by Morake (2011) revealed that teenagers were generally ignorant about issues such as puberty, pregnancy and contraception. A multi-site study conducted by Sulak et al. (2006) on adolescents found that sexuality education significantly increased adolescents' intent to delay their onset of sexual activity until after they complete high school. It was evident from literature that sexuality education was an important predictor of consistent condom use (Bankole, Ahmed, Neema, Ouedraogo, and Konyani, 2007). The findings from their study conducted in Sub-Saharan Africa revealed that adolescent men who received sexuality education in school were more likely to use condoms consistently, compared to those who did not.

Puberty is the period where boys and girls are capable of producing offspring. Puberty, according to Zang, Zhao, Yang, Pan, Li, and Liu (2011), denoted the manifestation of physical, psychosocial and sexual development. Puberty was characterised by growth of body hair, increased perspiration and oil production in hair and skin, growth in height and weight, breast and hip development and onset of menstruation in girls, and growth in the testicles and penis, wet dreams and deepening of the voice in boys, expand (Sawyer et al., 2012).

The findings of this study revealed that the majority of the SHNs talked to learners about the physical development that occurred as the learners reach puberty, such as the breast development in girls, the growth of pubic hair, voice changes in boys and menstruation. The SHNs stated that knowledge of puberty assisted learners to understand their bodies and the changes that occurred as they grow, and gave them the reassurance that they were developing normally. Similar results were reported, where school nurses noted that puberty resulted in different health concerns for many young people (Lee, 2011).

The literature revealed that adolescents needed support to reach an understanding about puberty and related health issues (Zang et al., 2011). This was also supported by Brewin et al. (2014), who stated that sexuality education in schools assisted learners as they traverse the physical and developmental processes of adolescent sexuality. The findings from previous studies by Morake (2011) and İşgüven, Yörük, and Çizmecioğlu (2015) revealed that teenagers had an insufficient level of knowledge about puberty. As a result, learners required enlightenment about normal pubertal development and menstrual patterns.

It was evident from this study that the SHNs found it crucial to educate adolescents about abstinence and birth control, in order to reduce the rate of teen pregnancy. The findings of this study revealed that talking to learners about teenage pregnancy was an important topic for the SRH programme and that there was still a lot of learners who fell pregnant while at school. Some of the participants expressed that they were not required to be judgemental when seeing a pregnant adolescent, as their pregnancy might have been the result of lack of information on contraceptives to make an educated decision about sex. The participants stated that it was their role to educate learners that if they had sex without any form of protection, they were likely of becoming pregnant.

Health promotor

The main emphasis of health promotion is about reducing or changing modifiable health risks, including irresponsible sexual practices. Health promotion empowers learners to make informed choices regarding key health related behaviours such as sexual practices (Banfield, McGorm, and Sargent, 2015). It emerged from this study that health promotion and primary prevention was the primary role of the SHNs. This was confirmed by Puskar and Bernardo (2007) in their study on the role of school nurses. Puskar and Bernardo (2007) stated that health promotion and prevention activities were the role of the SHN in schools, especially when it targeted adolescent's key health behaviours such as sexual practices (Sawyer et al., 2012).

According to Van Leuven and Prion (2007) school nurses, were a primary care providers for health promotion and disease management services, which fulfilled the objectives of the Healthy People 2010 initiative. The objective of the Healthy People 2020 initiative was to increase the number of schools that provide comprehensive school health education in the prevention of unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy; HIV/AIDS; and STIs; unhealthy dietary patterns; and inadequate physical activity (Inman, van Bakergem, LaRosa, and Garr, 2011). The goals of the Healthy People 2020 initiative was to promote quality of life, healthy development, and healthy behaviours across all life stages (Van Leuven and Prion, 2007).

It was evident from this study that the SHNs functioned at a preventative level, thus they dealt with health promotion in order to prevent diseases. The SHNs provided health promotion to individual students and to groups of students. The findings from this study revealed that the SHNs promoted comprehensive sexuality education messages which included abstinence, condom usage to prevent STIs such as HIV, and contraception to prevent unwanted pregnancy. This was in accordance with Wang, Chen, and Li (2012) who asserted that school nurses possessed the most accurate knowledge about sexual health and were in the best position to assume the responsibility for promoting sexual health in schools.

It was a concern that very few participants in this study emphasised abstinence as a way of preventing disease transmission and teenage pregnancy. Abstinence was just mentioned in passing, and little was mentioned about the importance of encouraging

learners to abstain from sex. According to Kohler et al. (2008) abstinence only messages emphasised that sex should be delayed until marriage. Literature states that supporting sexual abstinence for younger adolescents is essential, since engaging in sex before the age of 16 is less likely to be associated with contraceptive use (L'Engle, Jackson, and Brown, 2006). Interventions that encouraged abstinence are most successful with youths who had not yet experienced sexual intercourse, so targeting of younger adolescents in this regard is critical to bring about a change in the current pattern of behaviour.

A study that was conducted in a Chilean public high school found that the abstinence-centred 'TeenSTAR' sexuality education intervention is effective in the prevention of unintended adolescent pregnancy (Cabezón, Vigil, Rojas, Leiva, Riquelme, Aranda et al., 2005). Other literature supported the receipt of any type of sexuality education that was associated with delays in first sex in both genders, as compared to adolescents who received no sexuality education (Lindberg and Maddow-Zimet, 2012).

A study conducted in Nigeria by Inyang and Inyang (2013) found that young adolescents within the ages of 11-13 years were likely to be more receptive to abstinence only sexual education than 14-19 year olds. The reason for this was that during the imprint and modelling period of the 11-13 year age range, the behaviour of children was formed from instructions given to them and examples before them, while the 14-19 year olds would have already formed their opinions from different socialisation processes (Inyang and Inyang, 2013).

It was evident from this study that the few participants who mentioned abstinence encourages both the abstinence message as well as the provision of information on contraceptives for the prevention of pregnancy and on condoms for the prevention of STIs including HIV. According to Inyang and Inyang (2013) the data on adolescents' sexual behaviour in the developing world suggested an unacceptability of abstinence-only sexual education, while other literature found that young adolescents should be given a clear message on abstinence as well as safer sexual measures (Haglund, 2006).

A study conducted by Barlow, Espey, Leeman, Scott, Ogburn, and Singh (2016) found that students who received comprehensive sexuality education rather than abstinence-only education reported to have an improved ability to make decisions about sexual initiation, pregnancy prevention, STI prevention and the avoidance of unwanted sex.

Another study publicised that receiving instruction about abstinence and birth control was associated with the use of different forms of contraception including condoms at first sex (Lindberg and Maddow-Zimet, 2012).

The SHNs were of the view that they could not stop the learners from having sex. They felt that their role was rather to provide the learners with the necessary information so that they were able to make an informed decision about their behaviour. The literature review revealed that most abstinence programme did not delay the initiation of sex, whereas comprehensive programme showed a stronger evidence of change in young people's sexual behaviour, including both delaying the initiation of sex and increasing condom and contraceptive use (Kirby, 2008).

Contraceptives are methods or devices used by both women and men to avoid unwanted pregnancies. They consist of physical and hormonal methods and devices as well as permanent procedures. The findings from this study showed that most of the SHNs talked to the learners about the different types of contraceptives available to them once they had decided to become sexually active. The SHNs encouraged learners who were sexually active to visit the clinics for contraceptives, in order to prevent unintended pregnancy. To improve the effective use of reliable contraceptives, more adequate information should be given, targeting the wrong beliefs and false information (van den Brink, Boersma, Meyboom-de Jong, and de Bruijn, 2011).

According to Kohler et al. (2008) promotion of contraception was not associated with an increased risk of adolescent sexual activity and STIs but lowered the risk of pregnancy. The participants in this study used different techniques when teaching learners about contraceptives. Some SHNs stated that they brought samples to school in order to show the learners the different types of contraceptives and what they looked like. Other SHNs stated that they did not take samples to school as they were not allowed to do so. This shows that there was a lack of consistency in terms of this practice.

Safer sex, according to Carmody and Willis (2006) meant protecting oneself and a sexual partner against STIs, as well as against an unplanned pregnancy. The promotion of condom usage for responsible sexual behaviour was a priority objective for 'Healthy People 2020'. Condoms had the potential for a collective protection against STDs, HIV,

and unintended pregnancy, and so had become a popular method promoted for this combined protection (Bankole et al., 2007).

The findings of this study established that the SHNs promoted condom usage to the learners once they decided to engage in sexual activity, as part of responsible sexual behaviour. Bankole et al. (2007) argue that encouraging young people to use condoms was not enough, since it was equally important to support them to be effective users of the method. The SHNs stated that the condoms usage was important and was readily promoted to prevent both teenage pregnancy and STIs including HIV, as previously discussed. These findings were distinct from those found in a US study, where condom use was less addressed by health educators (Rhodes, Kirchofer, hammig, and Ogletree, 2013). Previous literature reveal that in schools where condom use was taught and condoms were freely available, adolescents were less likely to report ongoing or recent sexual intercourse than in comparative schools (De Rosa, Jeffries, Afifi, Cumberland, Chung, Kerndt et al., 2012); because the learners were knowledgeable about safer sex and had the necessary skills and took a decision to abstain.

Bankole et al. (2007) recommended that programmes promoting condom usage should also include condom use demonstrations as a way of promoting the correct use of the method. Bankole et al. (2007) added that demonstration of condom use was the strongest predictor of knowledge of correct condom use among both male and female adolescents. SHNs in this study agreed with this and demonstrated the correct technique when they were allowed to do so.

The WHO recommended MMC in developing countries with traditionally low rates of male circumcision and generalised heterosexual epidemics to aid in prevention of the spread of HIV (WHO, 2012). Literature revealed that demand creation among adolescents must be aimed at influencing the attitudes, intentions, social norms and ultimately the decisions to seek voluntary MMC services (George, Strauss, Chirawu, Rhodes, Frohlich, Montague et al., 2014).

The findings of this study showed that the promotion of MMC was viewed as one of the roles of the SHNs. Nonetheless, very few participants spoke about it to the learners. Those who did stated that they encouraged learners to undergo MMC since it ensured good hygiene and protection from STIs. It was important to provide clear information to emphasise the benefits and dispel myths, while encouraging learners to undergo

circumcision (Bertrand, Njeuhmeli, Forsythe, Mattison, Mahler, and Hankins, 2011; Mavhu, Buzdugan, Langhaug, Hatzold, Benedikt, Sherman et al., 2011). According to literature from the International Initiative for Impact Evaluation by Wouabe and Brown (2013) and George et al. (2014) hygiene, protection from STIs, sexual performance and satisfaction, positive peer pressure and preferences of female intimate sexual partners were the facilitators to the acceptance of voluntary MMC.

Literature on MMC from studies conducted in African countries including South Africa showed that male acquisition of HIV was reduced by 60 per cent by circumcision, during heterosexual intercourse (Bailey, Moses, Parker, Agot, Maclean, Krieger et al., 2007; Gray, Kigozi, Serwadda, Makumbi, Watya, Nalugoda et al., 2007; Auvert, Taljaard, Lagarde, Sobngwi-Tambekou, Sitta, and Puren, 2005). Previous studies had revealed that MMC done before sexual debut could reduce the risk of developing penile and prostate cancer (Morris and Waskett, 2012; Wright, Lin, and Stanford, 2012).

The findings from this study showed that the participants involved the parents of learners so that they understood the importance of MMC and gave consent for the procedure. These findings were in line with those stated by George et al. (2014) that service providers for voluntary MMC targeting adolescent boys should include the involvement of families, intimate partners, peers and the community in general, in a young man's decision to undergo the procedure. Literature from previous studies by the International Initiative for Impact Evaluation revealed that immediate families had a substantial influence on an adolescent's decision in this regard, since they were still in the care of parents or guardians (Wouabe and Brown 2013).

Health provider

This study revealed that one of the SHNs' roles was to do health assessments and provide treatment for minor ailments to learners. These findings mirrored those of Lee (2011) where school nurses also reported providing health examinations and nursing care to students who presented with minor injuries or illnesses.

The SHNs also referred learners who required contraceptives to the family planning clinics and those who were pregnant to the antenatal clinics. The learners who required a MMC to be performed were also referred to the relevant health facility to book for the procedure. These results were similar to the findings of a study by Lee (2011). The literature from that study stated that nurses referred learners to the appropriate external

government and non-government health services. In a preventive health promoting role, nurses referred clients to the appropriate preventive health services, for example, family planning and immunisation clinics, and also conduct health checks themselves.

Collaborator

It was important that SHNs work with parents, teachers, school governing bodies, as well as the community in an effort to effectively reduce the prevalence of STDs, HIV, and pregnancy among adolescents. Collaborators in health promotion activities included local hospitals, local health departments, and other health-related organisations. The findings from this study showed that most of the participants collaborated with the school personnel, school governing bodies, parents and the community in terms of what they taught to the learners. These findings were consistent with previous literature, where collaboration and communication with community stakeholders was found to be influential on how nursing roles could be practiced (Lee, 2011). These findings were in contrast with other literature where school nurses reported a lack of collaboration with the school teachers (Brewin et al., 2014).

It was also evident from this study that the participants collaborated with other health services, namely MMC clinics, to check on the availability of dates for the procedures to be performed. Parents were also engaged in order to obtain their support and consent for the procedure.

These findings were thus congruent with those found in Hong Kong, where school nurses liaised and collaborated with community stakeholders by maintaining contact with hospitals, government, parents and society to enhance the developing students' well-being in school settings (Lee, 2011).

Health counsellor

While for some SHNs the SRH involved mainly the provision of health promotion services, it was evident from the findings that some SHNs understood SRH to be more than just health promotion. Rather, it also involved the empowerment of young people with information and skills. These findings were consistent with those of Lee (2011), where school nurses provided counselling after delivering educational talks to promote sexual health and provided related information to students.

According to UNAIDS (2013) the provision of skills, information, tools and services to young people was a critical factor in halting the spread of HIV infection. Kong, Wu, and

Loke (2009) argued that accurate messages about safer sex and contraception should be delivered to the vulnerable groups within the community. Bankole et al. (2007) added that practical education of correct condom use was a major determinant of knowledge among both male and female adolescents.

The findings of this study revealed that the SHNs provided the learners with the necessary information to prevent teenage pregnancies and STIs including HIV. The findings also showed that the SHNs further demonstrated how to use condoms correctly. This was congruent with the findings of De Rosa et al. (2012) 'Improving the Implementation of a Condom Availability Program in Urban High Schools'. This study found that using trained distributor allowed for interaction between a learners and a SHN, as well as an opportunity to provide prevention counselling, promotion of skills development and health information. These finding were in contrast to the finding by Macintyre, Montero Vega, and Sagbakken (2015) in Chile, where the study found that a lack of practical information from health professionals hindered the development of skills necessary to make informed decisions.

The findings of this study related that the participants empowered the learners so that they could acquire the necessary skills to prevent teenage pregnancies and STDs. The participants talked about the services available to learners and how the learners could access the services. Results from a study done in Northern Ireland indicated that the distribution of generic information leaflets was often controlled by the staff, thus limiting their value to those who actively sought information (Thompson et al., 2008).

It also became evident that the participants in this study made it a point that they demonstrated how to use the condom to ensure that the learners had the necessary skills. Some participants even brought samples of contraceptive to school so as to show the learners. However one of the participants stated that they did not perform a demonstration of how to put on the condom as they did not have the necessary consent. Studies conducted in Burkina Faso, Ghana and Uganda revealed that adolescents who had seen a condom demonstration were more likely than those who had not to have a good knowledge of correct condom use (Bankole et al., 2007).

Sexual abuse of children remained a serious concern due to the increase in access to potential child and youth sexual targets through the internet (Tutty, 2014; Pereda, Guilera, Forns, and Gomez-Benito, 2009; Mitchell, Finkelhor, and Wolak, 2005).

Childhood sexual abuse (CSA) required intervention, including educating children about the dangers of CSA and providing them with the necessary the skills to protect themselves (Fryda and Hulme, 2015). Fryda and Hulme (2015) argued that school nurses were an invaluable resource for interventions that could prevent the abuse through school-based educational programmes. Having said that though, there was little documentation of school nurses and nurses in general being directly involved in CSA prevention through specific educational programmes for children.

The findings of the current study revealed that the participants created awareness about inappropriate touching with learners. The SHNs goal here was to reduce the incidence of child sexual abuse by making children aware of the danger signs, how to resist the inappropriate touching by drawing their attention to what constitutes a good and a bad touch, and to know what to do if abuse occurred. Unfortunately at the moment there was no evidence to support the theory that the acquisition of such knowledge and skills would prevent sexual abuse from occurring (Lalor and McElvaney, 2010; Topping and Barron, 2009). Fryda and Hulme (2015) however postulated that ongoing education and awareness through school-based CSA prevention programmes could be the key to achieving this.

5.3.2 Health services provision

Health services were important in improving adolescents' SRH. Health services were aimed at preventing a health problem, or detecting and treating one. These services according to Sannisto and Kosunen (2009) should be available, accessible, acceptable and appropriate for adolescents in order for the programmes to be effective. Access to health services was thus important in ensuring SRH as well as the adolescents' well-being. Shaw (2009) argued that reproductive health services were crucial in attaining the MDG 5 in the improvement of maternal health, family planning, prevention of unsafe abortion, control of STIs and the promotion of sexual health.

The findings in this study revealed that health services were available for learners in order to promote healthy sexuality. The SHNs stated that they informed learners about the available health services and how the learners could access these services. The availability and accessibility of health services essentially provided a support structure for the SHNs and the referred learners. This was similar to claims made by Hans (2007) that promotion of healthy sexuality required the availability of adequate sexual health

services. School-based or school-linked sexual health service provision complemented SRH (Formby, Hirst, Owen, Hayter, and Stapleton, 2010). According to (Kirby et al., 2007) the aim of providing family planning services to young people was to make reproductive health services and contraception including condoms available, and to improve their knowledge and skill on their use.

It was apparent from this study that the participants referred the learners to the respective health services for termination of pregnancy, family planning and MMC when necessary. Shaw (2009) felt that it was crucial for adolescents to have access to services that provided contraception, safe abortion, pregnancy care, and diagnosis as well as treatment of STIs which, according to Sannisto and Kosunen (2009) were the main elements in comprehensive sexual health services. Berresford (2006) in an earlier study stated that the basic elements of sexual health care services should include:

- Sexually Transmitted Infections/HIV prevention and HIV testing, counselling and treatment, including access to anti-retroviral therapy (ART), or referral services
- A range of contraceptive methods and education and counselling around contraceptive methods and choice
- Safe and accessible abortion services
- Prenatal and maternal health care
- Services or a referral system for sexual and gender-based violence

Regardless of the availability and accessibility of health services to young people, these services were still lacking. Young people in SA were still confronted with the negative and stigmatising attitudes of health staff, hence young women did not use contraception, delayed accessing antenatal care when pregnant, or resorted to illegal means for the termination of their pregnancy (Panday et al., 2009). The South African Children's Act (2005) had lowered the age of majority to 18 years and allowed children 12 years of age and above to access health care services, including HIV testing, contraceptives, and TOP services, without parental consent (RSA, 2006). Despite this Act, some health care providers only provided services to those over 18 years (Holt et al., 2012). It was thus evident that health care workers acted as gatekeepers to young women's SRH services.

5.3.3 Legislative components

Most of the participants understood that their role was guided by the legislation that governs their practice. The participants understood that they had to provide a service to all the learners in schools, according to their developmental stages. The participants dealt with topics that were appropriate for specific age groups and catered for learners from grade R to grade 12. This confirms the argument by Haberland and Rogow (2015) that SRH should be age appropriate, began as early as possible, and foster mature decision making.

Target population

The findings of this study established that the adolescent SRH programme was targeted at a specific population. The participants stated that when delivering the SRH programme, they (the SHNs) started with learners from grade one (or seven year old) and progressed to learners in grade 12. According to the participants, this was the requirement that was stipulated in the Integrated School Health Policy. A study conducted in Turkey also recommend that education about puberty should start at a young age, about 8 to 9 years of age, before the first signs of puberty became apparent (İşgüven et al., 2015). Young people before the onset of puberty were more receptive to guidance as they had not yet developed established sexual behavioural patterns.

This was supported by the literature where participants posited that formal sexuality education should begin at ages 9 to 10 years of age (Haglund, 2006). Similar results were found in a Nigerian study where young age was identified as an important factor in the success of abstinence-only sexual education (Inyang and Inyang, 2013). According to Jones (2008) the Netherlands had the lowest teenage pregnancy rate in Europe. This was attributed to the fact that SRE began at the age of five.

A study in Nigeria where sexuality education was provided at all the junior and senior secondary school levels revealed a high prevalence of unintended pregnancies among junior secondary students (Ochiogu, Miettola, Ilika, and Vaskilampi, 2011). This suggests that sexual health education starting from junior primary school might positively influence the reproductive behaviour of the students (Ochiogu et al., 2011).

Age appropriate information/topics

The results of this study reflected that the participants had to provide information that was age appropriate, which was in accordance with the Integrated School Health Policy. This was congruent with the findings of a study conducted by Lince-Deroche, Hargey,

Holt, and Shochet (2015). Their study looked at young women's access to SRH information and services and found that young women required access to age-appropriate information in order to have healthy sexual experiences. This supports the study by Wight (2008) who articulated that sexual health promotion programmes had to be feasible and appropriate to the specific setting and target group. Panday et al. (2009) argued that the focus of the programme should be dependent on the stage of development or the age of the learner, rather than the grade. This was to ensure that learners who were older for their grade received a developmentally appropriate message (Panday et al., 2009).

5.4 Motivators and barriers

The findings of this study indicated that SHNs experienced some motivating aspects of the SRH programme, as well as encountering a number of barriers. They were regarded as knowledgeable and able to provide advice to young people. However, some of the SHNs indicated that they were unable to provide services and information on sexual and reproductive health due to the attitudes of some of the parents and teachers. According to them, some parents were not cooperative in addressing sexual and reproductive health problems. Some parents were of the view that if adolescents were introduced to sexual and reproductive health issues they would engage in premarital sex.

5.4.1 Motivators

The study findings noted that, in spite of the barriers faced by SHNs in dealing with adolescents' SRH, there were some other aspects that enabled them to continue with the implementation of the SRH programme to adolescents. The participants in the study reported that despite the barriers experienced during the implementation of the programme, they had all experienced some encouragement when realising that some of the learners were interested in gaining information that could assist in the prevention of pregnancy, STIs and HIV. The SHNs were encouraged and drew strength if they saw a change in even just one learner, knowing that their message did not fall on deaf ears.

Acceptability

The findings of the study revealed that even though there were learners who did not want to attend the adolescent SRH programme sessions, some learners were interested in finding out as much as they could about the programme. The SHNs' stated that some learners asked questions not normally expected of someone their age. This, to the SHNs,

indicated that there were learners out there in need of lots of information on the subject, so that they could make informed decisions about their behaviour. A study by Westwood and Mullan (2009) surveyed both teachers and students and found that the teachers were more of the opinion that the school nurse were a good resource for sexual education than the students were. As the teachers were not surveyed in this study, the same conclusion cannot be drawn here, but it does appear that adults (in this case the SHNs) were more appreciative of the value of sexuality health education than adolescents.

Attitude of SHNs

The attitude of the SHNs might either facilitate or constitute a barrier to adolescents seeking sexual and reproductive health information. The positive attitude of the SHNs working in the SRH programmes in the selected health district was found to be one of the findings of this study. Most of the SHNs stated that they loved working with learners and were dedicated to the programme. The SHNs revealed that they were not judgemental of the learners, and showed an awareness that such an attitude would scare the learners away from seeking support and knowledge on the subject. These findings were in accordance with those found in Ethiopia by Tilahun, Mengistie, Egata, and Reda (2012) where most of the health workers had a positive attitudes toward the adolescents in the SRH programmes. Only a small minority demonstrated a negative attitude.

A study in Turkey also found that nurse-midwives with more education and those who had received continuing education on adolescent sexuality and reproduction displayed a more youth friendly attitudes (Rana et al., 2007). Similar results were found in studies of the attitudes of health professionals to adolescent SRH problems and the provision of services in Kenya, Zambia (Warenius et al., 2006), Swaziland (Mngadi et al., 2008), and Uganda (Kipp et al., 2007).

These results were in contrast with a study from Turkey where nurses were not comfortable talking about issues of sexuality with adolescent patients (Rana et al., 2007). This posed a significant barrier to the provision of sexual and reproductive health information and services to young unmarried people and the successful adoption of safe sex practices by young people.

Change in learner behaviour

The findings of the current study revealed that the participants were motivated by seeing a positive behavioural change in some learners' behaviour. They stated that a change in even just a few learners motivated them. According to findings from a study by Bankole et al. (2007), adolescent men who had received sexuality education in school were more likely to use condoms consistently, as compared to those who did not.

5.4.2 Barriers

The results indicated that the SHNs were confronted by a number of barriers. These included resistance from teachers and governing bodies, a lack of learner cooperation, a lack of resources, a lack of training/skills when teaching such a sensitive subject, and legislative issues. These findings were similar to those experienced by school nurses in Western settings (Alldred and David, 2007) as well as school nurses in Egypt (Farrag and Hayter, 2014).

Resistance from teachers and the school governing body/lack of support

The findings of this study revealed that the SRH programme was not acceptable to some teachers and members of the school governing bodies. This hindered the SHNs in providing the necessary information to the learners. These findings were similar to the findings of a study done in Iran, where most adults believed that knowledge about sexual relationships caused distortion and premature sexual activity before marriage (Roudsari, Javadnoori, Hasanpoui, Hazavehef, and Tdghipour, 2013). In this study the SHNs stated that in some schools the teachers dictated what the SHN should talk about to the learners and/or required that the SHN showed them their teaching material for approval. These findings were consistent with the findings of a study by Hayter et al. (2008) which found that SHNs expressed that the school used a more direct methods to monitor and control the content of SRH sessions. This was done by checking material and session content prior to delivery.

It was apparent from this study that the school governing bodies were resistant to the provision of sexual health services like condom distribution in schools, stating that it would encourage adolescents to engage in premarital sex. Similarly, a Malaysian study revealed resistance from a particular group, in this instance religious groups, to the dissemination of information about sexual health (Khalaf, Low, Merghati-Khoei, and Ghorbani, 2014).

Lack of resources

This study revealed that SHNs lacked teaching aids to assist them when providing health talks or education. Those who had been school health nurses for a longer period of time had tried to source some materials to assist them when teaching. A shortage of staff was also found to be a challenge, as it was impossible to provide all of the required services in both the primary school and the high school in the time allocated to them. These barriers mirrored the findings of Eisenberg, Madsen, Oliphant, and Sieving (2013) who also found that a lack of time and resources was a barrier to providing sexual education at the level required.

Lack of training/skills

Most of the SHNs in this study expressed concerns about their lack of proper training in adolescent SRH. Moreover, some even lacked basic training in school health nursing. As a result of this, they were not confident about providing sexual education to learners. Hans (2007) argued that promoting healthy sexuality required well trained health professionals, equipped to handle issues around sexuality with sensitivity. These findings supported the results of a study undertaken in Swaziland where most of the participants in that study reported never having received training in adolescent SRH (Mngadi et al., 2008).

The results of a study in the UK also suggested that although SHNs had sufficient general knowledge of the topic, they lacked the knowledge, confidence, and level of comfort required to effectively teach about sexually transmitted infections or emergency contraception. This implied that the SHNs in that context had inadequate knowledge about SRH to contribute meaningfully to sexuality education in schools (Westwood and Mullan, 2006). Similar findings were also found in Northern Ireland (Thompson et al., 2008) and in Egypt, where school nurses were also concerned about their lack of skills and knowledge in the area of sexuality education (Farrag and Hayter, 2014).

Borawski, Tufts, Trapl, Hayman, Yoder, and Lovegreen (2015) looked at the effectiveness of health education teachers and school nurses teaching sexually transmitted infection/human immunodeficiency virus prevention knowledge and skills in high school. In their study they found that both classroom teachers and school nurses were effective in delivering reproductive health information to students, however the school nurses had a unique skills and experiences in teaching the technical and interpersonal skills needed to reduce high-risk sexual behavior (Borawski et al., 2015).

The findings of the study by Alldred and David (2007) and thus contrast with the outcomes of this study and the studies by (Farrag and Hayter, 2014; Westwood and Mullan, 2006). Alldred and David (2007) interviewed 15 school nurses in the UK. The results revealed that all these school nurses had confidence and see themselves as crucial sexual health experts in the delivery of the sexual education.

According to Alldred and David (2007), these school nurses had a striking culture of commitment to continuing professional development. This was congruent with the findings of Brewin et al. (2014), where none of the nurses had formal education in sexuality education (SE) in their nursing programmes, but had attended continuing educational programmes to strengthen their skills in SE.

These school nurses were thus different from the SHNs in this study, as well as those in the studies by Hayter et al. (2008) and Westwood and Mullan (2006). According to Rhodes et al. (2013), who found that professionally prepared health teachers taught key sexuality topics more often than non-professionally prepared health teachers. This was also confirmed by the findings of Chang, Hayter, and Lin (2014), the promotion of reproductive health education in schools required a skilled and knowledgeable individual.

According to Farrag and Hayter (2014), the Western settings had established training courses, policy and practice guidance and clinical support for sexuality education in schools. This was in contrast to the school setting in South Africa, where sexuality education was not prominent in school nursing. Shepherd, Kavanagh, Picot, Cooper, Harden, and Barnett-page (2010) contended that the necessity for sexuality education was becoming imperative due to the rise in STIs and unplanned adolescent pregnancy rates. Hedman, Larsen, and Bohnenblust (2008) maintained that in order to ensure that students receive sufficient information and knowledge on the prevention of teenage pregnancies, increased training for sexual health educators was necessary.

Offsite provision of services

The participants in this study had an impression that the provision of offsite services for learners was problematic as learners did not want attend the clinics where they were referred for contraceptives, for fear of being seen in the family planning clinic by relatives and neighbours. This was also evident in the literature (Ritcher and Mlambo, 2005); who reported that teenagers were reluctant to visit clinics to obtain contraceptives and thus did not make use of available health services.

According to Formby et al. (2010) SRE was mandatory in countries like Germany, Finland and the Netherlands, sexual health services were school based. As a result the Netherlands had the lowest teenage pregnancy rate in Europe (Jones, 2008). Clarke (2010) had reported that in Berlin there was a network of female doctors who delivered both education and sexual health services in schools; while in Finland, school nurses provided emergency hormonal contraception (EHC) and condoms. Previous studies where learners had access to services in school based health centres had shown an increase in SRH service and contraceptive use (Formby et al., 2010).

Previous literature revealed that many young people anticipated and/or experienced dismissive, punitive or judgemental attitudes in their encounters with mainstream health service providers (Higginbottom, Mathers, Marsh, Kirham, and Owen, 2006). Chandra-Mouli et al. (2015) argued that literature had shown that in order to increase adolescent use of SRH services, four complementary approaches had to be implemented together: -

- Providers must be trained and supported to be non-judgmental and friendly to adolescent clients
- Health facilities must appear welcoming and appealing
- Communication and outreach activities must inform adolescents about services and encourage them to make use of the services
- Community members must be supportive of the importance of providing health services to adolescents (Denno, Hoopes, and Chandra-Mouli, 2015; Mavedzenge, Doyle, and Ross, 2011; Dick, Ferguson, Chandra-Mouli, Brabin, Chatterjee, and Ross, 2006).

Learner cooperation

The findings of the current study revealed that there was a lack of learner cooperation. Most participants stated that the majority of the learners did not come to the class where the SRH talks were held but disappeared while the others attended the sexuality health talks. According to the SHNs, the learners gave an impress that they were being taught something that they already knew. Newton et al. (2013) also reported a lack of involvement of the targeted community while similarly Kumi-Kyereme et al. (2014) reported on the negative attitude of adolescents towards SRH matters. These results were in contrast to those from a Nigerian study, where the learners had a positive

attitude to health education that involved nurses (Akpabio, Asuzu, Fajemilehin, and Ofi, 2009).

Persistent risky sexual behaviour/ unintended programme outcome

The findings from this study indicated that despite the sexuality health talks, learners still engaged in risky sexual behaviour, evidenced by the number of adolescents who were pregnant while still at school. Risky sexual behaviours included: the early initiation of sexual intercourse, multiple sexual partners, and the lack of condom use and/or birth control. These findings were consistent with other study by Morake (2011). According to the figures released by the South African Provincial Department of Education, school girl pregnancies had doubled despite a decade of spending on sexuality education and HIV prevention (Morake, 2011). Despite extensive efforts in promoting condom use, young people still engaged in risky sexual behaviours and condom use remained relatively low. Other literature also revealed that despite the attention given to adolescent sexuality and teenage pregnancy prevention, many teenagers were still falling pregnant (Van Eijk, 2007).

A study conducted in Burkina Faso, Ghana, Malawi and Uganda among adolescents found that much older male partners inclined to preclude consistent condom use, thus predisposing the young girls to STIs, including HIV, and unplanned pregnancy (Morake, 2011; Bankole et al., 2007). While Walcott et al. (2008) informed that adolescents who initiated sexual intercourse early in their life were at high risk because they inclined to have multiple sexual partners and engaged in unprotected sex, this behaviour might be averted. Evidence from literature revealed that formal sexuality education that was provided before sexual initiation might effectively reduce adolescent sexual risk behaviours (Mueller, Gavin, and Kulkami, 2008). Reis, Ramiro, de Mantos, and Diniz (2011) agreed that adolescents who were knowledgeable, informed, motivated and skilled were capable of changing their attitude and subsequently their sexual behaviour.

5.5 Conclusion

Sexual and reproductive health programmes were often linked to the prevention of STIs and unintended pregnancies, however sexual health should be viewed as a normal developmental process that starts from adolescence and extends to adulthood. The current study sought to explore the understanding and experiences of SHNs of the

implementation of the adolescent' SRH programme. It became clear that the SHNs fully understood their role in the SRH programme. What was also apparent from this study were the barriers that they encountered in the implementation of this programme. A lack of support and understanding for the SHNs in the school setting had an impact on the implementation of their role.

The SHNs in this study appeared to have a clear understanding of the SRH programme even though it seemed to be improperly implemented. There appeared to be gaps in the programme implementation such as the fact that the teenage pregnancy programme only focused on the prevention of pregnancy and ignored the needs of those already pregnant, such as PMTCT, HCT, stigma and suicide in relation to SRH. Traditional circumcision and drug and substance abuse were also ignored, however the fact that traditional circumcision was not practiced in KZN may be the reason that SHNs did not emphasise it in the SRH programme.

Most of the SHNs acknowledged that they were inadequately equipped with knowledge and skills to provide high-quality and comprehensive adolescent SRH programme. In support of previous research by (Westwood and Mullan, 2006) and (Westwood and Mullan, 2009) SHNs were presently not effectively contributing to SRH programme. Equipping SHNs with the necessary skills and optimal teaching resources would increase the effectiveness of school based sexuality education. In spite of the challenges and the lack of resources, the SHNs were implementing the programme according to the legislative requirements.

It was hoped that the findings of this study would inform the implementation of school health programme in general, and especially those relating to adolescent SRH programme. More attention was needed for the provision of systemic training of SHNs in comprehensive adolescent SRH programme. Sexual health too was often overlooked in nursing courses in SA. The curricula within nursing and midwifery preservice education required revision so as to prepare health care professionals to adequately address and deal with adolescents' health care needs. The findings of this study would contribute to the increased knowledge and literature regarding this important topic. These findings would also encourage the SHNs to participate in policy making as they understood the needs of adolescents especially those related to SRH.

5.6 Recommendations

The recommendations for this study had been drawn from the findings of this study and from other studies which were utilised in the presentation and discussions of the research findings. It was necessary to let the school administrators and teachers understand how school nurses could assist to promote students' sexual health.

It is evident from this study that there was a need for the inclusion of sexuality and reproductive health in basic and advanced nursing practice curricula, as well as in nursing continuing education programmes. Evidence from the participants in this study indicated that nurses' required increased knowledge and skill related to sexuality across the lifespan. The SHNs should partake in continuing education and advance their knowledge of sexuality. SHNs could collaborate with each other and form a network to support each other so that they can be able to perform better. School health nurses needed to be empowered with the tools for programme development, negotiation, and leadership.

To guarantee improvement on accessibility and acceptability of healthcare services for adolescents, it was important that health care workers were aware of the country's policies which were already in place that pertain to adolescent SRH. Health care workers were required to understand the policies and their implications, and policy implementation must be monitored. There was also a need for consistency in the implementation of the adolescents SRH programme as it was noted that there was inconsistency in some aspect of role implementation. It was recommended that a study is conducted that looks into the actual implementation from the learners' and educators' perspectives.

5.7 Limitations

While this study provides some very useful data on this under-researched issue in the South African context, the relatively small number of participants may reduce the generalizability of the findings. As well as the non-probability nature of the sampling technique used limits the representativeness of the study sample. However, qualitative studies do not seek to generalize study findings, but rather to transfer results for use in a similar context. The specific geographic location of this study means that the views of SHNs in other districts could not be included in this study. Moreover, the findings

reflect reported information rather than observed behaviour. It is advisable to do further research in this respect.

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LIST OF ANNEXURES

Annexure A: Interview guide

An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal

Section: A

Participant Demographic data

Please mark with an X in the appropriate box provided.

1. How old are you.

--

2. Indicate your gender.

1. Male	
2. Female	

3. Professional Education.

1. Bachelor degree	
2. Diploma	

4. Years involved in school health nursing.

--

5. Location of Work.

1. Rural	
2. Suburban	
3. Urban	

5. Do you have formal qualification in school health nursing

1. Yes	
2. No	

6. Received training in sex education.

1. Yes	
2. No	

Section: B

1. What is your understanding of adolescents' sexual and reproductive health programs?

Probing questions:

1.1 What does the programme entail?

1.2 What is involved in providing this programme?

- 1.3 What exactly do you do?
 - 1.4 Who is the targeted population?
 - 1.5 What information is given to adolescents during this programme?
 - 1.6 What policies or legislation guides the programme?
 - 2 What are your experiences in being involved in adolescent sexual and reproductive health programs?
 - 2.1 Are there any barriers/ challenges that prevent you from delivering effective adolescent sexual and reproductive health promotion programs?
- If yes, can you explain about these please?
- 2.2 What motivates / facilitates you in providing adolescent sexual and reproductive health programs?
3. Do you have any other comments or concerns?

Annexure B: Approval by School of Nursing and Public Health Research and Higher Degree Committee



02 October 2015

Student No: 211559211

Dear Ms P Khuzwayo ,

MASTER OF NURSING (Community Health)

Title: "An Exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programme in as selected health district in KwaZulu-Natal."

Supervisor: Prof GG Mchunu

The above-mentioned ethics application was considered and the protocol has been approved for the Master of Nursing coursework degree by a Committee member of the Research and Higher Degrees Committee, School of Nursing and Public Health. The ethics application together with the protocol has been forwarded to the Humanities and Social Sciences Research Ethics Committee for review.

Please note:

- The study may not begin without the full approval of the Humanities and Social Sciences Research Ethics Committee.

Yours sincerely

Carol Dhanraj
School of Nursing and Public Health
Postgraduate Administration

cc: Ms C Ngcobo
Prof GG Mchunu

Postgraduate Administration

School of Nursing and Public Health

University of KwaZulu-Natal

Postal Address: University of KZN, Durban, 4041, South Africa

Founding Campuses:

- Edgewood
- Howard College
- Medical School
- Pietermaritzburg
- Westville

Annexure C: Approval by Humanities and Social Science Research Ethics Committee



30 November 2015

Mrs PP Khuzwayo 211559211
School of Nursing and Public Health
Howard College Campus

Dear Mrs Khuzwayo

Protocol reference number: HSS/1448/015M

Project Title: An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu-Natal

Full Approval – Expedited Application

In response to your application received on 6 October 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


.....
pp Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Supervisor: Prof Gugu Mchunu
Academic Leader Research: Professor M Mars
School Administrator: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)





Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000


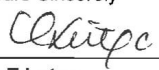
Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snymann@ukzn.ac.za / mohunp@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

Annexure D: Approval by KZN DOH

 health Department: Health PROVINCE OF KWAZULU-NATAL	DIRECTORATE: Health Research & Knowledge Management
Physical Address: 330 Langalibalele Street, Pietermaritzburg Postal Address: Private Bag X9051 Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782 Email: hrkm@kznhealth.gov.za www.kznhealth.gov.za	
Reference: 347/15 KZ_2015RP8_10	
Date: 27 November 2015	
Dear Mrs PP Khuzwayo University of KwaZulu Natal	
Email: ppkhuzwayo@gmail.com	
Approval of research	
The research proposal titled ' An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal ' was reviewed by the KwaZulu-Natal Department of Health.	
The proposal is hereby approved for research to be undertaken at [REDACTED] [REDACTED] [REDACTED] [REDACTED]	
1. You are requested to take note of the following: a. Make the necessary arrangement with the identified facility before commencing with your research project. b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.	
2. Your final report must be posted to HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200 and e-mail an electronic copy to hrkm@kznhealth.gov.za	
For any additional information please contact Mr X. Xaba on 033-395 2805.	
Yours Sincerely  Dr E Lutge Chairperson, Health Research Committee	
Date: <u>14/01/16</u> Fighting Disease, Fighting Poverty, Giving Hope	

Annexure E: Application letter to a selected Health District

Date: 19 November 2015

██████████ Health District

██████████

██████████

Dear Sir/Madam,

Re: REQUEST FOR A LETTER OF SUPPORT TO CONDUCT A RESEARCH STUDY

I hereby request for a letter of support to conduct a research study in your facility. I am a Masters student at the University of KwaZulu-Natal (UKZN), Department of Nursing and student no. 211559211. The title of my study is: **An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal.** The data collection process will only commence once I have obtained the full ethical approval from the UKZN ethical committee, the Provincial DOH and the selected Health District. The target group for my study is all school health nurses employed in the selected Health District.

Data collection process will behold confidentiality, anonymity, informed consent and the freedom of choice.

I hope that my request will be considered.

Yours faithfully,

Patience P. Khuzwayo

Student number: 211559211

Tel No: 0312628687

Fax No: 0312620019

Cell No: 0829282447

E-mail: ppkhuzwayo@gmail.com

Annexure F: Approval letter from the selected health district



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Physical Address: [REDACTED]

Postal Address: [REDACTED]

Tel: [REDACTED]

25 November 2015

Dear Ms Khuzwayo

Re: An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal

I have pleasure in informing you that your application to conduct research in [REDACTED] district has been approved at the following health care facilities:

- i. [REDACTED]
- ii. [REDACTED]
- iii. [REDACTED]
- iv. [REDACTED]
- v. [REDACTED]
- vi. [REDACTED]
- vii. [REDACTED]
- viii. [REDACTED]
- ix. [REDACTED]
- x. [REDACTED]
- xi. [REDACTED]
- xii. [REDACTED]

Please note the following:

- i. All research activities must be conducted in a manner that does not interrupt clinical care at the health care facility,

Fighting Disease, Fighting Poverty, Giving Hope

- ii. logistical details must be arranged with the CEO/medical manager /operational manager of the facility,
- iii. this research project should only commence after final approval by the KwaZulu-Natal Health Research and Knowledge Unit, and full ethical approval, has been granted, and
- iv. a report of your findings should be forwarded to the Ethekewini district office on completion of your project.

Yours sincerely



Medical Officer- Public Health Medicine

-
- KINDLY RETURN **ALL DOCUMENTATION** WHEN REPLYING

Annexure G: Application letters to health facilities

Date: 16 November 2015

██████ Clinic
C135 ██████████

Dear Sir/Madam,

Re: REQUEST FOR A LETTER OF SUPPORT TO CONDUCT A RESEARCH STUDY

I hereby request for a letter of support to conduct a research study in your facility. I am a Masters student at the University of KwaZulu-Natal (UKZN), Department of Nursing and student no. 211559211. The title of my study is: **An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal**. The data collection process will only commence once I have obtained the ethical approval from the UKZN ethical committee, the Provincial DOH and the selected Health District. The target group for my study is all school health nurses employed in the selected Health District.

Data collection process will behold confidentiality, anonymity, informed consent and the freedom of choice.

I hope that my request will be considered.

Yours faithfully,

Patience P. Khuzwayo
Student number: 211559211
Tel No: 0312628687
Fax No: 0312620019
Cell No: 0829282447
E-mail: ppkhuzwayo@gmail.com

Date: 25 September 2015

Community Health Centre
Road,

Dear Sir/Madam,

Re: REQUEST FOR A LETTER OF SUPPORT TO CONDUCT A RESEARCH STUDY


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Student number: 211559211
Tel No: 0312628687
Fax No: 0312620019
Cell No: 0829282447
E-mail: ppkhuzwayo@gmail.com

Date: 19 November 2015

 Clinics
Durban

Dear Sir/Madam,

Re: REQUEST FOR A LETTER OF SUPPORT TO CONDUCT A RESEARCH STUDY

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Student number: 211559211
Tel No: 0312628687
Fax No: 0312620019
Cell No: 0829282447
E-mail: ppkhuzwayo@gmail.com

Date: 25 September 2015

██████████ Clinic
30-32 ██████████
██████████

Dear Sir/Madam,

Re: REQUEST FOR A LETTER OF SUPPORT TO CONDUCT A RESEARCH STUDY

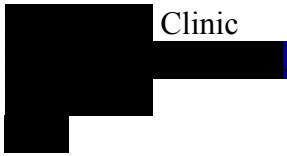
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Date: 25 September 2015



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I hope that my request will be considered.

Yours faithfully,

Patience P. Khuzwayo
Student number: 211559211
Tel No: 0312628687
Fax No: 0312620019
Cell No: 0829282447
E-mail: ppkhuzwayo@gmail.com

Date: 30 September 2015

██████████ Clinic
PO Box ██████████
██████████

Dear Sir/Madam,

Re: REQUEST FOR A LETTER OF SUPPORT TO CONDUCT A RESEARCH STUDY

I hereby request for a letter of support to conduct a research study in your facility. I am a Masters student at the University of KwaZulu-Natal (UKZN), Department of Nursing and student no. 211559211. The title of my study is: **An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal**. The data collection process will only commence once I have obtained the ethical approval from the UKZN ethical committee, the Provincial DOH and the selected Health District. The target group for my study is all school health nurses employed in the selected Health District.

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Patience P. Khuzwayo
Student number: 211559211
Tel No: 0312628687
Fax No: 0312620019
Cell No: 0829282447
E-mail: ppkhuzwayo@gmail.com

Annexure H: Approval letters from health facilities



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Postal Address:
Physical Address:
Tel:
www.kznhealth.gov.za

23rd November 2015

*Ms PP Khuzwayo
6A Winslow Road
Westville
3629*

RE: Letter of Support to do research at [REDACTED]

This letter serves to confirm that permission is hereby granted to undertake research on School Health Nurses and their understanding and experiences of adolescent sexual and reproductive health problems in KZN. This letter is granted on the following provisions:

- 1. That approval first be granted from the [REDACTED] District Office*
- 2. That permission is granted from Provincial Department of Health*
- 3. That the results of the research will be shared with this facility when available.*

Yours sincerely,


[REDACTED]
CEO/Medical Manager
[REDACTED]



28 September 2015

Enquiry: [REDACTED]

To
Patience P Khuzwayo
Principal Investigator
Dept. of Nursing and Public Health
UKZN

RE: PERMISSION TO CONDUCT RESEARCH AT OUR FACILITY

I have pleasure in informing you that permission has been granted to you by [REDACTED] to conduct your research on "An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu-Natal" at this health facility together with [REDACTED]

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once YOU PROVIDE THE FINAL ETHICAL CLEARANCE FROM THE UKZN ETICS COMMITTEE.
3. Please ensure this office is informed before you commence your research.
4. The [REDACTED] (Facility) will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Facility.

Thanking you

Sincerely


Medical Manager

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Enquiries: [REDACTED]
Date: 02/11/2015

P.P. Khuzwayo
University of Kwa Zulu Natal
Durban

RE: REQUEST TO CONDUCT THE RESEARCH STUDY

"An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal"

Dear Patience

I have pleasure in informing you that permission has been granted to you to continue with your research studies at [REDACTED] Clinics

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the DOH with regard to this research.
2. This research will only commence once you provided the final ethical clearance from the UKZN ethics committee and the DOH.
3. Please ensure that this office is informed before you commence your research.
4. The [REDACTED] clinics will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the facility.

Thank you

[REDACTED]
(PHC Supervisor-SSA)

[Signature] 2015/11/02

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

Reference: Research - [REDACTED]

Date : 10th November 2015

MRS. P.P. KUZWAYO
SCHOOL OF NURSING AND PUBLIC HEALTH
HOWARD COLLEGE CAMPUS
ppkhuzwayo@gmail.com

Dear Mrs. Kuzwayo,

RE: AN EXPLORATION OF SCHOOL HEALTH NURSES UNDERSTANDING AND EXPERIENCES OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES IN A SELECTED HEALTH DISTRICT IN KWAZULU NATAL

I have a pleasure in informing you that permission has been granted to you to conduct research on:

Kindly take note of the following information before you continue:-

1. Please adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KwaZulu Natal Department of Health.
3. Kindly ensure that this office is informed before you commence your research.
4. The hospital will not provide any resources for this research.
5. You will be expected to provide feedback once your research is complete to the Chief Executive Officer.

Yours faithfully

HOSPITAL MANAGER



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Enquiries: [REDACTED]
Extension: [REDACTED]
Date: 16 November 2015

Attention: Ms. P.P. Khuzwayo
University of KwaZulu Natal

Dear Madam

RE: PROVISIONAL PERMISSION TO CONDUCT RESEARCH – [REDACTED]
CHC

Please note that provisional permission has been granted for you to do Research at [REDACTED] CHC on the research proposal title: **An exploration of School Health nurses understanding and experiences of adolescent sexual and reproductive health programme in a selected health district in KwaZulu Natal.**

However, you are kindly advised to request permission at Head Office – Health Research & knowledge Management, their contract no is [REDACTED] and [REDACTED] Office, their contact number no is [REDACTED]

Wishing you all the best on your research study.

Thank you

[REDACTED]
Acting Chief Executive Officer



health

Department:
Health
PROVINCE OF KWAZULU-NATAL



Enquiries: [REDACTED]
Tel: [REDACTED]
Date: 28 September 2015

Patience P. Khuzwayo
University of KwaZulu-Natal
Durban

RE: REQUEST TO CONDUCT RESEARCH

"An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programs in a selected health district in KwaZulu-Natal"

Dear Patience

1. Your request to conduct research at [REDACTED] is hereby granted.
2. Please adhere to all the principles, guidelines and policies of the DOH as you conduct this research.
3. Please ensure that this office is informed of the date of commencement of your research.
4. [REDACTED] will not be able to provide you with any resources for this research.
5. You are requested to share your findings with us at [REDACTED].

Thank you

Yours sincerely

[REDACTED]
Medical Manager and CEO

Umnyango Wezempilo



Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope.

Annexure I: Information letter

Information sheet

Date :
Name of Research : Patience P. Khuzwayo
Address of student : UKZN
Student Number : 211559211
Contact Number : 0829282447
E mail : ppkhuzwayo@gmail.com
Name of Supervisor : Prof. Gugu Mchunu
Contact Number : 031-2601421
E mail : mchunug@ukzn.ac.za
Name of Department : School of Nursing
Name of Institution : University of KwaZulu Natal (Howard College Campus)

Dear Participant

I am completing a research project as part of the requirements for Master's Degree in Nursing (Community Health).

Title: An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal

Purpose of the research: The purpose of this study is to explore the selected school health nurses' understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal. It is hoped that the findings of this study will assist school health nurses to seek more information relating to school health programs in general and special on issues relating to adolescent health programmes. The research findings will hopefully also contribute to other areas nursing education, health policy development and in research.

Description of the Procedure: Your participation is requested as you represent the population under study. As part of the research process you are required to participate in an interview which will take about 45-60 minutes. The interview will be audio taped. The researcher will ask you the suitable time to use for the interview. All data collected will be used for the purpose of this study only. No names or personal information will appear on any transcripts. Collected data will be kept safely by the researcher. Computer data will be kept confidential on a computer which has a code of access known only by the researcher. The interview data will be kept in the locked cupboard accessible to the researcher only during the research period. Data will be kept for the period of five years in a secured location with arrangement of supervisor at the school. After five years data

stored on the computer will be erased from both programme files and the recycle bin and the hard copies will be incinerated.

Ethical Aspects: Please note that your identity and information will be treated with utmost confidentiality. Please feel free to ask any questions you may have so that you are clear about what is expected of you.

Please note:

- You are free to not participate
- You are free to withdraw at any stage without repercussions
- Your name will not be used nor will you be identified with any comment made when the data is published.
- There will be no risks attached to your participation

Advantages to you as a respondent: The findings of the study will be made available on completion.

Thank you.

Researcher:

Annexure J: Declaration for consent

PROJECT TITLE: An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal

Researcher

Full name: Patience P. Khuzwayo

School: Nursing and Public Health

College: Health Sciences

Campus: Howard

Proposed qualification: Masters in Nursing
Community health

Contact: 0829282447

Email: ppkhuzwayo@gmail.com

Supervisor

Full name: Prof. Gugu Mchunu

School: Nursing and Public
Health

College: Health Sciences

Campus: Howard

Contact: 0312602402

Email: Mchunug@ukzn.ac.za

HSSREC RESEARCH OFFICE

Full Name: Prem Mohun

HSS Research Office

Govan Mbeki Building

Westville Campus

Contact: 0312604557

Email: mohunp@ukzn.ac.za

I, **Patience P. Khuzwayo**, Student no. 211559221 am a Masters student, at the School of Nursing and Public Health, at the University of KwaZulu Natal. You are invited to participate in a research project entitled: **An exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal**. The purpose of this case study is to explore the selected school health nurses' understanding and experiences of their involvement in adolescent sexual and reproductive health promotion program in one of the selected health district.

Through your participation, I hope to exploration your understanding and experiences of adolescent sexual and reproductive health programmes. I guarantee that your responses will not be identified with you personally. Your participation is voluntary and there is no penalty if you do not participate in the study. Please sign on the dotted line to show that you have read and understood the contents of this letter. The interview will take approximate 45-60 minutes and will be audio taped.

DECLARATION FOR CONSENT

I.....
(Full Name) hereby confirm that I have read and understand the contents of this letter and the nature of the research project has been clearly defined prior to participating in this research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Participants Signature.....

Date.....

Annexure K: Informed consent letter

School of Nursing and Public Health, College of Health Sciences,
University of KwaZulu-Natal,
Howard Campus,

Dear Participant

INFORMED CONSENT LETTER

My name is Patience P. Khuzwayo. I am a Masters student in Nursing Community health candidate studying at the University of KwaZulu-Natal, Howard campus, South Africa.

I am interested in exploring the school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal. I am conducting a study from school health nurses in the selected CHC. Your facility is one of my case studies. To gather the information, I am interested in asking you some questions.

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- The research aims at an exploration of school health nurses understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu Natal.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	willing	Not willing
Audio equipment		
Photographic equipment		
Video equipment		

Annexure L: A sample of transcript of oral interview

Interview No.: 2

RESEARCH PROJECT ON EXPLORATION OF SCHOOL HEALTH NURSES UNDERSTANDING AND EXPERIENCES OF ADOLESCENCES AND SEXUAL REPRODUCTIVE HEALTH PROGRAMME

Good morning, my name is Patience Khuzwayo. I am a student at University of KwaZulu-Natal. I am doing a Master's Degree. As part of the programme I am required to conduct a research project and the title my Research Project is Exploration of School Health Nurses Understanding and Experiences of Adolescence Sexual and Reproductive Health Programme in a selected health District in KwaZulu-Natal. The purpose of the study is to explore the selected SHNs understanding and experiences of adolescence, sexual and reproductive health programme. It is hoped that the findings of the study will assist school health nurses to seek more information relating to school health programme, in general and specific on issues relating to adolescence health programme.

The research findings will hopefully also contribute to nursing education, health policy development and in research. Your participation is requested because you represent the selected population which is understudy. As part of the research project you are required to participate in an interview which will take about 45 to 60 minutes. The interview will be audio taped, the data collected will be used for the study only. No names or personal information will appear on any transcript. Collected data will be kept safely by the researcher. You are free not to participate in the study and you are free to withdraw at any stage without repercussions. Your name will not be used nor will your identity with any comments made when the data is published. There will be no risk attached to your participation. As I have mentioned the interview will be recorded. Do you agree to be recorded?

CANDIDATE : Yes, I do.

INTERVIEWER : Thank you. The first section of the interview deals with a demographic data. How old are you?

CANDIDATE : 60 years

INTERVIEWER : 60 years

Indicate your gender.

CANDIDATE : Female.

INTERVIEWER : Female.

Do you have a Diploma or Bachelor's degree?

CANDIDATE : Bachelor's degree.

INTERVIEWER : Bachelor's degree.

How long have you been involved in School Health Nursing?

CANDIDATE : Since 1991 with an interruption from 2003 up to 2014.

INTERVIEWER : From 2003 up to 2014 you haven't been doing school health nursing?

CANDIDATE : Yes.

INTERVIEWER : But you resumed in 2015?

CANDIDATE : Yes.

INTERVIEWER : So, it's between...

CANDIDATE : It's in 2014.

INTERVIEWER : In 2014.

CANDIDATE : February 2014.

INTERVIEWER : Okay, thank you. The area where you are working; is it a rural, sub-urban or urban area?

CANDIDATE : Sub-urban.

INTERVIEWER : Sub-urban. Do you have any formal training in School Health Nursing?

CANDIDATE : Yes.

INTERVIEWER : What is it?

CANDIDATE : Community health Diploma. It covered school health component.

INTERVIEWER : It covered school component?

CANDIDATE : Yes. And we had a workshop in 2015 on school health services from the Department of National Health.

INTERVIEWER : Have you received any training on sex education?

CANDIDATE : Sexuality education, yes.

INTERVIEWER : What did it pertain?

CANDIDATE : It was relating to youth and their body image, their figures and their... basically a whole concept of their sexuality, there being as a male and female and their relationships.

INTERVIEWER : Thank you.

What do you understand about Adolescence Sexual and Reproductive Health Programme?

CANDIDATE : These are programme that cover again their sexuality, there being as a sexual being male and female and their part of living in society and the practices that they undertake with regards to their sexual needs and the sexual and reproductive health.

Basically, they deal with their bodies and their bodies' needs and the relationships that they are bombarded with.

INTERVIEWER : What is the target population?

CANDIDATE : The target population is the youth but basically we start with the body changes with the grade 4's and then age related up to the grade 8's and 10's. That is our target now.

INTERVIEWER : In the grade 4's; what is it that you do?

CANDIDATE : We target basically that they know their bodies and the changes that occur and that they understand whether they are following the normal route of growth and development because they need to be reassured that what their body is going through is normal. And if they have any concerns then they need to bring it up and then we can refer them appropriately.

INTERVIEWER : And in the other age groups?

CANDIDATE : The other age groups, they would come to us on the one-to-one basis when they have their needs but generally they are very shy. You will find that very few learners that come up to you. So, we do them in groups and then the target groups that have been identified by the State.

INTERVIEWER : What are the targeted groups?

CANDIDATE : The target group is grade 4, boys and girls.

INTERVIEWER : Yes.

CANDIDATE : And then grade 8 and grade 10's, boys and girls.

INTERVIEWER : Okay, when you are dealing with them in groups just like grade 8's. What is it exactly that you convey to them?

CANDIDATE : We give them the messages on their growth and development. We give them information, we explore their values and their feelings and we also speak about the services available to them and how they can access these services that we have and the age groups for them. We deal with all the aspects that discovered in the legislation in the Sexual Reproductive Manuals and Health Act that is covered there. They know that they are taught what they have a right to, like they don't know what age they can be to access family planning services and we clarify these things for them so that they know what is available out there and that they do have access to a lot of protection regarding family planning and regarding the diseases, sexual transmitted infections.

There is a whole lot of stuff and we also talk about the stigma and the stuff where they can access services in any Clinic that they are comfortable with and we also re-enforce them that they do have rights and they can even go in their school uniform and they will be dealt with like any other person/any client with non-judgmental and with privacy. These are like important things for them. So, we cover all that with them.

INTERVIEWER : The intents of the real sexual health and reproductive aspects. What is it that you talk about?

CANDIDATE : As I did say, we speak about their bodies what is normal, their growth, and their development. We speak about pregnancies, we speak about contraception, again, and all the stuff that I have mentioned previously. I do have the file if you want to look at what we do cover and the services that are available, the options that we have, the services that they can access. It's all done over and over with them, whenever they need to.

INTERVIEWER : Do you find that there are kids that come and perhaps ask the questions about menstruation?

CANDIDATE : They do. We do cover menstruation, puberty. All that is covered, after their growth and development.

INTERVIEWER : What policies and legislations that guides this programme?

CANDIDATE : We have got Sexual and Reproductive Health Act, the Termination of Pregnancy Act. I don't know the exact numbers, I can't remember all. Health Act, Child care Act those are the Governing Act

INTERVIEWER : As a School Health Nurse what is your role in adolescence, sexual health programme?

CANDIDATE : We guide and educate a lot but regarding actual service delivery on site, to date we are not allowed to do HIV testing in schools, we are not allowed to distribute condoms.... we promote condom usage but we do not supply male and female condoms nor do we supply contraceptives. We only provide the information on where they can access that because that is still not approved of in the policy guide that we have on service delivery at schools.

INTERVIEWER : What are your experiences in delivering SRH information to adolescents?

CANDIDATE : The information goes down very well. In fact, the youth they do come up and ask a lot of questions, some of them are shy, some are not shy and they ask a lot of questions. But a lot of them still take risks, they are having unprotected sexual intercourse and they know about the morning-after pill and they know that services are available but still they don't access it.

INTERVIEWER : Are there any barriers or challenges that you come across when delivering the adolescent sexual health and reproductive programme?

CANDIDATE : Not from the youth per say but in certain schools certain governing bodies, depending on the cultural predominance at that school, some of them prefer not to be having these programs by us but they cover it in their own school life orientation topics with their educators. So, the school gives us a guide as to what we can cover and what we shouldn't cover because it is quite a sensitive issue at some of the ex-model C school and we just come in and only do the screening and don't worry about the rest, the teachers will cover it. So, we work according to what the school guides us with.

INTERVIEWER : What motivates you or facilitates you to provide the effective adolescence sexual and reproductive programme?

CANDIDATE : If we can save one single child and guide them onto the right path, that is the guiding force because, at the end of the day, the purpose at school is to be educated and to pass and to further their careers. So, there shouldn't be these road bumps that are called in when I do talk to them; that they shouldn't have these hitches where they have the psychological hang-ups with uncertainty about pregnancy and diseases. It can be prevented and we must totally acknowledge that this person is a sexual being and when it comes to certain ages that they are when they are in grade 8 and in grade 10, their hormones are at peak and they don't know how to deal with these feelings that they have.

So, we do little fun groups with them and you know how to deal with these feelings and at the end of the day we must understand that a person and individual has a right as to what happens to their body when they are deciding to have sex, we shouldn't be parental with them or judgmental and we should just guide them onto the right path, go to the Clinic and protect themselves so that they can further their goals in life.

INTERVIEWER : Thank you. Do you have any questions?

CANDIDATE : No.

INTERVIEWER : Are there any suggestion?

CANDIDATE : I think we must do more in line with educating parents on the way.... parenting, generally being a friend to their adolescent cause a lot of times when I do speak to the young people, they say ***"I wish I had a mother like you or a parent like you"***. A parent themselves forms this barrier where they will just go and be prescriptive and say you do this, you don't do this but forgetting that we were young people once, we walked through the same shoes maybe the times are different now, the dressing may be different, the technology is different but, when it comes to physiological changes and the hormones and things, we are still male and female, like we were in the 50's. It is just the eras that have changed and we must acknowledge we went through the same thing, we walked through the same mood swings and barriers and curiosity about sex, boys and relationships. So, we must acknowledge that and we must sit and be a friend to our kids. This is what is lacking in certain households and therefore we are having these problems.

Now, the support system is so different because the extended family has broken down, it is a no-clear family, it is a single-parent family and all these things have an impact on the youth of today. So, they go seeking love elsewhere and just thinking that it is love but it's not love it's just like comfort. A lot of them get comfort because sex is comforting, depending on the person, they feel that sex and love is the same whereas we tell them it is not the same, it can just be physical intimacy but it's not love. All these things need to be clarified and you cannot just tell your child don't have sex, they want to have, they are going to have sex, no matter how much you going to preach abstinence. So, you need to tell them that this is what is available and make it available. Basically, parenting skills should be taught to our parents which is a big lack.

INTERVIEWER : Thank you very much for your suggestion. I hope other parents would be happy if they are educated about how to parent children.

CANDIDATE : There are certain things that you can talk. If you are uncomfortable, rather just get your child to speak to somebody that can speak to your

child to give them the facts. Give them the facts because that is all they need and they will decide on their own what is good for them and what is not and you will be amazed that children, not matter how young they are, they make good decisions once they have the facts.

INTERVIEWER : Thank you.

Annexure M: Editors confirmation letter for editing of the project



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18 October 2016

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Patience Khuzwayo

EDITING OF RESEARCH ARTICLE OF PATIENCE KHUZWAYO

I have an MA in English from University of Natal (now UKZN) and have been performing editing services through my company for eleven years. My company regularly edits the research dissertations, articles and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal and other institutions, as well as editing for publishing firms and private individuals on contract.

I hereby confirm that Pauline Fogg edited the research dissertation of **Patience Khuzwayo** titled "*An exploration of school health nurses' understanding and experiences of adolescent sexual and reproductive health programmes in a selected health district in KwaZulu-Natal*" on behalf of WordWeavers cc and commented on the anomalies she was unable to rectify in the MS Word Track Changes and review mode by insertion of comment balloons prior to returning the document to the author. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense, referencing and language usage as well as to sense and flow.


I trust that the document will prove acceptable in terms of editing criteria.

Yours faithfully

C Eberle

Catherine P. Eberle (MA: University of Natal)

Annexure N: Turnitin Plagiarism report

Turnitin Originality Report	
Thesis by Patience Primrose Khuzwayo	
From Research submission (Research 2016)	
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