

**Factors that influence utilization of primary health  
facilities by adolescents in Tafelsig,  
Mitchells Plain**



**A mini-thesis submitted in partial fulfillment of the requirements for the degree of Masters  
in Public Health in the School of Public Health, Faculty of Community and Health  
Sciences, University of the Western Cape**

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**Key words**

Primary level public health facilities

Access to healthcare

Utilization of health facilities

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Urban poor

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## Abstract

Promoting positive and healthy decision-making practices and encouraging the utilization of health care facilities amongst adolescents is an important public health priority given that the period of adolescence is characterized by experimentation and risk taking behaviour. In the Tafelsig area of Mitchell's Plain, a poor socio-economic community within the Cape Town metropole, adolescents are exposed to a range of social problems (such as alcohol and substance abuse) that can potentially be harmful to their health. Given this context there was some concern raised by the sub-district health management team that adolescents are not making sufficient use of the local health facilities. The purpose of this study was to gain a greater understanding of the factors that contribute to, or hinder, the utilization by adolescents of the public health facilities in the Tafelsig area and in turn provide the Department of Health with information on adolescents' preferences concerning access to and use of the local primary-level health services in Mitchells Plain.

An exploratory descriptive study was conducted to explore the topic using qualitative research methods. Permission to conduct the research was obtained from the Higher Degrees Committee of the University of the Western Cape and the School Principal. In-depth interviews were conducted with eight Grade 9 and seven Grade 10 male and female learners from the local secondary school - all of whom were randomly selected from a list of learners who indicated their willingness to participate in the study and who had obtained the written consent from their parents or guardian to do so. Interviews with the learners explored the positive and negative experiences, perceptions and opinions they have of using – or contemplating the use of – the local health facilities. The data from these interviews were analyzed using thematic content analysis.

The study demonstrated that even when public health services are available, adolescents are often not in a position themselves to choose for themselves: their parents or guardians invariably make the choice for them. At times they are also reluctant to use public health facilities for fear of being judged by health personnel for being sexually active. The idea of waiting for long

periods of time to see a health professional, or being observed at the health facility by other members of their community, are also considered to be disincentives.

Many of the learners interviewed expressed a need for more information about sexual and reproductive health issues and matters that affect their health. The findings of this study also suggest that there is an urgent need for youth-friendly health services to be made available in the Mitchells Plain community. It is thus recommended that the Department of Health strategically assess whether an existing public health facility can be re-orientated to cater for the specific health needs of adolescents in Mitchells Plain.



## Declaration

I declare that the work presented herein; Factors that influence utilization of primary health facilities by adolescents in Tafelsig, Mitchells Plain, is original and that it has not been submitted for any degree or examination in any other university or institution for the award of a degree or certificate and that all sources of information and data used or quoted have been duly indicated and acknowledged.

Name and Surname: Thashlin Govender

Signature:



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This work is dedicated to the learners of Tafelsig and Thameshni Naidoo. You all have been a source of inspiration and have reinforced the researcher's commitment to making a difference.



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## List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
DOH	Department of Health
HIV	Human Immunodeficiency Virus
NAFCI	National Adolescent-Friendly Clinic Initiative
NPO	Not-For-Profit Organization
STATSA	Statistics South Africa
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization



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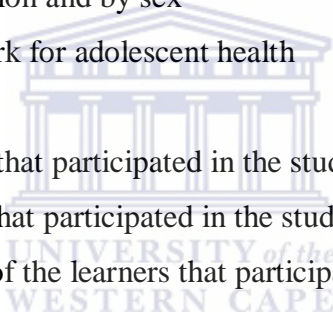
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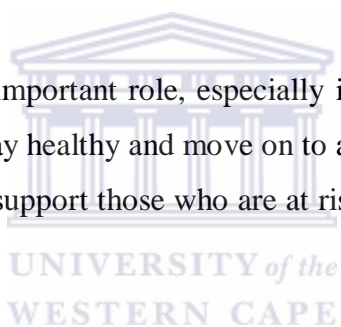


## Chapter 1: Introduction

### 1.1 Background information

The City of Cape Town is a reflection of the broader South African society, with many contrasts between the rich and poor, the skilled and unskilled, and the healthy and ill (Brookes, Shisana & Richter, 2004). It is also characterized by the presence of numerous vulnerable groups (such as adolescents, women, the disabled and those affected by extreme poverty) who find themselves on the margins of society (Brookes, Shisana & Richter, 2004). When social and human development is poor, the social fabric of communities begins to disintegrate (Parry & Dewing, 2006). This has a long-term effect on the development and health of children and adolescents (Hoffman, Futterman & Myerson, 1999).

Health services therefore play an important role, especially in vulnerable communities, as they help children and adolescents to stay healthy and move on to adulthood. They treat those who are ill or injured and reach out to and support those who are at risk as a result poor health (Stefan & Van der Merwe, 2008).



Promoting positive and healthy decision-making practices and encouraging the utilization of health care facilities by adolescents is an important public health priority, given that the period of adolescence is characterized by experimentation and risk-taking behaviour (Hawkins, Catalano & Miller, 1992). Initiatives that aim to protect adolescents from risks help to ensure longer, more productive lives for members of this group (Ijumba, Day & Ntuli, 2004). This is particularly true for those adolescents who are more likely to develop health problems as a result of economic, cultural and social factors which intensify their vulnerability (UNAIDS, 2010).

The commonly accepted term ‘adolescence’ is used in this study to refer to the age group between 10 and 19 years of age. This has been described as the fastest growing population group in sub-Saharan Africa (WHO, 2008). In South Africa, the number of adolescents is estimated at 9.95 million – almost 21% of the population (StatSA, 2006).

## 1.2 Outline of the research problem

The Tafelsig area of Mitchell's Plain is a poor socio-economic community within the Cape Town metropole, and approximately 62% of the population is younger than 29 years of age (StatSA, 2003). Adolescents in the Tafelsig community are exposed to a range of social problems that can potentially be harmful to their health. These include, for example, alcohol and substance abuse, as well as the endemic gang culture and the associated high levels of inter-personal violence. Drug and alcohol abuse was seen as the major health problem facing the youth in Mitchells Plain (Mpofu, Caldwell, Smith, et al., 2006). It is recognized that alcohol and drug abuse leads to risky adolescent behaviour (Hawkins, Catalano & Miller, 1992).

Teenage pregnancy is another issue of concern in this community. Almost 5.5% of all new-born infants in Mitchell's Plain are born to teenage mothers (Kapp, 2008; WC-NACOSA, undated). This statistic points not only to the need for sexual and reproductive health-related information, counselling and services to be made available to adolescents in this neighbourhood, but also is an indicator of how vulnerable these adolescents are to HIV and other sexually transmitted infections (STIs) through unprotected sex.

Information received from officials at the Mitchells Plain District Health Department described ten primary-level public health facilities that young people can access, none of which have been established as specifically "youth-friendly" clinics. Annual targets have been set by the City of Cape Town at the district health level regarding the number of adolescents that health facilities are expected to reach (Ms. Nqana, personal communication, 3 November 2010). However, in consultation with the Head of Primary Health Care and Programmes, Ms. Nqana, concern was expressed that health facilities within the Mitchells Plain community are being under-utilized by adolescents living in the area. This was evidenced by the fact that targets set for the provision of primary health care to adolescents (specifically in relation to sexual and reproductive health) were not being met (Ms. Nqana, personal communication, 3 November 2010). In addition, there was also a concern within the Sub-district health management team about the high rate of teenage pregnancy in the Mitchells Plain community – something which the department was

trying to address through its adolescent health programme, provided through the clinics (Ms. Nqana, personal communication, 3 November 2010).

Further consultation with the Principal of Tafelsig Secondary School confirmed that a significant number of Grade 9 and 10 learners were falling pregnant (Ms. O'Shey, personal communication, 15 November 2010).

The under-utilization by adolescents of the local health facilities, as described above, is not unexpected, given the findings of a 2009 WHO study which investigated the evolution of the national adolescent-friendly clinic initiative in South Africa:

*In spite of the high prevalence of HIV, STIs and teen pregnancy, many young people do not use public health services in South Africa, and have reported barriers when they have attended clinics. As in other countries, the barriers reported by young people relate to access and quality, including the attitude of staff, the time of the service, confidentiality, embarrassment at being seen in the clinic waiting room with adults from their community, and not understanding their diagnosis or treatment. (WHO, 2009:11)*

This study therefore aimed to identify and explore some of the possible factors that influence the utilization by adolescents of local primary-level healthcare facilities in their neighbourhood – in this case, the Tafelsig area of Mitchell's Plain, Cape Town.

### **1.3 Outline of the mini-thesis**

In Chapter 2 a review of international and local literature on adolescent health is provided. The health status of adolescents in South Africa, together with the associated risk factors, will also be examined. The chapter further attempts to provide background on adolescent-friendly health facilities, and briefly outlines Mechanic's theory (1978), one of the models used in the study to describe health-seeking behaviour.

Chapter 3 provides a description of the research methods used in this study, and includes details of the participants and the data-gathering tool utilized in the study. The Chapter also details the steps taken by the researcher to ensure representivity and rigour. Details of the registration and ethics approval of the study are also provided in Chapter 3.

In Chapter 4 the data from the study is presented. This is followed by a discussion of these results in the next chapter (Chapter 5). Finally, in Chapter 6 conclusions emanating from this study are presented, with specific recommendations for key stakeholders working within the Departments of Health and Education within the Mitchells Plain Sub-district.



## Chapter 2: Literature Review

### 2.1 Introduction: Defining Adolescence

The word ‘adolescence’ is a term derived from the Latin word *adolescere* which means to grow (Berk, 2007). Adolescence is also commonly referred to as the stage of physical and mental development that occurs between childhood and adulthood in humans (Berk, 2007).

According to the World Health Organisation (WHO), ‘adolescence’ covers the period between 10 and 19 years of age, while ‘youth’ has been defined as applying to the 15-24 year age group (WHO, 2004). The WHO’s definition of adolescence has been adopted and is used to describe and classify adolescents in South African policy documents. For the purposes of this study, the WHO definition will be used.

There are public health, human rights and economic motives for investing in the development and health of adolescents. In certain countries, poverty, war, early marriage and HIV force children into adult roles while they are still very young (WHO, 2004). This places the adolescent section of the population under strain and impacts on their adult lives. Factors that are crucial to adolescent development in any setting are (i) the legal framework and the social and health policy of the country; (ii) the safety of communities; (iii) opportunities for education and recreation (Bamjee et al., 2007); as well as (iv) the presence of a supportive and caring family. Positive and consistent emotional connection with a caring adult or mentor can help young boys and girls feel secure and safe, and give them the resilience to overcome the challenges they face in their lives (Betz, 2004).

### 2.2 Risk factors affecting the health of adolescents

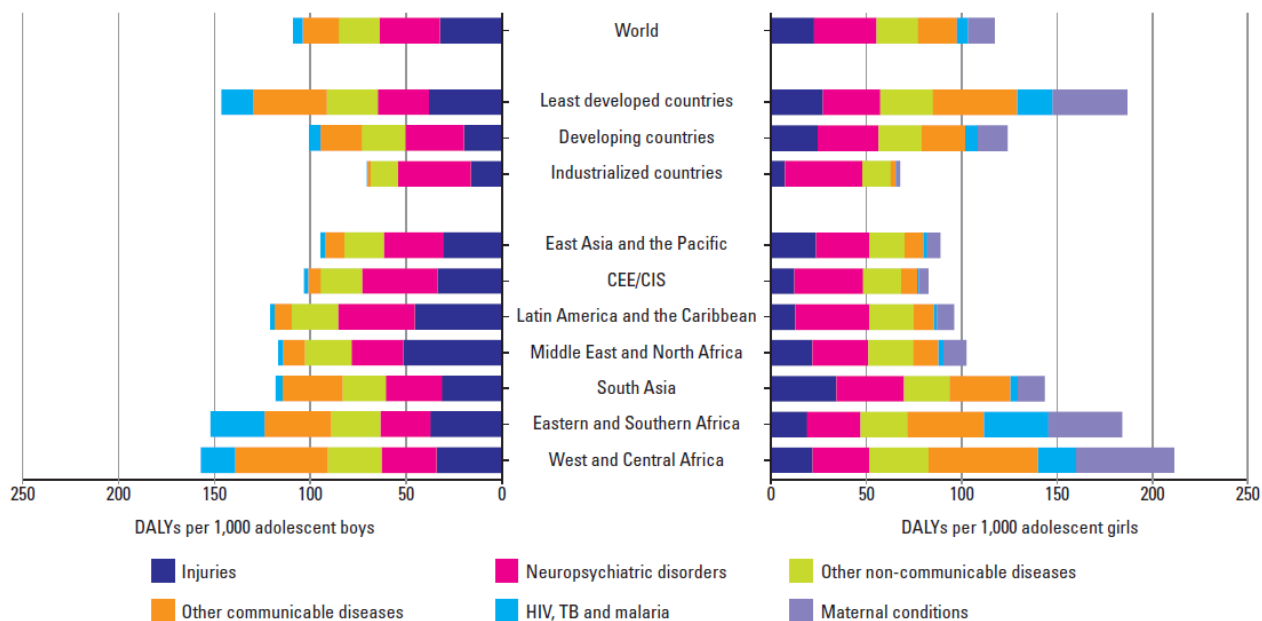
The period of adolescence involves biological, psychological, and social changes (Shaffer & Kipp, 2007). Adolescents have been reported to be negligent of their health. This is of major concern, as this will have long-term implications for their adult lives (Berk, 2007).

According to the UNICEF report card on adolescents (2012), annually, almost 1.4 million adolescents lose their lives as a result of suicide, road traffic injuries, violence, complications in childbirth, HIV/AIDS and other causes. It has been reported that the causes of adolescent death vary according to region, and that mortality patterns are associated with gender (UNICEF, 2012). For example, in Latin America, injuries (including homicide) are the main cause of death among adolescent boys (UNICEF, 2012). In Africa, complications resulting from pregnancy and childbirth are the leading cause of mortality among adolescent girls, while gang violence is common among adolescent boys (UNICEF, 2012).

The report card also describes adolescents with disabilities as being at increased risk from violence and sexual abuse (UNICEF, 2012). Figure 1.1 below, illustrates the injuries and neuropsychiatric disorders of mortality and morbidity among adolescents in all regions, as reported by the World Health Organization 2010 in the *Global Burden of Disease Update* (WHO, 2010). Neuropsychiatric disorders include depression, bipolar disorder, anxiety/panic disorders (including post-traumatic stress disorder and obsessive-compulsive disorder), psychotic disorders (including schizophrenia), seizure disorders (including epilepsy and Parkinson's disease) and alcohol and drug-use disorders.

Figure 1.1 illustrates that 'least developed' and 'developing' countries have a much larger disease burden in adolescents between the ages of 10-19 years, compared to developed or industrialized countries. A major cause of disease in the Eastern and Southern Africa region is unsafe sex; this is reported to be one of the greatest risk factors among boys and girls between the ages of 10 and 14 years (UNICEF, 2012). The risk for females is reported to be nearly double that for males between these ages in this region. These findings set the region apart from the others in terms of the key risk factors for this particular age group (UNICEF, 2012). The findings of the WHO report (WHO, 2010) are of particular interest, as the learners participating in this study are part of this age group and come from this region.





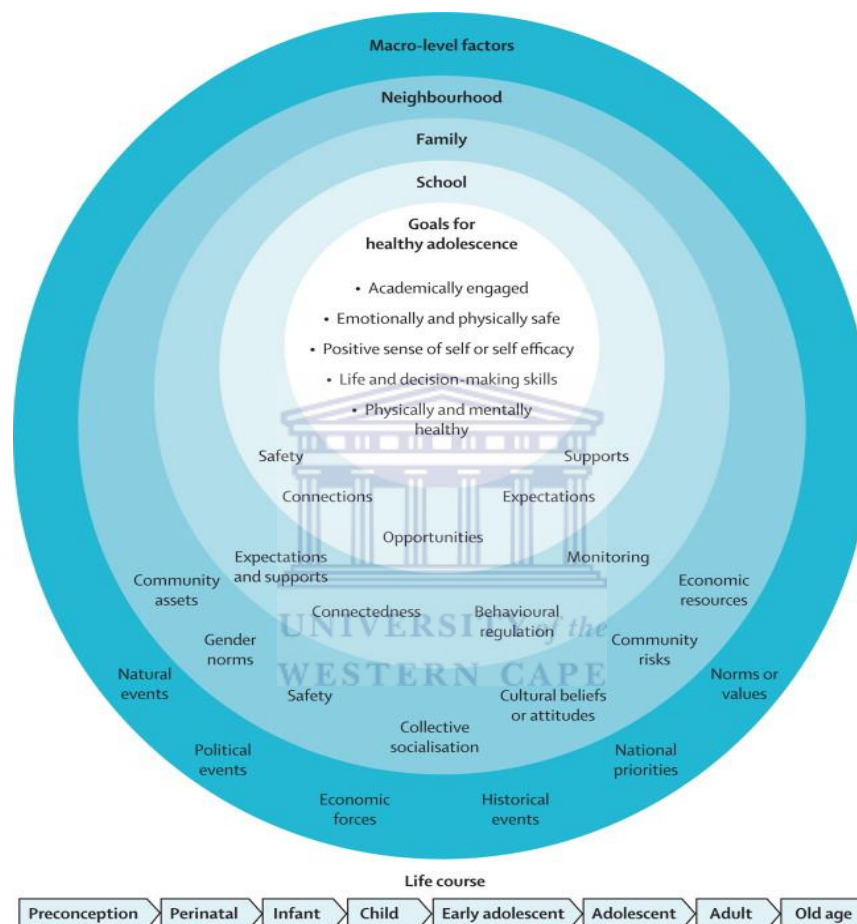
**Figure 1.1: Major causes of disease burden in disability adjusted life years (DALYs) per 1000 adolescents 10-19 years old, by region and by sex (WHO, 2010)**

The World Health Organization estimated that ‘two thirds of premature deaths and one third of the total disease burden in adults [are] associated with conditions or behaviour that began in youth’ (WHO, 2008:23). Some of these diseases can be prevented, or have as their outcomes minor health issues that can be improved if treated early – hence it is imperative that adolescents make use of health care facilities for trauma, screening and other ailments that they may encounter (WHO, 2010).

As part of the growth process, adolescence often take part in risk-taking activities, which they regard as usual behaviour among their peers (WHO, 2004). Instability in the family and extreme negative pressures from the environment can lead to adolescents engaging in risky or health-damaging activities. These include the use of tobacco, alcohol, narcotics, resorting to violence, and engaging in unprotected sex. The latter may lead to unwanted pregnancies, or to falling pregnant at a young age (Abbing, 1996).

Omori and Ingersoll (2005) reported that even though risk-taking behaviour was often recognized as a normal part of an adolescent’s development, much care should be taken to

prevent or manage the unintended outcomes of such behaviour (these outcomes may include disability or even death). Consequently, an ecological or life-course framework is crucial for understanding adolescent trajectories. A recent report by Blum et al., (2012) published in *The Lancet's* special publication on adolescent health, illustrated an ecological framework for adolescent health. This is shown in Figure 1.2 below:



**Figure 1.2: An ecological framework for adolescent health (Blum et al., 2012).**

Apart from describing the life-course of an adolescent and illustrating the external factors affecting adolescent health, the ecological framework in Figure 1.2 demonstrates that interventions to reduce risky behaviour and improve adolescent health should take place across multiple levels of influence. School, family, community and government agencies all have a direct or indirect influence on adolescent health. Further, an ecological approach to the measurement of adolescent health behaviours will contribute to our understanding of such risky behaviour in adolescents (Blum et al., 2012).

## **2.3 Health status and risk factors affecting the health of adolescents in South Africa**

Research indicates that adolescents in South African high schools are engaging in risky behaviour which includes the use of tobacco, drugs and alcohol (Parry et al., 2004), as well as sexual behaviour that may lead to unwanted pregnancy or sexually transmitted disease (Phillips & Malcolm, 2006). In an attempt to provide information on the extent of such behaviour among South African adolescents, the researcher will briefly review the literature on the use of tobacco, drugs and alcohol by adolescents, and adolescent sexual behaviour and reproductive health. While there may be many kinds of risk-taking behaviour that adolescents participate in, and while there are other health conditions that affect them, this review will focus on the specific topics mentioned above.

### **2.3.1 Tobacco, drugs and alcohol use**

Substance use at an early age has a number of negative consequences for the health and well-being of adolescents (Parry & Dewing, 2006). These include increased risk of injury and death from motor vehicle accidents, interpersonal violence and drowning; greater likelihood of engaging in high-risk sexual behaviour; and an increased tendencies for suicidal thoughts and behaviour (Parry & Dewing, 2006). Research has shown that there is a relationship between adolescent substance use and co-morbid psychiatric disorders, such as conduct and mood disorders (Thomas, 2009). Adolescent substance use may have a number of adverse social consequences. Adolescent use of alcohol and other drugs has been associated with academic difficulties, absenteeism, declining grades, school drop-out and truancy (Parry & Dewing, 2006). With such factors affecting the health of adolescents, health-care facilities have a significant role to play in supporting the youth.

Parry et al. (2004) conducted a study of alcohol and drug abuse in the Western Cape from 1997 to 2004 and found that risk-taking behaviour on the part of learners in the Western Cape (41%) exceeded the national average of 29%. This applied in particular to the following: binge drinking, cannabis use, the use of Mandrax and the use of club drugs (among males only).

In a study completed by Hamdulay and Mash (2011) in 12 secondary schools in the Mitchells Plain area, 438 learners from Grade 8 and Grade 11 classes reported lifetime and annual prevalence rates for the following substances: alcohol (50.6%/41.0%), tobacco smoking (49.7%/36.2%), cannabis (32.1%/21.1%), crystal methamphetamine (9.2%/4.6%), ecstasy (4.4%/2.7%), mandrax (2.1%/0.9%), solvents (3.0%/0.9%) and cocaine (0.9%/0.9%). Illicit substance use was significantly associated with age, and with substance abuse by other members of the household. (Hamdulay & Mash, 2011). The study concluded ‘the prevalence of substance use amongst adolescent students attending high schools in Mitchells Plain, Cape Town, was high for all substances relative to national and international figures’ (Hamdulay & Mash, 2011:89). Hamdulay and Mash (2011) recommended that ‘government officials, educators and health care workers [should be] alerted to the need for more comprehensive interventions to prevent and treat substance abuse in this and similar communities’ (Hamdulay & Mash, 2011:89).

In 2006, the then Director of Health Services in the City of Cape Town, Dr. Ivan Toms, noted that in 2005, 5.5% of births in Mitchells Plain were to teenage mothers, and that there was a similar percentage (5.4%) in 2006 (Kapp, 2008). He stated, ‘tik abuse among pregnant women led to low birth weights and the infants were often described as irritable, but not enough was known about the longer-term side-effects on the children’ (Kapp, 2008:193). There were an estimated 200 000 ‘tik’ (crystal meth) users in and around the City of Cape Town, most of whom came from the Mitchells Plain area (Kapp, 2008).

Alcohol and drug use among learners is not peculiar to the Western Cape. In a study carried out in Johannesburg by Thomas (2009), among 1139 learners in Grades 10 to 12 from lower income groups, a high prevalence of risk-taking behaviour was found among adolescents, particularly with regard to alcohol use and sexual activity. This study also confirmed that various forms of risk-taking behaviour co-exist in young people, which points to the need for a holistic approach to preventive service delivery.

### 2.3.2 Sexual behaviour and reproductive health

With adolescents engaging in sexual activities from a young age, unwanted pregnancies and complications related to teenage pregnancies are significant problems in South Africa. Teenage pregnancy increases the risk of maternal death and is associated with high school dropout rates, poverty and child abuse (WHO, 2008).

A study by Pettifor et al. (2004) focused on HIV and sexual behaviour among young South Africans: In a national survey of 15-24 year olds, almost 67% of the young people reported having engaged in penetrative sex. In the same study, it was reported that nearly one third of 15-to-19-year-old female learners and almost two-thirds of females aged 20 to 24 year-olds had fallen pregnant, with an overall pregnancy rate for 15–19-year-olds of 15.5%. Furthermore, 66% of the young women who participated in the study and then fell pregnant reported that the pregnancy was unwanted (Pettifor et al., 2004).

Sexually active adolescents are at risk of contracting sexually transmitted diseases. According to the 2005 report on the *National HIV and syphilis antenatal sero-prevalence in South Africa*, the prevalence of HIV in young people under the age of 20 increased from 14.8% in 2002 to 16.1% in 2004 (Department of Health, 2005). With HIV/AIDS affecting so many young people in South Africa, it is essential to consider this as one of the key health issues affecting this section of the population. Of all the health conditions associated with adolescents, HIV/AIDS is the most life-threatening. This is because adolescents are among those most vulnerable to infection. There is also a growing consensus that the most effective way to prevent the spread of HIV/AIDS is to focus on young people and on the prevention of new infections (UNAIDS, 2002).

In the *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey*, conducted in 2005 (Shisana et al., 2005), HIV incidence among youth aged from 15 to 24 years was reported to be 3.3%. An alarming finding in this particular study was that the incidence of HIV among females in this age group was eight times higher than that among males – 6.5% compared to 0.8% (Shisana et al., 2005).

## 2.4 Provision of health care services to adolescents

Kleinert (2007), in her commentary in response to *The Lancet's* Adolescent Health Series in 2007, suggests that adolescents lack services that respond to their distinctive needs as adolescents: they are either treated like children or have to share health facilities with adults (Kleinert, 2007). She goes on to state:

*'Rather than talking about an existing gap in services that needs to be bridged, adolescent health-care services should be perceived as the most important opportunity to treat emerging problems early and prevent ill-health by educating about and firmly establishing a healthy lifestyle. Only then will the full potential of the future generations be met.'* (Kleinert, 2007:1058).

A recent UNICEF report states that public health interventions for children very often focus on the younger age groups. Adolescents therefore do not qualify for paediatric health care, and they are often not reached by programmes designed for adults (UNICEF, 2012). This is alarming as health programmes, health facilities and health workers should play an important role in helping adolescents maintain good health by providing information, advice and preventive health services.

Information, counselling and preventive health care services are essential in providing adolescents with the support they need to make informed and appropriate decisions about their personal health (Buijs, Jociute, Paulus & Simovska, 2009). However, there are a number of barriers that prevent adolescents from accessing such health services. These include distance (Arcury et al., 2005), transport, cost of accessing health services (Baume, Helitzer & Kachur, 2000), unfriendly staff at health facilities (Tanser, Gijsbertsen & Herbst, 2006), long waiting periods (Valentine & McIntyre, 1994), and more especially the poor quality of health care (Chi, 1990).

In an exploratory descriptive survey, utilizing questionnaires and convenience sampling, Ehlers (2003) looked at five South African provinces, using a sample of 250 adolescent mothers (19

years of age or younger) who had delivered babies between 1999-2000. The study aimed to explore the extent of the mothers' knowledge of and access to contraception. The young mothers from the study reported a number of problems with regard to access and quality. These included confidentiality, the attitude of staff, the length of time needed to access the service, not understanding their diagnosis or treatment, and embarrassment at being seen in the clinic waiting room (Ehlers, 2003).

A health care facility should be a place where teenagers are able to discuss issues of concern in their lives and seek professional, non-judgmental advice (Stefan & van der Merwe, 2008). Such facilities should be able to provide counselling and appropriate services with regard to reproductive health. These include testing and treatment for sexually transmitted infections (STIs), HIV/AIDS prevention information, access to contraceptives and confidential testing, and counselling (Dickson-Tetteh, Pettifor & Moleko 2001). Given the other risk factors and health issues that affect adolescents, the health facility should not be limited to providing reproductive health services. Adolescent boys and girls with substance abuse problems might require psychosocial assistance or mental health care and should be able to access these services at a health facility.



While investing in health services, providing a friendly and satisfactory experience for adolescents is all-important: adolescent boys and girls must be willing to make use of these services (Kautzky & Tollman, 2008). The WHO (2009) reports that adolescents often do not appreciate the importance of seeking treatment when they are unwell, and often underestimate the severity of their condition (WHO, 2009). Their unwillingness to make use of a health facility should be explored further. Well-documented studies of the perceptions of adolescents can provide a sound body of knowledge to measure how effectively current programmes and health facilities are functioning, and may help one to understand reluctance to use existing health services. These perceptions can provide a basis for increased efforts to address the underlying factors, and may help health officials to find appropriate ways of improving health facilities. Furthermore, the successful implementation of any new health intervention or programme designed for adolescents provided by the primary health care facilities essentially depends on the utilization of the facility (Kautzky & Tollman, 2008).

## 2.5 Adolescent-friendly health facilities

Adolescents have been known to resist access to health care and to exhibit poor patterns of preventive health care (Perrin et al., 1992). Emblach (1993) is of the opinion that health services for adolescents have been planned by adults, and that many do not identify or provide services that take into account the age-appropriate behaviour of adolescents. Providing primary health care services that meet the needs of adolescents is critical in fighting the battle against HIV/AIDS, STIs and teenage pregnancy (Wood et al. 1998).

The World Health Organization (2002) prescribes a framework for the development of youth-friendly health services (Table 2.1). The framework provides a list of features for youth-friendly health services (WHO 2002:57).

**Table 2.1: World Health Organization framework for youth-friendly health services (WHO, 2002:27)**



<p><b><i>An equitable point of delivery is one in which:</i></b></p>	<ul style="list-style-type: none"> <li>• Policies and procedures are in place that do not restrict the provision of health services on any terms and that address issues that might hinder the equitable provision and experience of care</li> <li>• Health-care providers and support staff treat all their patients with equal care and respect, regardless of status</li> </ul>
<p><b><i>An accessible point of delivery is one in which:</i></b></p>	<ul style="list-style-type: none"> <li>• Policies and procedures are in place that ensure health services are either free or affordable to all young people</li> <li>• Point of delivery has convenient working hours and convenient location</li> <li>• Young people are well informed about the range of health services available and how to obtain them</li> <li>• Community members understand the benefits that young people will gain by obtaining health services, and support their</li> </ul>



	<p>provision</p> <ul style="list-style-type: none"> <li>• Outreach workers, selected community members and young people themselves are involved in reaching out with health services to young people in the community</li> </ul>
<p><b><i>An acceptable point of delivery is one in which policies and procedures are in place that guarantee client confidentiality and where support staff are motivated to work with young people and are non-judgmental, considerate, and easy to relate to:</i></b></p>	<p>Health-care providers</p> <ul style="list-style-type: none"> <li>• provide adequate information and support to enable each young person to make free and informed choices that are relevant to his or her individual needs</li> <li>• are motivated to work with young people</li> <li>• are non-judgmental, considerate, and easy to relate to</li> <li>• are able to devote adequate time to their patients</li> <li>• act in the best interests of their patients</li> </ul> <p>The point of delivery</p> <ul style="list-style-type: none"> <li>• ensures privacy (including a discreet entrance)</li> <li>• ensures that there is a short waiting period, with or without an appointment</li> <li>• ensures (where necessary) swift referral</li> <li>• lacks stigma</li> <li>• has an appealing and clean environment</li> <li>• has an environment that ensures physical safety</li> <li>• provides information with a variety of methods</li> </ul> <p>Young people are actively involved in the assessment and provision of health services</p>
<p><b><i>The appropriateness of health services for young people is best achieved if:</i></b></p>	<ul style="list-style-type: none"> <li>• The health services needed to fulfil the needs of all young people are provided either at the point of delivery or through referral linkages</li> </ul>

	<ul style="list-style-type: none"> <li>• Health-care providers deal adequately with the presenting issue, yet strive to go beyond it to address other issues that affect the health and development of adolescent patients</li> </ul>
<i>The effectiveness of health services for young people is best achieved if:</i>	<ul style="list-style-type: none"> <li>• Health-care providers have the required competencies</li> <li>• Health-service provision is guided by technically sound protocols and guidelines</li> <li>• Points of service delivery have the necessary equipment, supplies, and basic services to deliver health services</li> </ul>

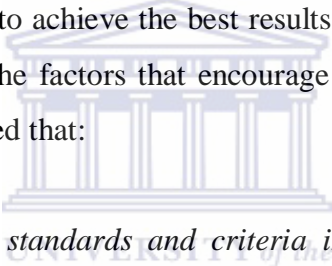
It is acknowledged that there are unique factors which discourage adolescents from receiving health care. A framework for youth-friendly health services in sub-Saharan Africa was first developed in the late 1970s in response to a growing recognition that young people were poorly informed on matters related to sexual and reproductive health. These initial programmes mainly focused on providing information to young people and on improving the capacity of parents and teachers to convey such information (Erulkar et al., 2005).

However, just before the turn of the new millennium, the WHO reported that the youth in Africa were experiencing a health crisis as the cases of STIs (per 1000 cases) in 1999 showed a rapid increase in sub-Saharan Africa (Department of Health, 2003). In South Africa, more specifically, nearly half a million adolescents under the age of 20 were infected with HIV. The prevalence of HIV was reported to have increased from 14.8% in 2002 to 16.1% in 2004 in adolescents (people under the age of 20) (Department of Health, 2004). This suggests that adolescents were engaging in unprotected sexual activity and that strategic interventions were needed to improve access to comprehensive health services.

The National Adolescent-Friendly Clinic Initiative (NAFCI) was developed to provide a supportive environment to address adolescents' reproductive health needs as well as their psychological needs and their general wellbeing (Dickson-Tetteh, Pettifor & Moleko 2001; WHO, 2009). An example of an organization which took the initiative in South Africa is Lovelife. Lovelife is a Not-For-Profit Organization (NPO) that promotes HIV/AIDS prevention among South Africans aged between 12 and 19 by employing a holistic approach to youth

development and behaviour change. Lovelife launched the National Adolescent-Friendly Clinic Initiative in an effort to ensure that young people throughout South Africa have access to comprehensive health services. NAFCI was established to offer public health service managers and providers with practical, achievable self-audit and external assessment processes to advance the quality of adolescent primary health-care services, and to enhance the public sector's ability to respond to adolescent health needs (Dickson-Tetteh, Pettifor, Moleko, 2001).

With the launch of NAFCI in South Africa, it was important to understand if implementing adolescent-friendly procedures would actually improve the quality of services for adolescent in clinics. Dickson et al. (2007) set out to do just this by evaluating 11 public health clinics involved in NAFCI as well as 11 control clinics. It was found that developing adolescent-friendly standards improved the quality of care provided to young people at public health clinics. However, the study suggested that to achieve the best results, clinics and health officials needed to gain a better understanding of the factors that encourage adolescents to make use of public health facilities. The study concluded that:



*'Setting and implementing standards and criteria improves the quality of adolescent services in clinics. The standards and criteria should be set on the basis of the characteristics of adolescent-friendly services and quality of care indicators. Best results are achieved when a facilitator trained in quality improvement methodologies supports clinics.'* (Dickson, et al., 2007: 80).

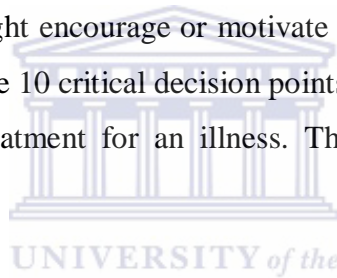
## **2.6 Theory and models of healthcare-seeking behaviour**

In spite of the high prevalence of HIV and STIs, young people engage in risky behaviour and teenage pregnancies are often the result. Many adolescents do not use public health services in South Africa, and/or have reported problems when they have attended public health clinics (Seekoe, 2006). As has been found in different contexts, the utilization of health services can be related to the distance to a clinic (Arcury et al., 2005), a lack of transport, the cost of accessing health services (Baume, Helitzer & Kachur, 2000), unfriendly staff at health facilities (Tanser, Gijssbertsen & Herbst, 2006), long waiting periods (Valentine & McIntyre, 1994), and the poor

quality of health care (Chi, 1990). Understanding health-care-seeking behaviour and the factors that influence the decision to access health-care services is clearly important.

From reviewing the existing body of literature, it is evident that there are a number of factors that influence the decision by adolescents to utilize health care. According to Rebhan (undated), these factors include age, finances, culture, perceptions, knowledge, access, belief in efficacy and social and gender roles. To gain a deeper understanding of the complexities involved in health care utilization, Mechanic's general theory of help-seeking (1978) and Young's choice-making model (1981) will be reviewed.

Theories and models are generally used in an attempt to explain an individual's behaviour. Mechanic's (1978) theory, which focuses on help-seeking, provides a useful framework for attempting to understand what might encourage or motivate a person to seek help for his or her illness. Mechanic suggests there are 10 critical decision points which determine whether a person will seek health assistance or treatment for an illness. These critical decision points are as follows:



- 1) Signs and symptoms that become unbearable to the person
- 2) The person's perception of the severity of the symptom
- 3) The person's daily life being disrupted due to the illness
- 4) The persistence and frequency of symptoms that the person experiences
- 5) The person's ability to tolerate his or her the symptoms
- 6) The person's understanding and cultural assumptions with regard to the illness
- 7) The person's rejection of the illness as a result of basic needs
- 8) The probability of the illness disrupting the person's daily activities
- 9) Alternative interpretations of the symptoms of the illness; and
- 10) The availability of treatment in terms of economic cost, location, psychological cost and treatment resources.

In addition to the above points, Mechanic's theory suggested that the response to an illness was often influenced by the person sick or another person (for example: a parent or caregiver) who

makes decisions for the particular individual (Wolinsky, 1988). Parents or caregivers play a critical role in promoting adolescent health and development.

Another model that helps one to understand the utilization of health services is described by Young (1982). Based on his ethnographic studies of health service utilization in two neighbouring rural communities, Pichátaro and Uricho in Mexico, Young found that while Pichátaro had only limited access to a treatment by a physician, Uricho had comparatively good access to a physician's services, some of which were available at no cost (Young, 1982). On the basis of this study, Young (1982) proposed a model which outlined the choice-making process of families who make use of health services. The model suggests that the process is systematic, i.e.: one goes through it one step at a time. This choice-making process (Figure 1.3) is represented diagrammatically below:



**Figure 1.3: Choice-Making Model (Young, 1982)**

This choice-making model incorporates four components that are considered essential to the individual's decision. These four components are described in Rehban's (undated) paper:

1. **Perceptions of the seriousness of illness** – both the individual's perception and their social network's perception of the seriousness of the illness are linked. Social networks can influence a person to either utilize or refrain from using health services and can assist in identifying the illness and influencing the response to the illness.

2. ***Knowledge of a home treatment*** – should an individual know of a home remedy that is effective, they will most likely use the home remedy before resorting to a health care facility.
3. ***Faith in treatment*** – this factor relates to the individual's belief of the efficacy of the treatment for the illness. A person will not accept the treatment if he or she does not believe the remedy will be effective.
4. ***Accessibility of treatment*** – this includes the individuals' evaluation of both the cost and the availability of health services. According to Young (1982), access may be the most important determinant of health care utilization.

Young's model (1982) provides a systematic sequence and describes the steps in the decision-making process. Mechanic's (1978) theory, which focuses on help-seeking, considers many more decision points or stages in the process. Both models emphasize that the response to an illness is often influenced by another person. While there are many other models and theories regarding decision-making with regard to health-care seeking, these two examples offer an initial understanding of the relevant factors.

With a better understanding of why adolescents use (or choose not to use) these services, health care organizations can improve the quality of the services provided to adolescents (WHO, 2010). However, to do this – and to respond to some of the dilemmas facing public health service managers in Mitchells Plain – one needs to understand adolescents' perceptions of their local health services and the factors that contribute to their (or their guardian's) decision-making.

Gaining a greater understanding of these factors will assist local health facility and programme managers to encourage new or potential clients to make use of their services. This will also help them to identify the concerns of current clients who are not entirely satisfied with the health services that are provided. In this way they may be able to improve customer satisfaction.

The next chapter describes the research design and the methods used to explore the various factors that influence utilization of local primary level health facilities in Mitchells Plain, Cape Town.

## Chapter 3: Research Design and Methodology

### 3.1 Aims and objectives of the study

The aim of this study is to gain an understanding of the factors that contribute to the utilization by adolescents of public health facilities in a historically disadvantaged community in the City of Cape Town, namely the Tafelsig area of Mitchells Plain. It is hoped that the information generated from the study will provide the sub-district health services with greater insight into how they can increase utilization of health facilities by adolescents, in the Tafelsig area specifically, and more broadly in Mitchells Plain.

The objectives of the study were as follows:

1. To explore and describe how adolescents perceive and make use of the local primary-level health-care facilities.
2. To describe what adolescents perceive or experience to be the key facilitators to their use of these healthcare services, as well as the factors that inhibit or discourage their use of these services.
3. To describe how adolescents believe their utilization of these health-care facilities could be improved, and how these factors might be taken into consideration by the local district health service.

### 3.2 Study design

An exploratory descriptive study design was used, employing qualitative research methods. A qualitative approach was considered most appropriate for this study, as it attempted to understand and document perceptions and complex experiences. A qualitative approach allows for free, unstructured expression and is not limited by the pre-determined boundaries that characterise the quantitative approach and are reflected in quantitative tools and methods (Pope & Mays, 1995). The Mitchells Plain sub-district has found that the number of adolescents using their local health services is lower than their projected or set target, but the officials remain uncertain as to the reasons for this. Marshall and Roseman (1995) suggest that in order to

understand human behaviour one has to understand the framework within which participants interpret their thoughts, feelings and actions. Thus, using a qualitative – as opposed to a quantitative research – approach enables the researcher to explore in greater depth the experiences, perceptions and feelings of the learners and to note what they believe to be some of the key facilitators and barriers to their use of the primary-level public health facilities in their local community.

### **3.3 Study population, sample and sampling procedure**

The study population for this research project comprised all adolescents living in the Tafelsig area of Mitchells Plain, as they all could potentially be clients of the primary health-care facilities in the area. In order to get a sample of this population the researcher selected adolescents from the local school, situated in Mitchell's Plain, Cape Town. This is the local school that most adolescents living in the Tafelsig community attend (Rushda O'Shey, personal communication, 19 March 2012) and is an established setting from which to obtain the opinions of the potential users of the local health facilities. The school starts in Grade 8 and ends in Grade 12 and the age of learners at the school ranges from 13 years (Grade 8) to 18 years (Grade 12).

The decision to use the local school to access adolescents for the study was based on practical considerations: the researcher is a part-time student and has limited time for field work; thus it was simpler to develop a relationship with the school and invite learners to participate in the study, rather than identify adolescents using other sampling strategies (such as making use of a 'snowballing' method); these strategies would entail interviewing a sample of adolescents in their homes or at the clinic itself.

Male and female learners were only sampled from Grades 9 and 10 in the school (i.e. learners between the ages of 14 and 18 years of age). These grades were selected because the school principal had informed the researcher that learners in these grades were particularly prone to experimenting with alcohol, drugs, or getting pregnant and dropping out of school; i.e. they were considered to be particularly vulnerable as a result of their participation in risk-taking behaviour.



The researcher had an initial telephonic conversation with the principal to explain his intentions and the aims of the study. A copy of the protocol for this study was requested by the school principal, together with the ethical clearance from the university, before the study could take place at the school. A meeting was then held at the local high school with the principal to hand over these documents, discuss the aims and objectives of the study, as well as the sampling strategy. At this meeting, the principal confirmed that these were the only documents that she would require before granting permission for the study to proceed.

At a second meeting, the questions that were to be used during the interviews were presented to the principal. The researcher felt confident that the principal understood the aim and objectives of the study, as well as the process of selecting the learners. In order to obtain an equal number of male and female learners, spread evenly between the two participating grades, teachers of these grades were briefed about the study by the principal in a staff meeting. The aims and objectives of the study were discussed with the six Grade 9 and 10 teachers, and a briefing document was prepared by the researcher and provided to the teachers to read out to the Grade 9 and 10 classes (Annexure A). No questions from the staff meeting were directed to the researcher via the principal, and all teachers appeared to understand the reasons for the study.

Subsequent to the staff meeting, teachers handed out consent forms to learners who expressed interest in participating in the study – after listening to the brief (the introduction to the study) that was read out aloud to the class by the teacher. Along this introduction, information and consent forms for parents or guardians (Annexure B) were presented to all interested learners by the teachers. Learners who were interested in participating in the study were then asked to take these documents to their parent(s) or guardian for their approval. The learners were also given a consent form to read, sign and return if they were still interested in participating in the study (Annexure C). The learners were given seven days to return the consent form to their teacher.

In total, there are 1336 learners attending the local high school, of these, 385 learners are in Grade 9 and 253 learners in grade 10. Learners in Grade 9 and Grade 10 were invited to participate in the study. Details of the study (Annexure A) were provided to the teachers of these grades. The teacher read out aloud details of the study to the class and invited learners in the

class to take part in the study. Interested learners received an information sheet and consent forms for the study (Annexure B and C). Fourteen learners from Grade 9 (9 females and 6 males) and 12 learners from Grade 10 (8 females and 4 males) returned the signed consent forms to the Grade 9 and Grade 10 teachers, who in turn provided the completed consent forms to the principal. The names of all of these learners were transferred to a list and a sample of 7 boys and 7 girls (from the two grades) was chosen randomly as potential interviewees. The researcher, with the assistance of the supervisor of the study, agreed that a total of 14 learners from both grades was appropriate for the initial round of interviews. It was also agreed between the researcher and supervisor that should saturation not be achieved after the 14 interviews, then additional learners from each of these grade (and who had returned their consent forms) would be invited to participate in the study.

In addition, one learner who consented to the study, but was not among the 14 learners chosen to participate in the study, was randomly chosen and invited to participate in a pilot interview. Two days prior to the actual interviews with the 14 selected learners, the draft interview guide was piloted with this female Grade 9 learner. The pilot interview took place at the school in the same classroom that was earmarked for the interviews by the principal of the school.

From the pilot interview, it was felt that the initial questions were appropriate and the study's interview guide thus remained unchanged from its draft to its final form. Given that the interview guide did not require significant changes to be made to it, the researcher thought it appropriate to include the data that was obtained from the pilot interview, along the data from the other 14 interviews, as part of the study data. Therefore, over the course of the study fifteen interviewees were provided with written details (i.e. date, time and venue) of their interview and interviewed by the researcher on the school premises. After interviewing all the 15 learners, the researcher felt that saturation had been achieved and no further learners were invited to participate in the study.

### **3.4 Data collection method, instruments and procedures**

Individual, in-depth interviews were selected as the means for the collection data for this study. The decision to use individual interviews rather than focus group discussions was based on the

assumption that it might be easier for the researcher to establish a sense of trust and openness with the learners on an individual rather than a group basis – particularly if the learners were reluctant to share personal experiences with their peers. Since one of the objectives of the study was to obtain a rich, detailed description of the factors that influenced the participants' use (or non-use) of primary-level public health facilities in their community, it was felt that a more contained and confidential one-to-one interview was appropriate for this study – and specifically for this age group.

A semi-structured interview guide (Annexure D) was designed. This included both demographic information and a series of themed questions that aimed to explore the positive and negative experiences and perceptions of learners when using – or considering the use of – the local health facilities. The interview guide was formulated by the researcher with the assistance of his supervisor. The draft guide was then discussed at a meeting with Ms. Nomsa Nqana, Manager for Personal Primary Health Care and Programmes for the Mitchells Plain district, prior to the commencement of the interviews. Her suggestions and feedback were used to modify the draft questionnaire and the necessary changes were made prior to the pilot interview. The draft interview guide was also shared with the principal of the school, Ms. O'Shey. Principal O'Shey had no further suggestions to offer with regard to the draft interview guide.

Permission was then received from the principal for interviews to take place between 5 and 8 June 2012. The interviews took place during school hours as the pending mid-year examination meant that learners were not engaged in lessons. The interviews took place in the multi-purpose classroom on the school premises. The classroom was suitable for the interviews, as there was privacy and the conversation was out of earshot of teachers or other learners.

At the start of each interview the motivation for conducting the study and the importance of gaining an understanding from adolescent clinic users (or potential users) themselves was explained to each respondent. The importance of the learners being able to share their experiences, suggestions, questions and reservations freely – so as to assist with improving of the current services – was emphasised. Where appropriate, the researcher asked probing questions to allow for greater depth of response or to obtain clarity on key factors related to the objectives of

the study. Each of the interviews were conducted in English – the medium of instruction at the local high school – and recorded (once consent for this had been obtained from the participants).

The shortest interview lasted 20 minutes while the longest interview lasted for 35 minutes. The learners that participated in the shorter interviews (lasting approximately 20 minutes) provided very brief answers, and even though the researcher probed, this did not elicit any further information. Four learners, of their own accord, indicated that they did not find the interview ‘scary’ and said that they ‘enjoyed the talk’. One learner wanted to find out what he could do to give further help to researcher.

*‘The questions you ask is very interesting. What else do you need from me? Is there anything else I can do to help with the project?’*

(Male learner # 5, Grade 9)

Each learner received a ‘brown bag lunch’ at the end of the interview, which included a healthy sandwich, a fruit juice, an energy bar and a packet of potato chips. All the participants gladly accepted the offering of refreshments or a meal at the end of the interview.

At the end of each day of interviewing, the recorded interviews were replayed so that emerging themes could be identified early on in the interview process; this helped to guide subsequent interviews. The interviews were also transcribed verbatim for the purposes of analysis. After the 15<sup>th</sup> interview the researcher felt that similar ideas were being expressed in each of the interviews; he decided that these provided sufficient answers to the research questions of this study. As explained by Guest, Bruce, and Johnson (2006) ‘saturation’ refers to a process in which the researcher continues to sample relevant cases, but without arriving at any new theoretical insights from the data. Having reached saturation, the researcher decided to not conduct further interviews. In addition, there were also limits imposed by considerations of time, by budgetary constraints as well as by the guidelines of the MPH programme. With the consent of the supervisor, data collection was concluded.

Interviews were also completed with one key informant from the Department of Health and Department of Education. Annexure E is a list of questions used during the interviews with the key informants. The interviews with the key informants took place at the office of the official on 30 May 2012.

### **3.5 Data analysis**

The transcripts from the interviews were the raw data of the study. Analysis proceeded at the same time as the data collection; this ensured that emerging themes were identified early on in the interview process and could be used to guide subsequent interviews. Themes are defined as ‘patterns that repetitively occur’ (Gullifer & Tyson, 2010:468). Once the data collection was concluded, the information received from the learners was coded, and then thematic content analysis was used to analyze the data. As Green and Thorogood (2004) and Pope and Mays (2000) describe, this required the researcher to become familiar with the data, indexing and charting the emerging themes, and using this process of analysis to make comparisons between and within the themes and categories. The interviews were printed out, read and reread by the researcher so that he was familiar with the data. A code, a word or short phrase, was assigned to main or emerging ideas found in the information received from the learners. These emerging and similar ideas were then compared and marked with a felt-tip pen highlighter for the easy identification of salient themes. A second round of analysis was then conducted to identify sub-themes. These themes (reported in Chapter 4) were then carefully grouped together and a pattern of responses was arrived at. This process was designed to meet the aims and objectives of the study.

A ‘thick’, ‘rich’ description was used to illustrate the themes that were revealed in the study. The use of such a description is significant since learners often used local slang or vocabulary that was specific to their area. The researcher in this study contextualized the findings within the socio-economic context of the research setting and reflected on the findings in relation to the issues raised by the literature review.

### 3.6 Rigour

The following strategies were deliberately used in this study to achieve the necessary rigour. The particular choice of strategies was governed by the context and setting as well as by the aims and objectives of the study. How these strategies were applied in this study is explained below.

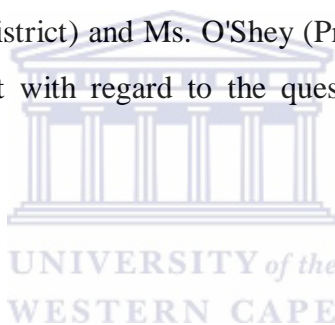
Triangulation assists in supporting validity in qualitative research (Mays and Pope, 2000). In data source triangulation the researcher searches for converging evidence from multiple sources to generate themes or categories within the study (Creswell & Miller, 2000). In this particular study, the different data sources were the learners from the local high school and the representatives of Departments of Health and Education that were associated with the local clinic and the school. Possible reasons for poor or low utilization of public health care facilities were explored, drawing on each of these data sources. The differences and similarities between perceptions and opinions as revealed by the data will be reported in Chapter 4 and discussed in Chapter 5.

An audit trail – i.e. the provision of clear documentation of all research decisions and activities (Creswell & Miller, 2000, Sandelowski, 1986) – was established. The decision-making with regard to the methods, sampling and process of data collection has been described in detail. By leaving an audit trail, dependability and transparency and trustworthiness were ensured (Sandelowski, 1986).

The researcher attempted to create a ‘thick’, ‘rich’ description of the study context and the related findings – Sandelowski (1986) suggests that this helps to create (for the reader) an immediacy and closeness to the actual situation, and also enhances the credibility of the study. Making use of such ‘thick’ or ‘rich’ description also allows for transferability (Creswell & Miller, 2000). Transferability refers to the degree to which the results of the qualitative research can be generalized or transferred to other contexts or settings. To allow for transferability, sufficient detail regarding the context of the fieldwork has been provided. This will enable the reader to be able to decide whether the findings can be transferred or applied to another situation with which she or he is familiar. However, as this is a qualitative study, it was not intended to

arrive at generalizable conclusions. It is, however, hoped that the use of ‘thick’ or ‘rich’ descriptions will allow readers to come to their own conclusions about the transferability of the findings to other settings (Cresswell and Miller, 2000).

Internal validity and ensuring quality at all stages of the study, helps to ensure the credibility of the study (Mays & Pope, 2000). This involves providing the results of qualitative research in such a way that a reliable picture is presented for others to assess. This means providing as accurate as possible a reflection of what participants actually expressed, experienced or perceived. In addressing credibility, the researcher has attempted to present the true picture of the phenomena, ideas or views under scrutiny (Sandelowski, 1986). The validity of the research tool was also ensured in the study. Once the researcher had developed the interview guide, the supervisor of the study, Ms. Nomsa Nqana (Manager for Personal Primary Health Care and Programs for the Mitchells Plain district) and Ms. O'Shey (Principal of the local high school) all had the opportunity provide input with regard to the question that were to be posed to the learners during the interviews.



### **3.7 Limitations of the study**

Given the study was conducted within the school context; the 15 learners interviewed did not necessarily cover all the potential categories of adolescent clients who might want to use the local health services. For example, the study did not include learners who had left school prematurely – often referred to as ‘out of school’ youth or ‘homeless’ adolescents or ‘street children’. It also did not include adolescents living with some form of disability. Thus the experiences and perspectives these sub-groups or categories of adolescents were not captured in this study. Given the marginalised situation of such sub-groups it is likely that their experiences and perspectives will differ considerably from those of the learners interviewed for this study.

It ought to be borne in mind that there is a high dropout rate at secondary school level in Mitchells Plain. School dropout rates in the Western Cape show a dramatic increase once learners reach the age of 15 (Grade 10), when schooling is no longer compulsory (Provincial Government of the Western Cape, 2010: 21):

*'Of the 94 784 learners who enrolled in public schools in the Western Cape in 1997, only 43 470 reached Grade 12. Of those learners who remained in school, only 33% qualified for a matric exemption.'*

Learners who have dropped out of school – and are no longer in a supervised environment – are more likely to need on-going health care information.

This study uses the WHO definition of adolescence (i.e. those in the age range of 10-19 years), and participants were recruited from a particular age group (from 14 to 16 years), based on the advice of the principal of the local high school. The study obviously excluded adolescents between the ages of 10-13 years and those adolescents who more than 19 years old. Adolescents in these age groups that might have opinions that differ from those of the target group, and they may have provided relevant information.

All of the learners in the study were born and grew up in the Mitchells Plain community. As the researcher did not grow up in a community with high levels of gangsterism and drugs, he may have missed or partly misunderstood some of the information provided by the participants regarding the complexities of living in such an environment.

The researcher was also 10 to 12 years older than the learners and some interviewees may have been reluctant to disclose some of the information for fear that this might be divulged to their teachers or parents or guardians. To minimize this possibility the researcher spent some time at the beginning of each interview introducing himself, explaining his motivation for doing the research, and explaining what would happen to the information they provided him with. Participants were assured that they would remain anonymous and that their individually-identified comments would never be shared with their teachers, or their parents/guardians or the local health-care workers. The researcher has limited experience of working with adolescents, and this may also have adversely affected the information he was able to gather through the interviews.



### 3.8 Ethical considerations

This study was approved by The University of the Western Cape Ethics Committee on 10 May 2012 under the registration number: 12/4/24. Permission to conduct the interviews with learners at the local high school was obtained from the School Principal on 15 November 2010 via a telephonic conversation and later (on 11 May 2012) confirmed at a meeting with her at the school. A copy of the study protocol and the ethical approval from the University of the Western Cape was requested and provided to the school principal by the researcher before the study could commence. The principal was satisfied with this documentation, which would be kept on file at the school.

As mentioned previously an invitation letter, together with a consent form (Annexure B and C), was given to each potential study participant (learner) in Grades 9 and 10 – along with a consent form for their parent(s) or guardian to complete (should their son/daughter want to take part in the study). The contact details of the researcher was also made available on the consent form so that if a parent required more information about the study he or she could contact the researcher. None of the learner's parents/guardians in fact contacted the researcher for further information.

The researcher ensured that should the situation arise in which one of the interviewees became emotionally distressed during the course of the interview, follow-up counselling would be provided to that learner. Arrangements were made that this would be provided by a guidance counsellor at the school, and the principal would closely monitor the situation thereafter. There was, however, no need for such action as none of the participants became distressed.

A high level of confidentiality was strictly adhered to during the study. The learners participating in the study was assured of their anonymity and informed that their individually-identified comments would never to be shared with their teachers, the principal, their parents/guardians or the local health care workers. All consent forms, tapes and transcribed materials were kept in the home office of the researcher. Transcribed material did not include the learner's proper names. When quoting a learner in this thesis, only the grade, age, race and sex of the learner will be

stated. At the end of the study, and after a reasonable period following the completion of the researcher's mini-thesis, the consent forms and tapes will be destroyed.



## **Chapter 4: Findings of the study**

### **4.1 Overview of the analysis**

In this chapter, a detailed report of how the participants made sense of and gave meaning to their experiences of public community health-care facilities is presented. Analysis of such data is useful for methodically identifying, categorizing and describing patterns in the qualitative data received from the respondent. These patterns become apparent when one compares the responses of the participants. Categorizing the qualitative data includes developing and applying codes to label the features of the data that are of interest (Baum, Johnston, & Sutton, 2004).

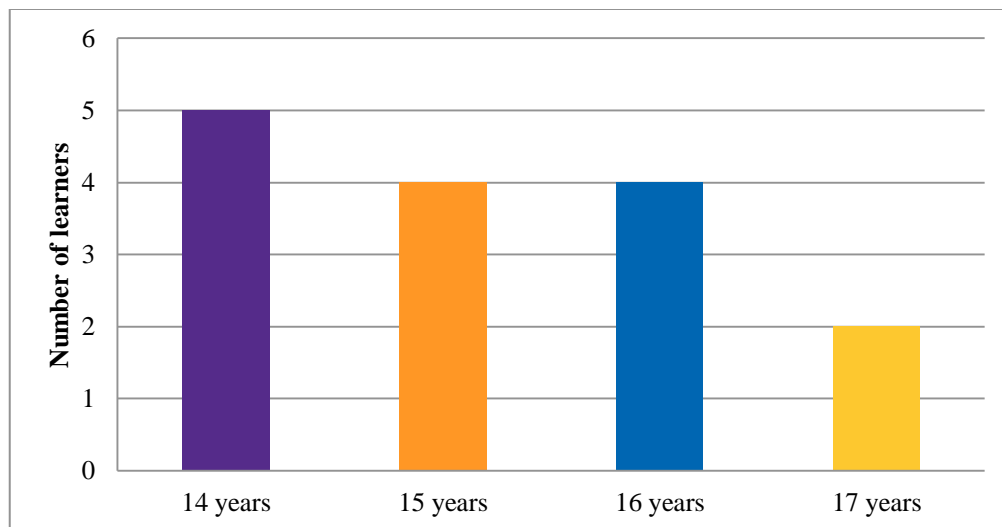
In an effort to gain a deeper understanding of the personal narratives of the participants in this study, all their experiences were subjected to a thematic analysis. This focused on identifiable themes and patterns in their responses (Aronson, 1994). Themes are described as units originating from patterns such as conversations meanings, topics, feelings, etc. (Taylor & Boglan, 1989; cited in Aronson, 1994). These themes are recognizable if ideas or responses which might be meaningless if viewed in isolation are grouped together (Leininger, 1985). The themes emerged from the narratives that were presented by the participants during the in-depth interviews. The consistent nature of the participants' experiences was of a great interest (i.e. the same themes emerged in the responses of different participants).

In section 4.2 the biographical details of the learners are summarised and in sections 4.3 to 4.7 the significant themes that emerged from the interviews with the learners are detailed.

### **4.2 Demographics of the learners in the study**

#### **4.2.1 Age**

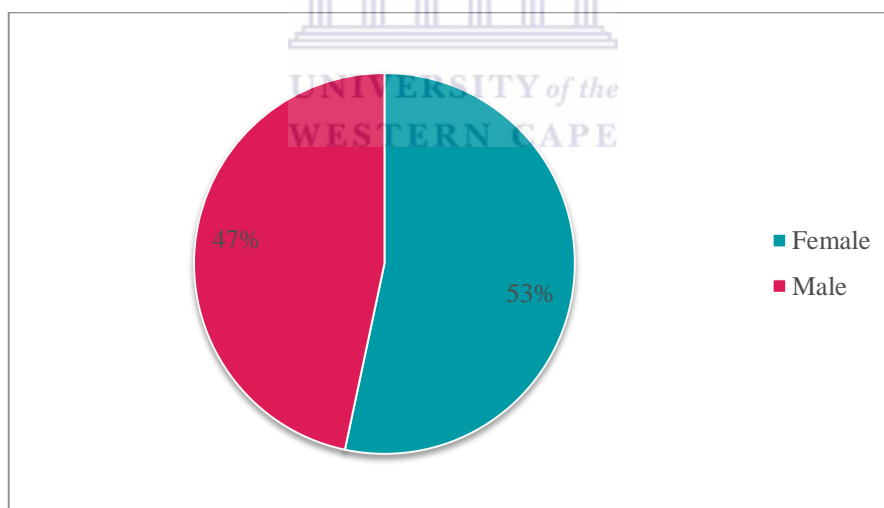
In this study 15 learners were interviewed. The age of the learners are illustrated in Figure 4.1. The study had a response rate of 100%.



**Figure 4.1:** *The age of the learners that participated in the study*

#### 4.2.2 Gender

Eight female and seven male respondents (Figure 4.2) participated in the study.



**Figure 4.2:** *Gender of the learners that participated in the study*

#### 4.2.3 Race

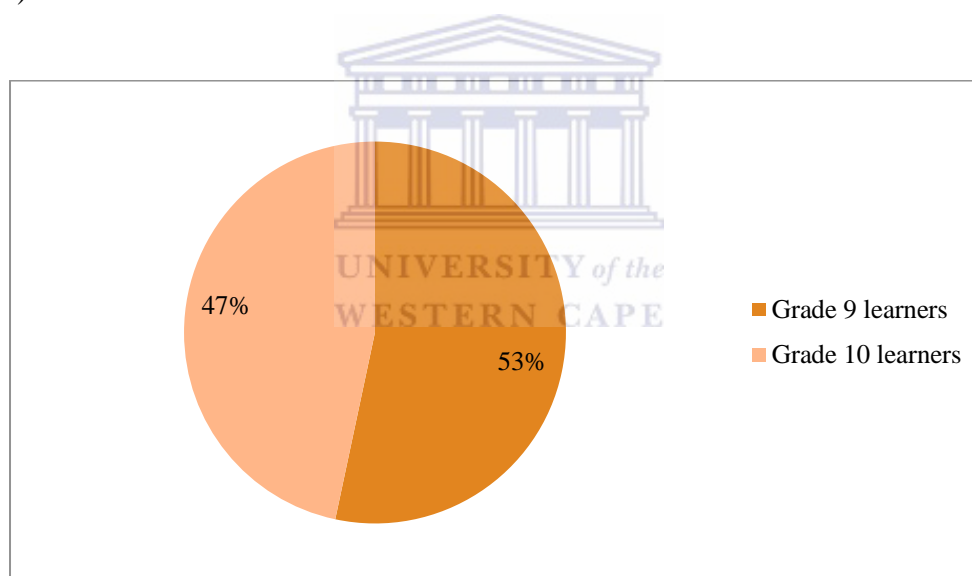
The school at which the study took place is predominantly attended by so-called ‘Coloured’ learners. Table 4.1 provides the race of the learners that participated in the study.

**Table 4.1: The racial distribution of learners in the study**

Race	Number of learners	Percentage
Black	1	6.6%
Coloured	13	86.6%
Indian	1	6.6%
Total	15	100%

#### **4.2.4 Educational status**

Grade 9 and 10 learners at the local school were invited and selected to take part in the study (Figure 4.3).



**Figure 4.3: The educational status of the learners that participated in the study**

#### **4.3 Choice and utilization of clinic/other service providers**

All learners in the study knew where the nearest health facility was located. The learners described its location in relation to their homes (their places of residence while at school). Thirteen of the 15 learners live with their parents, and two of the learners live with their grandparents. The learners that live with their grandparents described the health facility they

frequent, i.e.: the clinic in Mitchells Plain near their grandparent's home. According to one learner:

*'I stay with my grandma when I come to school and then I go to my mommy in the weekend or sometimes I just sommer stay here [with the grandmother]. So when I am sick here I go to the clinic near my mama's house and it is called Clinic X. We call my grandma, mama. Then when I am going to my mommy I go...well she then take me to the doctor. But I have not been sick by my mommy's house. But I have gotten sick here in my house in Tafelsig.'*

(Female learner #3, Grade 9)

Eleven of the 15 learners use the nearest public health facility (i.e the Clinic X) while the other four learners visit a General Practitioner (GP) in Mitchells Plain. A common theme that has been identified from the responses of all 15 learners was that the respondents do not decide which type of health provider or facility to use when ill. The parent or guardian decides this for them. In most instances, the learners report that the parent or guardian makes the decision based on their finances at the time of the learner falling ill. A learner said:

*'My daddy says that I must go to clinic X. He tell my mom that. It is because he is the only one working at home, so he mos don't have money all the time. You know things are tough at home and he is always working. He tries. He really does. We are five at home so he must see to all the things. So I don't mind going to the clinic. It is right there, just so, down the road from my house so it's mos alright.'*

(Female learner # 4, Grade 10)

The four learners that currently visit the General Practitioner in the town centre of Mitchells Plain had previously been to a public health facility when they were younger. One of these learners said:

*'I went to the clinic when I was much younger. But my mum said that it is a waste of time. So we now go to the doctor in the town. My dad is very, is very worrying and he don't like when me and my sister is sick. So he tell my mum, take the child to the doctor. But my*

*mum first see if we get better with sleep and some pills she got, but then we get more sick, so then my dad skel her out because then we take longer to get better. And my sister gets very sick. All the time. He gives her the money for me and my sister to go to the doctor. He says the doctor there is better because he also gives medication. We use to go to Dr. E there in Eastridge, but then he don't give medicine. So ya, that's why we go to there.'*

(Female learner # 7, Grade 10)

An emerging theme that came from the interviews was that when ill most learners prefer to go to a pharmacy first, rather than the clinic. Nine of the 15 learners felt that over-the-counter medication was a “better way of getting treatment.” As one learner said:

*'Sometimes I just tell my mommy that I am sick and then she go buy me some pills from the Clicks Pharmacy on her way from work. I take that and stay at home and then I get better. Only if I must, like I don't get better after say a week, then we go to the clinic.'*

(Male learner # 10, Grade 9)

Most of the 11 learners had visited the clinic in the past 12 months, while all of the four learners that used a private health care facility had consulted the doctor within the last 6 months (Table 4.2). Learners that used the private health care facilities had better recall of the details around their visit to the GP compared to the learners that used the local clinic.

**Table 4.2: Time since the learners' last visit to a health facility**

	<b>1 month</b>	<b>3 months</b>	<b>6 months</b>	<b>9 months</b>	<b>12 months</b>	<b>&gt;12 months</b>
11 learners that used the public health facility	1	4	2	2	1	1
4 learners that used the private health facility (GP)	2	2	-	-	-	-

Learners in the study reported that they were accompanied by either a parent or their guardian when visiting the health facility. When asked if they were also accompanied to the health facility

by their parent or guardian when requesting contraceptives, most of the learners responded, emphatically: *'No!'*

#### **4.4 Reasons for visiting the health facility**

When asked why they went to a health facility, the learners gave a range of reasons. These included: (i) when the learner felt ill; (ii) when the learner injured himself (for example, broke his arm); (iii) when the learners required an HIV test; (iv) when female learners required contraceptives; (v) when the learners was required to accompany a family member or friend; or when the learner was required to take her baby for treatment when the baby was unwell. Only one learner in the study disclosed that she had a baby.

The most frequently cited the reason for using the clinic was when the learner was ill. Eight of the 11 learners had gone to the clinic for an HIV test. While none of the learners reported going to the clinic for contraceptives for themselves, two learners had accompanied their friends. Both of these learners were females. One of these learners said the following:

*'Ya, my friend said I must go with her to the clinic. She wanted to get some pills. You know birth control. She is naughty, that's what I tell her. Anyway, I sometimes go with her and then they were giving AIDS tests. So my friend dared me to go for it, and then I say to her that I'm not the naughty one, so then I dare her. So then we both ask the nurse if we can go for the test. And she look at us funny, but then she smile and she say it is fine. So we then took the test and got the pills.'*

(Female learner # 12, Grade 10)

All of the learners (both males and females) in the study reported that they were aware that the clinic gave out contraceptives. While none of the learners revealed going the clinic to get contraceptives for themselves, three of the eight females reported trying out birth control pills. None of the learners knew what emergency contraceptives were. One learner said:



*'The other time, my friends and I were hanging out. We were just talking about girly stuff. And so my one friend, she is experienced, she say that she take the pill [contraceptives] and then we all wanted to try, because we all have boyfriends and you know. So we shared pills from my friend. We close, we always share things. But then I felt so funny ne and I didn't like it. And it's not just me, the others also. I will never take the pill because it makes you sick. I can still remember the feeling. What was worse was that she [the friend] said we must try it for two weeks. Yoh, I couldn't. I think I stopped after 6 days. It was not good.'*

(Female learner # 13, Grade 9)

#### **4.5 Access to health facility**

It would appear that all of the learners walk to the clinic. The four learners that visit the private GP travel by car. In both instances, none of the respondents reported having to travel far or experiencing problems with getting to the health facility.

The learners in the study reported that if they needed to go to the clinic (or if they were ill), they did not attend school on that day. The trip to the community clinic took place in the morning. A learner said:

*'My mother makes me to stand up by 6 am and we leave at 6:30 am. The queue is sometimes already there and then we know it's going to be a long day. The people [administrative staff and health professionals] come later and we wait so two to three hours to see the doctor. But then the longest thing is to get the thing. The file thingy that they use.'*

(Male learner # 15, Grade 9)

The learner returned to school after a few days at home with a 'sick note' from the parent or the guardian or the doctor. This sick note was required by the teacher if the learner stayed away from school. The average waiting time at the clinic was three hours (Table 4.3), which is much longer than the average waiting time reported by learners who consulted a GP.

**Table 4.3: Reported waiting time at the health facility**

	<1 hour	1 hour	2 hours	3 hours	4 hours
Learners that visited the clinic	-	-	3	7	1
Learners that visited the GP	4	-	-	-	-

#### 4.6 Experience of using the clinic

Learners stated that they used the public health clinic to get assistance when necessary, but they would prefer to visit a private doctor as they would be able to make an appointment and would not have to wait so long to receive medical attention.

*'It's like this ne, the doctor [in private practice] do not get a lot of people coming to him, so it is like not long waiting for the doctor. And he takes his time to listen to what is wrong and everything is then sharp! By the clinic you wait and wait and wait and still wait and the people there are just so rude by the front desk and it is smelly and dirty and you wait to see the doctors and it's like five minutes and it's over. Okay, I know the doctor is busy because the people is sitting there since early in the morning, but still. So quick then it's over.'*

(Male learner # 5, Grade 9)

Nurses at the public health facility were seen as hard-working by some of the learners, but were described by one learner as tired and “*not lus*” [not motivated] for their work. The learners who used the public health clinic stated that the doctor was friendly.

Learners that use a private health care facility seemed to have created a long-term relationship with their doctor, whom they trusted; their views regarding their visits to the doctor were generally positive. For example, one learner said:

*'We been going to Dr. P since like forever. My daddy was in school and he go there. Even my ouma says that she was a young lady, she so funny, and she take my daddy and his brothers there. Dr. P knows me and he always making jokes. Sometimes I am so sick ne and it's like I can laugh, but then he go on and on with me, so then ya it is nice there. And he give nice medicine. My mommy asks him to give us injections though. But that was when we were small. I hated it man. Yoh, I use to cry because it was so sore. But ya, the doctor has been seeing me since I was little.'*

(Female learner # 6, Grade 9)

All four learners who used a private health care facility knew what it was like to be at a public health clinic. All four had negative things to say about the public health clinic. As one learner put it:

*'The one time my friend's boyfriend got stabbed and they took him to the clinic and so I went with her from school to go see him. And yoh, he was bleeding all over the place and no one (was) seeing to him. And my friend was crying because we thought he was going to die. And then we call the nurses and they say that he was high and he must wait. I mean what's that got to do with it? And the people were all sitting there.'*

(Female learner # 11, Grade 10)

Another learner who accompanied his grandparents to the public health clinic, and who uses a private doctor when ill said the following:

*'I must walk my oupa and ouma to the clinic before I come to school. Yoh, sometimes I finish school and I go home and they not at home. So then I go fetch them from the clinic. And they sitting there all tired. It's junk man. They are old. That place is messed up. They must go there to get pills but it's not nice for them.'*

(Male learner # 8, Grade 9)

The physical environment of the public health facility was an important theme that emerged during the interviews with learners. Mitchells Plain is well known for its gangs so it was not surprising to hear the effect that these groups have on the public health facility:

*'It is not safe. They come into the clinic and they don't wait in the queue. They sommer tell the nurse that they want the doctor now. And the people are getting cross but we can't say anything. Cause you know what these gangsters are like. They will sommer get us if we say anything. And the nurses are scared, so they just see to the person that is stabbed or shot. And even though there is security by the door, but it is an old man. What can he do?'*

(Male learner # 2, Grade 9)

When the learners were asked if they would use the health facility again, most of the learners said that they would visit the clinic if they had to (when ill or in an emergency), as that was the closest health facility to their home. When asked if problems at the health facility were typical (i.e. occurred frequently) or were once-off problems, almost all learners that visited the public health facility stated that the same problems had been there since their very first visit. In other words, there had been no improvement in the environment or services rendered by the facility. One learner explained:

*'I've been going to the clinic a lot because my baby is 19 months old. And so every time I go to the clinic, it's like the same thing all the time. You wait and the people are rude and the baby is getting tired. That's why I ask my mother to take the baby to the clinic. But sometimes, she can't, so I must go.'*

(Female learner # 14, Grade 10)

When asked whether they went to the health facility to receive health information (for example, about changes to their bodies, reproductive health matters, etc.) or for advice about something that was worrying them, none of the learners said that they visited the clinic for these reasons.

Interestingly, when asked what their friends or peers thought about the use of public health facilities, none of the learners had any knowledge of the perceptions and attitudes of their peers towards public or private health facilities. A Grade 9 learner said that:

*'If you have money then you go to the doctor in the town. If you don't, then you go to the clinic. That's it. There's nothing to feel shame about, it's there to use.'*

(Male learner # 9, Grade 10)

#### **4.7 Satisfaction of services provided at clinic**

The learner's positive and negative experiences of the services provided by the public health facility are highlighted in this section. The learners responded positively to the doctor at the public health facility. Ten of the 11 learners felt that the doctor they saw at the health facility was friendly. One learner described the doctor as *'kwaai'* (slang for 'nice').

Eight of the 11 learners who visited the public health facility had positive comments to make about the nurses. They made comments like they *'work hard'*, were *'helpful'* and seem to be *'doing a lot'*. A learner said:

*'Ya, the nurses are always mos busy, They work hard and they look like they busy all the time. I don't know how they do it. But sometimes they also in a bad mood.'*

(Male learner # 9, Grade 10)

Four of the 11 learners remarked on how *'tired'* the nurses appeared and how they seemed not to be motivated to do their work. The learners judged this from the way the nurses spoke. One learner said:

*'It's as if they were working the whole day and night. She [the nurse] sounded like she was just fed up with working at the clinic. I know there is a lot of people there all the time and the people must know that the clinic need more nurses, because the ones there are just too tired.'*

(Female learner # 12, Grade 10)

All 11 learners that visited a public health facility felt that the clinic's proximity to their homes was an advantage. They liked the fact that they could walk to the facility and were not ashamed of using the clinic. All 11 learners were not impressed with the long waiting time required to receive their patient files and the long waiting time to receive treatment. One learner remarked that *'the clinic is a whole day story.'*

All but one of the 11 learners who attended the clinic expressed some form of negative opinion about the attitude of the administrative staff at the front desk. The time spent waiting to receive their patient files were described as "very long" and the learners could not understand this. One learner said:

*'You get more sick waiting for your file. The one time ne, I remember they even lost one ladies file. I mean, how can they do that? You did not even get to see the nurse or doctor and you made to wait so long. And they give you attitude. It's not right!'*

(Male learner # 8, Grade 9)

Quite a few of the learners (7 of the 11) remarked that the clinic was not clean. One learner said during her interview:

*'How the people can sit there when there floors are so dirty, I don't know. And the place is smelly. All the people are like so sick and the toilets are just so messed up. They must mos clean up the place.'*

(Female learner # 13, Grade 9)

Learners who used the public health facility felt that there was a lot that could be improved. While the researcher probed for solutions, none of the learners were very forthcoming with suggestions. At this point in the interview, most learners went quiet, paused to think, and then responded that they *'did not know.'* However after much probing, three recommendations emerged from a few of the learners during the interview. These recommendations were (i) to improve the waiting time at the public health facility; (ii) to improve the cleanliness of the public health facility; and (iii) to ensure that the clinic provides 'better' medication. Some learners felt that the medication given to them at the clinic was 'not working.'

The idea of a nurse or health practitioner visiting the school to speak about health topics was suggested and welcomed. Learners felt that they needed more information on changes that were taking place in their bodies. From the interviews, it was evident that female learners required more guidance on contraception, as well as on the birth control options available to them. One female learner said:

*'I don't know what must I take for not falling pregnant. I know I can take a pill or something, but what is it and what does it do for you? It's confusing. Cos like it's not something you can just take, just like that.'*

(Female learner # 11, Grade 10)

There was no evidence from the interviews to suggest that male learners were getting contraceptives from the clinic. None of the male learners admitted that they were sexually active. When asked if they got condoms from the clinic, none of the learners responded. They just smiled or looked blank and shook their head indicating no. When asked if they knew that they could get condoms from the clinic, the male learners replied "Yes!" When asked if they made use of the condoms provided from the clinic, again, there was no verbal answer from the learners – but they just shook their heads indicating 'no'.

When asked, if they would attend the clinic on a special day set aside just for youth, most learners responded positively. One learner said:

*'That would be so cool. I think all of the youth and teenagers in Tafelsig will go to the clinic on that day. It will also maybe go much quicker and the teenagers will want to go. But then there must also be a doctor there at the clinic on that day, not just a nurse.'*

(Male learner # 9, Grade 10)

#### **4.8 Findings from the Key Informant Interviews**

In addition to exploring the reasons for low utilization of health care facilities with learners from the local school, a key informant interview was held with an official from the Department of

Health that worked in the Mitchells Plain community (key informant 1). Another key informant interview was held with a member of staff at the local school (key informant 2). These two key informants both had many years' experience of working with adolescents in their respective roles in the Departments of Health and Education. During the course of interview with the key informant from the school some interesting background information on the socio-economic status of the learners attending the school was provided. The learners that attend the school were described as '*facing financial and social hardships.*' As the key informant noted:

*'The majority of the students cannot afford to pay the school fees [at this school]. I am applying to the department [of Basic Education] to make Tafelsig Secondary a no-fee school.'*

(Key Informant 2)

The school has a lunch scheme for learners who require meals during the school day. When asked what the most urgent needs of the school were, the informant said:

*'The needs of the school for students are clothing [school uniform], food and a mini bus to transport students to [sport or recreational] matches. The teachers in the school have a low morale. Teachers do not take initiative. I would love for teachers to go on a team building exercise.'*

(Key Informant 2)

The learners of the school were also described as likely to be engaging in risky behaviour:

*'I have confiscated a drawer filled with kitchen knives [as learners use these knives as weapons during fights], dagga and tik from students [at the school].'*

(Key Informant 2)



The key informant also highlighted the following:

*'Teenage girls [in this school] fall pregnant all the time. I generally ask the girls to leave the school once they start showing and readmit them to school [after the pregnancy] in the next term. There are also few students that ask to be excused from school as they are going to the clinic for ARVs. There are quite a number of students that are HIV-positive at [this] school.'*

(Key Informant 2)

During the interview with the representative from the Department of Health, possible reasons for the low utilization of the primary health facilities in the Mitchell's Plain community by adolescents were explored. The key informant stated the following:

*'There may be many reasons. For instance, long waiting time at the clinic; poor staffing; [the] layout of the clinic; accessibility; not being able to attend [the clinic] because of school; privacy issues; health personnel separating patients according to their illnesses within the clinic; limited birth control methods that have considerable low side effects (no one has explained these contraceptive methods to girls); adolescents; adolescents don't know that pregnancy tests are available at the clinic.'*

(Key Informant 1)

At the time of the interview, it was reported that there were no designated adolescent-friendly clinics in the City of Cape Town or in Mitchells Plain.

At the time of the interview, it was also reported that there were no health projects taking place at schools in Mitchells Plain community. The key informant stated:

*'There have been a few nurses that went to a few schools in the [Mitchells Plain] area to speak about sexual and reproductive health. Principals in [so-called] Afrikaans [coloured] schools don't allow [the nurses to] talking about contraceptive methods. The black schools are different though. They are fine [and allow us to speak about sexual and*

*reproductive health]. We are meant to do something about improving the number of clients [visiting health facilities] and [health] campaigns and maybe this project will help us understand [what is the reason for low utilization rates].'*

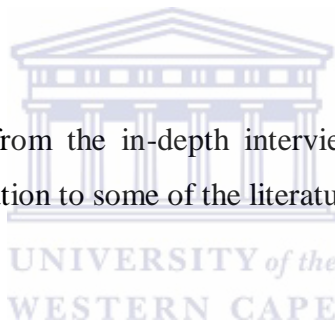
(Key Informant 1)

The key informant from the Department of Health reported that the department was willing to collaborate with schools to encourage teenagers to use the clinic more or to facilitate the learner's access to the services offered by the clinic. The key informant from the Department of Education suggested that:

*'A nurse coming once a week to speak to students [about health topics or changes to our body] would be useful.'*

(Key Informant 2)

In the next Chapter, the results from the in-depth interviews with the learners and the key informants will be discussed in relation to some of the literature that was consulted.



## **Chapter 5: Discussion**

### **5.1 Introduction**

Globally, there are about 1.8 billion adolescents who are exposed to harmful narcotics and alcohol consumption, to sexually transmitted diseases such as HIV, and to obesity (Blum et al., 2012). With a large subset of the population made up of adolescents, many low- and middle-income countries have yet to adopt measures to control problems of injury, infectious disease and maternal mortality (Blum et al., 2012). While adolescents are at risk from such health issues, there are also many barriers that influence their use of health services. These barriers range from problems with accessibility to dissatisfaction with the health services provided. This study aims at providing a better understanding of the use of primary-level health care facilities by adolescents living in the Tafelsig area of Mitchell's Plain, Cape Town. It also aims to explore possible reasons for the poor utilization of these health facilities by these adolescents.

Through in-depth interviews with a group of 15 learners (aged between 14 and 16 years) from a local school in the area the researcher has tried to uncover some of the reasons for the poor utilization of these facilities by young people living in the area.

### **5.2 Choice and utilization of clinic/other service providers**

In South Africa, public health care is provided by the government through a national healthcare system. Private health care, on the other hand, is provided by private hospitals and by self-employed health practitioners, as well as by not-for-profit non-governmental providers, which include faith-based organizations.

Results from the study indicate that a decision-making process takes place prior to the learner accessing either a public or private health-care facility. This is in keeping with Mechanic's theory (1978) which suggests that there are 10 critical decision points which prompt a person to seek health assistance or treatment for an illness. The learners in this study only contemplated using a health facility or seeking medical attention if they experienced severe discomfort, if the

learner could not tolerate the symptoms, or if the parent or guardian felt that the learner required medical attention.

The process would continue, with the learner consulting their parent or caregiver when they felt ill. The researcher *assumed* that at this point the parent would assess the symptoms displayed by the learners and try to find ‘cost and time effective’ methods of bringing relief to the learner. The parent might, for example, provide medication already available in the home, or advise the learner to get bed rest, or concoct a home remedy. Five learners mentioned that their parent or guardian (usually a mother or grandmother) would provide them with a home remedy when ill, and in ‘most instances’ these learners reported that the home remedies worked. If the home remedy, bed rest or self-medication was not effective, learners reported that the parent or guardian would then visit a pharmacy to get medication for the symptoms. The researcher would again *assume* that the parent or guardian would describe the symptoms of the learner to the pharmacist and that over-the-counter medication would then be dispensed. In South Africa, over-the-counter (OTC) medicines can be purchased at pharmacies without a prescription. These include Schedule 0, 1 and 2 drugs, such as medication for headaches, coughs and colds, and for minor skin conditions, etc. Prescription medicines are those medicines that one can only obtain following a visit to the doctor, who then writes a script if treatment is required.

If the OTC medication did not bring relief to the learner and the symptoms or illness persisted, only then would the learner be taken to a medical facility. This finding is disturbing as early diagnosis of an illness is better than delaying the diagnosis, and self-medication is often not advisable (Hem et al., 2005). While the intention of the parent or guardian was to help the learner by attending to the symptoms of the illness, there are dangers associated with self-medication (Hem et al., 2005).

All of learners in the study had visited or used the public health facility in the community (i.e. the Clinic X) on one or more occasions in the past. As reported, 11 of the 15 learners continued to use the public health facility while 4 of the 14 learners consulted a private health care professional when ill.

The above decision-making process was not followed in emergency situations, for example, when a learner broke an arm. In this instance, the learner was immediately rushed to the clinic. Eleven learners in the study reported that they would much rather visit a pharmacy or ask a parent or caregiver to purchase over-the-counter medication when ill. Interestingly, the 11 learners in the study who made use of the clinic felt that going to a clinic or a health-care professional was a last resort. If the symptoms or the illness became more severe, only then would the learners visit a health care facility. Seven of these 11 learners reported that they would much rather stay at home and rest, than go to the clinic for medical attention. The researcher asked if they required a sick note from a health professional if they stayed away from school. All the learners said that their parents or guardian would write them a sick note to explain their absence to the teacher.

All of the learners in the study indicated that they did not decide themselves which health facility to use when ill. Learners did not demonstrate that they gave much thought as to which health facility to visit when ill. The learners would rather allow their parent or caregiver to decide. Learners in the study felt that their parents or caregivers made the decision based on their finances. Parents or caregivers who were able to afford a consultation with a General Medical Practitioner (a medical doctor) would do so; if not, then the learner's parent would opt for a public health facility. The fact that the adolescents did not have a choice about which health care provider to consult was not unusual, given their age. The law that governs children in the health-care decision-making context is fairly well established in South Africa. The general rule is that children under the age of 18 years are not permitted to obtain (or refuse) medical treatment without their parents' consent (Department of Health, 2000). In this instance, only the parents' consent mattered, even if the child were to disagree. The rationale for this was that children were not seen as mature enough to make these decisions for themselves. As noted in a publication by UNICEF, 'Research on Poverty Alleviation' (UNICEF, 2007) children under the ages of 18 years lack the requisite capacity and experience to make a decision, and are vulnerable to pressures from others.

In one instance, one of the learners was herself a mother and visited the clinic to get treatment for her baby. The learner explained that she had no alternative but to use public health care

facilities as neither she nor her parents could afford medical aid to get access to a private health care facility. The learner also mentioned that she was sometimes unable to spend ‘an entire day’ at the clinic, so she sent her baby to the clinic with her mother.

From the points mentioned above, it is evident that the learners were not fully in control of the decision-making process or the choice of treatment for their illness (e.g. home remedy or OTC medication). In particular, the learners in the study did not decide whether to attend a public or private health-care facility. Their parents or guardians made the decision for them. Based on the description of the socio-economic status of the community and of the learners that attend the school, one would *assume* that the decision of the parent or guardian was mainly influenced by the cost of treating the illness and time spent in seeking treatment. These decision-making processes determine whether or not the learner will make use of the clinic (or a private doctor): in effect, the learner depends on the parent or guardian to make the decision. The study identified the following steps taken by parents or guardian when a learner is ill. These were: (i) do nothing; (ii) use a home remedy; (iii) wait and see whether the condition gets worse; (iv) consult a pharmacy for OTC medication; (v) wait to see if the learner responds to the treatment; (vi) if not, then take the learner to a private medical practitioner or to an affordable clinic. These steps were similar to those in Young’s choice-making model (1981) where a systematic process is followed before a health care facility is utilized.

The next theme of the study, is the decision-making process of learners when they are on their own (outside the control of their parents or guardians) and able to make decisions for themselves. This decision process is rather different. All learners in the study reported that they do not and/or would not seek sexual and reproductive health care (such as contraceptive methods and HIV tests) with the knowledge of their parent or guardian. From the responses of all the learners, there was a feeling of ‘shame’ or ‘not knowing how their parent would react’ or ‘discomfort’ at letting their parents or guardians know that they were sexually active or wanted information about sexual and reproductive health issues. In the study, learners suggested that they would not – or did not – speak openly to their parents about sexual health matters; they would only seek their advice when they felt ill for other reasons. Half of the learners interviewed felt that their

parent(s), as well as the nurse or medical doctor at the primary-level health facility would disapprove of their being sexually active at their age.

Not surprisingly, most learners in the study did not feel that they needed to go to a health facility for sexual or reproductive health care issues. All learners knew that they were at risk of getting HIV if they had unprotected sexual intercourse, but most learners had very little knowledge of any other sexually transmitted diseases. Adolescents' sexual health is threatened from early age as a result of intercourse (average age 15 years) and unprotected sex, leading to high risk of HIV transmission and other sexually transmitted diseases (Department of Health, 2001). Research has found that an increased consciousness or awareness of sexuality and a sensitivity to or preoccupation with body image is essential for psychosocial development during adolescence (Stang & Story, 2005).

Interestingly, when later asked in the interview if they required more information about the changes in their bodies, the learners answered in the affirmative. When asked who they get advice from about contraception, the learners often responded that a friend or family member (cousin or aunt) would provide them with such advice. When probed further, learners felt that a friend, cousin or aunt that was "close" and "approachable" about sexual issues was more appropriate to seek advice from. The learners felt that the people they consulted were 'young and experienced' with regard to such issues and so were the right people to speak with about contraception. The learners placed a great deal of emphasis on the experience of the friend, cousin or aunt. We can extrapolate from this that the learner knew that the friend, cousin or aunt was sexually active and felt they could raise such matters with these persons. However, the advice received from the friend, cousin or aunt by the learner was in some instances incorrect. One an example was when a learner said that she 'shared birth control with a friend.'

Research among African American and Latino women carried out by Yee and Simon (2010) found that young women rely for advice about contraceptive methods on family members and their social network, for example friends, and make their choices about contraceptive efficiency, side effects, safety, or use on this basis (Yee & Simon, 2010). These researchers also found that myths and misconceptions communicated through these social networks had a significant

influence on the use (or refusal to use) of effective contraceptive methods (Yee & Simon, 2010). This suggests that there is a need for young woman to seek proper medical advice about contraceptive methods. The phenomenon of learners sharing birth control pills warrants further research.

There was no evidence from the interviews which to suggest that male learners were getting condoms from the clinic. When the researcher probed further to establish if condoms were obtained from elsewhere, the male learners said that they did not get the condoms from another outlet. Only one of the male learners informed the researcher that he used condoms, but he did not disclose *where* he got the condoms from. One could only assume that the majority of the male learners interviewed were either not sexually active, or are not using condoms if they are having sex.

A qualitative study conducted by Sathipersad and Taylor (2006) with ten Grade 11 male learners from three different schools in Kwazulu Natal, also found that males were unwilling to disclose if they used condoms or (if they did) where they got condoms from. Further, the male learners in their study believed that women caused AIDS. Their descriptive study found that this belief was so firmly held that the youth saw no reason to reflect on and review their own sexual behaviour. The study also found that advertising campaigns, social marketing and the promotion of condom use to prevent HIV/AIDS infections, had little effect on the risk-taking behaviour of male participants in the study (Sathipersad & Taylor 2006).

### **5.3 Access to health facilities**

A significant body of research already exists about the barriers faced by adolescents when accessing health care. Initiatives are emerging worldwide that attempt to remove these barriers and help young people obtain the health services they require (Millstein et al., 1993). The accessibility of health care services is a basic tenant of primary health care in South Africa (Kibel & Wagstaff, 1995). However, in South Africa adolescents have to use existing primary health-care services that are overburdened (Kibel & Wagstaff, 1995). The ability to access these health facilities is of particular interest for the study, as this will influence the degree to which



public health care facilities are utilized. The key informant from the Department of Health provided an example of a barrier that prevented adolescents from accessing a health facility: this was learners might be at school during the clinic's operating hours.

None the 11 learners that visit a public health facility in this study reported having a problem getting to the clinic. Clinic X was close to their homes and within easy walking distance and they were able to access the clinic during its operating hours if they stayed away from school. None of the learners required money to travel to the clinic. Even though the learners were dissatisfied with the service at the clinic, they still visited the facility as it was close to home. Learners that visited a private medical practitioner had to travel much further to seek medical attention and travelled by car. None of the learners in the study indicated that they were ever turned away from the clinic when seeking treatment.

Another interesting factor that was identified in the study as influencing utilization of the health facility is safety at the health facility. Mitchells Plain is a community known for high levels of criminal and gang activity. Six learners in the study described how members of gangs had entered the clinic and demanded immediate treatment, without little thought for the people waiting for treatment. These six learners reported that there was a security guard at the clinic, but according to one learner the security guard has not been able to prevent gangs from hanging around or gaining entry to the clinic. These same six learners all thought that the clinic was unsafe. This is a clearly a barrier to accessing the health facility.

#### **5.4 Learners' satisfaction and experience of using public and private health care facilities**

In South Africa, a primary health-care clinic is the first line of treatment for health care and is the basis on which public health services are judged by patients or clients. It is therefore critical that these clinics function well within communities.

Ten of the 11 learners in the study who made use of the clinic did not have pleasant experiences at the clinic. They commonly described a visit to the clinic as long; they reported that the clinic was dirty; they found the nurses and front-desk staff to be unsympathetic and unfriendly; and

they felt the clinic was unsafe. Unfriendly, demotivated and unsympathetic nursing staff have also been reported in other studies. A paper by Gleeson and Robinson (2002) reviewed teenagers' perceived needs regarding access to primary health care. Their main finding was that a substantial minority of teenagers had health-related problems that were not met by existing health services. The authors also reported that the main barriers to accessing primary health care for adolescent boys and girls were a perceived lack of confidentiality, unsympathetic staff and embarrassment (Gleeson & Robinson, 2002).

The four learners who utilized private health care facilities in the study were able to do so because their parents or guardians were able to afford the consultation fees. These learners described the trip to the general practitioner as a pleasant experience. There were common responses among the four learners when asked to describe the experience of using a private health facility. They listed the following as characteristic of their visits: short waiting times; clean facilities; friendly doctor; positive previous experiences; the parent had confidence in the practitioner; and "better" medication was provided. Interestingly, all four learners thought that the private medical practitioner provided "better" medication than did the clinic. When probed further, however, it turned out that there was no previous experience of inferior quality of service from the clinic. However, this unfavourable perception of the clinic was common among all four learners.

Two learners mentioned that being able to make an appointment with a private doctor and being seen at that time was convenient for them and their parents. Three of the four learners mentioned that they had to call to check if the doctor was at the practice and available to see them for a consultation. Results from the interviews with the participants in the study indicated that there was a preference for making use of private health-care facilities. In particular, making an appointment and being seen at the given time was attractive to learners. The South African clinic system works on a first-come first-serve basis. Learners often associated their experience of the government clinic with having to wake up very early in the morning. Learners who visited the clinic reported if they did not get to the clinic early they would have spend a long time waiting for medical attention or treatment.

All four learners consulting private health care practitioners reported that there was a strong relationship between their families and the doctor. From the responses received from these four learners it seems that their family members had been visiting the particular general practitioner for a long time. One learner mentioned that their grandparents, parents and now they were being treated by same general practitioner. The researcher *assumed* that the family of these learners had confidence in the treatment offered by this general practitioner. Understanding the medical history of a patient and having access to generational family medical history is helpful to a practitioner and helps to ensure that the patient gets the best treatment (Dayman, 1853). Families have many factors in common, including their genes, their environment and their lifestyle, and this helps the medical practitioner to identify diseases to which they may be predisposed, such as heart disease, diabetes, high blood pressure, stroke, certain cancers, and high levels of cholesterol. In keeping with the Young's findings (1981) regarding choice-making, the researcher also *assumes* that the general practitioner's knowledge of the family history, gives the patient increased confidence in the prescribed treatment. This is of course influenced by the patient's previous experience of how illnesses were treated by the practitioner.

Interestingly, these four learners reported that they visited the general practitioner when they could no longer manage their symptoms. Two of the four learners reported that their parent would first give them medication that is available in the home (for example, paracetamol or aspirin), ask them to get bed rest and stay away from school for a day. If the symptoms persisted, the learner would be taken to a general practitioner. In line with Mechanic's theory (1978), this was similar to the steps taken by the parents or guardians of the learners who used the public health facility. All four learners reported that they were accompanied to the general practitioner by their parent or guardian. The parent or guardian was present when the doctor consulted with the learners, and three of the four learners mentioned that their parents or guardian preferred the doctor to give the learner an "injection" as this was considered more effective than taking pills. After reviewing all four learner interviews, this was the only negative aspect of this experience: According to one learner:

*'I don't like it when they [parent] make him [the doctor] give me an injection. It's so sore! I hate it!'*

(Female learner # 7, Grade 10)

When the 11 learners described their experience of utilizing the public health facility, they based their account on their most recent visit to the health facility. The participants in the study tried to recall the date or month of the last visit; those that consulted a private medical practitioner were able to recall this much more easily and they provided a more detailed account of the visit. The quick turnaround time during these visits was commented on by learners. Learners also made favourable comments about the surgery, and reported that the staff were friendly. The personality of the private doctor also made a favourable impression. A learner commented as follows:

*“Our doctor is lots of fun. He wants to know about school, about what movies I like. He even knows the [television] series I watch [which is] Gossip Girl.”*

(Female learner # 7, Grade 10)

A health facility is meant to be safe for all of its clients and personnel. Learners in the study reported that they were felt unsafe at the primary level health facility that they visited. Mitchells Plain is a community known its high incidence of crime. The community is home to many gangs; gangsters are often referred to ‘skollies’. Further research into the safety of clinics in Mitchells Plain is recommended.

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Interestingly, when the researcher compared what the key informants suggested were the possible reasons for low utilization by adolescents of the public health facilities, there was little overlap with what the learners themselves reported. Two points of agreement were that poor attendance of young people at public health facilities was (i) because of learners were not able to attend the clinic during school hours; and (ii) because the long waiting times were a problem for those requiring prompt medical attention. The key informants did not mention (i) how the attitude of the staff might adversely affect the learners’ experience; or (ii) how (the lack of) cleanliness might be a factor; or (iii) how the learners’ sense that their personal safety was at risk might discourage use of the public health facilities.

Eight participants felt that the medication prescribed or dispensed by the primary-level health facility was not effective, and this was cause for dissatisfaction. While the key informant from the Department of Health mentioned a concern that the side effects of contraceptives were not

being properly explained to adolescent girls, these eight learners (both male and female) reported they had ‘never’ received medication from the clinic that ‘helped them feel better’ first time around. These eight learners reported that they either got ‘more sick’ or had to return to the clinic to get ‘better medication’.

From the interviews it appears that there is an opportunity for health professionals from the clinic to work with schools in promoting discussion of sexual and reproductive health issues. While the key informant from the Department of Health was under the impression that the management of the school was not keen on nurses speaking about topics such as condom use, the key informant from the school felt that this would be useful. Most of the learners also mentioned that they would like more information about bodily changes and that it would be helpful if a health professional could visit the school to speak to them. The findings of this study suggest that it would be advantageous if both female and male learners were provided with information, within the school setting, on matters such as the types and use of contraceptive methods, and their side effects.

In addition, the findings of the study suggest that it is not solely up to the learner to decide which health facility to use. Further research needs to be done to understand the perceptions of parents or guardians of adolescents regarding their children’s use of public health facilities. They are the ones who usually make the decisions – hence the importance of ascertaining their views.

The results of the study also suggest that participants in the study were not comfortable going to the clinic on their own for matters relating to their sexual and reproductive health. The learners in the study would prefer to talk with their friends and receive advice from a peer who was ‘more experienced’. This has serious implications for the health of the learner, in particular female learners: incorrect advice on the use of contraceptives was reported by one learner. This learner reported that she was misinformed by her friend, shared contraceptives and felt ill from the side effects. The misuse of contraceptives may leave female learners with negative perceptions regarding their use, and this is likely to increase their chances of falling pregnant.

Some recurring themes emerged from the interviews. Learners were dissatisfied with the lack of sympathetic and motivated health professionals (i.e. nurses) at the clinic. Learners were, however, satisfied with the medical attention provided by the doctor at the clinic, but felt that the consultation was too short and that the doctor did not fully engage with learner. Learners were dissatisfied with their treatment by administrative staff at the clinic: the participants wanted to be treated in a friendly manner by receptionists or administrative staff. As described by the World Health Organization Framework for Youth-friendly Health Services (WHO, 2002:27), health-care workers have an important role to play in caring for the health of adolescents.

The WHO Framework for Youth-friendly Health Services recommends that health-care workers should:

- (i) provide adequate information and support to enable each young person to make free and informed choices that are relevant to his or her individual needs;
- (ii) be motivated to work with young people;
- (iii) be non-judgmental in their consultation with adolescents;
- (iv) show consideration for their adolescent patients;
- (v) be able to relate to and devote adequate time to their adolescent patients; and
- (vi) act in the best interests of their patients (WHO, 2002).

Research indicates that although staff in clinics generally feels that they offer care that is of good quality, there are problems with regard to management and staff attitudes (Sinanovic et al., 2001), and further investigation into the motivation of health professionals at clinics is needed.

When asked for recommendations, the 11 learners in this study that used public health facilities suggested the following:

- (i) they would appreciate an improvement in waiting times;
- (ii) they would like cleaner health facilities; and
- (iii) they would like safer clinics.

In general, there needed to be more emphasis on improving the experience of the patient at the point of delivery. The World Health Organization (2002) recommends that adolescent-friendly health facilities need to ensure the following: (i) privacy (including a discreet entrance); (ii) consultations should occur within a short waiting time, with or without an appointment; and (where necessary) there should be a swift referral. In addition, the health facility should (i) not have any stigma associated with it; (ii) have an appealing and clean environment; (iii) ensure the physical safety of visitors; and (iv) provide information about a variety of contraceptive methods available (WHO, 2002). Facility managers at the Department of Health as well as personnel at the public health facilities need to ensure that these standards are reached if they are to improve the experience of learners who attend the health facility. This will in turn encourage adolescents or young adults to attend the clinics in Mitchells Plain.



## Chapter 6: Conclusions and Recommendations

Adolescents represent the future of any country. If their health needs are not sufficiently met, the country's future prospects will be affected. In light of South Africa's significant adolescent population, the question of adolescent health is even more important. From a review of the literature, it seems that the most important area of health concern for adolescents is that of reproductive health. However, if adolescents have negative perceptions or do not make full use of the available health facilities, then the health needs of a significant subset of the population will not be met.

The study demonstrates that even when public health services are available, adolescents are often not in a position themselves to choose for themselves: their parents or guardians invariably make the choice for them. At times they are also reluctant use to public health facilities for fear of being judged by health personnel for being sexually active. The idea of waiting for long periods of time to see a health professional, or being observed at the health facility by members of their community, are also disincentives. The value of these findings is that they provide the Department of Health with some new information on adolescents' preferences concerning access to and use of the local primary-level health services in Mitchells Plain.

Many learners in the study expressed a need for more information about changes to their bodies and other aspects that affect their health. In South Africa, most health initiatives are either school-based or are implemented in government hospitals and clinics (Dickson-Tetteh et al. 2000). The secondary school which the learners in this study attended did not have any school-based health initiatives. Adolescents who attended the school therefore relied on health services and initiatives from the clinic and other government health facilities in the area.

It is recommended that a health professional (for example, a health promotion officer or a nurse) visit the school on a regular basis to give health talks on the issues that are of interest to and affect adolescents.



The findings of the study suggest that there is an urgent need for youth-friendly health services for the Mitchells Plain community. It is recommended that the Department of Health strategically assess whether an existing public health facility can be revamped to cater for the specific health needs of adolescents in Mitchells Plain. Further, it is recommended when youth-friendly facilities are being designed, they should take into consideration the World Health Organization framework for youth-friendly health facilities (WHO, 2002). However, should it be found that existing health facilities do already have certain services that appropriately cater for the needs of adolescents, then the Mitchells Plain community should be made aware of this.

Learners in the study expressed great enthusiasm for having a day specially allocated by the clinic to provide adolescents with health care. Notwithstanding the previous recommendation, the Department of Health could also investigate the feasibility of providing adolescent health services over weekends, especially for those adolescents attending school and/or working. The provision of a youth-friendly weekend service would be a step towards establishing a youth-friendly clinic *exclusively* for adolescents in the local area.

An important finding of the study was that the parents and guardians strongly influence which health facility the learner uses when ill. It is therefore recommended that further research be undertaken into the perceptions of parents and guardians of adolescents in the Mitchells Plain community. This might enable one to better understand the factors influencing the use of health facilities in Mitchells Plain.

There is a unique opportunity for officials of the Department of Health to meet with principals and teachers from schools in Mitchells Plain. This stakeholder engagement will create a working relationship between the Departments of Health and Education. Further, with greater awareness of the available adolescent health services, teachers and principals will be better able to promote these services to both learners and their parents or guardians.

The reported long waiting times, poor cleanliness and inadequate safety at the clinic ought to be investigated by the Department of Health. Strategies to reduce waiting times have been developed and the recommendations from such studies should be implemented in some form or

other. Communicating to clients the service what they can or should *expect* (in terms of a reasonable waiting time) might be one way of addressing this issue. Cleaning staff at the local clinic could also be informed about the findings of the study and, together with their managers, they could consider ways of addressing the negative perceptions of learners with regard to cleanliness.

It is recommended that the Department of Health implement a strategy for improving security at their health facilities. The findings of this study are that adolescents who visit the clinic feel unsafe.

It is recommended that a workshop or training should be conducted with administrative staff to improve client relations at the clinic. Health and administrative professionals need to be made aware of the perceptions that adolescents have of them and more care needs to be taken when dealing with young people at the clinic. In addition, health professionals need to ensure that when they dispense medication to a young adult that the side effects (as well as instructions on how to take the medication) are communicated effectively. Lack of knowledge of the side effects of medication contributes to a perception among adolescents that the medication available at the clinic makes them '*more sick*' – or that it "*does not work.*"

Finally, this study has certain limitations. It only considers the experiences and perceptions of a small group of learners from one secondary school in Mitchells Plain; thus the results do not necessarily reflect the views of a range of other adolescents in the area. For example, those who are living with a physical disability or those who have left school (and who might be particularly vulnerable) may well have different perspectives. Future studies focusing on these research issues might take the form of a quantitative study which would be more representative of the experiences and opinions of a broader range of adolescents living in Mitchells Plain

However, this study has provided a unique, initial insight into issues affecting adolescents' use of health services in their area. It deepens our understanding of their views – and the findings are consistent with those other published studies in South Africa.

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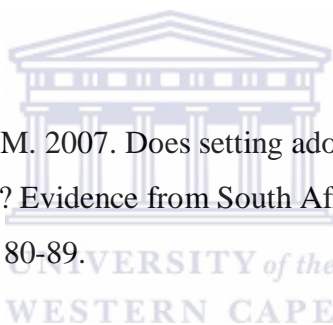
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## Annexure A: Briefing document prepared for Teachers



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### Briefing document prepared for Teachers to support them in introducing the study to learners in Grade 9 and 10

I would like to tell you about a research study that is going to take place in our school.

There is a researcher by the name of Thashlin Govender who is a Masters student at the School of Public Health from the University of the Western Cape. Thashlin is wanting to find out why teenagers in the Mitchells Plain area either visit or do not visit the local clinics in the Mitchells Plain area and what their experiences and / or opinions are of these clinics.

The researcher, Thashlin, would like to invite you to take part in this research study. He will randomly select seven Grade 9 learners and seven Grade 10 learners. He will select an equal number of boys and girls. The selection of these 14 learners is a bit like the lotto ie. not everyone who volunteers to participate in this study – and whose name then gets placed on a list of possible study participants will be chosen for an interview. Only 14 people will be chosen for an interview – but *everyone* who volunteers will have an equal chance of being selected!

If you would like to be considered as a *possible* participant in this study we would need you to take the information and consent form (the one that I have given you) home to your parents or your guardian to read. It is important that they are also made aware of this study and agree that they feel comfortable (a) that your name gets placed on the list of possible participants and (b) that you might be selected to be one of the 14 participants to be interviewed by Thashlin, the researcher.

It is important to remember that when deciding whether you want to put your name forward to participate in this study that you do not *have* to participate in this study. It is not for marks and is entirely a voluntary activity. There are no right or wrong answers to the questions that Thashlin will ask you. The interview will in fact be a type of conversation with you.

It is also important that you are informed that interviews, which will take about one hour to complete, will be conducted on the school premises but *after* school.

Another important thing to know about this study is that Thashlin, the researcher, will ensure that all the things that you say in the interview will remain confidential and that no one will be able to identify the comments you make in the interview in the report that Thashlin finally writes up about the study.

There will not be any teachers participating in the interview (nor will the Principal be a part of it) – it really is all about what young people experience and think about the local public health clinics in the Mitchells Plain area and what other types of health facilities they use.

*If* you decide you do want to be considered as a potential participant in this study please take the information and consent form back to your parent(s) / guardian today.

If they agree to your name being placed on a of potential participants then you must return the signed consent form back to me by ..... (*state the day and date 7 days from today*).

After this the researcher, Thashlin, will then inform you who has been selected to be one of the 14 participants and will then tell you of the date and time and venue of the interview.

If you decide that you don't want to be a part of this research study you don't then need to request the consent of your parents or guardian. It is also important to remember that this is a completely acceptable thing to do as well.

Do you have any questions about what I have just said – or about this study more generally?

## Annexure B: Information Sheet and Consent Form for Parents or Guardian

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Interviewer: Thashlin Govender

UWC Student no: 2706961

Tel: 083 730 2846

E-mail: thashlin@yahoo.com

Institution: University of the Western Cape



### Information about a Study being conducted at Tafelsig Secondary School

#### 1. Information about the researcher:

I am Thashlin Govender, a student at the School of Public Health, University of the Western Cape. As part of my Masters in Public Health, I am required to complete a mini-thesis. For my mini-thesis I will be focusing on the factors that contribute to the use by adolescents of the public health clinics in the Mitchells Plain area.

I am accountable to my Supervisor, Ms Nikki Schaay, a Senior Researcher at UWC who is contactable at 021 788 4186 / 021-959-2809 or c/o SOPH Fax: 021 959 2872. I can be reached on: 083 730 2846.

Here is some information to explain the purpose of the study and the request I have made to conduct interviews with 14 learners from Grades 9 and 10 in Tafelsig Secondary School. The Principal of the School, Mrs. O'Shey, has given me permission to conduct the study in the School.

## **2. The purpose and content of the research study:**

My research study aims to explore the factors that contribute to the use (or non-use) by adolescents of the public health clinics in Mitchells Plain. I would like to interview 14 learners from Grades 9 and 10 to find out their opinions of the clinic, their experiences of using the clinic (if they *have* attended the clinic) and what other facilities they use if they are sick or need some form of health-related care, assistance or advice.

## **3. The process of selecting and interviewing the learners:**

From a list of potential study participants (ie. all those Grade 9 and 10 learners that have expressed an interest in voluntarily participating in the study and have also obtained their parent's or guardian's written permission to do so) I will randomly select seven Grade 9 learners and seven Grade 10 learners. I will select an equal number of male and female learners to participate in the study.

The selection of these 14 learners is a bit like the lotto ie. not everyone who is willing to participate in this study – and whose name gets placed on a list of possible participants will be chosen. Only 14 will be – but everyone will have an equal chance of being selected!

Only the names of the learners who voluntarily would like to be considered as a *possible* participant in this study will be placed on this list. And only those learners whose parents or guardian has agreed to their son/daughter being considered as a potential participant in the study will be placed on the list.

It is for this reason that I am informing you about the study and requesting that if your daughter or son *is* interested in participating in this study – and you agree to them being interviewed (if they are one of the 14 chosen from the list of potential participants) – that you sign the consent form below.

It is important to remember that learners do not have to participate in this study. It is not for marks and it is an entirely voluntary activity. Similarly, you do *not* have to agree to allow your daughter / son to be considered as a potential participant in this study. It is entirely your choice!

For your information interviews, which will last about one hour, will be conducted on the school premises *after* school.

Another important thing to know about this study is that the researcher will ensure that any comments that the learners make in the interview will remain confidential and that no one will be able to identify their comments in the study report.

There will be no teachers present or participating in the interview (nor will the Principal be a part of the interviews) – it really is all about what young people experience and think about the local public health clinics in the Mitchells Plain area. The results of the study will assist the City of Cape Town Health Department to improve the services they provide to young people at their clinics in the Mitchells Plain area.

#### 4. Agreement

##### 4.1 Interviewee's parent/guardian agreement

I, \_\_\_\_\_ (name), the parent / guardian of \_\_\_\_\_ (learner's name) hereby give permission for my child to take part in the study described in this information and consent form.

##### 4.2 Interviewer's agreement

I shall keep the contents of the above research interview confidential and only refer to the above mentioned person by a pseudonym (ie. a false name) in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

**Signed by parent or guardian:**

**Date:**

**Place:**

## Annexure C: Information Sheet and Consent Form for Learners

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Interviewer: Thashlin Govender

UWC Student no: 2706961

Tel: 083 730 2846

E-mail: thashlin@yahoo.com

*This information and consent form is for learners between the ages of 14 - 18 years who attend Tafelsig Secondary School and who we are being invited to participate in a research study.*

### **Information about a research study being conducted at Tafelsig Secondary School**

My name is Thashlin Govender and I am a student at the School of Public Health at the University of the Western Cape. I would like to give you some information about a study I am conducting at this school and invite you to be a possible participant in this research study. You can choose whether or not you want to participate. If you do not wish to take part in the research you do not have to – it is not compulsory or something that your school requires of you – it is entirely up to you to decide whether you want to be considered as a potential participant in the study, and actually take part in an interview.

If you decide you would like to participate in the study your parent(s)/guardian also have to agree that you can take part in the study. They will be asked to read and approve of your participation in the study by signing a consent form. Your teacher will give you that consent form to take home with you if you feel you want to be considered as a possible participant in this study.

There may be some words you don't understand or things that you would like more information about. Please let your teacher know about these questions so that I can be made aware of your question and I can respond to your questions and provide you with more information. But for now: here is some basic information about my study and what it will involve for the study participants:

### **What is purpose of this research study?**

My research study is trying to find out what why young adults (between the ages of 14 - 18 years) in the Tafelsig area either visit or do not visit the local Tafelsig clinic – or other clinics in the Mitchells Plain area - and what their experiences and / or their opinions are of these clinics. I am wanting to interview 14 learners in Grades 9 and 10 about their own experiences, impressions and ideas about this.

### **Why are we asking learners to take part in the study?**

I would like to try and understand what are some of the reasons are that either facilitate (ie. help or encourage) and prevent (ie. stop) young adults from using the Tafelsig clinic – or other clinics in the Mitchells Plain area. The local Health Department would also like to understand this so that they can consider the opinions of young adults in their planning for better health services.

### **Do you have to take part in this study?**

No - you don't have to be in this research if you don't want to be! It's really up to you. If you decide you don't want to be considered as one of the possible 14 participants in this study - it's completely okay. Even if you say "yes" now, you can change your mind later and it's still okay. Taking part in this research will not earn you any marks, it is not something that you *have* to do because you are at school – it is an entirely a voluntary activity.

### **What will it involve – being part of this study?**

If you decide you would like to participate in this study and want to be considered as one of the 14 learners to be interviewed, you first have to ask your parents/guardian for their permission. They then need to agree and sign the consent form and you need to then return it to your Teacher in 7 days time.

I will collect all the completed consent forms from your teacher (ie. the ones that have been signed and returned from your parents / guardians). I will then place the names of those learners on a list and randomly select 14 learners to take part in an interview. I will select seven Grade 9 learners and seven Grade 10 learners (and an equal number of male and female learners).

The interview will be conducted between myself, Thashlin Govender, and yourself. *If you are selected to take part in the interview, you will receive a letter with the date and time of your interview.* This letter will be sent to you via your teacher, a week before the actual interview. The interview will not be longer than one hour and will be held *after* school at Tafelsig Secondary School. Before the interview starts I will ask you to sign the consent form below – which then shows that you have voluntarily given me permission to interview you. I will also ask your permission to record the interview on a tape recorder. This is also something that you can either agree to or not agree to. Again it is up to you decide what you feel *most* comfortable with.

It is important that you know that none of the information that you share with me during the interview will be shared with your teachers, fellow learners or parents – or the local health care workers. In other words, what you say to me in the interview is confidential and will not be shared with anyone else. I will write up my findings from the interviews without identifying who said what in the interviews. I will protect your anonymity by using a pseudonym (or false name) when I transcribe (ie. write up) your interview and report on the results of your interview.

You also have the right to request that we stop the interview at any point and also have the right to decline to answer certain questions if you feel uncomfortable about responding to them.

If you feel during or after the interview that you would like to discuss any of the issues that have been raised in the course of the interview with a Counselor I will be able to facilitate that. All you need to do is request that I arrange that for you and I will put you in contact with the School Counselor, or an alternative one if you think that would be more appropriate.

All the information that I obtain from the interview with you (including the tape recording of the interview) will be put safely away and no-one but myself as the researcher will have access to it.

Lastly, I need to also tell you that you will not receive any direct benefit from participating in this interview (in other words you will not get paid for your participation). However, the results



of this study will hopefully contribute to future planning in the Health Department and contribute to making the clinics in Mitchells Plain more youth-friendly.

### **Who can I talk to or ask questions to?**

I would like to encourage you to discuss anything in this document that you might want to know more about with your Teacher, your friends or anyone else you feel comfortable talking to. You can also contact me if you have further questions. I can be reached at 083 730 2846.

Another way of asking me a question is to write it down and put it in an envelope I have given to your teacher. She/he will then give me your questions and I can either contact you directly (if you also put a telephone number down on your piece of paper) or I can send my response to your question to your Teacher during the week.

### **Learners agreement**

I, \_\_\_\_\_ (name and surname) a Grade \_\_\_\_\_ (write which Grade you are in) learner from Tafelsig Secondary School, agree to take part in the study described above. I have read through the information and understand that if I would like to withdraw from the study, I can do so at any time.

Signed by learner:

Date:

Place:

## Annexure D: Interview Questions for learners

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### Introduction

- My name is Thashlin Govender. I am a student at the University of the Western Cape, School of Public Health. Thank you for agreeing to take part in this study.
- As you are aware by now I am trying to understand what you think of your local clinic and what your experience has been in using it.
- As I mentioned in the information sheet and consent form that you signed, no information that you provide me with during this interview will be attached to your identity.
- During the course of the interview please do not hesitate to ask me any questions that you may have about this study – or about the questions that I ask you.
- Are you ok to proceed with the interview now?
- Would it be ok with you if I recorded this interview on a tape recorder?

**Name of learner:**

**Time interview started:**

**Grade:**

**Gender:**

**Time interview ended:**

**Age:**

**Race:**

### ***CHOICE & UTILIZATION OF HEALTH CLINICS /OTHER SERVICE PROVIDERS***

- *Can you describe to me where your nearest clinic is located?*

- Have you ever gone to this clinic – or another clinic in Mitchells Plain?

**For those that have gone to a clinic in MP:**

- How many times have you gone to clinics in MP – perhaps think about this over the past year to begin with?

Can you tell me a little about the last time you went to a clinic in Mitchells Plain:

- Why did you choose to go to this clinic – and not another clinic or a General Practitioner or private clinic/hospital?
- How do you get to this clinic (eg. walk, public taxi, private car)?
- How much did it cost you to get to the clinic – and back from the clinic?
- When was your last visit? [Get the year ie. this year, or how many years back]
- Can you remember the time of the day that you went to the clinic (eg. 3pm or 4pm)?
- Can you remember how long you spent in the clinic (from the time you walked in to the time you walked out)?
- Did you go to the clinic by yourself (alone), or with a friend, or with a girl/boyfriend (ie. someone that they are involved in a relationship with) or with a family member?
- How did you feel about making a decision to go to the clinic the last time you went?

**EXPERIENCE OF USING THE CLINIC**

- And what was your actual experience of the clinic like - the last time you went? Perhaps you can start by telling me what things about your visit were positive / helpful/ good (if anything!) and what things about your visit were negative / not good / you hated. Let's start with the positive things....then after that, we can move onto the negative things.
- Are these experiences that you have described (both the positive and negative) what you generally experience every time you go to the clinic(s) in Mitchells Plain?

- *From the other times you have gone to the clinic: is there anything else you experienced that you felt really made the clinic visit a worthwhile and positive and a pleasant experience?*
- *Is there anything else negative or off-putting that you can remember from your previous visits to the clinic (apart from what you have described already) – and that you think is important for me to know about.*
- *If you needed to go to the clinic tomorrow – would you return to the same clinic you did last time or find a different clinic to go to? Why/why not?*
- *If you were sick with bad flu and needed some medicine to make you feel better - would you go to the same clinic as last time or find a different clinic?*
- *And if you were needing to get family planning (condoms, pills) or some advice about starting contraceptives – would you still go to this last clinic or a different one? Why/why not?*
- *If you wanted to do an HIV test – would you also go to this clinic – or go somewhere else? Why/why not?*
- *What kinds of things generally would make it easier for you to go to [NAME of clinic if they are using the same one every time] OR a clinic in Mitchells Plain [if they are not using the same one over and over again]?*
- *What things generally would put you going back to [NAME of clinic if they are using the same one every time] OR a clinic in Mitchells Plain [if they are not using the same one over and over again]?*
- *How different is your experience of this clinic/the clinics in Mitchells Plain from your peers ie. your friends, or the other learners in your Grade?*
- *Is it the same (and if so, how do you know this?), or*

- *different (and if so, why do you say this)?*

***For those that have not gone to a clinic in MP:***

- *If you have never visited your local clinic (or another one in MP) where do you go when you need medical advice or health related services?*
  - *Why did you choose this service provider rather than the other options available to you, for example the Tafelsig clinic?*
  - *Do you prefer to go to the local clinic or a hospital or to a private General Practitioner? Why?*
- *What do you think are some of the reasons for young people like yourself using – and not using the local clinic?*
- *What do you think are some important aspects that you think should be changed about the local clinic that you visit so that you would want to make more use of it?*



***ACCESS TO HEALTH FACILITY***

- *Do you feel ashamed to visit the local clinic – or the health facility that you generally go to? Why/why not?*
- *Is there anything you believe your school can do to help you get time or access to go to the clinic?*

***SATISFACTION OF SERVICES***

- *What are the key things you would like changed/ or would be the most important thing to find at a clinic to make you feel comfortable and make you want to go back to the clinic?*

*Thank you for taking part in the interview. We really appreciate your time and once again promise that whatever you have shared with me in this interview will not be linked to your name or identity (but will remain anonymous) and will not be shared with anyone else (but my research supervisor).*



### **Annexure E: Questions used in Key Informant interviews**

1. From your experience in working in the Mitchells Plain community – are these still the key things that the City Health Department is particularly concerned about in relation to the health of teenagers in this sub-district?
2. Are there any adolescent friendly health facilities available to teenagers in the Mitchells Plain community?
3. Have there been any health promotion campaigns at schools in the Mitchells Plain community to encourage learners to utilize their local community health facility? What was the aim of these programs? What did they do? What was the result? Why did she feel they did/did not work?
4. Can you see the Department of Health working in collaboration with schools (take Tafelsig Secondary as an example) – to encourage teenagers to use the clinic more – or to facilitate their access to services offered by the Department?
5. Are you able to share the present utilization figures of teenagers using health facilities in the Mitchells Plain district with me? Or who would I be able to get these figures from?
6. What is the current target set at clinics in Mitchell’s Plain? Are some clinics reaching better utilization rates than others? Why is that so? Are some of the services they offer used more than others by teenagers – and if so what are examples of each?
7. Why do you think the utilization is so low? In other words – how have you interpreted the problem (what all the reasons are that explain why teenagers are not using the services sufficiently).
8. What has the Department of Health done to get teenagers to use their clinics more? [both WITHIN the facilities itself and OUTSIDE i.e. in the community – whether that be in the schools, or through NGOs, or through general outreach campaigns].
9. Has the department of health identified any strategies that they may be rolling out in the near future to improve utilization rates of health facilities by teenagers? What are these?