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UTILISATION OF REPRODUCTIVE HEALTH SERVICES BY FEMALE STUDENTS AT THE UNIVERSITY IN JOHANNESBURG

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Dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand,

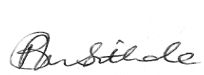
In fulfilment of the requirements for the degree of

Master of Science in Nursing Education

Johannesburg, 2015

DECLARATION

I Bongiwe Maureen Sithole hereby declare that this research report on Utilisation of Reproductive Health Services (RHS) by female students at a university in Johannesburg is my original work and that reference to work done by other people and material obtained from other sources have been appropriately cited and referenced.



……

BONGIWE MAUREEN SITHOLE DATE

DEDICATION

To my dear mother Thokozile Sophia for her incredible support and her undying love for me as her only child, to my children Andile Vumokuhle and Nokwanda Gugulethu for their support and understanding when I did not have sufficient family time to spare and lastly to my lovely grandson Nhlakanipho Njabulo for the joy he brought to my heart during stressful moments.

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UTILISATION OF REPRODUCTIVE HEALTH SERVICES BY STUDENTS

ABSTRACT

This is an exploratory, descriptive study intending to determine factors that influence the uptake of Reproductive Health Services (RHS) by female students at the university in Johannesburg with a view to improving access and delivery of service in a more efficient manner. Despite the availability of free, accessible and confidential RHS on campus, anecdotal data shows an increased number of students who present with unintended pregnancies and soliciting termination of pregnancy.

Through the survey and semi-structured interviews the researcher attempts to determine factors influencing the uptake of campus RHS by female students. The present text seeks to answer the following research questions: What is the socio-demographic profile of actual and potential users of RHS on campus and what factors influence the uptake of RHS on campus?

Keywords: Reproductive health, access, utilisation, unwanted pregnancy

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LIST OF ABBREVIATIONS

AGI	Alan Guttmacher Institute
CHWC	Campus Health and Wellness Centre
CSB	Care Seeking Behaviour
FWCW	Fourth World Conference on Women
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HRP	UNDP/UNFPA/ UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
ICPD	International Conference for Population and Development
IUD	Intra Uterine Device
MAP	Morning after Pill
NAFCI	National Adolescent - Friendly Clinic Initiative
NHI	South African National Health Insurance (NHI) Policy
NHP	National Youth Policy
O-Week	Orientation Week
RHS	Reproductive Health Service
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TL	Tubal Ligation
TOP	Termination of Pregnancy
TCSB	Theory of Care Seeking Behaviour
TRA	Theory of Reasoned Action

UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
W H O	World Health Organizations

UTILISATION OF REPRODUCTIVE HEALTH SERVICES BY STUDENTS

1.0 OVERVIEW OF THE STUDY

1.1Introduction

The absence of sexuality education and lack of accessible, affordable, and appropriate contraception services are some of the key factors leading to adolescents facing many sexual and reproductive health risks, which stem from early, unprotected, or unwanted sexual activity (UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) 2012, pp.2-3).

Cooper et al. (2004) pointed out that the Government introduced the provision of adolescent sexual and reproductive services and supported the launch of The National Adolescent - Friendly Clinic Initiative (NAFCI) through the Department of Health to increase the accessibility of health care services to the youth. Mfono (1998) highlighted the fact that teenage contraceptive use in South Africa is hindered by attitudes that link being sexually active with stable relationships and even marital commitment which is not the case with teenage relationships.

Few students in the sample were in the adolescent stage while the majority of the sample was in the youth stage. Adolescent stage is divided into early adolescence ages: 11 – 14 years, middle adolescence 15 – 17 years and 18 – 21 years is late adolescent stage (ANON, 2014). Youth stage refers to persons from 15 – 34 years of age (South Africa's National Youth Policy, 2009 – 2014). According to Commonwealth, youth is the age group between 15 – 29 years of age while United Nations defines youth as age group between 15 – 24 years of age (Curtain, 2001. p.3). For better understanding, the population in this study will be referred to as youth.

There is lack in the utilisation of Reproductive Health Service (RHS) by young people with potential risk of HIV, STI and unwanted pregnancy among sexually active youth. Many of the issues that

relate to unwanted pregnancy amongst adolescents affect the youth as they share many characteristics such as attending formal education and being dependent on parents and guardians for financial and emotional support. Some of the literature relating to adolescent pregnancy is therefore included. It is acknowledged that while the focus of the research is on utilisation of the RHS, it is an unfortunate but common consequence of unprotected intercourse that pregnancy will occur, hence the discussion on this matter.

Young people are prone to engage in high risk behaviour due to negative peer influence as indicated by de Guzman (2007), that peer pressure is one of the attributes in youth behaviour.

In the context of this study positive pressure from peers means adapting to responsible sexual behaviour including utilisation of RHS by sexually active students and negative peer influence means ignoring responsible sexual behaviour with likelihood of unwanted pregnancy and or contracting sexually transmitted infections including HIV.

Bearinger et al. (2007) stated that young people need access to quality youth-friendly services provided by clinicians trained to work with this population. Sex education programmes should offer accurate, comprehensive information while building skills for negotiating sexual behaviours. Girls and boys also need equal access to youth development programmes that connect them with supportive adults and with educational and economic opportunities.

Youth continues to face challenges in their sexual and reproductive health despite the progress achieved since the 1994 International Conference on Population and Development. The population under study has RHS on the premises of the university which offers quality youth friendly services and confidentiality is maintained all the time.

Two research questions were asked in this study. The first question sought to obtain the socio-demographic profile of actual and potential users of Campus RHS. Asking this question was significant since socio-demographic profile plays a role towards sexual behaviour of a young person particularly the age and ethnicity or race which is relevant to the population being studied. Andersen & Newman (2005) indicated that individual characteristics such as demographic, social structure, attitude and belief variables are likely to influence the individual to utilise health service although such characteristics are indirectly responsible for health service utilisation. Cubbin (2005) argued that racial or ethnic identity and socio-economic factors influence contraceptive (RHS) use by adolescents, but little is known about how they influence it (Cubbin et al., 2005, p. 125).

According to Academic Information & Systems Unit (AISU) (2012) at the university under study, 16584 female students were registered in the year 2012.Out of this number; 9183 were Black, 4217-White, 2383-Indians, 707-Coloured, and lastly 94 were Chinese female students. The racial diversity of the population in this study formed the basis for socio-demographics to be included in order to explore racial influence towards RHS utilisation.

1.1 Background of the study

Information about (RHS) is provided by Campus Health and Wellness Centre (CHWC) within the university to all students during the orientation week and throughout the year. The assumption is that the information has filtered through to students; however throughout the year some students registered at the university, came for pregnancy testing which indicated an initial lack in the utilisation of RHS for pregnancy preventative measures. The limited number of students who choose to utilise RHS has remained a great challenge in higher learning institutes. In the current study out of

16584 registered female students, only 3525 students utilised RHS on campus which is 21.3% of all female students who were registered (CHWC Statistics, 2012).

Inadequate utilisation of RHS by female university students is more likely to result in unwanted pregnancies for them. World Health Organisation (WHO) (2007), as summarised by Hoque & Ghuman (2012), estimated 15% of university students in Southern Africa who experience unwanted pregnancy and about 60% of unwanted pregnancies globally occur among university students.

Literature shows that sometimes young people fail to utilise RHS because they fear that they might be judged by health care providers (Wood et al., 1997, p.26).

Registered students at the university in Johannesburg are encouraged to utilize RHS which is one of the health services offered to students on campus. Students are taught about responsible sex to avoid unwanted pregnancy, a wide range of contraceptive methods available on campus, STIs including HIV, and all social and psychological challenges that come along with these situations. They also get assistance and guidance with screening procedures such as Papanicolaou smears and breast examination to ensure good reproductive health. Confidentiality and individual rights are upheld at all times.

1.2 An overview of RHS utilisation among university students

RHS utilisation involves any of the reproductive health components which are contraceptive use including emergency contraceptive, termination of pregnancy (TOP), STI diagnosis and treatment, HIV Counselling and Testing and HIV management. Literature indicates low uptake of RHS amongst university students.

A study conducted in Nigeria, 2009, on Patterns of contraceptive use among female undergraduates, showed that from a study sample of 425, only (n=78) (63.9%) of sexually active respondents had

used RHS for contraceptives previously. Thirty (n=30) 26.7% of sexually active respondents were currently on contraceptives (Cadmus & Owoaje, 2009, para.10).

In the current study, out of 3525 female students who utilised the RHS, (n=2516)71.4% of 21.3% utilised the service for contraceptives and (n=81) 2.3% of 21.3% used the service for emergency contraceptives. Nineteen (n=19) 0.5% of 21.3%, sought TOP and (n=397) 11.2% of 21.3% utilised the service for STI management while (n=504) 14.3% of 21.3% utilised the service for HIV counselling and testing (HCT). Only (n=8) 0.2% of 21.3% female students visited the RHS for HIV management (CHWC Statistics, 2012).

1.4 An Overview of Reproductive Health

According to MacDonald (2011) the notion of reproductive health transpired in the 1980s aiming at a comprehensive approach to women's health rather than demographic targets and population control. This idea was internationally accepted during the International Conference for Population and Development (ICPD) in 1994 and the Fourth World Conference on Women (FWCW) in 1995. It was greeted with great enthusiasm and was viewed as an enhancement for women's health. The ICDP was recognised internationally for its two fundamental principles of Reproductive and Sexual Health (RSH) which are: (1 the fact that emancipating women and improving their status are essential resolutions in themselves and essential for achieving continuous development; and 2) reproductive rights are not just part of family planning but they are adherent to basic human rights. The contribution by the ICPD conference led to the change in how women's health was perceived and how services were provided. Based on these changes, reproductive health started to focus more on promoting healthy reproductive lives, instead of preventing sexual morbidity (MacDonald, 2011, p.3).

1.5 Problem statement

This study is on utilisation of RHS by female students at the university campus. The identified problem is that this service is underutilised by students especially those living in the university residences who have little access to alternative services. According to the statistics of Campus Health Service, only 3525 students utilised RHS on campus which is 21.3 % of the total female students 16584 who were registered in 2012 (CHWC Statistics, 2012). Underutilisation of RHS has devastating financial consequences for students and the university. By finding out from the students their reasons for not utilising the service, the campus health staff will be able to take appropriate measures to improve access and delivery of RHS.

1.6 Purpose of the study

This study sought to determine the factors that influence the uptake of RHS by female students on campus with a view to improving access and delivery of service in a more efficient manner. A number of studies on teenage pregnancy have been conducted throughout the country such as a study on ‘Review of Teenage Pregnancy in South Africa, Partners in Sexual Health, 2013’. In this study it was concluded that poor access and inconsistent utilisation of RHS and unapproachable health care providers among other factors contributed to inadequate utilisation of RHS (Willan, 2013 p. 29). The above mentioned study is relevant to the current study for example poor access and inconsistent utilisation of RHS mentioned in that study, are the prevalent factors in the population being studied. The researcher in the current study, wanted to explore factors that influence the uptake of campus RHS by female students.

1.7 Research questions

1.7.1What is the socio-demographic profile of actual and potential users of campus RHS?

1.7.2 What factors influence the uptake of the RHS on campus?

1.8 Objectives of the study

1.8.1To determine the socio-demographic profile of potential and actual users of campus RHS

1.8.2 To explore and describe factors influencing the uptake of campus RHS by female students

1.9 Operational definitions

1.9.1 Students

Students are defined as people who are studying at a university or other place of higher education. Students at the university can be undergraduate or postgraduate. High school students are known as pupils or scholars (Oxford Dictionaries language matters, n.d.). Students in the context of this study are undergraduate female university students.

1.9.2 University

University is an institution of higher-level education that confers its own degrees, generates knowledge through academic research and scholarly activities disseminate that knowledge through publication, teaching and presentations (Stelmach, 2012, p.5). University in the context of this study is the university in Johannesburg where this study took place.

1.9.3 Utilisation

The term utilisation means; to make practical and effective use of: (Oxford Dictionaries language matters, n.d.). When patients or clients access or make use of the service, they are said to be utilising that service. Utilisation as used in this study refers to the utilisation of RHS by female students with the intention to prevent or treat sexually related problems and to learn and access measures to avoid unintended pregnancies.

1.9.4 Risk Behaviour

Risk behaviour is defined by de Guzman & Pohlmeier (2007), as the behaviour that has negative impact on the well-being of youth and which can hinder development and successes in future. Typical behaviours are substance abuse, engaging in unprotected sex, behaviour leading to physical harm such as fighting.

The mentioned risk behaviours including unwanted pregnancy are applicable to the population under current study hence students are encouraged to utilise RHS since it provides health education against these behaviours.

1.9.5 Reproductive Health

Reproductive Health is a state of being physically, mentally, and socially well and not solely the absence of disease or infirmity, in all matters pertaining to the reproductive system and to its function and process (Feleke & Gebresilassie, 2008, p.1) Utilisation of RHS is promoted in this study because it is vital to sustain good reproductive health.

1.9.6 Reproductive health service (RHS)

Reproductive Health Service is the delivery of comprehensive reproductive health support and assistance to both men and women to ensure a state of physical, mental and social well-being in all matters relating to the reproductive system. The students in this study are encouraged to access this service which is offered for free on campus.

1.9.7 Unwanted pregnancy

Unwanted pregnancy is an undesired pregnancy by both partners (McGraw-Hill Concise Dictionary of Modern Medicine, 2002, no pagination). Unwanted pregnancy in the present study is one of the outcomes likely to be experienced by sexually active students when not utilising RHS.

1.9.8 Termination of pregnancy (TOP)

Termination of pregnancy (TOP) or abortion is the term used to describe the process whereby pregnancy is voluntarily ended before the foetus is viable (Vilsack, Pederson & Stephen, 2002, p.3).

1.10 Conclusion

In this chapter an overview and the background of the study were discussed, an overview of reproductive health, problem statement, purpose as well as objectives of the study were given. In the next chapter literature review of completed research will be presented to provide a foundation for this study.

2.0 LITERATURE REVIEW

2.1 Introduction

Campus Health Services including (CHWC) at the university in Johannesburg are the units within the Student Affairs divisions in higher learning institutes. The Student Affairs divisions fall under a confederation called The International Association of Student Affairs and Services (IASAS). Some of the objectives of Campus Health Services are to provide Primary Health Care (PHC) to students at an affordable cost and to promote health and student well-being leading to holistic student development and academic success (United Nations Educational, Scientific and Cultural Organization (UNESCO), 2002, pp.1-39).

CHWC involved in the current study consists of a Medical Doctor, six Professional Nurses qualified in PHC nursing which involves diagnosis, treatment and care, an HIV Counsellor and Tester and four Administrative staff. There is a satellite RHS in Parktown Campus which operates with one PHC nurse and one administrative staff. Both these centres operate from 08h00 till 16h30. Reproductive health is among health care services offered at CHWC.

Utilisation of RHS forms the basis for promoting healthy reproductive lifestyles and it benefits individuals in three areas of sexual and reproductive health which are preventing unwanted pregnancy, improving maternal health and preventing, diagnosing and treating STI including HIV/AIDS (Cohen, 2004, p. 5).

It is imperative that more female students are motivated to utilise the RHS to empower them to take responsibility for their reproductive health. If students adapt to responsible sexual behaviour and utilise RHS, the likelihood is that they will not experience unwanted pregnancy and therefore they will be able to complete their university career as they have envisaged. Ehlers (2003) described teenage pregnancy as suggesting untoward effects on social, health, and economic status for the

teenage mothers, their children and their families as well. Adolescents are at risk for drug abuse, unwanted pregnancy, contracting STI including HIV, and even at risk for having to cease their schooling. The population under study is bound to enter into relationships which might put them at-risk of unwanted pregnancy and contracting STIs including HIV.

2.2 Implications of unwanted pregnancy

Unwanted pregnancy is one of the biggest challenges facing sexually active youth and making good choices can help young people enjoy their youth stage and able to focus on their studies.

2.2.1 Socio-economic implications

Pregnancy in young people adds on gender inequalities that are already in existence. The pregnant young woman or young mother is financially dependent on the male partner for her support and the baby and this situation exposes the young women to negative trajectories such as violence (UNFPA, 2007, p.10).

2.2.2 Educational implications

School dropout is associated with teenage pregnancy as documented in most studies. Kirby (2007), as summarised by Panday et al. (2009) indicated that the negative and costly outcomes of teenage pregnancy continue in generations. There is likelihood that children of teenage mothers report poor attendance record obtain low grades and even drop out of school. While not specifically stated, these problems are likely to affect young people attending tertiary education just as much.

In South Africa there is evidence suggesting that teenage pregnancy, and by implication unplanned pregnancy among the youth, leads to delay in completing school and there is likelihood that

educational aspirations are curtailed by delay in schooling due to unwanted pregnancy and performance in school is likely to be threatened (Morrell et al., 2012, p.11). Even though the legislation in South Africa allows pregnant young women to continue with their schooling after child birth, only a third of these young women re-enter the schooling system (Grant & Hallman, 2006, p.7).

Students in the university under current study who fall pregnant are at risk of having their studies disrupted by pregnancy leading to delay or failure to graduate. They are also prone to perform badly in their studies due to stresses posed by pregnancy as stated in The National Campaign to Prevent Teen and Unplanned Pregnancy study (2009), that poor academic performance among college students is likely to occur as a result of emotional and financial stress caused by unwanted pregnancy (The National Campaign to Prevent Teen and Unplanned Pregnancy study, 2009, p.2). The academic implications of unwanted pregnancy are that students face low self-esteem, psychological stress, poor scores and failure to graduate (Fekede, 2015, p.120).

2.2.3 Health-related implications

According to Taylor (2010), unwanted pregnancy for youth is the beginning of a miserable life for most of them. They face a lot of health challenges such as STIs including syphilis and HIV which come along with unprotected sex. The baby is also at risk of contracting these diseases especially if the mother undergoes normal vertex delivery. These young women undergo a lot of stress due to their unpreparedness for the current situation with the chances of miscarriage or premature labour. According to Lemos (2009), pregnant teenagers usually miss out on antenatal care during the first trimester because they seek medical advice late in pregnancy. Teenage mothers are 50% less likely to breastfeed their babies and this has a negative impact on the health of the baby. Babies born to

teenage mothers are likely to suffer from low birth weight with 60% chances of infant mortality rate. These children are also prone to accidents and behavioural problems than children born to older women. Teenage mothers are three times more likely to suffer from post-natal depression and higher risk of poor mental health compared to older women (Lemos, 2009, p.15).

The population under study fall within the age group discussed in the two abovementioned studies and they are susceptible to suffer the mentioned implications should they fall pregnant.

2.2.4 Family development implications

Unwanted pregnancy deprives the youth the pleasures of their developmental stage when they are still in the journey of discovering how their bodies work. Having no financial freedom they become the burden to their families and the society. Ashcraft & Lang (2006) argued that the prospects of marriage for young women are greatly affected by unwanted pregnancy with the possibility of being single mothers. Varga (2003), as summarised by Panday et al. (2009), indicated that acknowledging paternity by fathers is the key factor to reducing stigma of early pregnancy and it gives the child the opportunity to be supported by its father. It is however often that fathers driven by their financial and educational ambitions end up denying paternity.

The rate of pregnancy among sexually experienced young women in South Africa is estimated at one third of 15 -19 year olds and almost two thirds of 20 -24 year olds who had ever been pregnant (Pettifor et al., 2005, p.1531).

2.3 Frameworks for the analysis of healthcare utilisation

2.3.1 Introduction

Obrist et al. (2007) stated that access to health care is a key issue for health and development. Health-seeking studies provide an in-depth understanding about the trends in seeking access to health care services by individuals, social groups and communities (Montgomery et al., 2006, pp. 1663-1666).The issue of accessing health care service takes place when illness or the probability of its occurrence is perceived by the individual or the family (Andersen & Newman. 2005, p.16).

Obrist et al. (2007) mentioned five dimensions of access which influence the health care seeking process. These dimensions are: availability, accessibility, affordability, adequacy and acceptability. Availability of services should meet the needs of the people. If the resources are reasonably available, they are likely to be utilised more frequently (Andersen & Newman. 2005, p.14).

Health care services must be accessible to the client in terms of geographic location and the operational hours should match with the schedules of the clients. Affordability of service means the client can afford direct costs of the service and indirect costs such as transportation. Acceptable service is the one where the client has trust in the competence of the health care provider (Obrist et al., 2007, p. 1586). Phillips et al. (1998) stated that provider characteristics interact with individual characteristics to influence utilisation of health care service such as the gender or speciality of the service provider, for example; a female patient might feel uncomfortable being examined by a male service provider. In the context of this study, the focus is on factors influencing utilisation of RHS by a diverse educated youth population residing in an urban community irrespective of financial disparities.

According to Dorin et al. (2014), Andersen's Behavioural Model of Health Care use is the most popular frameworks used for the analysis of health care utilisation. The initial model was developed in 1960 and its purpose was to discover conditions that either facilitate or interfere with the utilisation of service. The initial measures of access were on potential access which includes enabling resources that provide the means and increase the possibility that use will take place.

2.3.2 Health Belief Model

In a study Compliance with Medical Advice, Becker and Rosenstock (1984), as summarised by Turner et al. (2004) defined The Health Belief Model (HBM) as a conceptual framework through which health behaviour and non-compliance with the recommended health action can be understood. According to Turner et al. (2004), perceived susceptibility in HBM is the logic behind people protecting themselves whenever they perceive that their wellbeing is threatened by danger. Individuals seek preventive health services if they believe they are vulnerable to disease.

Courtenay (1998) discovered that there is an association between perception of increased susceptibility to disease and healthier behaviours and between decreased susceptibility to disease and unhealthy behaviours. In college students even high perception of susceptibility to disease is not always linked to the adoption of healthier behaviours. Courtenay further indicated that, 3 out of 4 college men who were involved in high - risk sexual behaviour did not think that their risk of HIV was high. Their belief in decreased susceptibility to HIV stopped college men from changing their behaviour. It is not common to find a correlation between perceived susceptibility and positive changes in risk behaviours among college students (Courtenay, 1998, p.282).

Misconceptions such as beliefs that only those who engage in high risk behaviours, for example prostitutes, gay men and intravenous drug users contract STIs and HIV, mislead college students into

believing that they will not contract these diseases even when they engage in high –risk sexual behaviours as long as they do not engaged in the above mentioned practices (Courtenay, 1998, pp.279-290).

Sorenson (1973), as summarised by Tauer (1986) indicated that a discrepancy exists between actual behaviour and moral upbringing which is often evident in the adolescents who routinely do not use any type of birth control and are surprised when they become pregnant. It further pointed out that adolescents feel if they do not use contraception and are swept away on the spur of the moment, then the sexual behaviour is acceptable and that planning sexual activity conflicts with the moral code of their parents and their own beliefs and values. By not dealing with the possible outcomes of their decision, then they are acceptable to both their peer group and their parents (Tauer, 1986, p.276).

Self-efficacy, personal relationships, health professionals and media are mentioned in the HBM framework as modifying factors that affect compliance behaviour.

In this study HBM is used to understand the components for non-compliance with recommended utilisation of RHS for preventing and solving sexual health problems. Health professionals' attitude and personal relationships could be modifying factors among other factors that affect compliance behaviour of the population in this study.

2.3.3 Theory of Reasoned Action as applied to moral behaviour

Carmack & Lewis-Moss (2009) stated that Theory of Planned Behaviour which is a modification or extension of Theory of Reasoned Action was based on the premise that people are usually rational and make system use of the information at their disposal. This theory argues that people consider certain factors before they make decisions whether to engage or not to engage in behaviour.

Carmack & Lewis-Moss (2009), further explained that attitude towards the behaviour, control and subjective norms, are the global constructs that formulate the difference in intention to perform that behaviour. Theory of Reasoned Action and Theory of Planned Behaviour have been found useful in predicting behaviour and believed to provide a good foundation for investigating unethical behaviour (Chang, 1998, p.1825).

Theory of Planned Behaviour predicts the link between behavioural belief and one's attitude. It further explicates the possible sources where a person gets these behavioural beliefs namely parents, teachers, peers and significant others. When individuals are confronted with a moral situation, they make decisions based on their attitudes towards the behaviour and their perceptions of what their loved ones and community leaders (parents, friends, religious leaders, and professors) feel they should be doing (Vallerand et al., 1992, p. 100).

These two theories were included in the current study to provide insight about student behaviours. The student behaviour which entails taking responsibility to meet academic demands and responsible social life including responsible sexual behaviour, maybe affected by one or two of the mentioned possible sources of behavioural beliefs which are; loved ones and community leaders (parents, friends, religious leaders, and professors). Provision of RHS on campus provides guidance for students towards responsible sexual behaviour.

2.3.4 Theory of Care-Seeking Behaviour

Theory of Care-Seeking Behaviour was developed based upon Triandis's 1977, 1980, 1982 Theory of Behaviour (Lauver, 1992, p.284). Theory of Care-Seeking Behaviour differs from Triandis's theory in that arousal concepts such as behavioural intention and physiological arousal are not included (Lauver, 1992, p.284). Lauver (1992) found that the prospect of engaging in health

behaviour is brought about by a variety of factors such as psychosocial variables, habit, norm, and contributory conditions regarding the behaviour.

In the current study care-seeking behaviour is evident for example when anxiety and fear related to unplanned pregnancy encourage youth to seek care such as pregnancy testing for confirmation and or termination of pregnancy.

2.4 Health care service utilisation

The issue of access to health care service has been dealt with in most studies. Chomi et al. (2014) stated that lack of health insurance affordability has been the most identified contributing factor towards poor access to health care service amongst low income individuals. Peters et al. (2008) identified disparities that exist in low and middle income countries regarding access to health service. There is a trend in poor countries for people to have minimum access to health services compared to people in better-off countries and within countries, the poor have less access to health care services (Peters et al., 2008, p.161).

This paper presents an overview of access to reproductive health care service by educated diverse youth from urban and rural geographic backgrounds and different socio-economic backgrounds. In the context of this study, health insurance does not determine access to RHS; the population has equal access to care irrespective of socio-economic status. The next section discusses various barriers perceived to be contributory factors towards poor utilisation of RHS.

2.4 Perceived barriers to the utilisation of RHS

From the outset the issue of access to the practice of adolescent medicine cannot be ignored. There has been likelihood that political, economic and cultural changes affect how and why adolescents access health care (Booth et al., 2004, p.98).

According to the National Youth Policy (NYP) (2009 – 2014) teenage pregnancy, maternal mortality, reproductive and sexual health, HIV and AIDS are recognised as health challenges facing South African youth. The policy advocates for the improvement in the access to youth-friendly health related programmes and services. To enhance access, certain measures are stipulated by the policy which are geographic distribution of youth-friendly health related programmes and services to cover rural areas (Adolescent and Youth Health Policy, 2012, p.10).

2.4.1 Access barriers

To ensure that health care needs are met, there should be feasibility in utilising the services in terms of financial affordability, physical and social resources that are available and within reach (Rebhan, 2008, p.8). All people are entitled to medical care. Seeking health care service is greatly influenced by health insurance or financial affordability. According to Chomi et al. (2014) lack of money for consultation and to pay for treatment lead to the delays in seeking health care. López-Cevallos & Chi (2010), referred to lack of insurance coverage, poverty stricken conditions and limited access to health care services as political and societal problems which have direct effect on health care service utilisation.

Andersen & Newman (2005) identified two determinants of medical care utilisation which are societal and individual determinants. The societal determinant involves health service system which consists of resources and organisation as its dimensions. Resources include employees, equipment,

funding to mention a few. A well-resourced health care service leads to an increase in the utilisation of that service.

One of the components of organization is access as stated by Aday & Andersen (1974), and that the structural component of the organization is about who treats the patient, how he is treated and how the patient perceives the treatment given to him/ her (Aday & Andersen, 1974, p.213). Health care personnel as a resource in the organization can be a barrier to utilising the service if they have a negative unwelcoming attitude and are insensitive towards patients. Accessing the service is dependent on overcoming the barriers such as travel time to the health facility including transport fare; payments for the medical care service to be rendered which can be through health insurance or government subsidised service. The more the service is subsidised, paid for by third party or paid for through health insurance, the higher the utilisation rate (Andersen & Newman, 2005, p. 8).

The RHS for the population in the current study is assumed to be easily accessible based on the premise that the study population stay in the university residences and therefore transport fee is not applicable for them and reproductive health services are provided at no cost.

Enabling conditions are individual determinants which facilitate utilisation of service. Availability of service without long waiting periods is one of the enabling conditions. In this study standing in long queues at the clinic might leave students despondent about utilising the service.

According to section 27(1) South African Bill of Rights (1996), accessing health care services including reproductive health care is the right for everyone. Access to basic health care is a human right. This section emphasises certain key actions: respect, protect, promote and fulfil. The State is governed by this act to ensure that the right of accessing health-care services is respected, by not

impeding people's access to existing health-care services, whether in the public or private sector (Sekhejane, 2013, p.1).

Kipke (1999), as summarised by Kamau (2006) identified problems that adolescents undergo particularly the lack of access to health care services. He noted that many adolescents lack a consistent source of basic care and are less likely to visit a doctor or have any regular source of medical care than young children or adults. Kipke further noted that many of the health issues of adolescents, such as sexuality issues, are socially stigmatised or difficult to discuss (Kamau, 2006, p.15). Equitable access to the service occurs when socio-demographic and need variables account for most of the variance in utilisation. Inequitable access is determined by social structures such as race, individual health beliefs and enabling resources such as income (Andersen, 1995, pp. 4-5).

2.4.2 Economic barriers

In developed countries, the lack of health insurance is one of the major barriers in accessing health care. Health insurance reduces the barriers caused by financial constraints to access health services. It also encourages health care seeking behaviour and allows quick response to illness and the freedom to choose where and when to seek care and the form of care the individual prefers. According to Chomi et al. (2014), structural features of the health insurance system influence health seeking behaviour. The type of services the individual is covered for and the benefits entitled to that individual is based on the monthly contributions the individual is paying towards the health insurance.

Seeking and utilising the service entails time spent seeking the service, affording transportation if the health centre is not within walking distance and payments for the treatment. Taylor (2003), as summarised by Rebhan (2008) indicated that payment for treatment becomes a serious problem for

someone who does not have health insurance or subsidized health care plan or cash. Moss (2004) indicated that young people feel it is humiliating to ask if services are offered for free or if they are subsidized, instead they avoid seeking health care. The lack of health insurance is not applicable when accessing primary health care service in South Africa and also not the issue for the target population of this study.

2.4.3 Social barriers

Moss (2004) stated that influences from family, peers, religious community and mass media are factors that form social barriers to utilising the health service. Parents and/or religious community may discourage youth from seeking services that will assist them avoid unwanted pregnancy by disapproving the use of family planning services before marriage. Peers who have had bad experiences with health care service might discourage their friends from seeking health care service. Images of sexual behaviour that are shown in the music videos and movies surpass the efforts to raise awareness on the use of preventive health services (Moss, 2004, p.9).

2.4.4 Cultural barriers

American College of Obstetricians and Gynecologists (ACOG) (2011) defines culture as a dynamic and multidimensional context of many aspects of the individual's life which includes age, sexual orientation, religion, disability, gender, race or ethnicity among others. Lack of cultural awareness among health care providers becomes a barrier for the community to access health care. Provision of quality care is likely to be compromised if the individual's culture is at odds with the established culture of the health care service. Reaching out to a particular segment of the community, such as gay and lesbian can be beneficial for the individual and the health

care service (ACOG, 2011, p.4).

With regard to race/ethnicity, Barr & Wanat (2005) argued that provision of health care services should be culturally appropriate and show sensitivity to linguistically diverse patients with no discrimination based on race or ethnicity. Cubbin et al. (2005) stated that teenage pregnancy, childbearing and STI have been found to be associated with racial and ethnic disparities. These findings suggest that there is lack in the utilisation of RHS among the individuals of affected race or ethnicity. Rashid et al. (2001), as summarised by Ensor & Cooper (2004) stated that certain cultures have norms which are an obstruction for women to seek health care for themselves and their children.

Rashid et al. (2001) also stated that depending on the economic situation and class of the women and their families, victimization and harassment is always experienced by women in public spaces even though norms are flexible. Whiteford & Szelag (2000), as summarised by Ensor & Cooper (2004) highlighted that cultural restrictions have made women to be so conservative that even Asian women who live in western countries are reluctant to utilize health services if such services are provided by men. According to Whiteford & Szelag (2000), in societies where social identity and interaction is defined by female meekness and well defined male and female social territories, women would find it improper to undergo an internal examination by a male physician during antenatal visits. In Indian culture, women even if they have similar incomes with men, experience distance as a huge barrier because they are not supposed to leave their homes for long periods; otherwise it implies that the household cannot afford to pay for transport (Vissandjiee et al., 1997, p. 135).

A study conducted on Southeast Asian Refugees indicated that based on their cultural attitudes many Southeast Asian Refugees believe that a person should live life as it is and if illness and suffering set in no effort should be made to seek health care as an attempt to save life because according to the

nature of life; suffering and dying is inevitable. Stoicism among Southeast Asians is culturally valued to an extent of blocking seeking health care (Uba, 1992, pp.544-545).

In the context of this study, the population being studied is diverse in many aspects such as religion, sexual orientation, race and ethnicity to name a few. These aspects could be the barriers to utilisation of RHS by the population being studied.

2.4.5 Perception barriers

Rosenstock, Strecher & Becker (1994), as summarised by Rebhan (2008) indicated that according to Health Belief Model, the individual treats and prevents diseases by considering four central variables namely; the individual's perceived susceptibility to disease, perception of illness and severity, the rational perception between benefits and costs and lastly the individual's cues to action. Individuals seek preventive health services if they believe they are at risk of contracting a serious disease. They also seek health care if they believe that the benefits of seeking care outweigh the cost for seeking care. The important referents such as family and friends motivate the individual to take preventive measures against the disease but if there are no referents prevention is unlikely.

2.4.6 Efficacy barrier

People utilise the service if they believe in its effectiveness. If a person knows of a home remedy that is efficacious, they will be likely to utilise that treatment before utilising a professional health care system. "The component of faith in remedy incorporates the individual's belief in efficacy of treatment for the present illness. An individual will not utilise the treatment if he/she does not believe the treatment is effective" (Rebhan, 2008, p. 8). Some young people refrain from utilising

RHS because they do not believe in the effectiveness of contraceptives as they are misguided by myths and misconceptions they have about contraceptives.

Young women in Kenya narrated a number of myths and misconceptions regarding contraceptive methods for instance; they associated contraceptives especially the pill and the injection with birth defects, development of cancerous growths, sterility and the fear that implants could get displaced in the body via the blood stream (Alaii, Nanda & Njeru, 2012, pp.2-4). Students from the population under study, who come for pregnancy testing, when they are advised on contraception use, some of them indicate their concerns about the effects of contraception on their bodies such as sterility.

2.4.7 Knowledge barrier

Knowledge of illnesses and illness treatments form part of social resources that are vital to utilisation of service. The individual's knowledge and social support available, influences the decision to access specific health care services. Home remedy knowledge is based on lay referral and the faith in remedy (Rebhan, 2008, p.8). Knowledge barrier in this study refers to lack of knowledge about the existence of RHS or various services that are offered from the RHS on campus.

2.5 Conclusion

A number of studies have been reviewed by the researcher to ascertain the contributory factors to non-utilization of RHS. In the next chapter a detailed description of the methodology used in this study and the population being studied will be discussed.

3.0 METHODOLOGY

3.1 Introduction

An overview of the study was described in the first chapter followed by a detailed literature review in the previous chapter. This chapter presents the full description of the methodology which includes research design, the purpose and objectives of the study and the population being studied. Procedures that involve sampling methods, data collection and analysis are also discussed.

3.2 Research design

Research design is a master plan for conducting the study that broadens control over factors that could interfere with the validity of the findings (Burns & Grove, 2001, p. 223). The current study is a concurrent mixed method research. Mixed method research is an avenue to inquiry that involves data collected from quantitative and qualitative designs. The two forms of data are integrated using explicit designs that may involve philosophical inference and theoretical frameworks (Creswell, 2014, p. 4).

The survey in this study consisted of two sections. The first section had three items which attempted to obtain socio-demographic profile of the study sample such as age, ethnic group and the country of origin. The second section consisted of eighteen items which attempted to obtain respondents' knowledge and attitudes towards utilisation of RHS. Some of the questions that were asked focused on initial sex education, sex debut and knowledge about available legal termination of pregnancy and information regarding contraceptive knowledge and their use. Other questions focused on the utilisation of the RHS if students have ever used the service, the waiting period and the quality of

service they received including the attitude of the health care providers. Respondents were also given an opportunity to make recommendations or comments.

Semi-structured interviews consisted of five items which attempted to obtain information on the participants' knowledge about reproductive health and their source of information about reproductive health. Other specific questions included factors that would make them choose to utilise RHS on campus and the methods and services they would prefer to get from campus RHS. Participants were also given an opportunity to make recommendations or comments. Participants' answers were probed further for more in-depth information.

3.3 Research setting

The research site was a university in Johannesburg providing undergraduate and postgraduate education for young people from multi-cultural and ethnic backgrounds. Johannesburg is the capitol of Gauteng. It is also known as Jozi place of gold, Joburg, and Egoli and is abbreviated as JHB. This university is situated central in the city of Johannesburg and attracts candidates from locally, around the African continent and globally. It has quite a number of student residences but the target population was selected from certain residences that met the inclusion criteria.

3.4 Population

Population is the entire set of individuals, objects or substances that meet the sample criteria for inclusion in a study. Population refers to individuals, substances or objects that meet the criteria for inclusion in the study (Burns & Grove, 2001, p.806). The population that met the inclusion criteria in this study, comprised 1523 female students from a total of 16584 female students who were

registered in five Faculties at the university in Johannesburg in the year 2012.The study sample consisted of 300 participants who completed the survey and 20 participants who participated in semi-structured interviews. The total sample size was therefore 320 female students.

3.5 Sample selection

Burns & Grove (2001) define sampling as a process of selecting a group of people or any elements that are representative of the population being studied. In this study, the researcher used probability sampling method in the quantitative phase and non-probability sampling method in the qualitative phase to select the sample.

3.6 Sample inclusion criteria

The inclusion criteria were that participants stayed in the undergraduate female only residences that provide full catering. The reason for choosing residences that provided catering is that these students are usually dependant on university facilities for all their needs and are less likely to have access to reproductive services off campus.

3.7 Phase 1: Quantitative phase

Simple random sampling was used to select students who participated in the research. The researcher spent three evenings in the selected residences on main campus distributing questionnaires to every third student coming into or going out of the residence. The researcher ensured that duplication did not take place with students who already got the questionnaires when coming into residence and were later going out.

In the Parktown residences, the researcher approached students as they came for their evening

meals. Every third student was approached and given a questionnaire. In this way, the researcher tried to ensure that each student from each of the three residences had an equal chance of being included in the survey. Four hundred and ten (n=410) potential respondents were approached but five of them declined to participate with the excuse that they were busy with their studies.

3.8 Phase 2: Qualitative phase

Convenience sampling was used as the researcher requested students according to their accessibility and proximity to the researcher, to participate in the study. The researcher requested students from within the selected residences. Convenience sampling also known as accidental sampling includes participants in the study who happened to be in the right place at the right time, with available participants being added until the desired sample size is reached (Burns & Grove, 2001, p.789).

3.9 Data collection

3.9.1 Phase 1

A pretested tool developed by Professor Valerie Ehlers from the University of South Africa (Ehlers, 2003) was used in the survey for the current study. The researcher sought permission to use this tool, see annexure 5. A survey consisted of two sections: the first section sought to determine the socio-demographic profile of respondents to ascertain the influence of socio-demographic profile on sexual behaviour. The second section sought to determine knowledge and attitudes towards utilisation of RHS. This section included questions on sources of information about sex and contraceptive methods, whether respondents have ever used contraceptives or not and respondents' age at sexual debut. Other questions attempted to identify if respondents know about legally available termination of pregnancy services, whether they know and have used campus RHS and how they find out about

the service. Respondents were requested to make comments and suggestions about campus RHS and to state the waiting period they experienced at the clinic.

The nature of the survey was cross-sectional since the data was collected at one point in time. The researcher distributed the questionnaires that were placed in envelopes and students had to replace the completed or uncompleted questionnaires in envelopes before posting them back to the researcher. The boxes were provided by the researcher at the reception of each residence. This was to ensure confidentiality. The boxes were collected by the researcher after two weeks from the day of distributing the questionnaires. Out of distributed questionnaires, 105 of potential respondents were lost with no success when trying to follow-up on them.

3.9.2 Phase 2

The semi-structured interviews were held to explore and describe factors influencing the uptake of campus RHS by female students (see annexure7). Semi-structured interviews included questions on what students understand about reproductive health, what implications of intimate sexual contact do students know, factors that would make students consider campus reproductive health as a place of choice to get reproductive health information and assistance, services and contraceptive methods that students felt should be offered.

Participants were approached through convenience sampling method and interviewed on a one on one basis by the researcher. Convenience sampling was done until saturation of data occurred. Twenty (n=20) participants were interviewed and they all signed two informed consent forms one to participate in the study and the second one to have the interview tape recorded. Each interview was labelled according to the number of the participant being interviewed for example 1st interview for

the first participant being interviewed. Transcription of interviews was done after all participants were interviewed. A written copy for each interview is kept to retain the data gathered.

3.10 Data analysis

Phase 1

Data were entered into excel spread sheet, screened and cleaned for any errors. Descriptive statistics were used including frequencies, means and standard deviations. Data were allocated codes for confidentiality purposes. Each residence was allocated a number to be identified with for example, Residence 1, 2, 3 and Residence 4. With regard to country of origin, all countries from the Sub-Saharan Africa were collapsed into one category which is category B leaving South Africa as category A. This was done due to the relative small number of respondents from other countries. A wide variety of ethnic groups were represented but many respondents were reluctant to indicate their ethnic groups and instead stated their race. Ethnic groups were therefore collapsed into four racial groups present in South Africa. The racial groups were coded as Racial Group 1, 2, 3 and 4. Four categories were provided in the questionnaires as sources of information about sex and contraception. Each respondent was required to select her source or sources of information accordingly. Two new categories namely “Siblings” and “Media” emerged, as they were added by respondents as an alternative source of information to the choice given on the questionnaires. See annexure 8 for a list of codes used.

Phase 2

All interviews were transcribed verbatim and subjected to a content analysis. Words and phrases pertinent to the research questions were identified and coded and categories and subcategories

developed from the words and phrases by the researcher and checked by the supervisor who acted as a co-coder. Some categories arose from responses in the open sections of the questionnaires. These categories and subcategories were sorted and coded according to similar ideas or themes. Where closed ended questions were asked, the following codes were used for answers;

Yes = 1

No = 2

No response = 0

Some questions yielded similar responses that were dealt with as nominal. Frequencies and percentages were used to analyse the nominal data that arose from qualitative data.

3.11 Validity and reliability

Reliability refers to the consistency of the measurement technique and validating the instrument is to ascertain how well does the instrument reflect the abstract concept that is being examined (Burns & Grove, 2001, pp.395-400).

The current study utilised the instrument that was previously used in a study titled “Adolescent mother’s utilisation of contraceptive services in South Africa”, (Ehlers, 2003). This tool was critically reviewed by two medical practitioners; four nurses working in contraceptive clinics; researchers who participated in the Reproductive Health Workshop that was organised by the World Health Organization (WHO) and the Commonwealth in Harare, Zimbabwe, during the month of May1998 (Ehlers, 2003, p.233). It was also pretested on two adolescent mothers who did not participate in the actual research. The questions were understood by 12 adolescent mothers and the fieldworker.

Qualitative data in this study was subjected to the criteria for trustworthiness as proposed by Lincoln & Guba (1985) and the researcher complied with the rules stated in these criteria.

3.11.1 Credibility

According to Lincoln & Guba (1985), to ensure credibility the investigator should spend sufficient time through prolonged engagement, persistent observations and triangulation. These activities provide the opportunity for the investigator to learn the culture, be able to identify and take account of the discrepancies that might creep into the data. In the current study, the researcher works as a PHC Practitioner in the university under study which involves consultations and interactions with students on daily basis. Sometimes the researcher does residence visits, where close engagements with students occur. These activities provided the researcher with the opportunity to learn more about the population being studied.

Credibility of data was also based on the fact that participants showed their willingness to participate in the interviews and therefore their responses were regarded as genuine. Whilst participants knew that the researcher is a staff member in the RHS under study, they remained frank with their responses stating their unhappiness about the service and the inapproachability of the staff.

3.11.2 Transferability

The study site was located in an urban setting. Qualitative data in the present study was collected from twenty (n=20) diverse, undergraduate urban youth participants residing in the university residents. Data was collected through semi structured interviews. The length of sessions ranged from ten to thirteen minutes. The fact that the researcher was fully employed, led to the time period over which data was collected to spread over fifteen days due to time constraints.

3.11.3 Dependability

The current study was designed as a concurrent mixed method study. A survey questionnaire was administered to collect quantitative data while semi structured interviews were commenced at the same time for qualitative data collection. Each interview session was conducted in a secluded area and each participant was requested to be truthful and reassured that the researcher had an obligation to maintain confidentiality.

3.11.4 Confirmability

Twenty semi-structured interviews were conducted. Despite the fact that participants showed interest when invited to participate in the study, some of them did not want to make comments or suggestions at the end of the interview. The researcher respected their rights to choose not to make any comments. Although there was no subordinate relation between the researcher and the participants since the researcher has a professional nurse-patient relationship with the students, bias in the study was inevitable.

3.11 Ethical considerations

Research ethics has evolved over time from when the Nuremberg Code (NC) was drafted in 1947 to the Declaration of Helsinki in 1964. The NC states that the physician/researcher should protect the interests of participants and in turn the participants must be able to protect themselves to an extent of being able to end participation anytime they deem it necessary. The Declaration of Helsinki has undergone several revisions and the latest was done in October 2013. One of the principles of the Declaration of Helsinki stipulates that the physician/researcher has an obligation to protect the health

and rights of the patients and those participating in research (Dhai, 2014, pp.178-180). To safeguard the ethics of the current study, the researcher adhered to the requirements of NC and the Declaration of Helsinki by complying with the following principles:

3.11.1 Permission to conduct the study

The researcher sought and obtained permission to conduct the study from the Research Ethics Committee, Research Committee School of Therapeutic Sciences and the University Registrar. Permission was also obtained from the office of Residence Life to conduct the study in the residences. See the annexure for the permission letters.

Guiding principles of ethics that underpin any study were observed by the researcher:

Resnik, (2013) defined ethics in research as norms for conduct that guide the person to differentiate between acceptable and unacceptable conduct. Ethics gives perspective to decide how to act when faced with complex situations. Adhering to ethical norms is of utmost importance in order to produce research with integrity.

3.11.2.1 Autonomy

Autonomy refers to the act by an individual who makes informed decision independently without being controlled or influenced by any other person. Normally there is conflict between autonomy when the individual decides what he/she wants and beneficence when the caregiver intervenes to save the life. The concept of autonomy in this study was respected when the researcher reminded the participants of the right they had as individuals to decide whether they want to participate in this

study or not. There is no possibility that the participants could have been coerced into participating in the study.

3.11.2.2 Consent

Wiles (2013) stated that informed consent is a prerequisite in research whereby participants are provided with information clearly stating what the research involves and what will be expected of them. Signing informed consent by participants was mandatory in this study in line with the guiding principles of ethics. All participants in this study had legal capacity to give consent to participate. They were given detailed information about the nature of this study and what to expect when participating and then they voluntarily gave informed consent in writing before taking part in the study. Regarding semi-structured interviews, participants had to give consent to participate in the study and also gave consent to have the interview tape recorded. The semi-structured interviews were conducted on a one on one basis by the researcher and were audio-tape recorded. The tape recordings are kept in a secure place only accessible to the researcher and will be destroyed two years after publication of the findings.

3.11.2.3 Confidentiality

Confidentiality is the practice of keeping patient's or participant's sensitive personal information confidential without divulging it to any other person (Kling, 2010, p. 196).

The Protection of Personal Information Act 4 of 2013 stipulates that personal information must be processed, protected and handled efficiently to ensure privacy of the participant. According to this Act 'personal information' pertains to information relating to race, ethnicity, gender, sexual orientation, social origin among the rest.

In this current study the researcher observed The Protection of Personal Information Act 4 of 2013 by excluding the names of the respondents in the response sheets. The cultural groups identified in the survey were only mentioned as Racial Group 1, 2, 3 and 4 in the report phase. Respondents returned completed questionnaires in sealed envelopes provided by the researcher and they placed these envelopes in boxes also provided by the researcher at the reception of each selected residence to ensure confidentiality.

It took about two weeks for some respondents to return the completed questionnaires. Semi-structured interviews were conducted by the researcher confidentially with no possibility of anyone interrupting the interview. There was no invasion of participants' privacy or sensitive questions that could cause embarrassment or uncomfortable feelings during the interview. The purpose of the study was to determine the factors that influence the uptake of RHS by female students on campus with a view to improving access and delivery of service in a more efficient manner and to identify socio-demographic profile of students who attend the clinic and students who do not attend the clinic.

3.11.2.4 Harm and Prejudice – There was no possible harm to the participants as the study did not include procedures or activities that could have exposed the participants to injury or harm. Those who did not return the questionnaires or who withdrew from the study did not suffer any prejudice.

3.12 Conclusion

This chapter discussed the research design and methodology used in this study. A semi- structured interview schedule was used to explore and describe factors influencing the uptake of campus RHS by female students. Chapter 4 described data analysis and interpretation.

4.0 DATA ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter describes the analysis of data followed by the research findings which relate to the research questions that influenced the study. Data were analysed to determine the socio-demographic profile of potential and actual users of the campus RHS and to explore and describe factors influencing the uptake of campus RHS by female students.

A survey and semi-structured interviews were the two methods of data collection used.

The questionnaires comprised of two sections with closed and open-ended questions. The first section consisted of demographic data (age, country of origin and race). The second section consisted of data describing knowledge and attitudes towards utilization of RHS and this section of the questionnaires contained 18 questions. The semi-structured interview section consisted of questions intending to explore and describe the factors that influence the uptake of campus RHS by female students.

4.2 Findings

These were the findings to Phase 1 which sought to determine the socio-demographic profile of potential and actual users of campus RHS. The sample of actual users was limited and only descriptive analysis was used.

4.2.1 Demographic data (Total Responses 300)

A socio-demographic profile of the population being studied is shown below. This data was useful in exploring if race and ethnicity influence whether individuals utilise the service or not. Regmi, Simkhada &Van Teijligen (2008), argued that race and ethnicity embrace norms and beliefs which

usually contribute towards individual behaviour which in the context of this study includes decision making towards utilising RHS.

4.2.1.1 Age distribution

Table 4.1: Respondents' age distribution

Age Group	Frequency (n)	Percentage %
17 - 20	175	58.33
21 - 25	121	40.33
26 -30	4	1.33

This table illustrates that most participants in this study were between the ages of 17 - 20 years which constituted 58.33% (n=175) of the sample, followed by 40.33 %(n=121) of participants who were between the ages of 21 – 25 years. Lastly students who fell within ages 26 – 30 years made up only 1.33% (n=4) of the sample. The average age was 20.4 years and the standard deviation (1.7).

4.2.1.2. University residence (Total responses = 300)

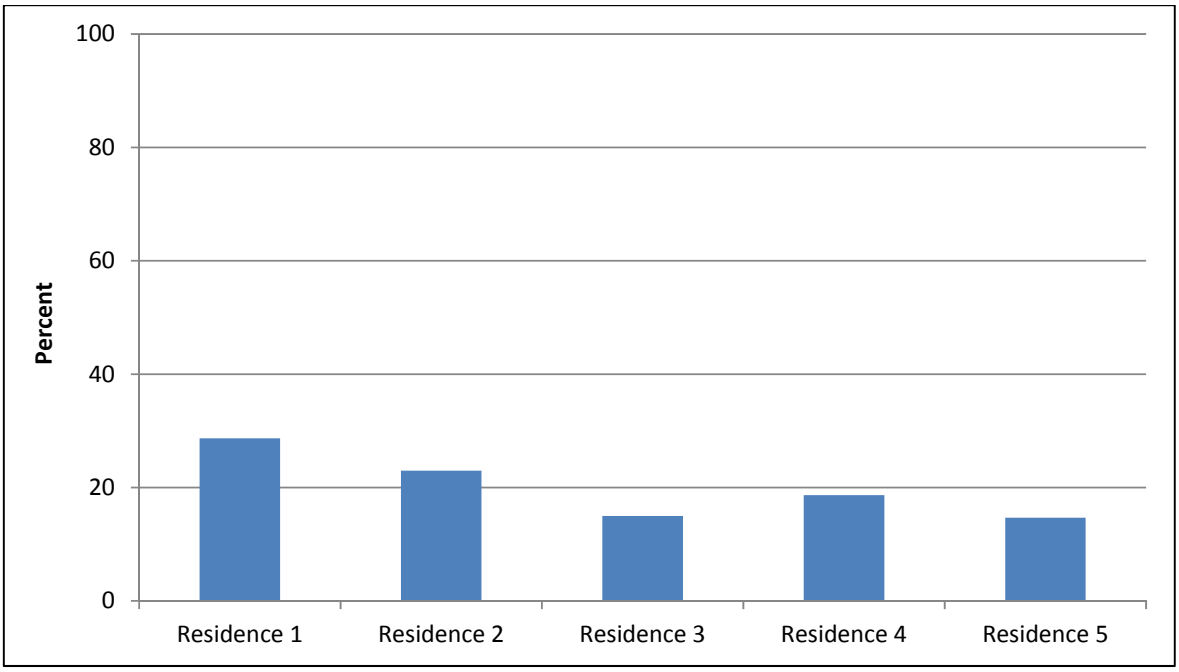


Figure 4.1: Respondents' residential accommodation

This graph shows that the majority of participants occupied residences which are located on Main Campus in the close vicinity with the university RHS. The first residence had 29% (n=85) of occupants from the sample. Twenty three 23% (n=69) of participants stayed in the second residence. Third, fourth and fifth residences are located in Parktown Campus in the close vicinity with the satellite RHS of the university. These three residences had the sample occupation of between 15% and 19%. The third and fifth residences had respectively 15% (n=45) of participants staying there and 19% (n=56) participants stayed in the fourth residence. This information indicated that more students occupied residences on main campus compared to residences located in Parktown Campus.

4.2.1.3 Country of origin (Total responses = 295)

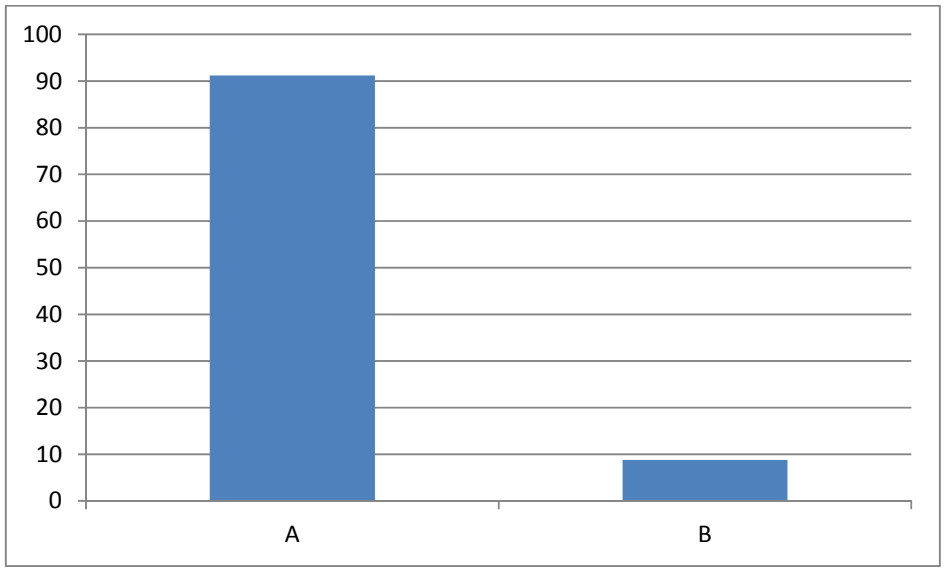


Figure 4.2: Respondents' country of origin

The majority 91.2% (n=269) of participants in the study came from country A and 8.8% (n= 26) from country B. All countries from the Sub-Saharan Africa were grouped together and coded Country B. Five respondents (n=5) did not answer this question. The residence selection criteria had an influence on the country of origin section in this study. This section of the survey demonstrated that most international students are excluded in this study because the residence that accommodated most of them did not meet the inclusion criteria.

4.2.1.4 Race (Total responses = 281)

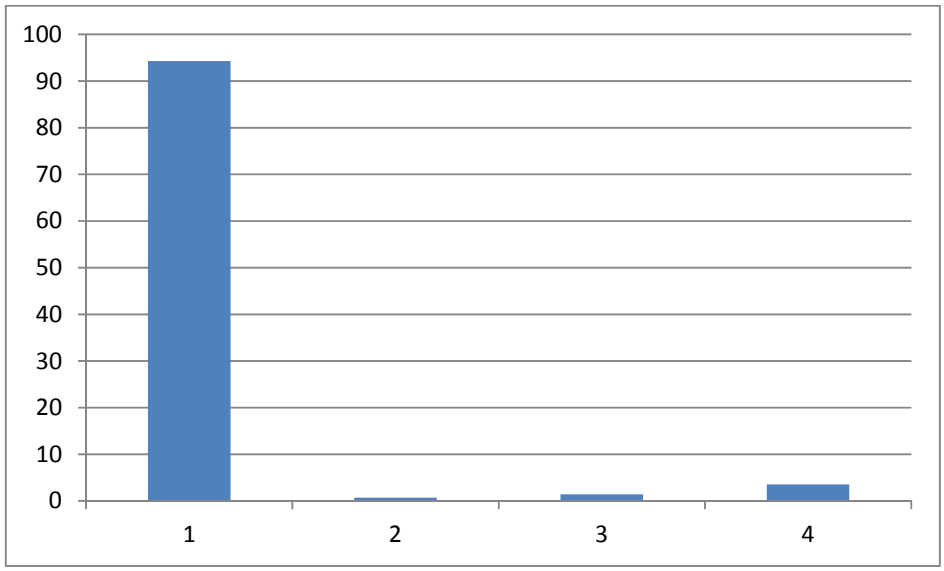


Figure 4.3: Respondents' race

The participants in this study belonged to four different racial groups coded 1- 4. Two hundred and sixty five (n=265) 94.31% of participants fell under racial group1. Two (n=2) 0.71% of participants belonged to racial group 2 and (n=4) 1.42 participants belonged to racial group 3. Lastly (n=10) 3.56% of participants belonged to racial group 4. The racial presentation of the sample was similar to the racial distribution of this country. The residences that met the inclusion criteria are mostly occupied by students from the first category of the racial groups.

4.2.1.5 Table 4.2: Socio-demographic profile of potential users

Potential users		
Socio-Demographic Characteristics	**Frequency (n)**	**Percentage of total sample (%)**
Age Group		
17 - 20	175	58.33
21 -25	121	40.33
26 - 30	4	1.33
All respondents indicated their age groups		
Total sample	300	
Country of Origin		
Country: A	269	91.2
Country: B	26	8.8
Total number of respondents who did not state their country of origin = 5		
Total sample minus those who did not state their country of origin	295	
Race		
Racial Group 1	265	94.31
Racial Group 2	2	0.71
Racial Group 3	4	1.42
Racial Group 4	10	3.56
Total number of respondents who did not indicate their race = 19		
Total sample minus those who did not state their race	281	

The above table represents the socio-demographic profile for potential users. From the total sample, (n=175) 58.33% of the respondents were from the age group of 18 – 20 years. One hundred and twenty one respondents (n=121) 40.33% belonged to the age group of 21 – 25 years. Only four respondents (n=4) 1.33% were older between the ages of 26 – 30 years.

The country of origin was the second feature in the socio-demographic section of the questionnaires. Two hundred and sixty nine (n=269) 91.2% of the respondents came from Country A. All countries from the Sub-Saharan Africa were grouped together and coded Country B. Twenty six (n=26) 8.8% respondents came from Country B. Five (n=5) respondents did not indicate their country of origin. The percentages were therefore calculated out of the total number of those who responded i.e. 295 respondents.

With regard to race, the majority of the respondents (n=265) 94.31% were from racial group 1 which reflects the demographics of the country. Only a few respondents belonged to other race groups. Two (n=2) 0.71% belonged to racial group 2, four (n=4) 1.42% to racial group 3 while ten (n=10) 3.56% belonged to racial group 4. Nineteen (n=19) of the respondents did not indicate their race. The percentages were therefore calculated out of the total number who responded i.e. 281respondents.

4.2.1.6 Table 4.3: Socio-demographic profile of actual users

Actual users		
Socio-Demographic Characteristics	**Frequency (n)**	**Percentage of total sample (%)**
Age Group		
17 – 20	13	38.2
21 -25	20	58.8
26 – 30	1	2.9
Total sample	34	
Race		
Racial Group 1	30	100
Racial Group 2	0	0
Racial Group 3	0	0
Racial Group 4	0	0
Total number of respondents who did not indicate their race = 4		
Total sample	30	
Country of Origin		
Country A	28	84.8
Country B	5	15.2
Total number of respondents who did not specify their country of origin = 1		
Total sample	33	

The above table illustrates the socio-demographic profile of actual users. Actual users were those who indicated in the survey that they had used the RHS. Only 34 (11.33%) of the total sample of 300 use the RHS. In this category a certain portion of the data is missing due to the respondents omitting some questions. Four (n=4) respondents omitted to indicate their race and one respondent did not indicate her country of origin.

4.2.2 Section 2 Knowledge and attitudes towards utilisation of RHS

This section focused on the knowledge that students had regarding RHS including the use of contraception. The source of information that students received about reproductive health issues is identified in this section. The focus is also on attitudes that students have towards utilising RHS

A total number of 300 respondents completed the survey. The number of responses does not necessarily reflect the number of respondents (i.e. each respondent could choose more than one option). For questions 1, 4 and 5 the number of each option reflects the total number of entries for each option therefore the percentages are worked out based on the total entries for each option (i.e. total number of selections/300 for each option). For questions 8, 12, 15, 16 and 18 the number of valid options is based on the total number of selections across the options therefore the percentages are worked out based on the total of all responses. For all pie charts, the number of responses and percentage are given in the graph.

Question 1

Who provided you with information about sex? ***(Valid responses per option = 300)***

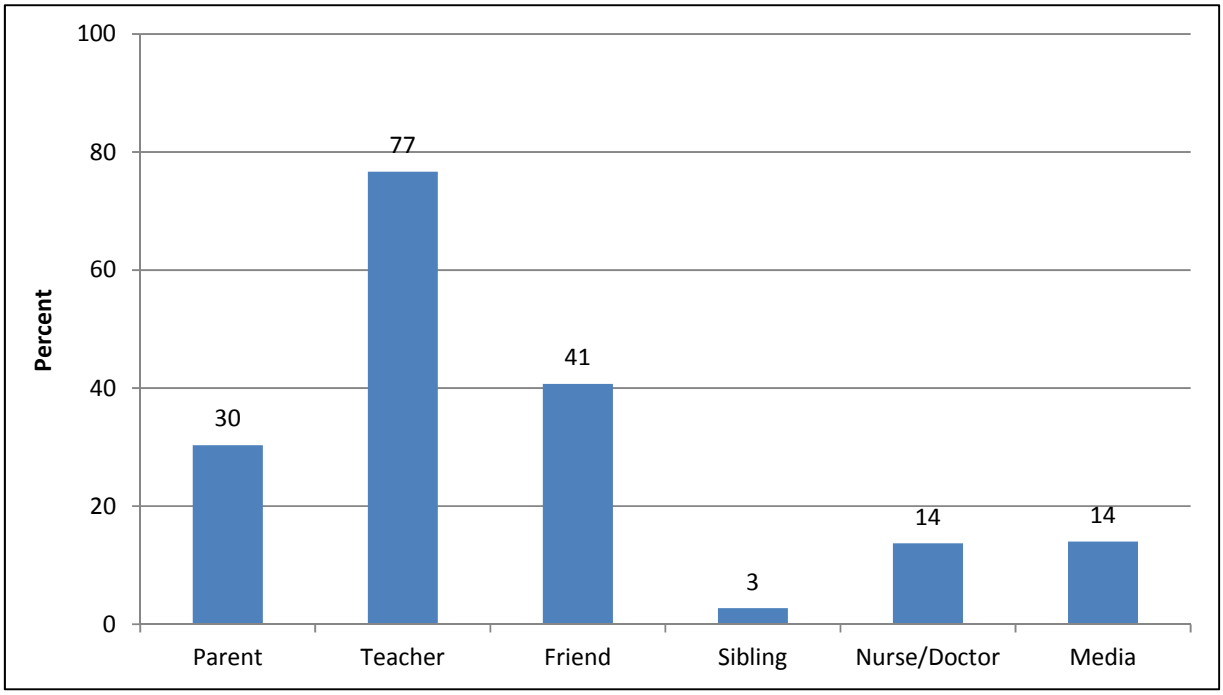


Figure 4.4 Source of information about sex

This graph shows that teachers play a crucial role in disseminating information about sexuality to young people. The majority of respondents 77% (n=230) stated that teachers were their source of information about sexuality compared to parents who came third with 30% (n=91) as source of information about sexuality. These findings are surprising given the usual societal expectation that parents would take on this role as stated by Miller et al. (1998), that the family is a primary source of socialisation for adolescents and can exert a strong influence on sexual attitudes and behaviours (Miller et al., 1998, P.1542).

Forty one percent 41% (n=122) participants received information on sexuality from friends. Siblings were stated as source of information by 3% (n=8) of respondents. Older siblings have a potential to serve as agents of socialisation and impact positive influence towards responsible sexual behaviour

and entire reproductive health knowledge and attitudes of their younger siblings especially if they have had unwanted pregnancy experience (Kusi-Appouh, 2013, p. 3).

Health care professionals and media were each the source of information for 14 % of respondents. Nurse/Doctor 14% (n=41) and media 14% (n=42). Students, who consulted with the health care personnel for other health related reasons, should be advised about the importance of RHS to market the service.

Question 2

Age at which first sex education was received (Given as mean ± standard deviation)

(Valid responses = 275)

Age = 13.13 (± 2.2)

Table 4.4: Age at which first sex education was received

Age Group	**Frequency (n)**	**Percentage (%)**
7 – 10	33	11
11 – 15	205	68
16 – 18	37	13
No response	25	8

This table illustrates the age at which respondents received sex education for the first time. According to this table some respondents received sex education at the age of 7 years. The majority of respondents 14% (n=58) started being taught about sex at the age of 13 years. Eight percent 8% (n=25) students did not respond to this question.

Question 3

Do you know about methods of contraception?

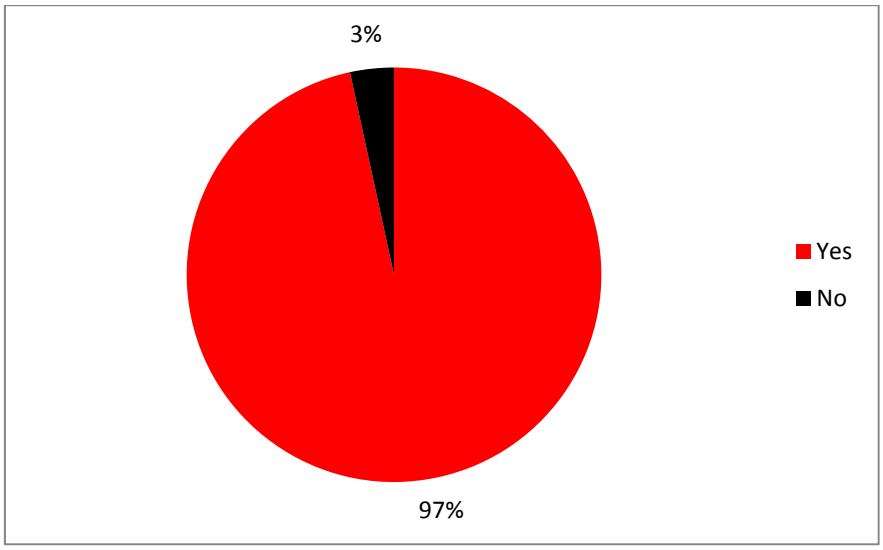


Figure 4.5 Awareness about methods of contraception

This figure shows that 97% (n=283) participants knew about methods of contraception and only 3% (n=10) had no knowledge about methods of contraception.

Question 4

If the answer is "yes", please list the known methods *(Valid responses per option = 300)*

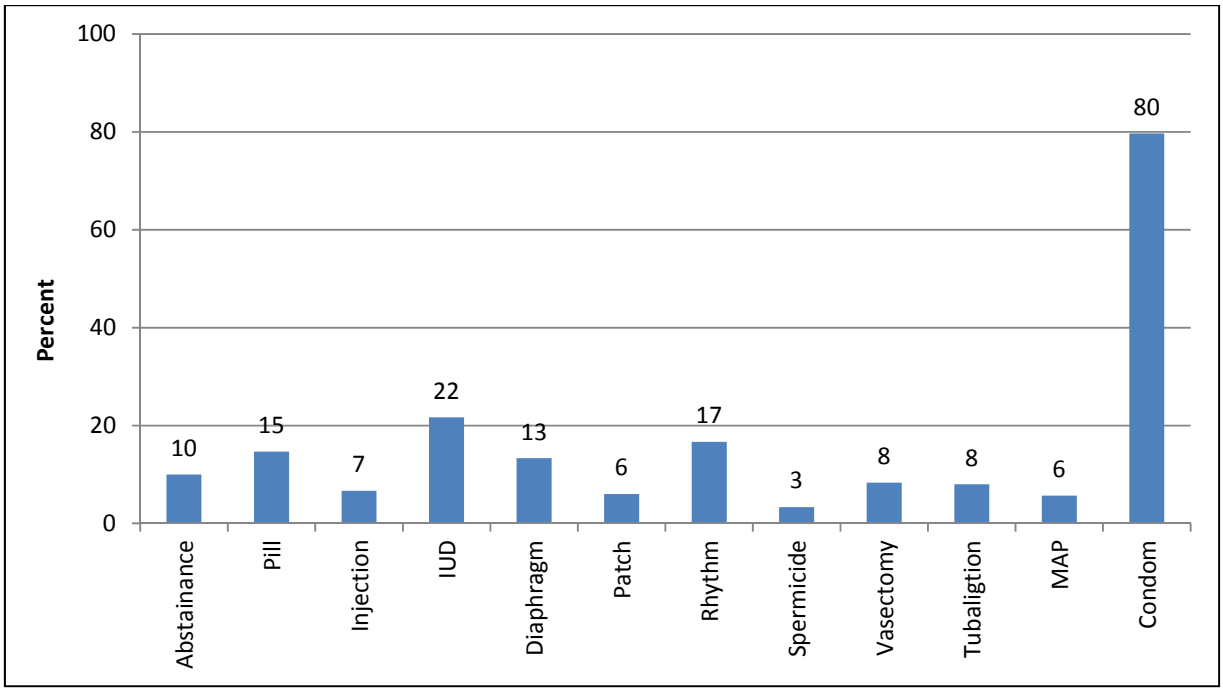
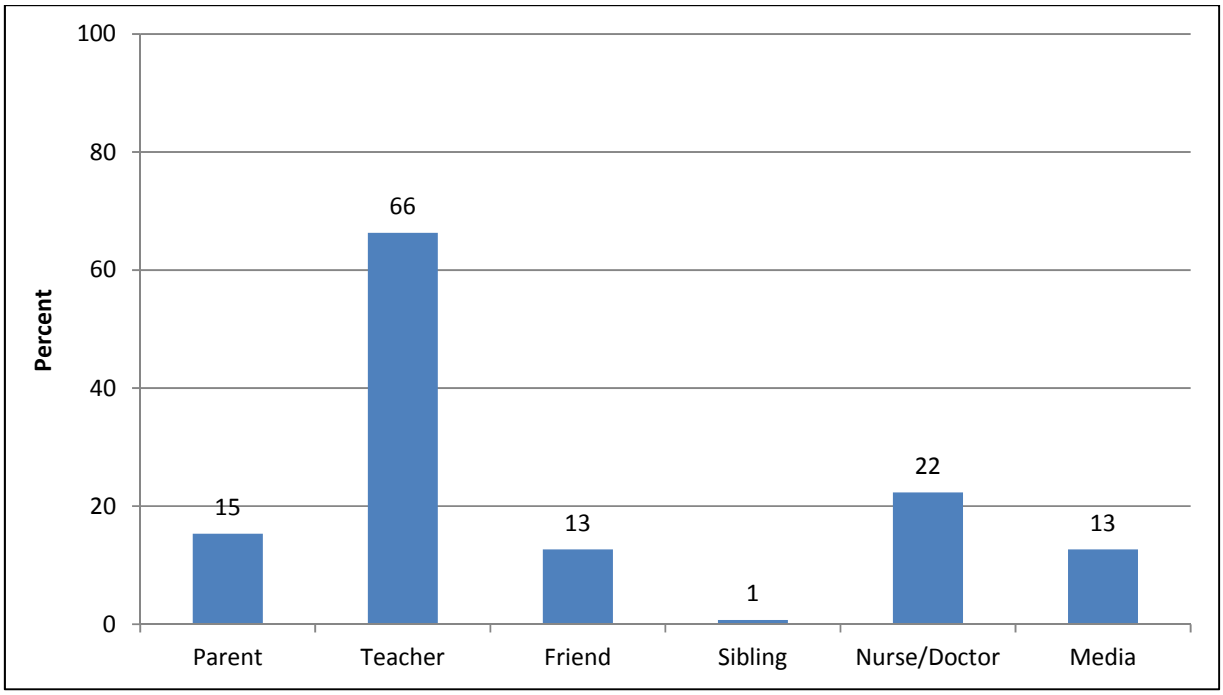


Figure 4.6 Known methods of contraception

Amongst the 12 different contraceptive methods that were known to participants, the condom was the best - known method and was mentioned by 80% (n=230) of the respondents. Intra uterine device was mentioned by 22% (n=64) and the rhythm method was known by 17% (n= 50) of the respondents followed by the pill which was known by 15% of the respondents and the diaphragm by 13% (n=38) of the respondents. The least known methods were abstinence which was mentioned by 10% (n=30), vasectomy and tubal ligation mentioned by 8% respectively. The morning after pill or emergency contraceptive was known by 6% (n=17) of the respondents and so was the patch method. The spermicide method was known by 3% (n=10) of respondents. Generally all methods of contraception were known by some of the respondents.

Question 5

Who provided you with information about contraception? (Valid responses per option = 300)



4.7 Source of information about contraception

The findings in this graph are consistent with the findings from the graph in question 1. The teacher was still the main source of information on sexuality confirmed by 66% (n=199) of respondents. Nurse/Doctor was mentioned by 22% (n=68) of the respondents compared to 14% of the respondents who mentioned Nurse/Doctor in question 1. Parents as a source of information went down by half from 30% to 15% (n=44) and friends from 41% to 13% (n=37). Media was mentioned by 13% (n=40) of the respondents compared to 14% mentioned in question 1. Only 1% (n=2) of the respondents mentioned siblings as a source of contraceptive information. Information about contraception is elusive to a lay person and therefore the people who are likely to be approached for this kind of information will be teachers and those in the medical profession.

Question 6

Have you ever used any method of contraception?

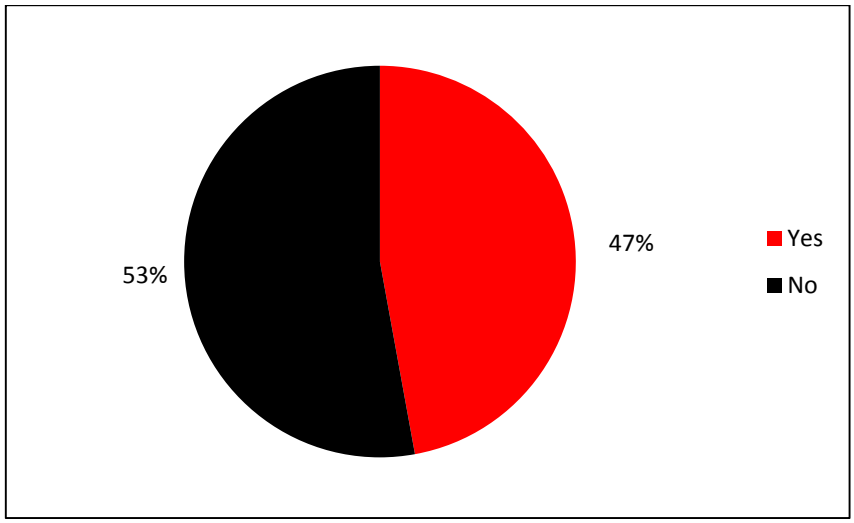


Figure 4.8 Contraception usage

This figure provides information about respondents who had used contraception and those who had never used contraception before. It shows that 47 % (n=140) of respondents had used contraception and the majority of respondents 53% (n=157) had never used contraceptives in their lives. Unfortunately some of the respondents who had never used contraceptives in their lives are sexually active yet they do not use contraception. Some students rely on the condom only as a method of contraception and this raises some concern because of the condom failure rate that young people often experience with likelihood of unwanted pregnancy, STI including HIV as a consequence. Crosby et al. (2012) conducted a study on condom use among 15 – 24 year old persons in which condom use events were monitored. Out of 800 condom use events monitored, 22.4% respondents reported one or more forms of condom failure. From these findings it was suggested that there should be safer sex programs with a focus on correct use of condoms on a wide spread basis for persons aged 15 – 24 years regardless of sex or motive for condom use. Moore et al. (2011) found that sexually active female students are sometimes misled by myths associated with contraception.

According to Broder (2010) oral contraceptive methods are one of the most-studied medications available, with data supporting their safety and effectiveness for over 50 years. Despite this history, adolescents still underrate the benefits and overemphasized the side-effects associated with contraception.

Question 7

How old were you when you used contraception for the first time? (Given as mean ± standard deviation) – (valid response = 134)

Age = 17.5 (± 1.9)

Table 4.5 Age at which contraception was used for the first time

Age when contraception was used for the first time		
Age	Frequency (n)	Percentage (%)
10 - 15	12	9
16 - 19	85	63
20 -23	37	28

This table elicits different ages at which students started using contraceptives. Findings showed that (n=12) 9% of the sample started using contraception as early as 10 - 15 years of age followed by (n=85) 63% who started between the ages of 16 - 19 years. Lastly 28% (n=37) respondents started late from the ages of 20-23 years. The most important thing is that they are protecting themselves against unwanted pregnancy but there are still some students who are sexually active but not utilising RHS which raises concern. One hundred and sixty six (166) of respondents did not answer this question which interfered with the accuracy of the findings.

Question 8

Method of contraception used (Total valid responses = 177)

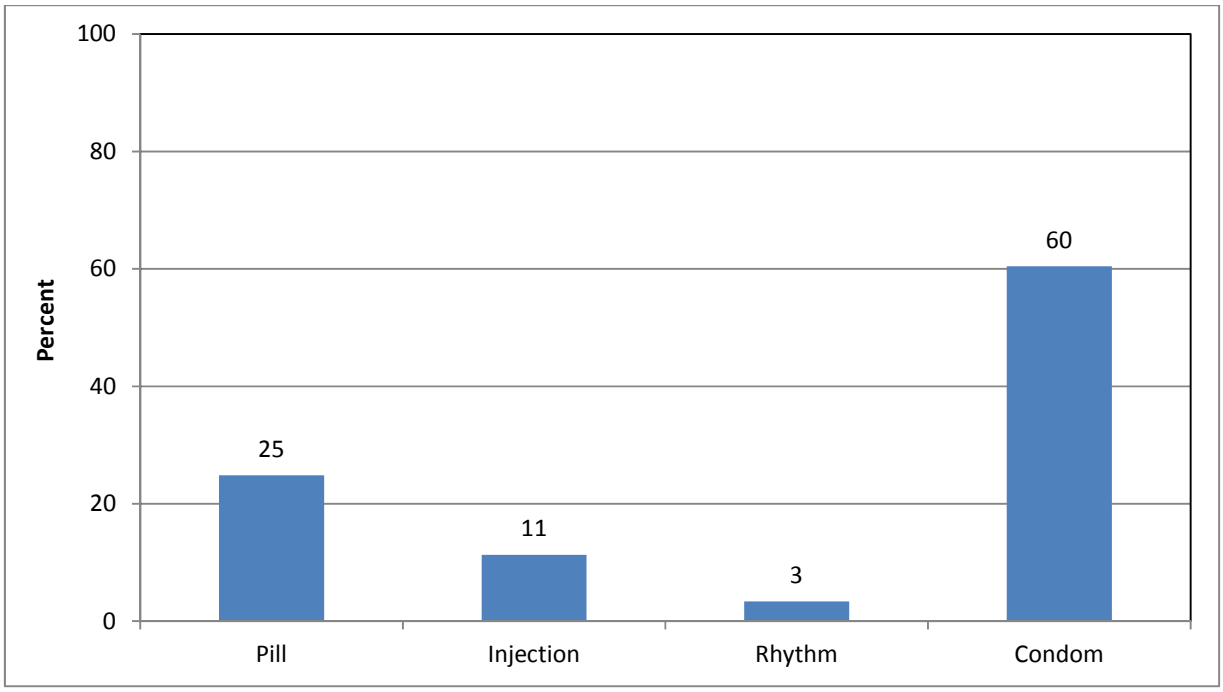


Figure4.9 Method of contraception used

Figure 4.10 indicates that the mostly used method of contraception is the condom. Condoms are easily accessible in the bathrooms and other designated areas where they can be confidentially accessed without asking anyone. They are also preferred because of the potential they have of protecting against unwanted pregnancy and STIs including HIV. Condoms are not binding they offer occasional contraceptive effect with no daily commitment as in oral contraception. When using oral method of contraception, the individual needs to take the pill daily yet with the condom you only use it when engaging in sexual intimacy. As mentioned previously the biggest concern though is the failure rate in protection associated with condoms if not used correctly and consistently. Dual protection whereby the condom and another method of contraception are jointly used is highly recommended to guarantee protection.

Many young people feel uncomfortable approaching a health care worker to ask for contraception. In a study conducted about adolescent sex in the Northern Province, Wood et al. (1997); findings showed that nurses' attitudes proved to be a barrier to contraceptive use for some teenagers who had heard about occurrences regarding how nurses rebuke adolescent clients and asked personal questions. Informants in that study preferred General Practitioner (GP) than clinic nurses who were reported that they change attitude immediately you enter the clinic (Wood et al, 1997, pp.24-26).

Question 9

If the answer to question 6 is "no", why did you not use any contraception?

One hundred and forty two (n=142) 47% of respondents stated that they did not use contraception because they were not sexually active and (n=158) 53% of respondents did not answer this question. Some students enter into relationships but decide not to engage in sexual intercourse. Such relationships are risky especially if one partner is not happy with a relationship in which sex is not an option. One female student came requesting to test for HIV. She said "Yesterday evening my partner raped me when I refused to engage in sex with him but when we started the relationship, he agreed when I told him that I wanted to keep my virginity". Sorenson (1973), as summarised by Tauer (1986) stated that planning sexual activity by young people such as getting contraception, conflicts with the moral code of their parents and their own confused beliefs and values.

Question 10

Do you know about legally available termination of pregnancy (TOP) services?

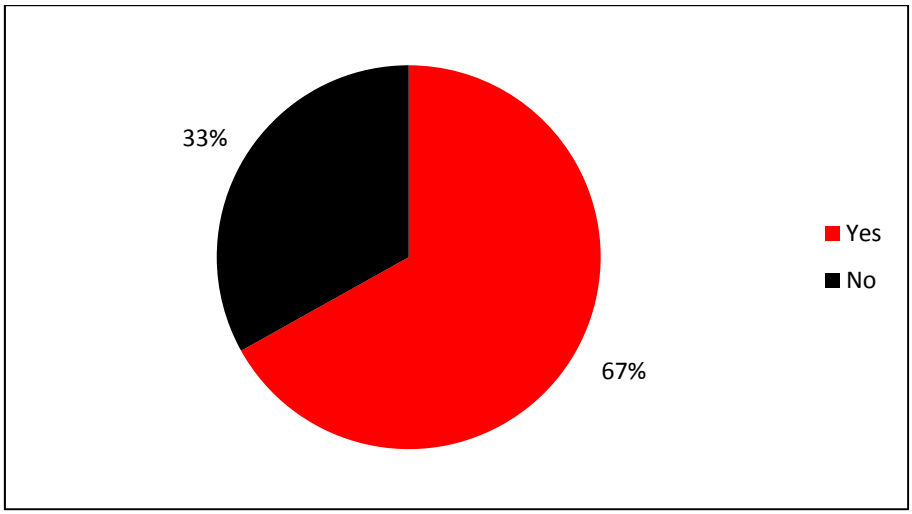


Figure 4.10 Awareness about legally available Termination of Pregnancy (TOP) Services

The above figure shows that the majority of students 67% (n=198) were aware about legally available termination of pregnancy (TOP) services. The South African government introduced the Choice on Termination of Pregnancy Act no 92 of 1996, which allows termination of pregnancy on request to be performed by a certified midwife or doctor up to 12 weeks of gestation. Termination of pregnancies of 13 – 20 weeks gestation can only be performed if they pose social, economic or psychological risk to the well-being of a pregnant women or girl (Cooper et al., 2004, p. 75). This Act led to a great deal of debate and controversy amongst South Africans. Some were against this act while others supported it. Through this controversy awareness about legally available TOP Services was created throughout the country especially among adolescents being the generation that mostly experience unwanted pregnancy and end up seeking these services.

Question 11

Have you ever attended the university RHS?

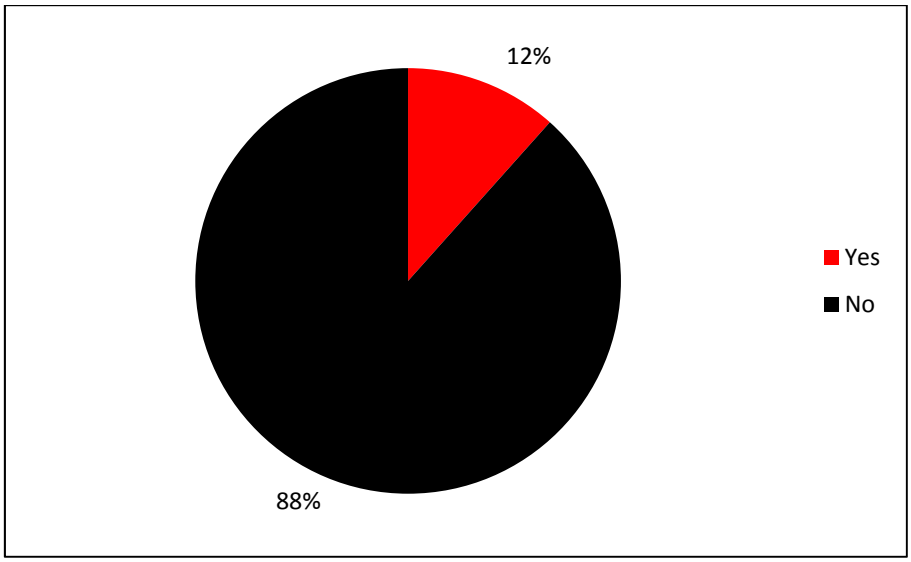


Figure 4.11 RHS attendances in the university

According to the findings in this chart 12% (n=34) of the total sample utilised the Campus RHS, while the majority 86% (n=259) of the respondents have never utilised the RHS service and 2% (7) of the respondents did not answer this question. These findings could imply that some of the sexually active respondents seek help from other Reproductive Health Care centres outside the university. If this statement is true; the bearing on this study is that it further decreases utilisation of RHS on campus as students seek assistance from alternate sources thus confirming the researcher's assumption that there is underutilisation of RHS by female students in this particular university. These findings could also be an indication of inconsistency in the responses especially when compared with the findings from the previous questions.

Question12

If the answer is "yes", why did you attend this service? (Total valid responses = 34)

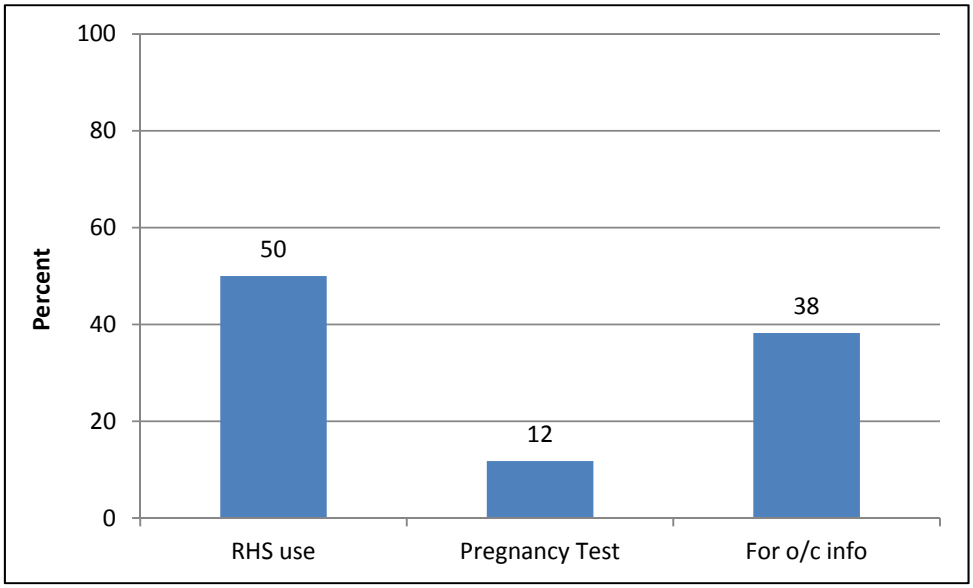


Figure 4.12 Reasons for attending the clinic

This graph indicates that among 34 total valid responses, 50% (n=16) of respondents who utilised RHS did so to collect contraceptives. Thirty eight percent 38% (n=13) of respondents used it to get information about reproductive health related matters. Twelve percent 12% (n=5) of respondents attended the service to ascertain whether they are pregnant or not. Pregnancy testing is indicative of unsafe sex and this confirms that some students do not take precautions to protect themselves and are therefore at risk of falling pregnant and getting infected with STIs including HIV. This group of students do utilise the service but for damage control after the problem has already occurred i.e. engaging in unprotected intercourse. The purpose for this study is to determine the factors that influence the uptake of RHS by female students on campus with a view to improving access and delivery of service in a more efficient manner. The fact that these students need to come for pregnancy testing could indicate failure of the RHS in that the primary purpose is promotion of good

reproductive health through education about responsible sexual behaviour; preventative measures to avoid unwanted pregnancies and STIs including HIV. Another purpose of RHS is curative and rehabilitative whereby young people are treated for reproductive health problems that they present with and rehabilitated on incurable reproductive health diseases. A large number of respondents 266 did not respond to this question.

Question13

How long did you have to wait at the clinic? (Total valid responses = 57)

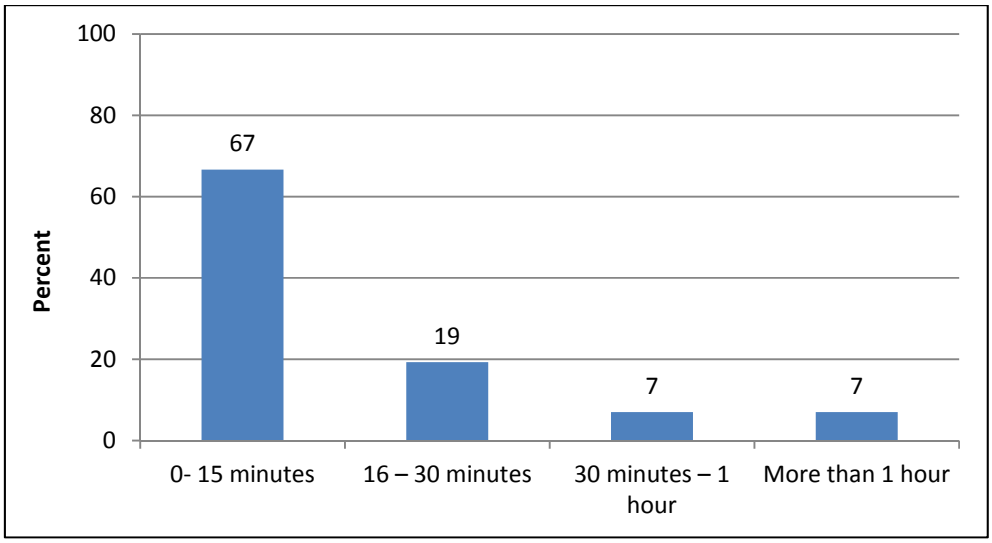


Figure 4.13 waiting period at the clinic

From the sample of 300 respondents, when asked if they have ever attended the university's RHS, only 12% (n=34) answered on the affirmative. This explains why such a small number of respondents answered this question about how long they had to wait at the clinic. This question was important to determine how long the students waited before they could be assisted. Long waiting period is a source of dissatisfaction with the health care system (Anderson et al., 2007). According to the Constitution of the Republic of South Africa, 1996 (Act 109 of 1996) everyone has the right to access to health care services that include receiving timely emergency care at any health care facility that is open, regardless of one's ability to pay.

In a qualitative study conducted in Limpopo Province, (2005) waiting period was one of the major components of quality care that were assessed. The participants stated that they waited for long periods while nurses took long breaks for teatime and lunchtime. They pointed out that nurses appeared to care less for patients that needed urgent attention (Mashego & Peltzer, 2005, p.19).

A study was conducted in North Carolina (2007) to determine the key qualities that influence patient satisfaction. Seven domains of health care quality valued by patients were identified. Among those domains was access to the doctor or health care service. Access entailed short waiting times, seeing the physician in short notice and having the doctor who keeps appointments and who is timely. Poor access was translated into waiting for 45 minutes minimum before being seen by the health care provider (Anderson et al., 2007, pp. 256-257).

In the current study the waiting period for some respondents was long as they waited for more than an hour to get service as depicted in the graph below. The graph indicated that 67% (n=38) of respondents waited for 15 minutes to be attended to. This could be an indication that RHS is underutilised since there are no too many people waiting. Nineteen percent 19% (n=11) of respondents waited up to 30 minutes and 7% (n=4) of respondents waited up to an hour to get service. Lastly another 7% (n=4) of respondents waited more than an hour to get service.

Question 14

Were the nurses kind and helpful at the clinic?

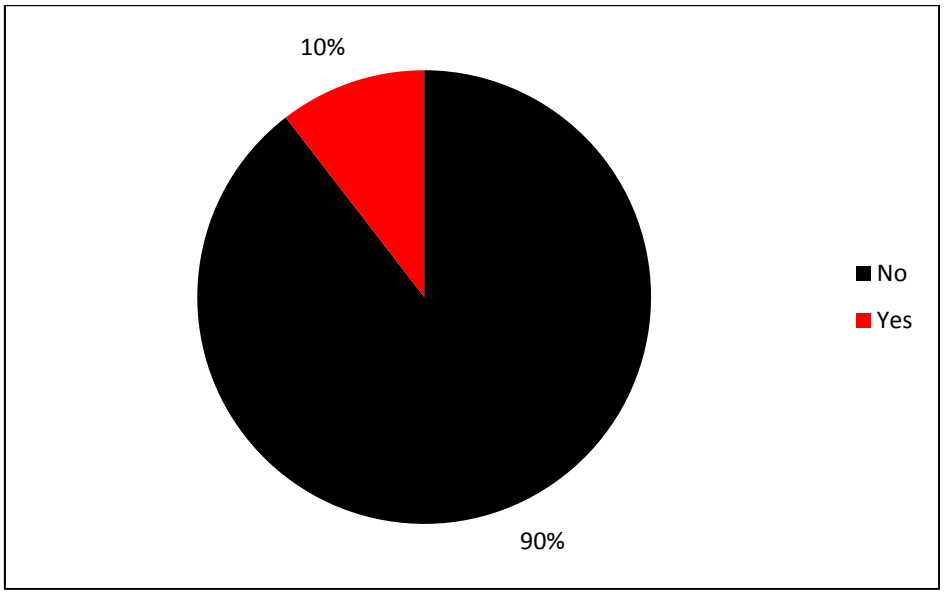


Figure 4.14 were the nurses kind and helpful at the clinic?

This question is important in this study because the response whether negative or positive is likely to influence the utilisation of RHS by students. If the service providers are kind and approachable the likelihood is that students will feel comfortable utilising the service but if they have negative attitude and unapproachable students will be scared to come and utilise the service. Negative staff attitudes have been identified as one of the obstacles for young people when trying to gain entry to the RHS. In a study conducted about adolescent sex in the Northern Province (1997); findings pointed out that the commonly reported dilemma experienced by teenagers were the negative attitudes of nursing staff. A number of teenagers recited their own experiences of verbal harassment by clinic nurses while others narrated their friends' description of it (Wood et al., 1997, p.28). In this study the findings indicated that 90% (n=60) of respondents felt that nurses were not kind and helpful. Only 10% (n=7) students were satisfied by service providers' behaviour at the clinic.

Question15

What advice were you given at the clinic? (Total valid responses = 46)

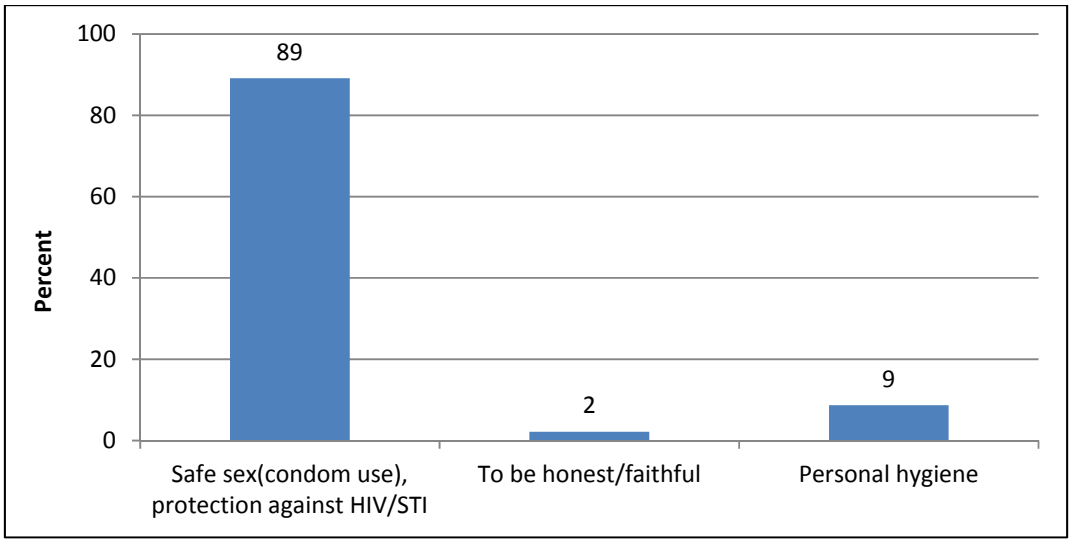


Figure 4.15 Advice given at the clinic

This chart indicates that the common advice given to students who utilised the service was safe sex and protection against HIV and STI. Eighty nine percent 89% (n=41) of the 12% respondents who have ever attended the RHS received this advice. Nine percent 9% (n=4) of the 12% respondents received advice on personal hygiene which forms part of the holistic approach for patient care. To be honest and faithful was the advice received by 2% (n=1) of 12% respondents who utilised RHS. This advice was given as guidance towards achieving a healthy and responsible sexual behaviour.

Question16

How did you find out about the university clinic (RHS)? – (Total valid responses = 94)

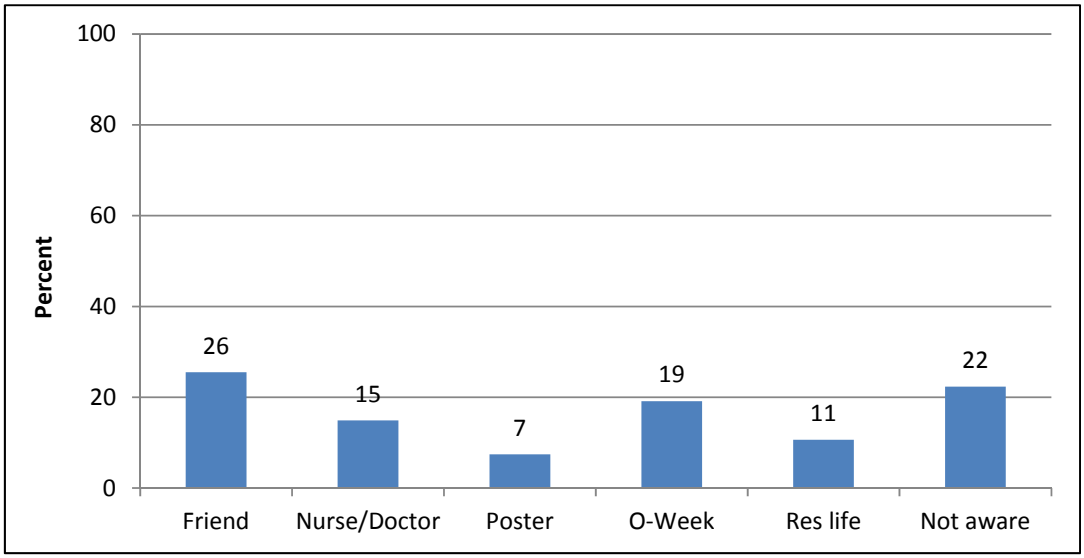


Figure 4.16 How respondents located the university clinic

It is essential to know how the respondents who had utilised the service before find out about the service in order to improve future access. Twenty six percent 26% (n=24) of the 12% respondents who had ever attended the RHS were made aware by friends and 15% (n=14) of) of the 12% respondents got to know about the RHS through the health care providers maybe when they went for other health related services. Posters reached out to 7% (n=7) of the 12% respondents and 19% (n=18) of the 12% respondents got information during the orientation week. About 11% (n=10) of the 12% respondents were told about this service in their residences through Residence Life orientation. Twenty two percent 22% (n=21) of respondents stated that they were not aware about the existence of the campus RHS. The year of study need to be considered in future when conducting similar studies given the fact that this 22% is comprised of first year students who attend the orientation programme at the beginning of the year. The overall requirement is for service providers to advertise the service adequately.

Question 17

Were you satisfied with the service you received at the clinic?

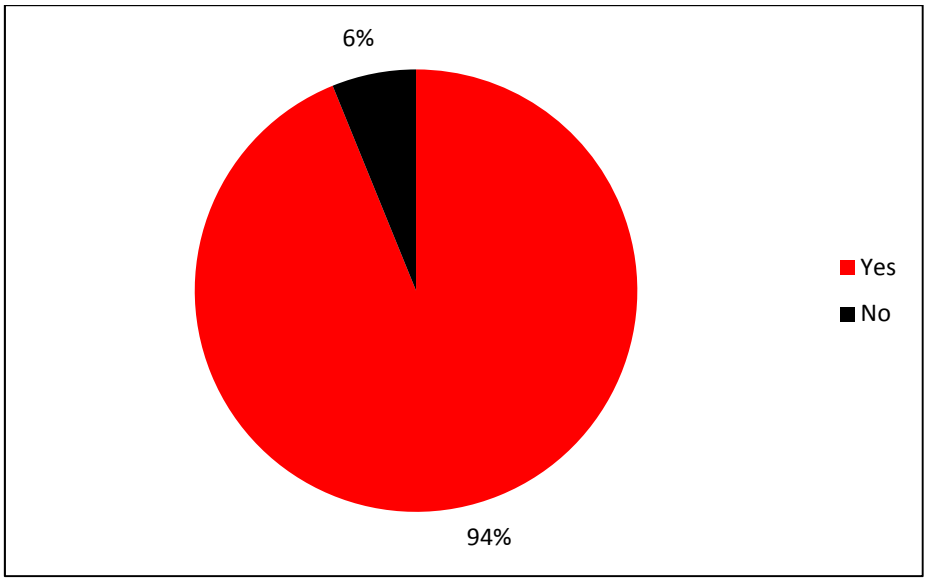


Figure 4.17 Service satisfaction

Client satisfaction needed to be ascertained so that modifications can be done to increase the service uptake by the targeted population. The findings indicated that 94% (n=61) of the 12% respondents were satisfied with the service rendered. Only 6% of respondents were not satisfied. These findings are not consistent with the findings in question 14 where respondents were asked if nurses were kind and helpful at the clinic and 90% of respondents indicated that nurses were not kind and helpful. More effort must be made such as provision of evaluation forms for students to complete. This will assist in identifying and addressing the negative concerns raised by adolescents regarding service delivery.

Question18

What could you recommend to improve services at this clinic? (Total valid responses = 62)

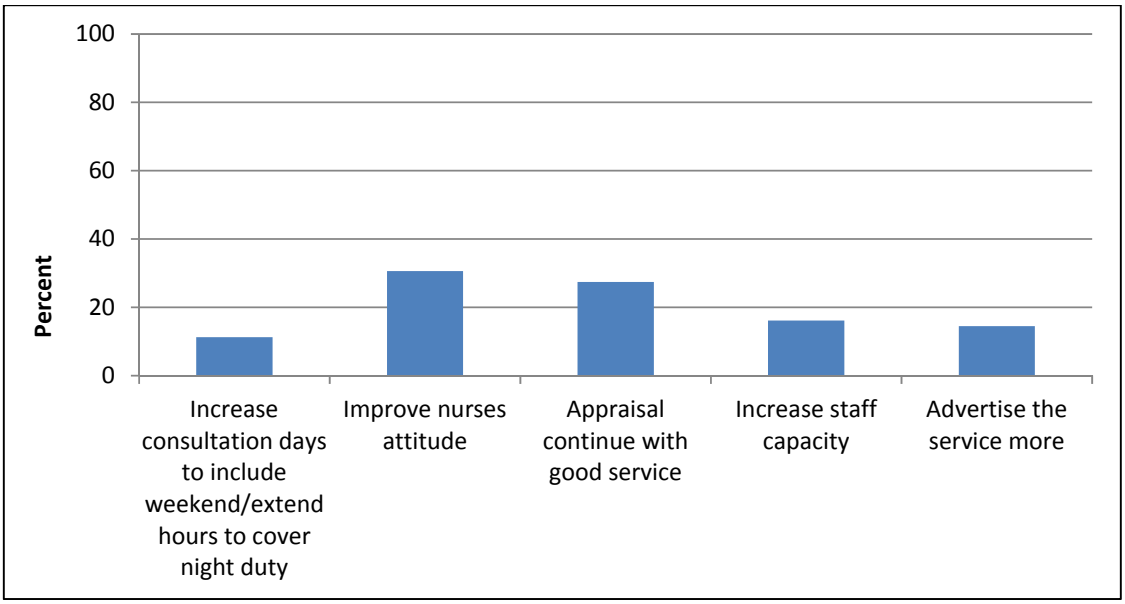


Figure 4.19 Respondents' recommendations to improve services at this clinic

Recommendations from respondents are fundamental in this study as they highlight the students' preferences of an ideal RHS. If these recommendations are positively considered, they could enhance student utilisation of RHS. These findings show that the majority of respondents 31% (n=19) recommended that nurses attitude should improve. Twenty seven percent 27% (n=17) of respondents praised service providers for good service delivery and recommended that they continue with their good work. Increase staff capacity was recommended by 16% (n=11) of respondents.

Increasing consultation hours to include weekends or evenings can enable greater utilisation of the service. The assumption is that services will not be utilised if they are only available during "office" hours when the students are often attending lectures. Building staff capacity and adequate supplies of working material is important for increased service provision. Health care providers, who are considerate and sensitive to the youth population, are needed for efficient service provision.

4.3 Semi – structured interviews

The semi-structured interviews were held to explore and describe factors influencing the uptake of campus RHS by female students. Questions were asked in the same sequence throughout the interviews in order to maintain consistency across all participants. This approach was useful in facilitating comparison of their answers.

Question 1

What do you understand about reproductive health?

This category was developed to obtain information about what participants understand about reproductive health. In this study it was important to assess their level of knowledge as most reproductive health problems occur due to lack of appropriate knowledge and this knowledge may influence why and when they may use RHS. World Health Organization defined reproductive health as a state of being physically, mentally, and socially well and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its function and process (Feleke & Gebresilassie, 2008, p.1).The following subcategories emerged based on the responses from participants.

Subcategories	Explanation
1.1 Contraceptive Methods (M)	Various hormonal methods used to prevent conception such as oral or injectable methods and devices such as intra-uterine device and implantable contraceptives. Other methods are permanent resulting in sterilization such as tubal ligation and vasectomy.
1.2 Physiology (P)	The normal mechanism of the reproductive system including the menstrual cycle
1.3 Personal Management of reproductive health (PM)	Personal efforts to maximize reproductive health and measures to prevent disease
1.4 Lack of knowledge (LK)	Participants uncertain of the facts or had no idea of what reproductive health is all about

1.1 Contraceptive methods

Findings showed that (n=7) participants understood reproductive health as pertaining to taking contraceptive methods as stated by participant number 2: “Reproductive health? I think it means that what is done in terms of meeting relevant decisions and considering reproduction and giving birth and all. I think it means taking contraceptives and using condoms and just to prevent any sort of reproduction before the actual time or while you pregnant protecting yourself and the baby from any diseases or and any dangers”.

Participant number 8 said “Is it not that you must eh it has got to do with contraceptives sex and whatever like family planning and whatsoever” Participant number 1 stated “Okay what I understand is it has to do with contraceptive methods and ways to prevent STI any help like you get related to sexual activities or something like that”. Responses from this subcategory showed that participants had an idea about what reproductive health entails.

1.2 Physiology

Results showed that (n=12) of participants understood the physiology part of reproductive health as stated by participant number 10 who said “I have learnt how the reproductive system works and the menstrual cycle how it takes place after 28 days.” Participant number 15 stated “Reproductive health is the care of your reproductive system and it goes as far as menstrual cycle to increase child birth and childbearing.” The responses in this subcategory indicated that students understood what reproductive health entails especially if they associate it with childbearing, however there is a risk of unwanted pregnancy for students who time their menstrual cycle in relation to having unprotected intercourse with the belief that they cannot fall pregnant because it is a safe period.

1.3 Personal management of reproductive health

Eight (n=8) participants believed that reproductive health is about taking care of yourself especially reproductive organs and being aware of the reproductive hereditary diseases. Participant number 7 said “It is taking care of your reproductive organs I think”. Participant number 13 said “Reproductive health is about practicing safe sex understanding your hereditary disease that you probably have”. The findings from these subcategories revealed that students knew various components of reproductive health not the whole.

1.4 Lack of knowledge

Three (n=3) participants were uncertain or had no idea of what reproductive health is all about. Participant number 6 stated “My understanding is reproductive health right, okay basically a measurement during the reproduction system (laughing) I think not quite sure”

Participant number 12 when asked what she understands about reproductive health, she said "Nothing I do not know honestly I cannot think of anything to say".

Reproductive health as defined by Feleke & Gebresilassie (2008) is a state of being physically, mentally, and socially well, in all matters pertaining to the reproductive system and to its function and process. According to (United Nations Population Fund (UNFPA), n.d.), good reproductive health entails satisfying and safe sex life, the ability to reproduce, and the freedom to decide if, when, and how often to do so. People need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They also need to be informed and empowered to protect themselves from sexually transmitted infections.

In the context of this study, utilisation of RHS will ensure good reproductive health for the population under study through empowerment and provision of preventative, promotive, curative and rehabilitative reproductive health services.

Question 2

How much do you think female students know about the implications of intimate sexual contact?

Intimate sexual contact is an activity that involves sexual contact and is mutually and voluntarily carried out by two people irrespective of whether intercourse or orgasm occurs or not (Lindau et al., 2007, p.763). Assessing the participants' level of awareness about the implications of intimate sexual contact was important in this study because lack of knowledge about the implications of intimate sexual contact might make the students think they are fine and do not see the need to utilise the RHS. Given the responses received, the following subcategories emerged.

Subcategories	Explanation
2.1 Deficient Information(DI)	The information that students have is inadequate
2.2 Lack of Responsibility(LR)	Students know the implications but they do not want to take responsibility or do as they supposed to do
Naivety (N)	They know the implications but they do not think it can happen to them
Resources (R)	Inadequate knowledge due to lack of resources such as the internet

2.1 Deficient information

Eleven (n=11) participants believed students are informed but the information that they have is not enough, this is evidenced by the risky behaviour they still engage in. Participant number 15 said “I think some people do not especially this generation they tend to think it is okay they do not think it’s a big deal. They do not know much because there are so much unwanted pregnancies, now unwanted diseases as well so they do not know what they are getting themselves into”.

Participant number 10 stated “I do not think they know much eh because I did not get that much information in high school I do not know much about it”. Participant number 20 said “From my experience you don’t understand these things until you realise the mistake you have made, so students know little bit”.

Students are a vulnerable population at risk of making wrong decisions based on deficient information. Knowledge empowerment and guidance is needed for this growing generation to help them develop into responsible well informed individuals.

2.2 Responsibility

Seven (n=7) participants indicated that students are well informed but they lack responsibility to do the right thing. Participant number 8 said in relation to responsibility; “I think we do know as much as we are all adults. It is just that we do not want to take responsibility sometimes we just ignore them or whatever.” Participant number 5 reaffirmed this by saying “I think a lot of people know a lot about the implications but I just feel like sometimes we tend to be ignorant of the implications of engaging into sexual activity”. Participant number 7 said “Few things you know from high school and when you come here you become ignorant with certain things like sex and your organs and stuff like that. Basically the things that they tell us we do not take them to heart we do not think it is important”. Participant number 13 said “Very few we know the implications but we do not want to think about it. The majority knows about it but just ignoring the fact that they know it”.

The findings from this subcategory raised the important issue of how to encourage students to take responsibility for their reproductive health and support the findings of Courtenay on page 16 of this study.

2.3 Naivety

Findings also show that other students are well informed but they remain naïve as shown by participant number 5 when she said “I think a lot of people know a lot about the implications but I just feel like sometimes we tend to be ignorant of the implications of engaging into sexual activity. So they do know that if you have sex without a condom you have the chance of contracting HIV/STI. Personally I am in a relationship and we don’t use condoms because we feel it is a very committed relationship but people have it for other reasons like probably people get drunk and engage in sex and irresponsibility”.

UTILISATION OF REPRODUCTIVE HEALTH SERVICES BY STUDENTS

This subcategory indicated that some students believed that consequences of unsafe sex will not occur to them because they trust each other and that is very risky especially in new relationships when you still do not know much about the person you are involved with especially not knowing the HIV status of your partner. National Cervical Cancer Coalition (2015) supports this statement by suggesting that with a new relationship it may be good to date for a certain period to allow aspects of relationships besides sex to develop while getting to know each other and becoming closer.

2.4 Resources

A small percentage of participants, 5% believed that students lack information due to unavailable resources such as internet. Participant number 16 confirmed this by saying “Those who are privileged have access to internet and resources know but unfortunately those who come from disadvantaged backgrounds cannot tell the difference”. Technology especially the internet is the biggest source of a variety of information such as E-health program, which is an internet-based health care delivery program used for clinical, educational, preventative, research and administrative purposes (Minichiello., 2013, p. 1). The population in this study has the privilege of unlimited access to the internet and the availability of RHS as a reproductive health information resource.

Nwagwu (2007) stated that young people need resources to access information, education and resources that promote their development. Information technology such as the internet is viewed as a significant source of information.

2.5 Where do they get information from?

The quality of information that students receive depends on the source of that information and the nature of information has a great influence on whether students would consider it necessary to utilize RHS or not. Below are the various sources of information that were mentioned during the interviews.

Table: 4.6 Source of information about the implications of intimate sexual contact

Source of information		
Source	**Frequency (n)**	**Percentage (%)**
2.5.1 Media	19	29
2.5.2 Friends	17	26
2.5.3 Parents	9	14
2.5.4 Service providers	7	11
2.5.5 Siblings	6	9
2.5.6 Other (Posters, High school)	7	11

2.5.1 Media

Nineteen (n=19) of participants got information from the media that is audio-visual and printed media. Participant number 6 stated “Students get information from the media of course whether it is television or printed media, the social network and everything”. When participant number 18 was asked if media could be one of the sources of information, her response was; “Ya media is a big one as well”, but participant number 7 said “They (media) do not show like the implications like if you using contraception do not do this, what will happen what the catch to it if not using protection, contraception and infections sometimes they do not show that”.

Media provides youth with a lot of information on sex and sexual matters among other issues. The tendency of most families to be reluctant to address issues on sexual matters with their children in order to put these issues into moral context, has made youth to rely more on media as a source of information (Cloete, 2012, p.4). Cloete (2012) further argues that an alternative voice is needed other than the voice of media to guide the youth to live their sexual life in a dignified and respectable manner. Media plays a major role in human race by dissipating a wide range of information; however youth need guidance especially with explicit sexual material that is portrayed in different forms of media.

2.5.2 **Friends**

Friends were mentioned following media as a source of information by seventeen (n=17) participants. Participant number 10 said “Me and my friends we talk like we encourage each other like do not rush into sexual affairs at this stage because you may become pregnant that is what we talk about we worry about our future”. This is consistent with the response from the survey in this current study whereby friends were ranked high by 41% as a source of information on sexual issues. In a study conducted in the Klang Valley in Malaysia (2011), friends were ranked at 57.3% as a source of information (Kamran et.al., 2011. pp. 30-31).These findings highlighted the fact that students rely on their friends for information however the concern is how reliable is that information?

2.5.3 Parents

Nine (n=9) participants mentioned parents as their source of reproductive health information while eight (n=8) participants disagreed to the fact that parents were a source of reproductive health

information. Participant number 5 said "With my parents we never talk about sex we never talk about HIV, we talk about these things when we talk about other people if someone is sick so they say you see what happens if you sleep around? We never like my mother does not even know I have a boyfriend probably she assumes." Participant number 19 when asked if parents are a source of information said "Parents no, like I live with my dad we never talk about such things ever".

Racial differences came up in this issue of parents as source of information where some participants stated that black parents are reluctant to share information compared to parents from other races. Participant number 12 confirmed this when she said "most of the time in black families you are told not to date and that's it they do not want to know anything or how you feel like it is not for discussion you are not allowed to date until you get your degree and whatsoever".

In the study about the effects of race on discussions about sexual issues between mothers and their daughters (2006); findings indicated that ethnicity does influence mother-daughter communication about sex- related topics and maternal awareness of the sexual status of their daughters (Meneses et.al., 2006, p. 131).

Age difference was also highlighted as having an influence on whether parents share reproductive health related information with their children or not. Participants indicated that younger parents share information with their children compared to older parents. Participant number 14 said "It is hard to ask parents about these things especially the traditional parents or older parents they are hard to approach but younger parents are able to speak to us about that". Eight (n= 8) participants said that they rarely get information from parents and three (n=3) participants were not sure if parents are the source of information or not. These findings were consistent with the findings from the survey where respondents ranked parents low as the source of information.

2.5.4. Service providers

Seven (n=7) participants mentioned service providers as source of information while (n= 12) participants highlighted the fact that service providers only give out information if you ask them. Participant number 11 stated “I think most people go to service providers when they need something like contraceptive, only then will they go. They do not go there for enquiry.” participant number 13 said “Service providers if you approach them they will tell you about it but then most people do not approach them”. When participant 16 was probed if service providers are the source of information, she said “My Doctor and I don’t really discuss this” What about health care workers in this Institution? She stated “It’s my first time actually here so I have never discussed it with health care workers”

In 2013 a study was conducted in the Department of Health Promotion and Education, University of Utah, USA, which recommended that STI screening should be encouraged in the context of responsible sexual behaviour as a strategy of promoting sexual health. Awareness about responsible sexual behaviors and STI screening should also be incorporated into social media campaigns to reduce the stigma associated with utilising the RHS (Reel & Hellstrom, 2013, p.1). In the context of this study, the above recommended awareness campaigns can be posted as pop-up messages on Sakai which is the university’s learning platform that reaches the entire student body. Service providers can do the awareness campaigns but it might not be very effective seeing that health care providers have a reputation of being judgemental.

2.5.5 Siblings

Only (n=9) participants supported the fact that siblings do share reproductive health information among themselves. Participant number 3 said “My sister is older and she tells me everything about

it." Participant number 4 stated "I think siblings do talk about it; it's just that I do not know if it is always the right information". Participant number 11 indicated that her sister is 12 years old, but if she had an older sister she would discuss it with her.

Participant number 5 stated "I find it very uncomfortable talking to my sister she is only 13 years and she is having periods already so I find it weird that my sister is growing up. I mean we are both women but I find it weird that she is growing through that stage and we have never talked about sex but if it is necessary that for me to sit down with her to talk about it I would probably do it."

The findings about this source of information indicated that for some participants sharing such information depends on the age difference between siblings the lesser the discrepancy the better.

Kusi-Appouh (2013) argued that older siblings have a potential to serve as agents of socialisation and impact positive influence towards responsible sexual behaviour and entire reproductive health knowledge and attitudes of their younger siblings. In the same study participants indicated that siblings encouraged abstinence and avoidance of unwanted pregnancy and STIs. In some instances siblings gave advice based on their personal experiences, for example premarital pregnancy. Their contributions to adolescent's reproductive health were found to be unique compared to other sources of information.

2.5.6 Other (Posters, Teachers from High school)

Seven participants (n=7) indicated that posters and high school teachers were the sources of reproductive health information. This part indicated low ranking of posters and high school teachers as source of information. In the survey posters were ranked lowest by respondents as a way of communicating information. Posters did not seem to be good source of information. This is further

confirmed by participants from the interviews. The ratings for high school teachers had always been high in the survey but interview participants came out different with teachers they ranked them low.

Question 3: What factors would make you consider campus RHS a place of choice to get reproductive health related information and assistance?

This category was developed to ascertain the students' preferences of an ideal RHS which would enhance their utilisation of the service. Findings showed that fourteen participants (n=14) considered campus RHS as a place of choice because it is easily accessible, reliable, affordable and offers professional advice. Three (n=3) participants felt they do not know what to say because they have never been to the RHS before and another three (n=3) participants did not answer this question.

The following subcategories were developed based on the information received.

Subcategories	Explanation
3.1 Convenient (C)	Service easily accessible
3.2 Inexpensive (I)	Affordable charges
3.3 Quality service (QS)	Service offered at a professional level
3.4 Reliability (R)	Trustworthy information

3.1 Convenience

Participant number 1 said "Okay I think because it is closer to res and also because it is one of those places you can go without your friends noticing it". Participant number 3 "Because it is nearby and you do not need a lot I think you just need your student card and the ID".

The service location in the current study is in line with the location of the population with regard to geographical distance. Students who stay outside the university residences, can access the service by using the university transport which transport students in and around university campuses and residences.

3.2 Inexpensive

Participant number 1 said “It’s less expensive and also because it is one of those places you can go without your friends noticing it” Participant number 9 said “It is near, no charge probably not expensive” Participant number 11 stated “I would say convenience, good service and the price”

RHS in this study is offered at no cost except for screening procedures such as Papanicolaou smears for which they pay the laboratory fee only.

3.3 Quality service

Participant number 17 said “Because I will get professional advice” Participant number 18 stated “it is close, convenient and probably they understand because they work with students a lot” Professional standards are maintained to meet the needs of the population and services are offered in a clean well-kept environment.

3.4 Reliability

Participant number 16 said “Reliability, confidentiality ya” Service provision is user-friendly and privacy is offered for each client who visit the service and confidentiality is upheld all the time.

3.5 Factors that influence the uptake of the RHS on campus

Through probing further on the factors that would make participants consider campus RHS as a place of choice to get reproductive health related information and assistance, the following subcategories emerged as some of the factors that influence the uptake of RHS on campus.

Factors that influence the uptake of the RHS on campus		
	Frequency (n)	**Percentage (%)**
Staff not approachable	6	30
Stigma present	11	55
Confidentiality	15	75

3.5.1 Approachability of staff

Six (n=6) participants felt that service providers are not approachable. Participant number 1 said "Nurses tend to be rude to students and that is why students do not go to campus RHS. The service providers are not approachable even if you are sick they are not at all friendly". Participant number 5 said "There is this nurse she is judgmental and cheeky like she would ask why you did that can you see now? The last time I told her that I'm not using protection and she was like where is your boyfriend now you see he is not even here to support you. Do not make stupid decisions. I felt very patronized because I know what I did was stupid and very wrong… that's why I came here to get help not to be judged or shouted at". Participant number 14 said "Not everyone I remember when I went to get my Papanicolaou smear result, she gave me my result and asked me in a judgemental tone that; are you sexually active? Already that created a barrier because I could not ask her anything else because I was afraid of being judged"

Six (n=6) participants felt comfortable about staff approachability. Participant number 13 when asked whether the staff is approachable or not, she said "Ya I think they are, I have been there to

consult a few times and they are okay but then I do not know because people know they have to go to consult but they do not go". Participant number 20 said "Ya the staff is kind and nice".

Eight (n=8) participants said that they would not know because they have never been to this Service Centre before. Participant number 16 stated "I have not really used the Campus Health that much so I would not know." Staff attitude plays a major role towards clients whether they utilise the service or not.

3.5.2 Stigma

Findings showed that eleven (n=11) participants affirmed the presence of stigma as stated by participant no.14 who said "Immediately you get there and you say you are there for family planning people are already looking at you thinking yo! This girl is so sexually active she even wants the pill for it". Seven (n=7) participants highlighted that there is no stigma and two (n=2) participants said that they have never utilised the service before so they do not know if there is stigma or not. Some participants who have never utilised the service before agreed to the fact that there is stigma because they heard it from their friends who have utilised the service. Stigma is a sign of disapproval associated with doing something regarded as socially unacceptable and it can lead to loss of confidence and dignity. It is a potential contributing factor towards students not utilising the RHS. Including stigma as a probe question was essential to get students' views whether they experience a great deal of stigma when attempting to utilise the service or not.

3.5.3 Confidentiality

Confidentiality is a token of respect for the next person. Kling, (2010) stated that confidentiality safeguards the respect for the patient and his or her vulnerability and it gives the patient confidence

to trust the health care professional with his or her personal information. Oppong-Odiseng and Heycock identified factors that influence confidentiality which are: The close proximity of the service provider to the familiar environment of the adolescent such as home, experience from the previous utilisation of the service, attendance with the parent, relationship between service provider and either the adolescent, adolescent's parents, and other context, for example relationship with adolescent's school, service provider's legal obligation, and severity of the condition. These factors are referred to as PPARLS (Oppong-Odiseng & Heycock 1997 p.117).

Well maintained confidentiality in this study would influence students to utilise RHS due to the confidence they have for the health care providers to keep their personal information confidential. It is noted from the findings that fifteen (n=15) participants said that there is confidentiality. Participant number11 said "confidentiality is maintained because I have never heard people discussing what I went there for". Participant number 20 said "confidentiality is maintained 100%". Five (n=5) participants had never utilised the service before and they said that they do not know if confidentiality is well maintained or not.

Question 4: What services and contraceptive methods do you think should be offered?

This category was included in the study in order to accommodate students' preferred services and contraceptive methods which could possibly motivate them to utilise the RHS if they are offered.

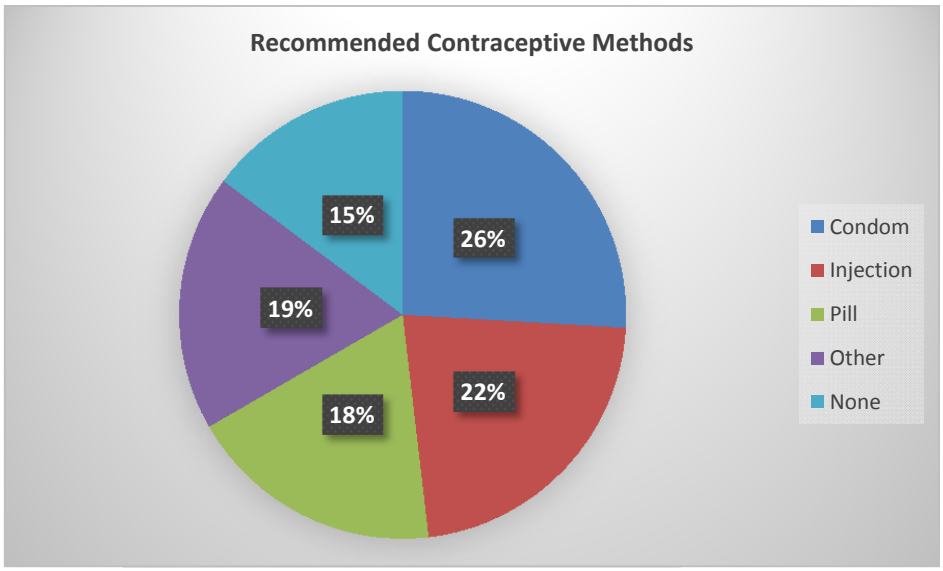


Figure 4.19 Services and contraceptive methods recommended

In this section the number of recommended methods did not necessarily match the number of participants because each participant could mention more than one preferred method. The findings in this category showed that seven (n=7) participants preferred condoms as a method of contraception. There were six (n=6) participants who preferred the injectable method while five (n=5) participants recommended the oral method (pill). Results further indicated that five (n=5) participants suggested other methods such as the intra-uterine device, diaphragm and the patch and four (n=4) participants did not suggest any method because they said they are not well informed about different contraceptive methods.

The suggested methods are already being offered on campus. This means that students are not aware about the available services offered in the clinic. This could be because students do not visit the

reproductive health centre to find out if what they want is available or maybe because the available services are not adequately advertised.

Question 5: Are there any comments or suggestions you would like to talk about?

Participants were requested to make comments and suggestions on the issue of RHS utilisation or anything they deemed important. Various comments and suggestions were made that merit improvement of the available RHS on campus

5.1 Conduct awareness campaigns

Findings showed that three (n=3) participants suggested that awareness campaigns must be conducted on campus. Participant number 1 said “More awareness campaigns are needed because there are unwanted pregnancies on campus and more of awareness programs are needed in all campuses to reduce the stigma associated with reproductive health”. Participant number 6 stated “We should have people from RHS coming to do some campaigns especially for us females so that we can be alert because we do not know actually the whole implications of reproductive health and pregnancy”.

5.2 Advertise the service

About (n=8) participants recommended that proper advertising of the service is done as some students are not even aware of such service being offered on campus. Participant number 2 stated “Reproductive health is really important obviously. Looking at it because of it you can or cannot make it to your future”. Twelve (n=12) participants did not comment or made any suggestions.

5.3 Conclusion

The socio-demographic profile of potential and actual users was presented in this chapter but it was difficult to interpret the data due to the small number (n=34) of students who were using the RHS. The entire sample of users was from racial group 1 and a very small sample of other race groups constituted the total sample. These factors made it difficult to answer the first research question. The second research question was answered in this chapter. According to the responses in the survey and in the semi-structured interviews, it was concluded that the RHS on campus is not well marketed. Most students from the sample are not aware of what services are offered. Some do not even know if such service exists on campus. The following chapter will discuss the findings and the summary of the study as a whole. The limitations of this study and recommendations will be made.

5.0 SUMMARY OF FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION OF THE STUDY

5.1 Introduction

This chapter presents the summary and discussion of findings, limitations and recommendations based on the data collected.

5.2 Socio-demographic profile

The descriptive data is difficult to interpret definitively due to the small number (n=34) of students who are using the RHS. With regard to the age of the users it would appear that there is a relatively poor uptake of the services from the younger age group (17 to 20 year olds). This age group constitutes 58.3% of the total population but only 38.2% are using the services. This could be because they are not yet sexually active and therefore do not see the need to use the services but further investigation would be needed to confirm if they are sexually active, as they constitute a vulnerable group. The older group (21 to 25 years) have a larger uptake (58.8%) of the actual users who fall into this category whereas they constitute 40.33% of the total population.

With regard to the country of origin, the non-South Africans are making relatively better use of the services than the South Africans. This is seen by the fact that the non-South Africans constitute 8.8% of the total population but 15.2% are using the service. This is probably because they do not have other options such as using their private doctors.

It was not possible to make any inferences about racial group as the entire sample of users are from racial group 1 and a very small sample of other race groups constitute the total sample. The socio-demographic profile information obtained was significant however the intended goal for including this section in the questionnaire which was to ascertain if race/ethnicity had an influence towards

utilisation of RHS, was not met due to insufficient data regarding race/ethnicity. More respondents did not indicate their ethnic groups

5.3 Sources of information

The responses in the survey indicated that most information on reproductive health was obtained from the teachers. Literature shows that parents are selective with the information they give to their children as stated by Whitehead (1994) that rather than parents educating their children about their sexuality, they assert that sex is sinful, unwholesome and is likely to cause harm.

Unfortunately as a result of parents not giving complete reproductive health information to their children, the likelihood is that sexual information is obtained from alternative sources, some of which may be distorted and unreliable. Findings in the current study showed that teachers are the most common source (77%) of information on sexual matters.

If teachers are well informed this may be a positive finding. The concern however, as expressed by Whitehead (1994) is that, since parents are not fulfilling their role of educating their children about reproductive health which is the usual societal expectation, the job is handed over to the teachers who are credible adults in a position to reach out many young people. When teachers give information about reproductive health, they give most emphasis on factual information rather than addressing issues of morality personal concern for the learners. Information series was provided in schools (UNESCO/UNFPA, 1998b) focusing on family life, reproductive health and population education. Teachers discuss these issues by first acknowledging that cultural norms, religion, social structures and school environment differ globally and that determines how teachers address these issues. According to WHO reproductive health education is directed at empowering adolescents to understand their sexuality in the context of biological, psychological, socio-cultural and reproductive

dimensions. It also aimed at empowering them towards responsible decision making regarding sexual behaviour and reproductive health behaviour (UNESCO/UNFPA, 1998b, p.13).

Friends constituted an important source of information on reproductive health issues in this study (41%). This trend was found to be similar in a study conducted in the Klang Valley in Malaysia, where friends were ranked at 57.3% as a source of information (Kamran et al., 2011. pp.30-31).The concern lies with the credibility of the information they give.

5.4 Accessibility of the RHS

The results showed that proximity to the RHS in this study did not influence the utilisation of the service by students because there was poor uptake despite close proximity of RHS. This raised interesting implication for the public sector guidelines which stipulates that the maximum travel distance to a PHC service point should be within 3km of the community it serves (Department of Public Service and Administration, 2011**,** p. 28).

The assumption of this policy is that if health services are available they will also be utilised which is clearly not the case in this study since participants mentioned that the clinic is easily accessible. It was noted however that 22% of respondents stated that they were not aware about the existence of the campus RHS. All students are informed of the existence of the RHS services during the orientation week. Their ignorance regarding the service despite being informed could well be due to the fact that during the orientation week students are given a great deal of information on the available services and the operations of the university. The focus is not just on RHS. With this in mind there is likelihood that they forget. The marketing strategy to inform students about the RHS services therefore needs to be augmented or changed.

5.5 Approachability of staff

Qualitative data showed that there is a problem with approachability of staff. Participants stated that some of the nurses are not approachable. The nurses' judgemental behaviour expressed by students had a detrimental effect on the willingness of the youth to utilise the service. RHS are managed and run by nurses who belong to a unique profession whose primary focus is caring for people.

Nursing is a caring profession by defending patient's human rights, promoting the best interests of others through relieving pain, comforting and rehabilitating and by living moral life through embracing virtues of compassion which are sympathy and empathy (Landman (2002,pp.21-22).

The judgemental and bullying behaviour of nurses among themselves and towards patients has been widely documented in literature. A study on bullying conducted by Vessey et al. (2009), as summarized by Ludwig (2013) discovered that perpetrators of bullying included senior nurses (24%), charge nurses (17%), nurse managers (14%) and physicians (8%). Felblinger (2008) described bullying as an act of deliberate rudeness that causes humiliation and shame to the victim. Nathanson (1992), as summarized by Felblinger (2008) indicated that when the victim of bullying experiences shame, he or she might respond in any of the defensive patterns which are withdrawal, avoidance, attack-others, or attack-self. If the response is by attacking others, bullying becomes a vicious cycle.

When the victims cannot express feelings of frustration due to fear of being bullied further, they lack control of the situation which in turn lowers their self-esteem. Low self-esteem triggers the cycle of oppressed individual behaviour as a way to boost self-esteem. This array of events leads to more frustration and conflict in the workplace and patient safety is compromised. Certain situations in

workplace are likely to promote and perpetuate oppressive conditions such as inadequate staffing ratios and lack of recognition for nurses as critical thinkers (Townsend, 2012, p.12).

In the current study unapproachable nursing staff and their judgemental attitude towards students could be the barrier for students utilising the service. This is of great concern and needs attention by management.

5.6 Contraceptive methods

Findings in this study indicated that students are relatively knowledgeable about contraceptive methods. Ninety seven (97%) of respondents indicated that they know about contraceptive methods. This is consistent with the findings from the study conducted by Rahman & Kabir (2005) on adolescent knowledge about contraceptives which showed that 99.8% of adolescents were aware of contraceptive methods. Amongst these contraceptive methods, findings in this study showed that the condom was the most used method of contraception probably due to the success of the HIV campaign to condomise. None of the respondents mentioned the female condom. This could be due to the fact that the global female condom awareness campaign took place in this institution after the data was collected.

5.7 Overview of findings

The purpose of this study was to determine the factors that influence the uptake of RHS by female students on campus with a view to improving access and delivery of service in a more efficient manner. Evidence showed that the socio-demographic profile of the students was not a significant factor in whether or not they access the services. It also showed that students are knowledgeable about available methods of contraception and that their main source of information is from teachers.

Lack of knowledge of contraceptive methods therefore did not appear to be the reason for them either choosing to come and collect them from the RHS services or not. The motivation to use them or not appeared to be a more compelling reason than a knowledge of the methods. This could be influenced by the fact that information comes primarily from school teachers rather than parents who may possibly use a more individualised and caring approach to emphasise responsibility and the importance of relationships and choices, were they to take on the parental role of preparing their children for life choices.

Lack of knowledge about the existence of RHS contributed to non-utilisation of service but for most students, the physical availability of RHS was not enough. Access is an additional issue and is influenced by the approachability of staff and information about the services, and even the hours of service. It is a reasonable assumption that if the services are only available during “office” hours when the students are often attending lectures they will not be utilised. These findings influence the uptake of RHS by students at this university.

5.8 Limitations

5.8.1 The sample of actual users was limited and only descriptive analysis was possible. The year of study was not included in this study which could have assisted to identify if the potential users between the ages of 17-20 years were in their first year of study or not.

5.8.2 The exclusion of other residences and day students in this study affected the findings of the socio-demographic profile for potential and actual users of campus RHS for example one residence accommodates international students. Including other residences in this study could have influenced the socio-demographic profile of potential and actual users

5.8.3 The tendency of respondents to omit answering certain questions was a limitation of the study as some aspects of data analysis were not completed as planned. The likelihood is that this was due to the sensitive nature of the sex related questions.

5.9 Recommendations

The following recommendations were made based on the findings of this study:

5.9.1 Education

5.9.1.1 It is crucial to consider a comprehensive reproductive health education in schools that will include the fundamentals of reproduction, the rationale behind responsible relationships and health education that will instil self-consciousness and help reduce the risks of unplanned pregnancies and sexually transmitted diseases among adolescents and youth.

5.9.1.2 It is essential to examine the association between parents as source of information on sexuality and utilisation of RHS.

5.9.2 Research

5.9.2.1 A study is recommended to monitor the uptake of female condoms after the launch during the Global Female Condom Campaign in September 2014.

This recommendation is based on the study that was conducted in South Africa in 2012 on progress and challenges to male and female condom (FC) use which showed that there is a lack in data for FC failure and problems in use in the general population (Beksinska, Smit & Mantell, 2012, p. 5).

Another study contributing to the need to monitor FC uptake was conducted by Smit et al. (2006) as summarised by Beksinska, Smit & Mantell, (2012) on early acceptability studies which reported that the media have often portrayed the FC in a negative light focusing on aspects of acceptability namely the appearance and the noise which have only been reported as minor user issues.

5.9.2.2 There is a need to explore what policies exist to curb bullying behaviour in the nursing institutions

5.9.3 Services

5.9.3.1 Increasing consultation hours to include weekends and evenings as recommended by some respondents might increase the uptake of the RHS. Based on the experience with the library services in this university, it appears that there is an increase in the utilisation of these services by students after hours and during weekends and holidays.

5.9.3.2 It is recommended that postings are created on Sakai (the university learning platform) to advertise the service in the form of pop up messages that will reach the entire student body.

5.9.3.3 The introduction of peer educators should be considered. This concept is already used successfully in the Counselling and Careers Development Unit in this university.

5.10 Conclusion

The purpose of this study was to determine the factors that influence the uptake of RHS by female students on campus with a view to improving access and delivery of service in a more efficient manner. The results point to important factors associated with inadequate utilisation of RHS by students such as lack of knowledge about the existence of these services, approachability of staff and operation hours of service. Utilisation of RHS can increase if the target population is aware about the existence of the service and if the service is easily accessible. From the survey 22% of respondents and one participant stated that there were not aware about the existence of RHS. This chapter provided a detailed discussion of the results and explained the limitations and the recommendations of this study. To enhance utilisation of RHS by students, it would seem appropriate to adequately market the service and the provision of the service should be user-friendly. Providing the service in the evenings and over the weekends should be taken into account and inapproachability of staff needs to be assessed and rectified. Encouraging health care providers to be considerate and sensitive towards students' needs will enhance utilisation of RHS.

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HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M130437

NAME: (Principal Investigator) Ms Bongiwe M Sithole

DEPARTMENT: Department of Nursing Education
CM Johannesburg Academic Hospital

PROJECT TITLE: Utilization of Reproductive Health Services by Female Students at the University in Johannebsurg

DATE CONSIDERED: 26/04/2013

DECISION: Approved unconditionally

CONDITIONS:

SUPERVISOR: Dr Sue Armstrong

APPROVED BY: Professor PE Cleaton-Jones, Chairperson, HREC (Medical)

DATE OF APPROVAL: 30/08/2013

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.**

Principal Investigator Signature M130437Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Deputy Registrar: Academic

Private Bag 3, Wits 2050, South Africa • Tel: +27 (0) 11 717-1204 • Fax: +27 (0) 86 553 3695 • E-mail: nita.lawton-misra@wits.ac.za

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

E-mail nita.lawton-misra@wits.ac.za
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Tel +27 (0)11 717-1204

19 November 2013

TO WHOM IT MAY CONCERN

"Utilization of Reproductive Health Services by Female Students at the University in Johannesburg"

It is hereby confirmed that the enclosed research material has been distributed in accordance with the University's approval procedures for such a project. Please be advised that it is your right to withdraw from participating in the process if you find the contents intrusive, too time-consuming, or inappropriate. The necessary ethical clearance has been obtained.

Should the University's internal mailing system be the mechanism whereby this questionnaire has been distributed, this notice serves as proof that permission to use it has been granted.

Students conducting surveys must seek permission in advance from Heads of Schools or individual academics concerned should surveys be conducted during teaching time.

Nita Lawton-Misra
Deputy Registrar: Academic

Faculty of Health Sciences

7 York Road, Parktown 2193, South Africa • Tel: +27 11 717-2000 • Fax: +27 11 643-4318 • Telegrams: 'Witsmed'

5th December 2013

Ms B Sithole
Department of Nursing Education
CM Johannesburg Academic Hospital

Dear Ms Sithole

Utilization of Reproductive Health Services by Female Students at the University of the Witswatersrand, Johannesburg

Permission is granted to conduct the study "Utilization of Reproductive Health Services by Female Students", subject to the conditions set out in the letter from the Deputy Registrar: Academic, dated 19th November 2013, being adhered to.

Yours sincerely

Professor Sharon Fonn
Acting Dean

Telephone: +27 11 717 2099 Facsimile: +27 11 717 2129

Campus Housing and Residence Life

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Ernest Oppenheimer hall
2 St David's Place,
Parktown 2193, Johannesburg, South Africa

Tel: 011-717 3821
Fax: 086 553 4676
email: Nazime.randera@wits.ac.za

21 November 2013

To whom it may Concern

Re: Research conducted by B Sithole-granting of permission to conduct a survey and interviews amongst female residence students

This note serves to confirm that permission had been granted to Ms B Sithole to conduct a survey and one to one interviews with female residents at all the 5 university female residences. The research was on "The utilization of Reproductive Health Services by Female students at the University of Witwatersrand, Johannesburg".

The permission was granted for the survey and one to one interviews to be conducted over a period of time that stretched between 2013 and 2014.

Participation by residents was entirely on a voluntary basis.

Yours sincerely

Nazime Randera
Acting Head
Campus Housing and Residence Life
082 588 3522

ANNEXURE 5

Authorisation letter to use the pre-tested tool

This message (and attachments) is subject to restrictions and a disclaimer. Please refer to http://www.unisa.ac.za/disclaimer for full details.

Dear Ms Sithole

Please find attached the promised questionnaire. Please note that it contains only 5 pages (3, 4, 5, 6, and 7) pg1&2 had to be sent to someone else so this is definitely the complete questionnaire.

I give you permission to use this questionnaire on conditions that you

* indicate clearly in your methodology section that you are using this questionnaire
* mention in the background to the study that you read the article in the Int N Review and requested permission to use the questionnaire
* Supply me with a copy of any article published based on the use of this questionnaire.

ANNEXURE 6

Age:		**Country of origin:**
Ethnic Group:		

SECTION 2: KNOWLEDGE AND ATTITUDES TOWARDS UTILISATION OF REPRODUCTIVE HEALTH SERVICES(According to the tool developed by Professor V. J. Ehlers)											
1. Who provided you with information about sex?											
Parents		Teachers		Friends		Nurses/Doctors					
Other, please specify**……**											
2. Age at which first sex education was received…….											
3. Do you know about methods of contraception? Yes		No									
4. If the answer is "yes", please list the known methods …….											
5. Who provided you with information about contraception? …….											
6. Have you ever used any method of contraception? Yes		No									
7. How old were you when you used contraception for the first time?											
8. Please tick the method used	Condoms		Pills		Injection		Diaphragm				
Rhythm method		Other specify……									
9. If the answer to question 6 is "no", why did you not use any contraception?											
10. Do you know about legally available termination of pregnancy (TOP) services? Yes		No									
11. Have you ever attended the University reproductive health service? Yes		No									
12. If the answer is "yes", why did you attend this service? ……											
13. How long did you have to wait at the clinic? ……											
14. Were the nurses kind and helpful at the clinic? Yes		No									
15. What advice were you given at the clinic?											
16. How did you find out about the University clinic (Reproductive Health Service)?											
17. Were you satisfied with the service you received at the clinic? Yes		No									
18. What could you recommend to improve services at this clinic? ……											

ANNEXURE 7

Semi-Structured Interview
1. What do you understand about reproductive health?
2. How much do you think female students know about the implications of intimate sexual contact? Probe: Where do they get information from? e.g. ➢ Health care worker ➢ Parents ➢ Older sibling ➢ Peers ➢ Media ➢ Other, please specify
3. What factors would make you consider Campus Health Reproductive Service as a place of choice to get Reproductive Health related information and assistance? Probe: ➢ Approachability of staff ➢ Stigma ➢ Confidentiality
4. What services and contraceptive methods do you think should be offered?
5. Anything else you would like to talk about…?

ANNEXURE 8

DATA CODING
Residences: Sunnyside = 1 Jubilee = 2 Girton = 3 Medhurst = 4 Reith Hall = 5
Section1: Participant Details: Age: entered raw as it is
Country of origin: South Africa = A Sub-Saharan Africa = B
Racial Group: Black = 1 White = 2 Indian= 3 Coloured= 4
1= Yes 2= No 0= No response
Question 9: Why did you not use any contraception? 1 = Not sexually active 2= Use condoms 0 = No response
Question 12: Why did you attend this service? For RHS use which means: To collect contraception pills or to get contraception injection For o/c info = To enquire about contraception
Question 13. How long did you have to wait at the clinic? 0- 15 minutes =1 16 – 30 minutes = 2 30 minutes – 1 hour = 3 More than 1 hour = 4
Question 15. What advice were you given at the clinic? 1= Safe sex(condom use), protection against HIV/STI 2= To be honest/faithful 3= Personal hygiene
18. What could you recommend to improve services at this clinic? 1= Increase consultation days to include weekend/extend hours to cover night duty 2= Improve nurses attitude 3= Continue with good service 4= Increase staff capacity 5= Advertise the service more

ANNEXURE 9

Information letter for participants completing Quantitative questionnaire

Dear Participant

I am a post graduate student doing Master's Degree in Nursing Education. My research is on Utilisation of Reproductive Health Services by female students at the University in Johannesburg. This study will determine what needs to be done and the changes that must be put in place in order to assist students with their reproductive health needs.

I hereby request your participation in completing the anonymous questionnaire to the best of your ability and with honesty. You have the right not to participate or to stop even after consenting to participate and there will be no prejudice or consequences for that. This protocol has been submitted to the Human Research Ethics Committee of the University.

After completing the questionnaire you are requested to put it back in an envelope and post it in the box that is provided. Please be informed that completion and posting of the questionnaire implies consent. Your input is highly appreciated.

Thank you for your time

Yours faithfully

Bongiwe Sithole

072 537 1303/011 717- 9113

Bongiwe.sithole@wits.ac.za

ANNEXURE 10

Information letter for Semi-Structured Interview Participants

Dear Participant

I am a post graduate student doing Master's Degree in Nursing Education. My research study is on Utilisation of Reproductive Health Services by female students at the University in Johannesburg. This study will determine what needs to be done and the changes that must be put in place in order to assist students with their reproductive health needs.

I hereby request your participation in a semi-structured interview where issues regarding access to reproductive health services will be discussed. The semi-structured interview will be conducted on a one on one basis by the researcher. These interviews will be audio-tape recorded and the tape recordings will be kept in a secure place only accessible to the researcher and will be destroyed two years after publication of the findings. Should I use direct quotations from your interview they will be anonymous and no one will be able to identify you in the research report. Your name will not be used in the report; confidentiality and anonymity will be upheld at all times. You have the right not to participate or to stop even after giving the consent to participate and there will be no prejudice or consequences for that. This protocol has been submitted to the Human Research Ethics Committee of the University in Johannesburg. Please will you sign the consent form if you agree to participate in the research study? Your input is highly appreciated.

Thank you for your time

Yours faithfully

Bongiwe Sithole
072 537 1303/011 717- 9113
Bongiwe.sithole@wits.ac.za

ANNEXURE 11

CONSENT FORM

Semi-Structured Interview Participants

I have been given the information sheet and I understand the objectives of the study. I understand that the interview will be conducted on a one on one basis by the researcher and that participation in this project is completely voluntary. I also understand that I may withdraw from it at any time without suffering any prejudice. My refusal to participate will in no way cause me any harm or prejudice. I also understand that should quotes from my interview be used in the research report the quotes will be anonymous and I consent to this.

Signature & initial of participant: ……

Date:

ANNEXURE 12

CONSENT FORM (To have Semi-Structured Interview audio-tape recorded)

Semi-Structured Interview Participant

I have been given the information sheet and I understand the objectives of the study.

I fully understand that the discussion will be audio tape recorded for data analysis purposes and I agree to the audio tape recording of the discussion. I also understand that the tape recordings will be kept in a secure place and only the researcher will have access to the data which will be destroyed two years after publication of the findings. I understand that participation in this project is completely voluntary and that I may withdraw from it at any time without suffering any prejudice.

Signature & initial of participant: ……

Date: